Oklahoma Health Care Authority
MEDICAL ADVISORY COMMITTEE
January 4th, 2024
1:00 – 3:30 PM
Charles Ed McFall Board Room

AGENDA

Please access via zoom:
https://www.zoomgov.com/webinar/register/WN_HUo3lfoXRzqo-Yt3gYU8Sg
Telephone: 1-669-254-5252 **Webinar ID: 160 120 2080**

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

II. Action Item: Approval of Minutes of the November 2nd, 2023: **Medical Advisory Committee Meeting**

III. Public Comments (2 minute limit)

IV. MAC Member Comments/Discussion

V. Financial Report: **Josh Richards, Senior Director of Financial Services**

VI. State Readiness- MAC Implications: **Christina Foss, Deputy Chief of Staff**

VII. Medicaid Directors Update: **Traylor Rains, State Medicaid Director**

- **A. SoonerSelect Update: Sandra Puebla, Deputy State Medicaid Director**
- **B. HIE Updates: Stephen Miller, State Coordinator for Health Information Exchange**

VIII. Proposed Rule Changes: Presentation, Discussion, and Vote: **Kasie McCarty, Senior Director of Federal and State Authorities**

- **A. APA WF # 24-01 Opioid Overdose Reversal Agents**
- **B. APA WF # 24-02 Federally Qualified Health Center (FQHC) Substance Use Disorder (SUD) Certification Requirements**
- **C. APA WF # 24-06 Living Choice Timeline**
- **D. APA WF # 23-06A&B Transition to SoonerSelect**
- **E. APA WF # 23-09 Update Services Exempt from Copayment**
- **F. APA WF # 23-20 TEFRA Psychological Evaluations and ICF/IID Level of Care Reevaluations**
- **G. APA WF # 23-22 Streamline Behavioral Health Workforce Credentialling**
- **H. APA WF # 23-23 Update Hospital Services Policy**
- **I. APA WF # 23-24 Update and Clarify Policy Regarding Coverage of Prosthetic Hearing Implants and Surrounding Audiology Services for Adults**
- **J. APA WF # 23-25A&B Advantage and State Plan Personal Care Revisions**

K. APA WF # 23-26 340B Non-Compliant Providers

L. APA WF # 23-27A&B Developmental Disabilities Services (DDS) Updates

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

X. Future Meeting: **Chairman, Jason Rhynes, O.D.**

March 7, 2024
May 2, 2024
July 11, 2024
September 12, 2024
November 7, 2024

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

Oklahoma Health Care Authority
MEDICAL ADVISORY COMMITTEE
MINUTES of the November 2nd, 2023, Meeting
4345 N. Lincoln Blvd., Oklahoma City, OK 73105

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

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

Delegates present were: Dr. Steven Crawford, Ms. Wanda Felty, Ms. Jennifer King, Ms. Melissa Miller, Dr. J. Daniel Post, Dr. Jason Rhynes, and Dr. Marny Dunlap.

Alternates present were: Ms. Heather Pike and Ms. Buffy Heater providing a quorum.

***Delegates absent without an alternate were*:** Mr. Nick Barton, Mr. Brett Coble, Ms. Janet Cizek, Dr. Arlen Foulks, Dr. Raymond Smith, and Dr. Whitney Yeates.

II. Approval of the September 7th, 2023 Minutes

Medical Advisory Committee

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

III. Public Comments (2-minute limit):

There were no public comments.

IV. MAC Member Comments/Discussion:

There were no MAC Member comments.

V. 2023 Post Award Forum: Oklahoma's Institution for Mental Disease (IMD) Section 1115(a) Medicaid Demonstration Project Waiver:

Melissa Miller Senior Director, Behavioral Health Policy, and Planning

Ms. Miller discussed the overview of the Oklahoma's IMD Waiver, the included populations, and services, as well as updates and achievements for CY 2023. For more detailed information see agenda items 5 in the MAC agenda.

VI. State Readiness- MAC Implications:

Christina Foss, Deputy Chief of Staff

Ms. Foss stated that since the last MAC meeting, communications has been working on some marketing guardrails for our CE's to ensure that the language used, as well as the tone is perceived well and universal. One of these rules is asking for no action items. We don't want to tell members to choose a plan before open enrollment is open. Another rule we are implanting is instead of using

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the work Medicaid, use the word SoonerCare, when we are talking about the program in general. This will allow the members to see themselves as SoonerCare members and not Medicaid members. Lastly, when discussing open enrollment, use the SoonerSelect term.

VII. Medicaid Directors Update:

Traylor Rains, State Medicaid Director

Mr. Rains stated that we are requiring one-single portal, however, providers will still need to check eligibility on our website. There will be one centralized credentialing verification process, which we have directed plans and been cleared through NCQA, that they will adopt OHCA's provider file. This will allow them to just pick up our file and accept it as their network without going through any additional steps. As for Supplemental Payments were getting close to the pre-print that were going to submit to CMS for approval with focus on services in the primary care space through an enhanced fee schedule. We are requiring the plans by the end of year 4 to have their medical spent around 11%, we currently hoover around 4 or 4.2%. On and Admin update, OHCA is going to share our building with some sister agencies. OHCA staff has been moved to the 1st floor, opening our 2nd floor to the Department of corrections, and allowing the Department of Mental Health to move into our 3rd floor.

VIII. Proposed Rule Change: Presentation, Discussions, and Vote:

Kasie McCarty, Senior Director of Federal and State Authorities

APA WF # 23-16A&B Minimum Age for Enrollment into ADvantage Waiver — The Oklahoma Health Care Authority (OHCA) seeks to align rules with the 1915(c) HCBS ADvantage Waiver which was recently amended to lower the eligibility age that an individual can enter the program from 21 to 19 years of age to better facilitate their transition into the ADvantage Program.

Budget Impact: Budget neutral

The rule change motion to approve as by Dr. Steven Crawford and seconded by Dr. Marny Dunlap and passes unanimously.

APA WF # 23-19 Adult Day Health Services Revisions — These emergency revisions are necessary to maintain the level of support for individuals who are eligible to receive HCBS 1915(c) waiver services by providing the same amount of adult day health they were receiving while on the DDS Aging state-funded services wait list. The maximum number of adult day health units that can be provided in a day will increase from six (6) to eight (8) hours. Additionally, policy revisions will change the name from adult day services to adult day health.

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Budget Impact: The estimated budget impact for SFYs 2024 and 2025 is a savings in state funds of $1,020,564 for SFY 2024 and a savings in state funds of $2,041,128 for SFY 2025. Adult Day Health is paid 100% from state funds when eligible individuals need eight hours of services per day but receive fewer than eight. Increasing the cap to eight hours per day allows use of federal dollars.

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

APA WF # 23-20 TEFRA Psychological Evaluations and ICF/IID Level of Care Reevaluations — The proposed rule changes will help alleviate wait times for TEFRA approval by adding additional provider types to conduct psychological evaluations for TEFRA applicants. In addition to licensed psychologists or school psychologists as currently outlined in policy, certified psychometrists, psychological technicians of a psychologist, and licensed behavioral health professionals will be added to policy. Further revisions will reflect a new business process of conducting ICF/IID level of care reevaluations biennially rather than annually.

Budget Impact: The estimated budget impact for SFY 2024 is $83,395, of which $27,078 is state share. The estimated budget impact for SFY 2025 is $166,790, of which $53,390 is state share.

The rule change motion to approve as by Dr. Marny Dunlap and seconded by Dr. Steven Crawford and passes unanimously.

APA WF # 23-21 Quarterly Payments for Orthodontic Services — The Agency proposes to transition the current orthodontic payment protocol from a bulk payment to a quarterly payment system. The new payment protocol will be based on twenty-four (24) months with built in progress reports. Proposed revisions will remove outdated language and add new language to delineate the new payment criteria and billing instructions.

Budget Impact: Budget neutral

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

IX. <u>Election of Chairman and Vice-Chairman:</u>

Chairman, Jason Rhynes, O.D.

Dr. Jason Rhynes made a motion for the election of officers for 2024. Dr. Jason Rhynes was nominated for Chair by Dr. Steven Crawford and seconded by Ms. Wanda Felty and passed

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unanimously. Ms. Wanda Felty was nominated for Vice Chairman by Dr. Rhynes and seconded by Dr. J. Daniel Post and passed unanimously.

X. MAC Meeting Dates for Calendar 2024:

Chairman, Jason Rhynes, O.D.

January 4, 2024
March 7, 2024
May 2, 2024
July 11, 2024
September 12, 2024
November 7, 2024

XI. **New Business:**

Chairman, Jason Rhynes, O.D.

XII. Adjourn:

Chairman, Jason Rhynes, O.D.

Chairman Rhynes asked for a motion to adjourn. Motion was provided by Dr. Steven Crawford and seconded by Ms. Wanda Felty, there was no dissent and the meeting adjourned at 2:19pm.

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OKLAHOMA
Health Care Authority

FINANCIAL REPORT

For the Three Month Period Ending September 30, 2023
Submitted to the CEO & Board

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- Revenues for OHCA through September, accounting for receivables, were **$2,097,977,592** or **1.7% over** budget.
- Expenditures for OHCA, accounting for encumbrances, were **$2,118,630,502** or **1.0% over** budget.
- The state dollar budget variance through September is a positive **$13,289,020.**
- The budget variance is primarily attributable to the following (in millions):

Expenditures:		
Medicaid Program Variance		(17.7)
Administration		(3.6)
Revenues:		
Federal Funds		(4.7)
Drug Rebate		26.9
Medical Refunds		11.6
Taxes and Fees		0.8
Total FY 24 Variance	**$**	**13.3**

ATTACHMENTS

OKLAHOMA HEALTH CARE AUTHORITY
Summary of Revenues & Expenditures: OHCA
SFY 2024, For the Three Month Period Ending September 30, 2023

REVENUES	FY 24 Budget YTD	FY 24 Actual YTD	Variance	% Over/ (Under)
State Appropriations	$ 279,650,896	$ 279,650,896	$ -	0.0%
Federal Funds	1,323,653,679	1,318,980,861	(4,672,818)	(0.4)%
Tobacco Tax Collections	10,986,306	10,357,986	(628,320)	(5.7)%
Quality of Care Collections	22,707,463	23,559,984	852,521	3.8%
Prior Year Carryover	167,877,422	167,877,422	-	0.0%
Federal Deferral - Interest	398,301	398,301	-	0.0%
Drug Rebates	170,027,278	196,896,656	26,869,379	15.8%
Medical Refunds	9,610,198	21,257,849	11,647,650	121.2%
Prior Year Carryover Supplemental Hospital Offset Payment Program	-	-	-	0.0%
Supplemental Hospital Offset Payment Program	76,756,081	77,234,561	478,480	0.6%
Other Revenues	1,672,622	1,763,075	90,453	5.4%
TOTAL REVENUES	**$ 2,063,340,246**	**$ 2,097,977,592**	**$ 34,637,345**	**1.7%**

EXPENDITURES	FY 24 Budget YTD	FY 24 Actual YTD	Variance	% (Over)/ Under
ADMINISTRATION - OPERATING	**$ 16,562,825**	**$ 16,181,794**	**$ 381,031**	**2.3%**
ADMINISTRATION - CONTRACTS	**$ 36,858,058**	**$ 40,813,553**	**$ (3,955,496)**	**(10.7)%**
MEDICAID PROGRAMS				
Managed Care:				
SoonerCare Choice	15,080,839	14,296,578	784,261	5.2%
Acute Fee for Service Payments:				
Hospital Services	422,184,205	438,183,310	(15,999,105)	(3.8)%
Behavioral Health	8,708,237	8,431,135	277,102	3.2%
Physicians	154,489,288	154,355,218	134,070	0.1%
Dentists	60,931,509	64,251,449	(3,319,940)	(5.4)%
Other Practitioners	24,403,119	21,602,627	2,800,492	11.5%
Home Health Care	8,256,783	8,748,067	(491,284)	(6.0)%
Lab & Radiology	12,250,232	11,792,385	457,847	3.7%
Medical Supplies	24,746,342	29,685,442	(4,939,100)	(20.0)%
Ambulatory/Clinics	155,811,597	169,657,881	(13,846,284)	(8.9)%
Prescription Drugs	415,829,292	434,026,151	(18,196,859)	(4.4)%
OHCA Therapeutic Foster Care	119,718	145,137	(25,419)	(21.2)%
Other Payments:				
Nursing Facilities	203,562,810	201,454,652	2,108,158	1.0%
Intermediate Care Facilities for Individuals with Intellectual Disabilities Private	21,288,052	21,440,412	(152,359)	(0.7)%
Medicare Buy-In	61,352,166	61,055,246	296,920	0.5%
Transportation	28,145,940	30,489,369	(2,343,428)	(8.3)%
Money Follows the Person-OHCA	160,617	254,438	(93,820)	(58.4)%
Electronic Health Records-Incentive Payments	(750)	(750)	-	0.0%
Part D Phase-In Contribution	26,329,072	26,395,369	(66,297)	(0.3)%
Supplemental Hospital Offset Payment Program	196,982,836	187,311,816	9,671,020	4.9%
Telligen	3,140,006	3,059,224	80,782	2.6%
Total OHCA Medical Programs	**1,843,771,912**	**1,886,635,154**	**(42,863,242)**	**(2.3)%**
OHCA Non-Title XIX Medical Payments	200,089,382	175,000,000	25,089,382	12.5%
TOTAL OHCA	**$ 2,097,282,176**	**$ 2,118,630,502**	**$ (21,348,326)**	**(1.0)%**
REVENUES OVER/(UNDER) EXPENDITURES	**$ (33,941,930)**	**$ (20,652,910)**	**$ 13,289,020**	

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OKLAHOMA HEALTH CARE AUTHORITY

Total Medicaid Program Expenditures
by Source of State Funds
SFY 2024, For the Three Month Period Ending September 30, 2023

Category of Service	Total	Health Care Authority	Quality of Care	Insure Oklahoma	SHOPP	BCC	Other State Agencies
SoonerCare Choice	$ 14,296,578	$ 14,295,840	$ -	$ -	$ -	$ 738	$ -
Inpatient Acute Care	373,244,986	238,200,944	121,672	(345)	132,123,362	111,906	2,687,448
Outpatient Acute Care	246,922,841	199,210,424	10,401	(567)	47,174,620	527,963	-
Behavioral Health - Inpatient	31,389,247	5,293,327	-	-	6,925,981	-	19,169,939
Behavioral Health - Psychiatrist	4,225,661	3,137,808	-	-	1,087,853	-	-
Behavioral Health - Outpatient	5,602,549	-	-	-	-	-	5,602,549
Behaviorial Health-Health Home	-	-	-	-	-	-	-
Behavioral Health Facility- Rehab	69,277,813	-	-	-	-	63,134	69,277,813
Behavioral Health - Case Management	1,761,906	-	-	-	-	-	1,761,906
Behavioral Health - PRTF	2,912,808	-	-	-	-	-	2,912,808
Behavioral Health - CCBHC	100,814,368	-					100,814,368
Residential Behavioral Management	4,412,755	-	-	-	-	-	4,412,755
Targeted Case Management	20,936,690	-	-	-	-	-	20,936,690
Therapeutic Foster Care	145,137	145,137	-	-	-	-	-
Physicians	187,994,202	154,124,833	14,525	(149)	-	215,860	33,639,134
Dentists	64,251,449	64,230,618	-	-	-	20,831	-
Mid Level Practitioners	282,794	282,728	-	-	-	66	-
Other Practitioners	21,319,833	21,192,771	111,591	-	-	15,471	-
Home Health Care	8,748,067	8,747,554	-	-	-	513	-
Lab & Radiology	11,792,385	11,777,545	-	-	-	14,840	-
Medical Supplies	29,685,442	28,995,584	677,883	-	-	11,976	-
Clinic Services	172,042,708	165,922,254	-	-	-	52,607	6,067,846
Ambulatory Surgery Centers	3,683,020	3,681,283	-	-	-	1,737	-
Personal Care Services	2,672,997	-	-	-	-	-	2,672,997
Nursing Facilities	201,454,652	131,914,407	69,539,163	-	-	1,083	-
Transportation	30,344,472	29,712,798	586,827	-	-	44,846	-
IME/DME	48,325,960	-	-	-	-	-	48,325,960
ICF/IID Private	21,440,412	18,171,157	3,269,255	-	-	-	-
ICF/IID Public	5,365,382	-	-	-	-	-	5,365,382
CMS Payments	87,450,615	87,327,215	123,400	-	-	-	-
Prescription Drugs	434,024,906	433,474,954	-	(1,245)	-	551,196	-
Miscellaneous Medical Payments	144,897	144,460	-	-	-	437	-
Home and Community Based Waiver	73,988,882	-	-	-	-	-	73,988,882
Homeward Bound Waiver	20,773,997	-	-	-	-	-	20,773,997
Money Follows the Person	1,156,098	254,438	-	-	-	-	901,660
In-Home Support Waiver	11,082,864	-	-	-	-	-	11,082,864
ADvantage Waiver	64,088,163	-	-	-	-	-	64,088,163
Family Planning/Family Planning Waiver	503,752	-	-	-	-	-	503,752
Premium Assistance*	8,159,141	-	-	8,159,140.61	-	-	-
Telligen	3,059,224	3,059,224	-	-	-	-	-
Electronic Health Records Incentive Payments	(750)	(750)	-	-	-	-	-
Total Medicaid Expenditures	**$ 2,389,778,902**	**$ 1,623,296,551**	**$ 74,454,717**	**$ 8,156,834**	**$ 187,311,816**	**$ 1,635,204**	**$ 494,986,914**

* Includes $8,114,337.94 paid out of Fund 245

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OKLAHOMA HEALTH CARE AUTHORITY

Summary of Revenues & Expenditures:
Other State Agencies
SFY 2024, For the Three Month Period Ending September 30, 2023

REVENUE		FY 24 Actual YTD
Revenues from Other State Agencies		122,868,972
Federal Funds		364,255,407
TOTAL REVENUES	**$**	**487,124,379**

EXPENDITURES	Actual YTD
Oklahoma Human Services	
Home and Community Based Waiver	73,988,882
Money Follows the Person	901,660
Homeward Bound Waiver	20,773,997
In-Home Support Waivers	11,082,864
Advantage Waiver	64,088,163
Intermediate Care Facilities for Individuals with Intellectual Disabilities Public	5,365,382
Personal Care	2,672,997
Residential Behavioral Management	2,962,855
Targeted Case Management	18,637,668
Total Oklahoma Human Services	**200,474,469**
State Employees Physician Payment	
Physician Payments	33,639,134
Total State Employees Physician Payment	**33,639,134**
Education Payments	
Indirect Medical Education	40,220,498
Direct Medical Education	1,453,839
DSH	6,651,623
Total Education Payments	**48,325,960**
Office of Juvenile Affairs	
Targeted Case Management	572,529
Residential Behavioral Management	1,449,901
Total Office of Juvenile Affairs	**2,022,430**
Department of Mental Health & Substance Abuse Services	
Case Management	1,761,906
Inpatient Psychiatric Free-standing	19,169,939
Outpatient	5,602,549
Health Homes	-
Psychiatric Residential Treatment Facility	2,912,808
Certified Community Behavioral Health Clinics	100,814,368
Rehabilitation Centers	69,277,813
Total Department of Mental Health & Substance Abuse Services	**199,539,382**
State Department of Health	
Children's First	221,814
Sooner Start	-
Early Intervention	1,154,733
Early and Periodic Screening, Diagnosis, and Treatment Clinic	406,519
Family Planning	237,604
Family Planning Waiver	266,149
Maternity Clinic	16,339
Total Department of Health	**2,303,157**
County Health Departments	
EPSDT Clinic	153,062
Family Planning Waiver	-
Total County Health Departments	**153,062**
State Department of Education	**31,681**
Public Schools	**318,266**
Medicare DRG Limit	**-**
Native American Tribal Agreements	**5,491,926**
Department of Corrections	**1,500,000**
JD McCarty	**1,187,448**

Total OSA Medicaid Programs	**$**	**494,986,914**
OSA Non-Medicaid Programs	**$**	**13,685,419**
Accounts Receivable from OSA	**$**	**21,547,954**

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OKLAHOMA HEALTH CARE AUTHORITY

SUMMARY OF REVENUES & EXPENDITURES:

Fund 205: Supplemental Hospital Offset Payment Program Fund

SFY 2024, For the Three Month Period Ending September 30, 2023

REVENUES		FY 24 Revenue
SHOPP Assessment Fee		77,179,721
Federal Draws	$	148,638,536
Interest		54,841
Penalties		-
TOTAL REVENUES	$	225,873,097

EXPENDITURES	Quarter	Quarter	Quarter	Quarter		FY 24 Expenditures
Program Costs:	7/1/23 - 9/30/23	10/1/23 - 12/31/23	1/1/24 - 3/31/24	4/1/24 - 6/30/24		
Hospital - Inpatient Care	72,804,465	-	-	-	$	72,804,465
Hospital -Outpatient Care	21,789,985	-	-	-	$	21,789,985
Psychiatric Facilities-Inpatient	3,822,524	-	-	-	$	3,822,524
Rehabilitation Facilities-Inpatient	600,398	-	-	-	$	600,398
Hospital - Inpatient Care - Expansion	59,318,897	-	-	-	$	59,318,897
Hospital -Outpatient Care - Expansion	25,384,635	-	-	-	$	25,384,635
Psychiatric Facilities-Inpatient - Expansion	3,103,457	-	-	-	$	3,103,457
Rehabilitation Facilities-Inpatient - Expansion	487,455	-	-	-	$	487,455
Total OHCA Program Costs	187,311,816	-	-	-		187,311,816
Total Expenditures					$	187,311,816

SHOPP Revenue transferred to Fund 340 for Medicaid Program expense	$	38,561,281

*** Expenditures and Federal Revenue processed through Fund 340

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OKLAHOMA HEALTH CARE AUTHORITY
SUMMARY OF REVENUES & EXPENDITURES:
Fund 230: Nursing Facility Quality of Care Fund
SFY 2024, For the Three Month Period Ending September 30, 2023

REVENUES	Total Revenue	State Share
FY22 EFMAP Surplus		$ -
Quality of Care Assessment	$ 23,546,242	$ 23,546,242
*Quality of Care Penalties (*Non-Spendable Revenue)*	$ 154,345	$ 154,345
Interest Earned	$ 13,742	$ 13,742
TOTAL REVENUES	**$ 23,714,329**	**$ 23,714,329**

EXPENDITURES	FY 24 Total $ YTD	FY 24 State $ YTD	Total State $ Cost
Program Costs			
Nursing Facility Rate Adjustment	$ 68,679,051	$ 20,699,866	
Eyeglasses and Dentures	65,073	$ 19,613	
Personal Allowance Increase	795,040	$ 239,625	
Coverage for Durable Medical Equipment and Supplies	677,883	$ 204,314	
Coverage of Qualified Medicare Beneficiary	258,189	$ 77,818	
Part D Phase-In	123,400	$ 123,400	
ICF/IID Rate Adjustment	1,222,639	$ 368,503	
Acute Services ICF/IID	2,046,616	$ 616,850	
Non-emergency Transportation - Soonerride	586,827	$ 176,870	
NF Covid-19 Supplemental Payment	-	$ -	
ICF Covid-19 Supplemental Payment	-	$ -	
Ventilator NF DME Supplemental Payment		$ -	
Total Program Costs	**$ 74,454,717**	**$ 22,526,859**	**$ 22,526,859**
Administration			
OHCA Administration Costs	$ 75,971	$ 37,985	
OHS-Ombudsmen	-	-	
OSDH-Nursing Facility Inspectors	-	-	
Mike Fine, CPA	-	-	
Total Administration Costs	**$ 75,971**	**$ 37,985**	**$ 37,985**
Total Quality of Care Fee Costs	**$ 74,530,688**	**$ 22,564,844**	
TOTAL STATE SHARE OF COSTS			**$ 22,564,844**

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.

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OKLAHOMA HEALTH CARE AUTHORITY
SUMMARY OF REVENUES & EXPENDITURES:
Insure Oklahoma Program (Fund 245: HEEIA)
SFY 2024, For the Three Month Period Ending September 30, 2023

REVENUES	FY 23 Carryover	FY 24 Revenue	Total Revenue
Prior Year Balance	$ 4,153,089		
State Appropriations	-		
Federal Draws - Prior Year	163,131		
Total Prior Year Revenue			4,316,220
Transfer to 340 for Expansion-current year		-	-
Tobacco Tax Collections	-	8,519,080	8,519,080
Interest Income	-	43,453	43,453
Federal Draws	-	5,806,735	5,806,735
TOTAL REVENUES	**$ 4,316,220**	**$ 14,369,267**	**$ 18,685,488**

EXPENDITURES		FY 23 Expenditures	FY 24 Expenditures	Total State $ YTD
Program Costs:				
	Employer Sponsored Insurance		$ 8,114,338	$ 8,114,338
	College Students/ESI Dental		44,803	13,504
Individual Plan				
	SoonerCare Choice		$ -	$ -
	Inpatient Hospital		(322)	(97)
	Outpatient Hospital		(545)	(164)
	BH - Inpatient Services-DRG		-	-
	BH -Psychiatrist		-	-
	Physicians		(149)	(45)
	Dentists		-	-
	Mid Level Practitioner		-	-
	Other Practitioners		-	-
	Home Health		-	-
	Lab and Radiology		-	-
	Medical Supplies		-	-
	Clinic Services		-	-
	Ambulatory Surgery Center		-	-
	Skilled Nursing		-	-
	Prescription Drugs		(1,190)	(359)
	Transportation		-	-
	Premiums Collected			-
Total Individual Plan			**$ (2,207)**	**$ (665)**
	College Students-Service Costs		**$ (101)**	**$ (30)**
Total OHCA Program Costs			**$ 8,156,834**	**$ 8,127,146**
Administrative Costs				
	Salaries	$ (25)	$ 367,981	$ 367,956
	Operating Costs	1,612	174	1,785
	E&E Development Gainwell	-	-	-
	Contract - Gainwell	187,653	188,741	376,394
			-	
Total Administrative Costs		**$ 189,239**	**$ 556,896**	**$ 746,135**
Total Expenditures				**$ 8,873,282**
Transfer to Fund 340 for Expansion Costs				**$ 5,135,638**
NET CASH BALANCE		**$ 4,126,981**	**$ 549,587**	**$ 4,676,568**

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OKLAHOMA HEALTH CARE AUTHORITY

Combining Statement of Revenues, Expenditures and Changes in Fund Balance

SFY 2024, For the Three Month Period Ending September 30, 2023

	Administration Fund 200	Supplemental Hospital Offset Payment Program Fund 205	Quality of Care Fund 230	Rate Preservation Fund 236	Federal Deferral Fund 240	Health Employee and Economy Act Fund 245	Belle Maxine Hilliard Breast & Cervical Cancer Treatment (Tobacco) Fund 250	Medicaid Program (Tobacco) Fund 255	Ambulance Service Provider Access Payment Program Fund 270	Medicaid Program Fund 340	Clearing Account 1807B	Total Cash Balance
September Beginning Fund Balance:												
Prior year	37,457,164	340,832	991,429	331,540,779	62,110,169	4,123,937	-	-	49,189	1,096,915,593	38,887,949	1,572,417,041
Current year	2,924,289	(131,267)	(971,998)	27,356,342	258,505	563,930	-	-	(49,189)	(128,122,570)	2,407,893	(95,764,066)
Total	40,381,452	209,565	19,431	358,897,121	62,368,674	4,687,867	-	-	-	968,793,023	41,295,841	1,476,652,975
September Revenues:												
Prior year	10,016,312	-	-	-	-	3,044	-	-	-	36,007,241	-	46,026,596
Current year	3,362,499	1,071,795	8,054,046	-	139,797	4,605,172	53,896	3,229,597	-	559,484,527	148,351,180	728,352,510
Total	13,378,811	1,071,795	8,054,046	-	139,797	4,608,216	53,896	3,229,597	-	595,491,768	148,351,180	774,379,106
September Expenditures:												
Prior year	10,680,198	-	-	-	-	-	-	-	-	-	-	10,680,198
Current year	17,640,229	-	-	-	-	2,894,828	-	-	-	742,351,817	-	762,886,874
Total	28,320,427	-	-	-	-	2,894,828	-	-	-	742,351,817		773,567,072
Operating Transfers In												
Prior year												
Current year	5,880,667	-	-	13,678,171	-	-	-	-	-	112,927,162	-	132,486,000
Total	5,880,667	-	-	13,678,171	-	-	-	-	-	112,927,162	-	132,486,000
Operating Transfers Out												
Prior year	1,978,519	-	-	-	-	-	-	-	-	53,980,622		55,959,141
Current year	-	-	7,969,684	-	-	1,711,879	53,896	3,229,597	-	-	38,887,949	51,853,005
Total	1,978,519	-	7,969,684	-	-	1,711,879	53,896	3,229,597	-	53,980,622	38,887,949	107,812,146
Change in CY Fund Balance	***(5,472,774)***	***940,528***	***(887,636)***	***41,034,513***	***398,301***	***562,395***	***-***	***-***	***(49,189)***	***(198,062,698)***	***111,871,123***	***(49,665,436)***
Ending Fund Balance	**29,341,984**	**1,281,360**	**103,793**	**372,575,292**	**62,508,470**	**4,689,376**	**-**	**-**	**-**	**880,879,514**	**150,759,072**	**1,502,138,863**

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OKLAHOMA HEALTH CARE AUTHORITY
HEALTHY ADULT PROGRAM EXPENDITURES - OHCA
SFY 2024, For the Three Month Period Ending September 30, 2023

August Beginning Fund Balance:	FY24 BUDGETED EXPENDITURES Full Year	FY24 BUDGETED EXPENDITURES Year to Date	FY24 ACTUAL EXPENDITURES YTD through September	BUDGET VARIANCE (Over)/ Under
OHCA MEDICAID PROGRAMS				
Managed Care				
SoonerCare Choice	5,789,439	1,417,484	1,175,133	242,351
Total Managed Care	**5,789,439**	**1,417,484**	**1,175,133**	**242,351**
Fee for Service				
Hospital Services:				
Inpatient Acute Care	291,431,643	70,175,566	62,312,726	7,862,841
SHOPP	382,583,441	94,551,761	88,294,445	6,257,317
Outpatient Acute Care	319,817,537	70,892,864	79,358,620	(8,465,756)
Total Hospitals	**993,832,621**	**235,620,192**	**229,965,790**	**5,654,401**
Behavioral Mental Health:				
Inpatient Services - DRG	10,426,282	2,111,541	7,757,468	(5,645,927)
Outpatient	-	-	-	-
Total Behavioral Mental Health	**10,426,282**	**2,111,541**	**7,757,468**	**(5,645,927)**
Physicians & Other Providers:				
Physicians	205,315,208	49,259,069	53,107,346	(3,848,277)
Dentists	70,836,608	17,030,866	16,411,151	619,715
Mid-Level Practitioner	478,694	114,823	81,680	33,143
Other Practitioners	24,616,049	5,906,320	7,093,377	(1,187,057)
Home Health Care	1,250,393	301,697	334,375	(32,678)
Lab & Radiology	24,049,698	5,778,104	5,702,232	75,872
Medical Supplies	21,911,470	5,282,334	6,925,488	(1,643,154)
Clinic Services	202,765,818	48,834,258	47,131,851	1,702,407
Ambulatory Clinics	6,406,782	1,544,485	1,518,448	26,037
Total Physicians & Other Providers	**557,630,720**	**134,051,956**	**138,305,949**	**(4,253,992)**
Misc Medical & Health Access Network	**166,019**	**41,505**	**59,782**	(18,278)
Transportation	**36,001,530**	**8,717,288**	**8,247,029**	470,258
Health Access Network	**-**	**-**	**14,370**	(14,370)
Prescription Drugs	**861,352,299**	**207,438,701**	**207,822,669**	(383,968)
Total OHCA Medicaid Programs	**2,465,198,912**	**589,398,666**	**593,348,190**	**(3,949,524)**

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DEPUTY MEDICAID DIRECTOR UPDATE

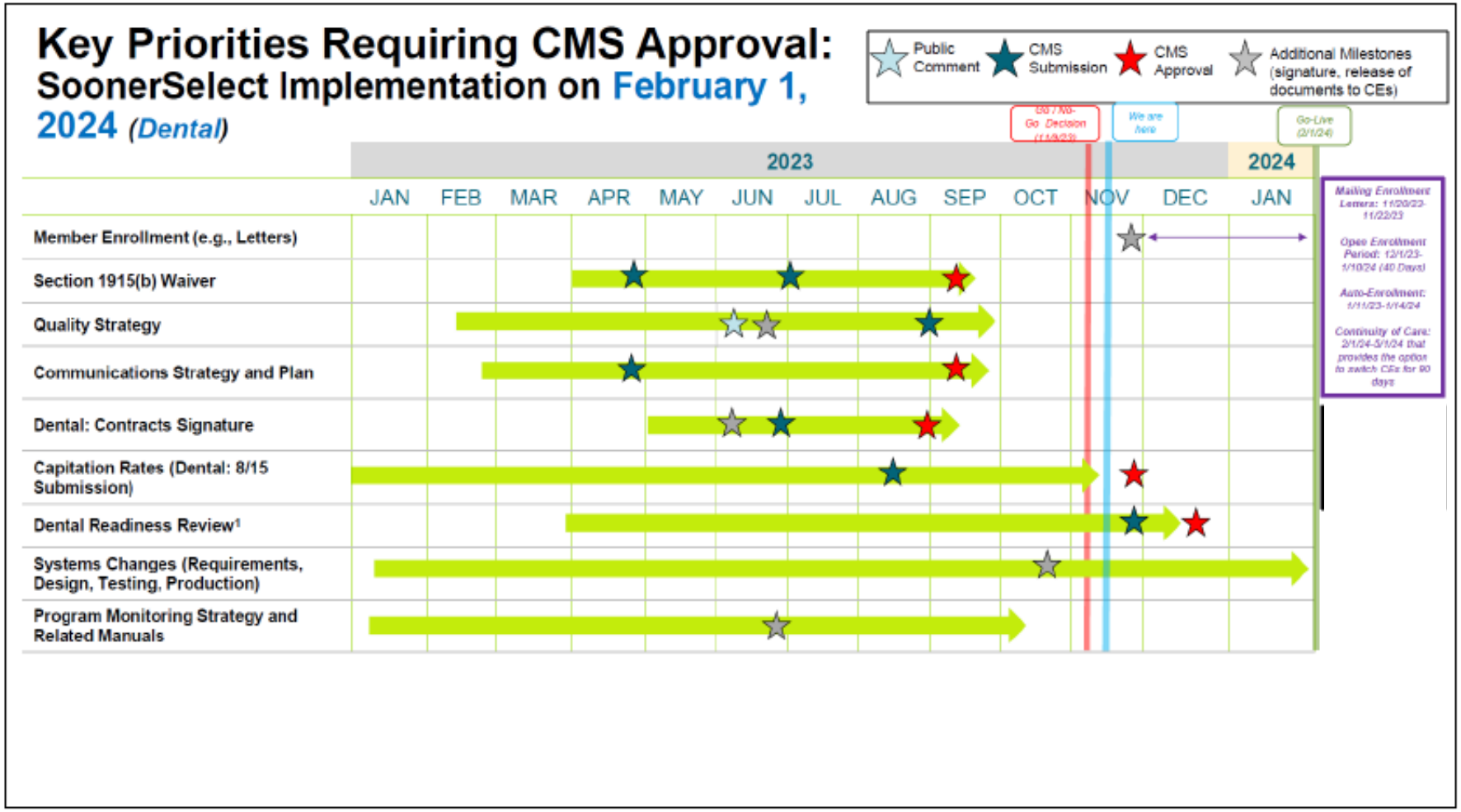
JANUARY 4, 2024

SOONERSELECT UPDATE

MILESTONES ACHIEVED

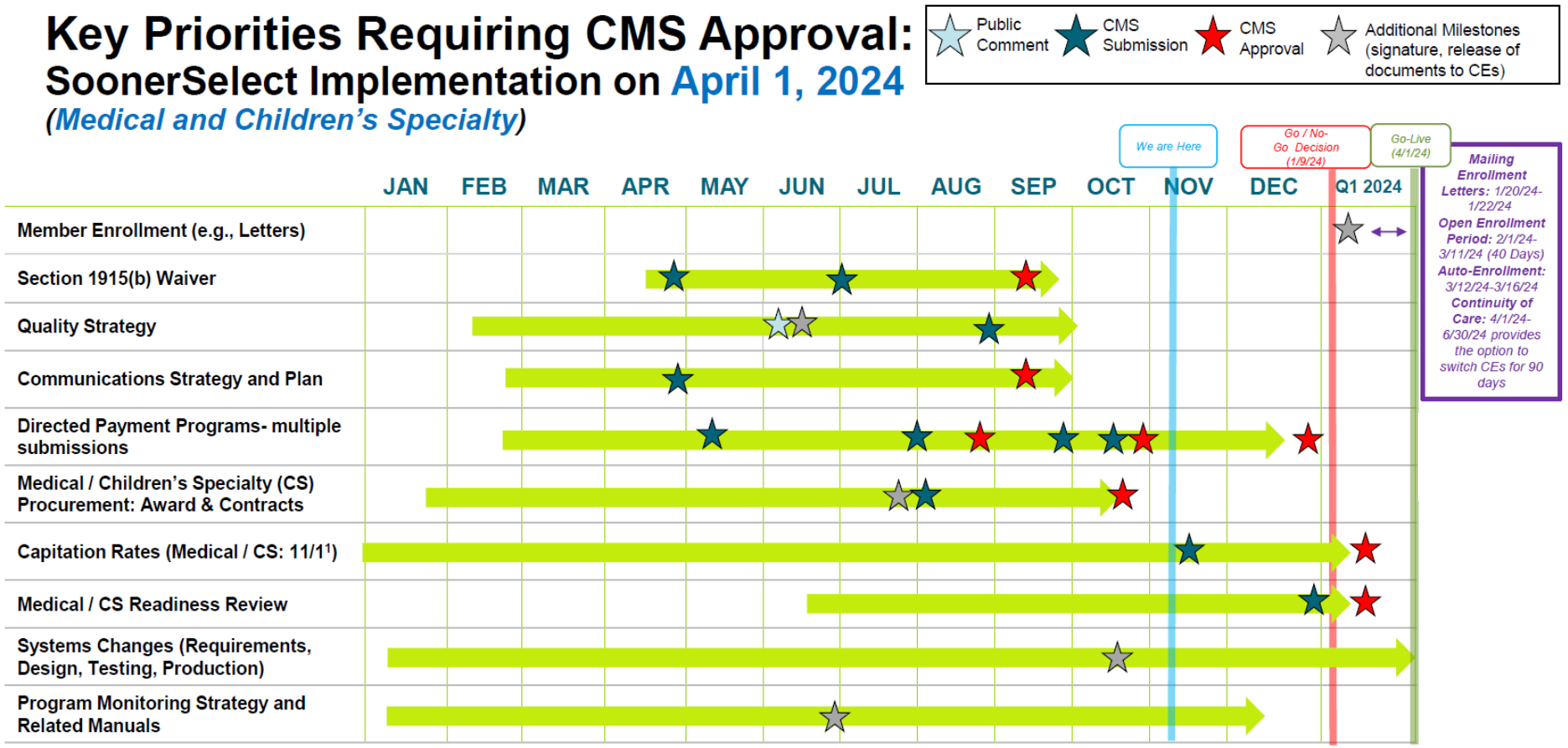
- ✓ Choice counselors hired and trained to receive open enrollment calls and educate members on plan selection
- ✓ Dental enrollment stakeholder toolkit published, and enrollment letters mailed to members November 20
- ✓ Dental open enrollment began December 1
- ✓ Monitoring and Compliance RFP submitted to CMS for approval
- ✓ On-site readiness reviews completed for all 6 plans
- ✓ State readiness report as well as readiness report for both dental plans submitted to CMS
- ✓ Cycle 1 of systems testing complete, and Cycle 2 is well underway
- ✓ All State Directed Payment PrePrints have been submitted to CMS. OHCA has received approval for the following:
  - ✓ Academic medical center
  - ✓ SHOPP Average Commercial Rate
  - ✓ Level 1 Trauma Hospital
- ✓ Capitation rates submitted to CMS for approval and certification
- ✓ SoonerSelect Operations team is fully staffed and onboarded
- ✓ Quality Advisory Committee meetings have taken place and will continue

IMPORTANT MILESTONES DENTAL



IMPORTANT MILESTONES MEDICAL AND CSP

Key Priorities Requiring CMS Approval:
SoonerSelect Implementation on April 1, 2024
(Medical and Children's Specialty)



PROVIDER INCENTIVE DIRECTED PAYMENT PROGRAM

- Eligible Providers
  - Advance practice nurse, mid-level practitioner, mental health provider and licensed behavioral health practitioners, podiatrist, physician, and anesthesiology assistant
- Incentive pool for initial 15-month rate year = $134,330,110
- Add on payments for certain services to support quality assurance and access improvement initiatives. SBIRT screenings, after hours care, and well visit services are eligible for a $25 increase payment
- Percentage increase on payments for all covered services provided by eligible providers
  - Almost 19% for services billed by an entity that is not HIE-connected
  - The increase for services billed by an HIE-connected entity will be 1.5 times the uniform percentage increase for non-HIE connected entities
  - Only services covered under the Oklahoma Medicaid State Plan, covered by the SoonerSelect medical program, and provided by in-network providers will be eligible for the uniform dollar increase and/or uniform percentage increase amounts.

OKLAHOMA
Health Care Authority

GET IN TOUCH

4345 N. Lincoln Blvd.
Oklahoma City, OK 73105

oklahoma.gov/ohca
mysoonercare.org

Agency: 405-522-7300
Helpline: 800-987-7767

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SOONERCARE OPERATIONS UPDATE

HEPATITIS-C CONNECT TO CARE INITIATIVE

- OHCA is leveraging value-based contracting with AbbVie with the objective of facilitating member access to AbbVie's drug Mavyret for members with a current Hepatitis-C diagnosis.
- OHCA utilization committee identified members with a diagnosis of Hepatitis C with no prior history of treatment
- Dedicated care management staff conducted outreach and care management with identified members
- So far, 25% of the members identified have been connected to curative treatment options. This far exceeds OHCA's initial year 1 goal of 5%.

OKLAHOMA
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HIE UPDATE

- Progress Statistics
  - Averaging over 35,000 Unique Patient's records accessed monthly by providers in
    - **75% increase in Utilization from Sept 2022**
  - Over 500 organizations participate in the HIE serving patients in 1500 Locations
  - 130 Organizations joined in last Year, **that's a 35% increase in membership**
  - **Over 100 organization are in the queue to be connected to the HIE and utilize connectivity funding**
  - All 6 MCE's are in-progress with their connection to the HIE
  - Exemptions: **Granted: 2621**, Requested: 4759 (980 not required, 1078 not identifiable, 84 in review)
- Directed Payments
  - Select Medicaid provider types who participate in the HIE (send data & utilize) can receive & additional +/- 9.5% reimbursement
  - Provider Types: Advance practice nurses, mid-level practitioners, mental health providers and licensed behavioral health practitioners[1], podiatrist, physicianS[2], or anesthesiologist assistant.
- Continuity and Connectivity Contract with MyHealth
  - Legal Review & Negotiation Completed and OMES Security Approval given 12/11/23
  - We are anticipating many providers will request to utilize connectivity funding
  - Not expecting to utilize entire $30M in first year and requesting carry-over

January 7, 2024 MAC
Proposed Rule Amendment Summaries

EMERGENCY RULES

These proposed **EMERGENCY** rules were presented at the Oct. 31, 2023 Tribal Consultation, and were subject to at least a 15-day public comment period.

The Agency is requesting the effective date to be immediately upon receiving gubernatorial approval, or **Mar. 1, 2024**, whichever date is later.

A. **APA WF # 24-01 Opioid Overdose Reversal Agents –** The proposed policy additions are to provide coverage for new opioid overdose reversal agents as they come to market. Current language allows coverage of Naloxone by name but no other such agents, as Naloxone was the first available and no others had been available until recently. With new opioid overdose reversal agents coming available, broader language will allow coverage of those products when appropriate.

   Budget Impact: Budget neutral.

B. **APA WF 24-02 Federally Qualified Health Center (FQHC) Substance Use Disorder (SUD) Certification Requirements –** The proposed revisions amend rules to comply with state statute at Title 43 Oklahoma Statute § 3-415. House Bill 1071 of the 2021 legislative session added Health Centers (FQHCs) to the list of providers that do not require certification by the Oklahoma Department of Mental Health and Substance Abuse Services (ODHMSAS) to provide SUD services. The intent of this legislation was to remove barriers for ambulatory SUD services in the primary care setting. Proposed revisions update and clarify the certification requirements for Health Centers.

   Budget Impact: Budget neutral.

C. **APA WF # 24-06 Living Choice Timeline –** The proposed additions clarify that time a member spends within a skilled nursing facility will be considered when assessing timeline requirements for applications to the Living Choice program. Current policy requires a member to live in a qualifying facility for at least 60 days before applying for Living Choice, but excludes time spent in a skilled nursing facility (SNF) from this 60-day period. This change also aligns OHCA policy with current federal requirements.

   Budget Impact: Budget neutral.

PERMANENT RULES

These proposed **PERMANENT** rules were previously adopted by the Agency and submitted to the governor for **EMERGENCY** approval.

The Agency proposes additional revisions which have been presented to Tribal Partners within ITU Notice # 23-08 on Dec. 1, 2023 and were subject to at least a 30-day comment period from **Dec. 1 through Jan. 2, 2024**.

D. APA WF 23-06A&B Transition to SoonerSelect – The proposed policy provision implement managed care rules for contracted entities, dental benefit managers, and provider-led entities. Proposed revisions will remove definitions that are not used elsewhere in the chapter, adds additional language regarding cost-sharing protections for members, and removes a section that

could obligate members to payment recoupment for services provided during an appeal if an adverse benefit determination was made.

Budget Impact: Budget neutral.

E. APA WF # 23-09 Update Services Exempt from Copayment – The Affordable Care Act (ACA) requires states to cover preventive services for expansion adults without any cost sharing. The proposed rules will update the list of services exempted from copayments to ensure the ACA requirement is reflected in the rule. Additionally, the proposed rule changes will exempt vaccine administration and, changes made through the permanent rule process will also exempt opioid overdose reversal agents from cost-sharing requirements.

Budget Impact: The estimated budget impact, for SFY2023, will be an increase in the total amount of $81,123; with $8,122 in state share. The estimated budget impact, for SFY2024 will be an increase in the total amount of $81,123; with $8,112 in state share.

F. **APA WF # 23-20 TEFRA Psychological Evaluations and ICF/IID Level of Care Reevaluations –** The proposed rule **changes** help alleviate wait times for TEFRA approval by adding additional provider types to conduct psychological evaluations for TEFRA applicants. In addition to licensed psychologists or school psychologists as currently outlined in policy, certified psychometrists, psychological technicians under the supervision of a psychologist, and licensed behavioral health professionals will be added to policy. Additionally, policy will be revised to reflect a new business process of conducting ICF/IID level of care reevaluations biennially rather than annually. Finally, and in addition to the emergency rule changes revisions, the proposed revisions will allow providers to determine the appropriate intelligence testing alternative for small children.

Budget Impact: Budget neutral.

These proposed **PERMANENT** rules were previously presented for Tribal Consultation and were subject to a 30-day public comment period from **Dec. 1 through Jan. 2, 2024**.

The agency is requesting the effective date to be within **Sept. of 2024**, contingent upon receiving legislature and gubernatorial approval.

G. APA WF # 23-22 Streamline Behavioral Health Workforce Credentialling – The proposed rule changes streamline behavioral health workforce credentialling and modify the qualifications for case managers I and II. Specifically, these changes include the incorporation of Family Support Providers (FSPs) as certified Peer Recovery Support Specialists (PRSS), similar to other states. Moreover, these changes create multiple career pathways through work experience and/or college credit to increase availability of case managers. Revisions will reduce the experience required for CM I and add alternative qualifications for CM II other than a college degree.

Budget Impact: Budget neutral.

H. **APA WF 23-23 Update Hospital Services Policy –** The proposed revisions seek to revise the Oklahoma Health Care Authority's hospital policy to reflect current business practices. Revisions will remove outdated language, definitions, and requirements. Other revisions will provide clarification to existing criteria surrounding items including split billing by providers, how a member is considered inpatient versus outpatient, payment structures, etc. Final revisions will make other grammatical and formatting changes as needed.

Budget Impact: The proposed rule changes are budget neutral and could result in a slight savings from excluding certain charges from the DRG on some outlier claims.

I. **APA WF 23-24 Update and Clarify Policy Regarding Coverage of Prosthetic Hearing Implants and Surrounding Audiology Services for Adults –** The agency proposes rule revisions to clarify coverage of prosthetic hearing implants and ocular prosthetics for adults in the expansion population. These services and devices are authorized within the Medicaid State Plan; policy revisions will clarify coverage for these devices and the surrounding services.

Budget Impact: The estimated total cost for SFY 2025 is $28,333 ($19,006 in federal share and $9,327 in state share). The estimated total cost for SFY 2026 is $34,000 ($22,807 in federal share and $11,193 in state share).

J. **APA WF # 23-25A&B Advantage and State Plan Personal Care Revisions –** The proposed rule revisions for the 1915(c) Home and Community Based Services (HCBS) ADvantage Waiver program and State Plan Personal Care Services seek to remove outdated processes, reduce unnecessary timeline and procedural burdens, clarify modalities used in medical eligibility assessments, and match recent system changes. Proposed revocations remove individual personal care assistants (IPCA) which are no longer used in these programs. Resumption of services information is removed from the closure section to reduce duplication. Proposed revisions also add Living Choice as a referral option when appropriate and provide general cleanup to the language.

Budget impact: Budget neutral.

K. APA WF # 23-26 340B Non-Compliant Providers – The proposed revisions ensure OHCA has mechanisms in place to preserve the net cost on prescription drug services through the current 340B Shared Savings model. The revisions institute a 45-day due date from receipt of invoice, a monetary penalty/interest for paying after the due date (modeled on the methodology used in Prompt Payment Rules promulgated by OMES, OAC 260:10-3-3), and the ability to withhold payment from facilities that are non-compliant in order to receive the unpaid invoice amounts.

Budget Impact: Budget neutral.

L. **APA WF 23-27A&B Developmental Disabilities Services (DDS) Updates –** The proposed revisions seek to update Developmental Disabilities Services (DDS) rules to align with the amendments to the DDS 1915(c) Home and Community Based Services (HCBS) waiver programs that were approved by the Centers for Medicare and Medicaid Services (CMS), effective July 1, 2023. The proposed revisions increase the annual cap for Community Transition Services from $2,400 to $3,000, update outdated terms relating to agency and division names, and remove obsolete references to architectural modifications.

Budget impact: Expected cost of increasing the cap for Community Transition Services is $64,800 for SFY 2025, of which $21,040.56 is state funds.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY

CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 5. PHARMACIES

317:30-5-72. Categories of service eligibility

(a) **Coverage for adults.** Prescription drugs for categorically needy adults are covered as set forth in this subsection.

(1) With the exception of (2) and (3) of this subsection, categorically needy adults are eligible for a maximum of six (6) covered prescriptions per month with a limit of two (2) brand name prescriptions. A prior authorization may be granted for a third brand name if determined to be medically necessary by OHCA and if the member has not already utilized their six (6) covered prescriptions for the month.

(2) Subject to the limitations set forth in Oklahoma Administrative Code (OAC) 317:30-5-72.1, 317:30-5-77.2, and 317:30-5-77.3, exceptions to the six (6) medically necessary prescriptions per month limit are:

(A) Unlimited monthly medically necessary prescriptions for categorically related individuals who are residents of nursing facilities (NF) or intermediate care facilities for individuals with an intellectual disability (ICF/IID); and

(B) Seven (7) additional medically necessary prescriptions which are generic products per month to the six (6) covered under the State Plan [including three (3) brand name prescriptions] are allowed for adults receiving services under the 1915(c) Home and Community-Based Services (HCBS) waivers. Medically necessary prescriptions beyond the three (3) brand name or thirteen (13) total prescriptions will be covered with prior authorization.

(3) For purposes of this Section, "exempt from the prescription limit" means claims filed for any of these prescriptions will not count toward the prescriptions allowed per month. Drugs exempt from the prescription limit include:

(A) Antineoplastics;

(B) Anti-retroviral agents for persons diagnosed with Acquired Immune Deficiency Syndrome (AIDS) or who have tested positive for the Human Immunodeficiency Virus (HIV);

(C) Frequently monitored prescription drugs. A complete list of the selected drugs considered as frequently monitored can be viewed on the agency's website at www.okhca.org.

(D) Medication-assisted treatment (MAT) drugs for opioid use disorder;

(E) Contraceptives;

(F) Hemophilia drugs;

(G) Compensable smoking and tobacco cessation products;

(H) ~~Naloxone for use in opioid overdose~~Opioid overdose reversal agents;

(I) Certain carrier or diluent solutions used in compounds (i.e., sodium chloride, sterile water, etc.);

(J) Drugs used for the treatment of tuberculosis; and

(K) Prenatal vitamins.

(4) When a brand drug is preferred over its generic equivalent due to lower net cost, that drug

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shall not count toward the brand limit; however, it will count toward the monthly prescription limit.

(b) **Coverage for children**. Prescription drugs for SoonerCare eligible individuals under twenty-one (21) years of age are not limited in number per month, but may be subject to prior authorization, quantity limits or other restrictions.

(c) **Individuals eligible for Part B of Medicare.** Individuals eligible for Part B of Medicare are also eligible for the Medicare Part D prescription drug benefit. Coordination of benefits between Medicare Part B and Medicare Part D is the responsibility of the pharmacy provider. The SoonerCare pharmacy benefit does not include any products which are available through either Part B or Part D of Medicare.

(d) **Individuals eligible for a prescription drug benefit through a Prescription Drug Plan (PDP) or Medicare Advantage - Prescription Drug (MA-PD) plan as described in the Medicare Modernization Act (MMA) of 2003.** Individuals who qualify for enrollment in a PDP or MA-PD are specifically excluded from coverage under the SoonerCare pharmacy benefit. This exclusion applies to these individuals in any situation which results in a loss of Federal Financial Participation for the SoonerCare program. This exclusion shall not apply to items covered at OAC 317:30-5-72.1(2) unless those items are required to be covered by the prescription drug provider in the MMA or subsequent federal action.

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 75. FEDERALLY QUALIFIED HEALTH CENTERS

317:30-5-660.3. Health Center enrollment requirements for specialty behavioral health services

~~(a)~~ For the provision of behavioral health related case management services and psychosocial rehabilitation services, Health Centers must contract as an outpatient behavioral health agency and meet the requirements found at OAC 317:30-5-241.3 and 317:30-5-241.6.

~~(b) Health Centers which provide substance use treatment services must also be certified by the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS)~~

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

SUBCHAPTER 23. LIVING CHOICE PROGRAM

317:35-23-2. Eligibility criteria

Adults with disabilities or long-term illnesses, members with intellectual disabilities and members with physical disabilities are eligible to transition into the community through the Living Choice program if they meet all of the criteria in paragraphs (1) through (7) of this subsection.

(1) He/she must be at least nineteen (19) years of age.

(2) He/she must reside in a nursing facility, skilled nursing facility, ~~or a~~ qualified long term care facility, or a public or private Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) for at least sixty (60) consecutive days prior to the proposed transition date. ~~If any portion of the sixty (60) days includes time in a skilled nursing facility, those days cannot be counted toward the sixty (60) day requirement, if the member received Medicare post-hospital extended care rehabilitative services.~~

(3) He/she must have at least one (1) day of Medicaid paid long-term care services prior to transition.

(4) If transitioning from an out of state institution, he/she must be SoonerCare eligible.

(5) He/she requires at least the same level of care that necessitated admission to the institution.

(6) He/she must reside in a qualified residence after leaving the institution. A qualified residence is defined in (A) through (C) of this paragraph.

(A) a home owned or leased by the individual or the individual's family member;

(B) an apartment with an individual lease, with a locking entrance/exit, and which includes living, sleeping, bathing, and cooking areas over which the individual or the individual's family has domain and control; and

(C) a residence, in a community-based residential setting, in which no more than four (4) unrelated individuals reside.

(7) His/her needs can be met by the Living Choice program while living in the community.

(8) He/she must not be a resident of a nursing facility or ICF/IID in lieu of incarceration.

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

SUBCHAPTER 1. ADMINISTRATIVE APPEALS

317:2-1-2. Appeals

(a) **Request for appeals.**

(1) For the purpose of calculating the timeframe for requesting an administrative appeal of an ~~agency~~Agency action, the date on the written notice shall not be included. The last day of the timeframe shall be included, unless it is a legal holiday as defined by Title 25 of the Oklahoma Statutes (O.S.) Section (§) 82.1, or any other day the Oklahoma Health Care Authority (OHCA) is closed or closes early, in which case, the timeframe runs until the close of the next full business day.

(2) An appeals request that an aggrieved member or provider sends via mail is deemed filed on the date that the ~~agency~~Agency receives it.

(b) **Member process overview.**

(1) The appeals process allows a member to appeal a decision relating to program benefits. Examples are decisions involving medical services, prior authorizations for medical services, or discrimination complaints.

(2) In order to initiate an appeal, the member must file a LD-1 (Member Complaint/Grievance Form) within thirty (30) calendar days of the date the OHCA sends written notice of its action, in accordance with Oklahoma Administrative Code (OAC) 317:2-1-2(a), above, or, in matters in which a formal notice is not sent by the ~~agency~~Agency, within thirty (30) days of the date on which the member knew or should have known the facts or circumstances serving as the basis for appeal.

(3) If the LD-1 form is not received timely, the OHCA administrative law judge (ALJ) will cause to be issued a letter stating the appeal will not be heard. In the case of tax warrant intercept appeals, if the LD-1 form is not received by OHCA within the timeframe pursuant to 68 O.S. § 205.2, OHCA similarly will cause to be issued a letter stating the appeal will not be heard because it is untimely.

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

(5) OHCA will advise members that if assistance is needed in reading or completing the grievance form, arrangements will be made to provide such assistance.

(6) Upon receipt of the member's appeal, a fair hearing before the OHCA ALJ will be scheduled. The member will be notified in writing of the date and time of the hearing. The member, and/or his/her designated authorized ~~representive~~representative, must appear at the hearing, either in person or telephonically. The preferred method for a hearing is telephonically, requests for an in-person hearing must be received in writing on OHCA's Form LD-4 (Request for In-Person Hearing) no later than ten (10) calendar days prior to the scheduled hearing date.

(7) The hearing shall be conducted according to OAC 317:2-1-5. The OHCA ALJ's decision may in certain instances be appealed to the CEO of the OHCA, or his or her designated independent ALJ, which is a record review at which the parties do not appear (OAC 317:2-1-13).

(8) Member appeals are ordinarily decided within ninety (90) days from the date on which the member's timely request for a fair hearing is received, unless:

(A) The appellant was granted an expedited appeal pursuant to OAC 317:2-1-2.5;

(B) The OHCA cannot reach a decision because the appellant requests a delay or fails to

take a required action, as reflected in the record;

(C) There is an administrative or other emergency beyond OHCA's control, as reflected in the record; or

(D) The appellant filed a request for an appeal of a denied step therapy exception request, pursuant to OAC 317:2-1-18.

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

(c) **Provider process overview.**

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

(2) All provider appeals are initially heard by the OHCA ALJ under OAC 317:2-1-2(d)(2).

(A) In order to initiate an appeal, a provider must file the appropriate LD form within thirty (30) calendar days of the date the OHCA sends written notice of its action, in accordance with OAC 317:2-1-2(a), above. LD-2 forms should be used for Program Integrity audit appeals; LD-3 forms are to be used for all other provider appeals.

(B) Except for OHCA Program Integrity audit appeals, if the appropriate LD form is not received timely, the OHCA ALJ will cause a letter to be issued stating that the appeal will not be heard.

(C) A decision ordinarily will be issued by the OHCA ALJ within forty-five (45) days of the close of all evidence in the appeal.

(D) Unless otherwise limited by OAC 317:2-1-7 or 317:2-1-13, the OHCA ALJ's decision is appealable to OHCA's CEO, or his or her designated independent ALJ.

(d) **OHCA ALJ jurisdiction.** The OHCA ALJ has jurisdiction of the following matters:

(1) **Member appeals.**

(A) Discrimination complaints regarding the SoonerCare program;

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

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

(D) Appeals which relate to the tax warrant intercept system through the OHCA. Tax warrant intercept appeals will be heard directly by the OHCA ALJ. A decision will be rendered by the OHCA ALJ within twenty (20) days of the hearing;

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

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

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

(H) Appeals which relate to a requested step therapy protocol exception as provided by 63 O.S. § 7310; and

(I) Requests for ~~State~~state fair hearing arising from a member's appeal of a ~~managed care~~CE or DBM adverse benefit determination.

(2) **Provider appeals.**

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

(B) Denial of request to disenroll member from provider's SoonerCare Choice panel;
(C) Appeals by long-term care facilities for administrative penalty determinations as a result of findings made under OAC 317:30-5-131.2(b)(5)(B) and (d)(8);
(D) Appeals of Professional Service Contract awards and other matters related to the Central Purchasing Act pursuant to Title 74 O.S. § 85.1 et seq.;
(E) Drug rebate appeals;
(F) Provider appeals of OHCA Program Integrity audit findings pursuant to OAC 317:2-1-7. This is the final and only appeals process for appeals of OHCA Program Integrity audit findings;
(G) Oklahoma Electronic Health Records Incentive program appeals related only to incentive payments, incentive payment amounts, provider eligibility determinations, and demonstration of adopting, implementing, upgrading, and meaningful use eligibility for incentives;
(H) Supplemental Hospital Offset Payment Program (SHOPP) annual assessment, supplemental payment, fees, or penalties as specifically provided in OAC 317:2-1-15; and
(I) Appeals from any adjustment made to a long-term care facility's cost report pursuant to OAC 317:30-5-132, including any appeal following a request for reconsideration made pursuant to OAC 317:30-5-132.1.
~~(J) Request for a State fair hearing arising from provider's appeal of managed care audit findings, for cause or immediate termination of the provider's managed care contract, or managed care claims denial.~~

317:2-1-2.6. Continuation of benefits or services pending appeal

(a) In accordance with Section 431.230 of Title 42 of the Code of Federal Regulations, if an ~~Appellant~~appellant submits a written request for a hearing within ~~ten (10)~~sixty (60) days of the notice of the adverse ~~agency~~Agency action, the ~~Appellant~~appellant may also request that existing benefits or services (hereinafter, collectively referred to as "services") be continued or reinstated until the earlier of dismissal of the appeal, ~~Appellant's~~appellant's withdrawal of the appeal, or an initial hearing decision adverse to the ~~Appellant~~appellant.

(b) If the ~~Appellant~~appellant fails to indicate a preference as to continuation or reinstatement of services in a written request for hearing made within ~~ten (10)~~sixty (60) days of the notice of the adverse ~~agency~~Agency action, services shall be continued or reinstated. Provided, however, that a SoonerCare member shall not be entitled to continuation or reinstatement of services pending an appeal related to the following:

(1) When a service is denied because the member has exceeded the limit applicable to that service;
(2) When a request for a prior authorization is denied for a prescription drug. However:
(A) The Oklahoma Health Care Authority (OHCA) may authorize a single seventy-two (72) hour emergency supply of the drug, in accordance with Oklahoma Administrative Code (OAC) 317:30-5-77.2;
(B) A SoonerCare provider may initiate a step therapy exception request on behalf of a member, in accordance with OAC 317:30-5-77.4;
(3) When coverage of a prescription drug or service is denied because the requested drug or service is not a category or class of drugs or services covered by OHCA;
(4) When coverage for a prescription drug is denied because the ~~enrollee~~Enrollee has been locked into one (1) pharmacy and the member seeks to fill a prescription at another pharmacy; or
(5) When a physician or other licensed health care practitioner has failed to prescribe or order

the service or level of service for which continuation or reinstatement is requested.
~~(c) If services are continued or reinstated during the appeals process and the hearing is not decided in the Appellant's favor, OHCA may seek to recover reimbursement of all services received pending the hearing decision.~~

SUBCHAPTER 3. MEMBER GRIEVANCES AND APPEALS, PROVIDER COMPLAINTS, AND STATE FAIR HEARINGS IN ~~MANAGED CARE~~SOONERSELECT

317:2-3-1. Definitions

The following words or terms used in the Subchapter shall have the following meaning, unless the context clearly indicates otherwise:

"**Adverse benefit determination"** means a determination by a health carrier or its designee utilization review organization that an admission, availability of care, continued stay, or other health care service that is a covered benefit has been reviewed and, based upon the information provided, does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness, and the requested service or payment for the service is therefore denied, reduced or terminated and in accordance with Title 36 of Oklahoma Statute (O.S.) § 6475.3.

"**Appeal**" means a review of an adverse benefit determination performed by a ~~managed care entity~~CE or DBM or according to managed care law, regulations, and contracts.

"**C.F.R.**" means the Code of Federal Regulations.

"Contracted entity" or **"CE"** means an organization or entity that enters into or will enter into a capitated contract with the Oklahoma Health Care Authority (OHCA) for the delivery of services that will assume financial risk, operational accountability, and state-wide or regional functionality in this act in managing comprehensive health outcomes of Medicaid members. This includes an accountable care organization, a provider-led entity, a commercial plan, a dental benefit manager, or any other entity as determined by the OHCA.

"Dental benefits manager" or **"DBM"** means an entity that meets the definition of a Prepaid Ambulatory Health Plan (PAHP) as per 42 C.F.R. § 438.2 and is under contract with the OHCA to manage and deliver all services described in this SoonerSelect Dental Contract and who handles claims payment and prior authorizations and coordinates dental care with participating providers and Enrollees. Also referred to as a "Contractor".

"**Exigent circumstances**" means a situation in which a reasonable person applying the appropriate standard would consider a member's health condition to be urgent with identifiable harm that could reasonably be expected to occur if the requested health care service is not provided promptly. The appropriate standard requires the assessment of a member's health condition through application, at minimum, of established, accepted standards of medical practice. Evidence of the member's condition may be demonstrated by indications from the treating provider or from the member's medical record, including but not limited to such information as the member's diagnosis, symptoms, or test results.

"**Grievance**" means a member's expression of dissatisfaction about any ~~managed care program~~ matter other than an adverse benefit determination and may include, but is not limited to, the quality of care or services provided, aspects of interpersonal relationships such as rudeness of a ~~managed care~~contracted entity employee or contracted provider, or failure to respect the ~~member's~~Enrollee's rights regardless of whether remedial action is requested. A grievance includes a ~~member's~~Enrollee's right to dispute an extension of time to make an authorization decision when proposed by the ~~managed care entity~~Contractor.

"**Health plan**" means any person or entity that is licensed as a health maintenance organization (HMO) by the State of Oklahoma to provide or arrange for the delivery of basic health care services to ~~enrollees~~Enrollees on a prepaid basis, except for copayments or deductibles for which ~~enrollee~~Enrollee is responsible, or both, that meets the definition of an HMO as delineated in the Oklahoma State Medicaid Plan and that contracts with the ~~State~~state to provide services to ~~enrollees~~Enrollees. "Health plan" is synonymous with "health carrier".

~~"**Managed care entity**" or "**MCE**" means any entity permitted under 42 C.F.R. Part 438 to contract with a state for services provided under a risk contract or a nonrisk contract within the state's Medicaid managed care program, including but not limited to managed care organization (MCO), primary care case management (PCCM), primary care case management entity (PCCM entity), prepaid ambulatory health plan (PAHP), and prepaid inpatient health plan (PIHP).~~

~~"**Managed care organization**" or "**MCO**" means the same in these rules as defined at 42 Code of Federal Regulations (C.F.R.) § 438.2.~~

~~"**Managed care program**" or "**managed care**" or "**MCP**" means a health care delivery system organized to manage cost, utilization, and quality that is operated by a state as authorized under sections 1915(a), 1915(b), 1932(a), or 1115(a) of the Social Security Act and relevant state law.~~

"**Member**" means an individual eligible for Medicaid in the State of Oklahoma, eligible for a managed care program, and enrolled in a ~~managed care entity~~CE or DBM. "Member" is synonymous with "~~health plan enrollee~~Enrollee".

"OAC" means the Oklahoma Administrative Code.

"OHCA" means the Oklahoma Health Care Authority.

"O.S." means the Oklahoma Statutes.

"**Prepaid ambulatory health plan**" or "**PAHP**" means the same in these rules as defined at 42 C.F.R. § 438.2.

"**Prepaid inpatient health plan**" or "**PIHP**" means the same in these rules as defined at 42 C.F.R. § 438.2.

"**Primary care case management**" or "**PCCM**" means the same in these rules as defined at 42 C.F.R. § 438.2.

"**Primary care case management entity**" or "**PCCM entity**" means the same in these rules as defined at 42 C.F.R. § 438.2.

"Prior authorization ~~(PA)~~" or **"PA"** means a requirement that a member, through a provider, obtain the ~~managed care entity's~~CE or DBM approval before a requested medical service is provided or before services by a non-participating provider are received. Prior authorization is not a guarantee of claims payment; however, failure to obtain prior authorization may result in denial of the claim or reduction in payment of the claim. For purposes of these rules, "prior authorization" is included as a determination of health care services within the term "adverse benefit determination".

"Provider" means a health care or dental provider licensed or certified in this state.

317:2-3-2. Timeframes

(a) For the purpose of calculating a timeframe in this Subchapter, the date on the written notice is not included. The last day of the timeframe is included, unless the last day is a legal holiday, as defined by 25 ~~Oklahoma Statutes (O.S.)~~O.S. § 82.1, or any other day OHCA is closed or closes early, in which case, the timeframe runs until the close of the next full business day.

(b) A grievance or appeal a member sends via mail is deemed filed on the date the ~~MCE~~CE receives request.

(c) A request for reconsideration or appeal a provider sends via mail is deemed filed on the date the ~~MCE~~CE receives the request.

(d) A request for ~~State~~state fair hearing by a member or provider is deemed filed on the date the

OHCA receives the request.

317:2-3-3. Grievance and appeals system

In accordance with state and federal law, including but not limited to 63 ~~Oklahoma Statutes (O.S.)~~O.S. § 7310 and 42 ~~Code of Federal Regulations (C.F.R.)~~C.F.R. §§ 438.210, 431.213-14, 438.402, 438.404, 438.408, and 438.410, each ~~MCE~~CE and DBM will have an established grievance and appeals system by which to receive, process, and resolve grievances and appeals, including requests for extensions of relevant timeframes, and by which to afford parties proper notice.

317:2-3-4. Member grievances

(a) **Filing**.

(1) **Filing with ~~managed care entity~~a CE or DBM**. Except as described in this ~~section~~Section, when the member is enrolled in a managed care program, the member initially files a grievance with the ~~managed care entity~~CE or DBM in which the member is enrolled.

(2) **Exception: Filing with OHCA.** When the member is enrolled in a ~~managed care~~SoonerSelect program and the grievance deals with direct interaction with OHCA or its employees or officers, the member first files the grievance with OHCA as an administrative appeal pursuant to applicable rules set forth at ~~Oklahoma Administrative Code (OAC)~~OAC 317:2-1-2 et seq.

(b) **Timing.** A member may file a grievance, orally or in writing, at any time.

(c) **Provider's and authorized representative's right to file a grievance.** A provider or an authorized representative may file a grievance on behalf of a member, provided that the provider or authorized representative has obtained the member's written consent to do so. The authorized representative of a deceased member's estate may also be a party to the ~~litigation~~resolution of a grievance, as applicable.

(d) **Clinical expertise in a grievance decision.** When a grievance involves clinical issues or is related to a denial of an expedited resolution of an appeal, the decision maker(s) of such a grievance will have clinical expertise as discussed at OAC 317:2-3-6.

(e) **Consideration of information in an appeal decision.** The decision maker(s) for any appeal will take into account all comments, documents, records, and other information submitted without regard to whether such information was submitted or considered in the initial determination.

(f) **OHCA-established timeframes for grievance decisions.** A grievance related in any way to the member's health condition will be resolved, with notice provided, as expeditiously as the member's health condition requires.

(1) Per 42 ~~Code of Federal Regulations (C.F.R.)~~C.F.R. § 438.408, the standard resolution of a grievance will occur within ninety (90) calendar days after the ~~managed care entity~~CE or DBM receives the grievance. The OHCA may choose to adopt a shorter timeframe for the grievance resolution. The CE and DBM must adhere to such timeframes that are described within the Contract.

~~(2) OHCA sets the standard resolution of a grievance to occur within sixty (60) calendar days, inclusive of any extensions, after the MCE receives the grievance.~~

~~(3)~~(2) The ~~MCE~~CE and DBM may extend the timeframe ~~in (f)(2)~~ up to fourteen (14) days if:

(A) The member requests the extension; or

(B) The ~~MCE~~CE and DBM shows (to the OHCA's satisfaction upon OHCA's request) that there is need for additional information and how the delay is in the member's interest.

~~(4)~~(3) If the ~~MCE~~CE and DBM extends the timeframes not at the request of the member, it must complete all of the following:

(A) Make reasonable efforts to give the member prompt oral notice of the delay; and

(B) Within two (2) calendar days give the member written notice of the reason for the decision to extend the timeframe and inform ~~the~~ ~~enrollee~~Enrollee of the right to file a grievance if he or she disagrees with that decision; and

~~(5)~~(4) The ~~MCE~~CE and DBM will adhere to all OHCA rules related to grievances, including but not limited to:

(A) Observing the timeframe for standard resolution of a grievance;

(B) Sending acknowledgement of receiving the grievance in writing to the member or the member's authorized representative within ten (10) calendar days of receipt; and

(C) Sending written notice conforming with this ~~subchapter~~Subchapter to the affected parties within three (3) calendar days following resolution of the grievance.

317:2-3-5. Member appeals

(a) **Filing**.

(1) **Filing with ~~managed care entity~~a CE or DBM.** Except as described in this Section, when the member is enrolled in a managed care program, the member initially files an appeal with the ~~managed care entity~~CE or DBM in which the member is enrolled.

(2) **Exception: Filing with OHCA.** When the member is enrolled in a ~~managed care~~SoonerSelect program, the member initially files administrative appeals with OHCA and follows the appeals rules set forth at ~~Oklahoma Administrative Code (OAC)~~OAC 317:2-1-2 et seq. whenever the appeal concerns a decision the ~~Oklahoma Health Care Authority (OHCA)~~OHCA made regarding:

(A) Eligibility for Oklahoma Medicaid;

(B) Eligibility for a ~~managed care~~SoonerSelect program;

(C) Enrollment into Oklahoma Medicaid;

(D) Enrollment, including use of an auto-assignment algorithm, into a ~~managed care entity~~CE or DBM;

(E) Disenrollment from a ~~managed care entity~~CE or DBM; or

(F) Any other matter, so long as OHCA made the decision in the matter.

(b) **Timing.** ~~A member may file an appeal, orally or in writing, at any time. An administrative appeal or State fair hearing request made to OHCA shall conform with the requirements of OAC 317:2-1-2 et seq. in terms of the manner and timing of any such filing.~~

(1) Per OAC 317:2-3-4(b), a member may file a grievance at any time. If the grievance decision is adverse to the member, the member may file an appeal. The member has sixty (60) days from the adverse decision notice to file an appeal.

(2) An administrative appeal or state-fair hearing request made to OHCA shall conform with the requirements of OAC 317:2-1-2 et seq. in terms of the manner and timing of any such filing.

(c) **Levels of appeals.** The ~~managed care entity~~CE or DBM will use only one (1) level of ~~appeals~~appeal, in accordance with 42 ~~Code of Federal Regulations (C.F.R.)~~C.F.R. § 438.402.

(d) **Provider's and authorized representative's right to file an appeal.** A provider or an authorized representative may file an appeal on behalf of a member, provided that the provider or authorized representative has obtained the member's written consent to do so. The authorized representative of a deceased member's estate may also be a party to the litigation of an appeal, as applicable.

(e) **Clinical expertise in an appeal decision.** When an appeal involves clinical issues or is related to a denial based on lack of medical necessity, the decision maker(s) of such an appeal will have clinical expertise as discussed at OAC 317:2-3-6.

(f) **Consideration of information in an appeal decision.** The decision maker(s) for any appeal will take into account all comments, documents, records, and other information submitted without regard

to whether such information was submitted or considered in the initial determination.

(g) **OHCA-established timeframes for appeals decisions.** An appeal related in any way to the member's health condition will be resolved, with notice provided, as expeditiously as the member's health condition requires.

~~(1) Per 42 C.F.R. § 438.408, the standard resolution of an appeal will occur within thirty (30) calendar days after the managed care entity receives the appeal.~~

~~(2)~~ (1) Per 42 C.F.R. § 438.408, the OHCA establishes the following timeframes for appeals:

(A) Standard resolution of an appeal will occur within thirty (30) calendar days, excluding any extensions, after the ~~managed care entity~~CE or DBM receives the appeal;

(B) ~~Expedited resolution of an appeal will occur within seventy-two (72) clock-hours after the MCE receives the appeal;~~The CE and DBM will be responsible for expedited resolutions.

(i) An expedited appeal resolution should occur if the standard resolution timeframe could jeopardize the Enrollee's life or health or ability to attain, maintain, or regain maximum function.

(ii) Per 42 C.F.R. § 438.408(b)(2), if the CE or DBM denies a request for expedited appeal resolution, the CE or DBM must transfer the appeal to the standard appeal resolution timeframe.

(C) In exigent circumstances, resolution of a step therapy request appeal will occur within twenty-four (24) clock-hours after the ~~MCE~~CE receives the appeal; and

(D) In all other circumstances, resolution of a step therapy request appeal will occur within seventy-two (72) clock-hours after the ~~MCE~~CE receives the appeal.

~~(3)~~(2) The ~~MCE~~CE and DBM may extend the timeframes in (g)~~(2)~~(1)(A) or (B) up to fourteen (14) days if:

(A) The member requests the extension; or

(B) The ~~MCE~~CE and DBM shows (to the OHCA's satisfaction upon OHCA's request) that there is need for additional information and how the delay is in the member's interest.

~~(4)~~(3) If the ~~MCE~~CE and DBM extends the timeframes not at the request of the member, it must complete all of the following:

(A) Make reasonable efforts to give the member prompt oral notice of the delay;

(B) Within two (2) calendar days give the member written notice of the reason for the decision to extend the timeframe and inform ~~the enrollee~~Enrollee of the right to file a grievance if he or she disagrees with that decision; and

(C) Resolve the appeal as expeditiously as the member's health condition requires and no later than the date the extension expires.

~~(5)~~(4) The ~~MCE~~CE and DBM will adhere to all OHCA policies related to appeals, including but not limited to:

(A) Observing the timeframes for resolving appeals, including standard resolution, expedited resolution, and resolution of step therapy appeals (in both exigent and other circumstances);

(B) Sending acknowledgement of receiving the appeal in writing to the member or the member's authorized representative within five (5) calendar days of receipt;

(C) Sending written notice conforming with this ~~subchapter~~Subchapter to the affected parties within three (3) calendar days following resolution of the appeal; and

(D) Sending documentation, in conformance with OAC 317:2-3-12(d) and any established OHCA forms or processes, to OHCA within fifteen (15) calendar days after a request for ~~State~~state fair hearing.

317:2-3-5.1. Continuation of benefits pending appeal and state fair hearing

(a) Per OAC 317:2-1-2.6 and 42 C.F.R. § 438.420, the CE or DBM shall continue a member's benefits under the plan when all of the following occur:

(1) The member files the request for an appeal within sixty (60) calendar days following the date on the adverse benefit determination notice in accordance with 42 C.F.R. § 438.402(c)(1)(ii) and (c)(2)(ii):

(2) The appeal involves the termination, suspension, or reduction of previously authorized services;

(3) The services were ordered by an authorized provider;

(4) The period covered by the original authorization has not expired; and

(5) The member timely files for continuation of benefits, meaning on or before the later of the following:

(A) Within ten (10) calendar days of the CE or DBM sending the notice of adverse benefit determination; or

(B) The intended effective date of the CE or DBM's proposed adverse benefit determination.

(b) If the member fails to indicate a preference as to continuation or reinstatement of services in a written request for hearing made within sixty (60) calendar days of the adverse benefit determination, services shall be continued or reinstated. Notwithstanding the foregoing, continuation or reinstatement of benefits shall not occur under the following circumstances:

(1) The member has exceeded the limit applicable to the services; or

(2) When a provider has failed to prescribe or order the service or level of service for which continuation or reinstatement is requested.

(c) The CE or DBM shall continue or reinstate benefits if the member:

(1) Files a request for a state fair hearing within one hundred twenty (120) days of the adverse resolution notice; and

(2) Files a request for continuation of benefits within thirty (30) calendar days of the adverse resolution notice.

(d) If the CE or DBM continues or reinstates the member's benefits at the member's request while the appeal or state fair hearing is pending, the benefits must be continued until one (1) of the following occurs:

(1) The member withdraws the appeal or request for state fair hearing;

(2) The member fails to request a state fair hearing and continuation of benefits within ten (10) calendar days after the CE or DBM sends the notice of an adverse resolution to the member's appeal under 42 C.F.R. §§ 438.420 (c)(2) and 438.408 (d)(2); or

(3) A state fair hearing officer issues a hearing decision adverse to the member.

317:2-3-6. External medical review and clinical expertise

(a) **~~No external~~External medical review.** The ~~Oklahoma Health Care Authority (OHCA)~~OHCA will not offer an external medical review for the purposes of grievances or appeals.

(b) **Clinical expertise standards.** Individuals making the decision for a grievance or appeal regarding an adverse benefit determination will be unbiased with appropriate clinical expertise in treating the member's condition or disease.

(1) Medical review staff of the ~~MCE~~CE and DBM will be licensed or credentialed health care clinicians with relevant clinical training and/or experience.

(2) All CE and DBM will use medical review staff for such appeals and shall not use any automated claim review software or other automated functionality for such appeals.

(3) Bias is deemed to exist if an individual making a decision on a grievance or appeal was

involved in, or a subordinate of any individual involved in, any previous level of review or decision regarding the subject matter of the grievance or appeal.

(4) Clinical expertise is deemed necessary for decisions makers whenever:

(A) The denial is based on a lack of medical necessity;

(B) The grievance is regarding a denial of an expedited resolution an appeal; and

(C) The grievance or appeal involves clinical issues.

317:2-3-7. Obligation to pay costs of services

~~(a) In accordance with 42 Code of Federal Regulations (C.F.R.) § 438.420(d), the MCE may recover from the member the costs of services provided to the member while an appeal or State fair hearing is pending:~~

~~(1) To the extent the services were continued solely due to the requirements set forth in 42 C.F.R. §§ 438.420 or 431.230(b); and~~

~~(2) The final resolution of the appeal or State~~state fair hearing upholds the adverse benefit determination.

~~(b)~~(a) If OHCA or the ~~MCE~~CE and DBM reverses a decision to deny, limit, or delay services and these services were not furnished while the appeal or ~~State~~state fair hearing was pending, the ~~MCE~~CE and DBM will authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires.

~~(c)~~(b) If OHCA or the ~~MCE~~CE and DBM reverses a decision to deny, limit, or delay services and the member received the disputed services while the appeal or ~~State~~state fair hearing was pending, the ~~MCE~~CE and DBM will pay for these services.

317:2-3-8. Grievances and appeals notice

(a) The ~~MCE~~CE and DBM will provide timely written notices per OAC 317:2-3-4 and 317:2-3-5.

(b) Each notice will conform to the provisions of 42 ~~Code of Federal Regulations (C.F.R.)~~C.F.R. § 438.10 related to information provided from an ~~MCE~~CE and DBM to a member.

(c) At minimum, each notice will:

(1) Be written in a manner and format, as outlined in the Contract, that may be easily understood and is readily accessible by members;

(2) Use OHCA-developed definitions for terms as those terms are defined in the ~~Model Member~~Enrollee Handbook related to the ~~contract~~Contract;

(3) Use a font size no smaller than twelve-point (12-point);

(4) Be made available in alternative formats and through the provision of auxiliary aids and services in an appropriate manner that takes into consideration the special needs of members with disabilities or limited English proficiency; and

(5) Include a large-print tagline, in minimum eighteen-point (18-point) font, and information on how to request auxiliary aids and services, including the provision of materials in alternative formats.

(d) Per the delegation choice of 42 C.F.R. § 438.228, OHCA does not delegate responsibility to the ~~MCE~~CE and DBM for timely notices of action under 42 C.F.R. Part 431, Subpart E.

(1) OHCA retains all responsibility for timely notices of action under 42 C.F.R. Part 431, Subpart E, including:

(A) A termination, suspension of, or reduction in covered benefits or services, when termination, suspension, or reduction is determined by OHCA;

(B) A termination, suspension of, or reduction in Medicaid eligibility, when termination, suspension, or reduction is determined by OHCA; and

(C) An increase in beneficiary liability, including determination that a beneficiary will

incur a greater amount of medical expenses in order to establish income eligibility or is subject to an increase in premiums or cost sharing charges, when such increase is determined by OHCA.

(2) The foregoing (d)(1) does not apply to:

(A) Any grievance notice required to be sent by the ~~MCE~~CE and DBM by ~~contract~~Contract or 42 C.F.R. § 438.408;

(B) Any adverse benefit determination notice based on the termination, suspension, or reduction of authorized covered services, payment denial, or standard, expedited, or untimely service authorization denial or limitation as required to be sent by the ~~MCE~~CE and DBM by contract or 42 C.F.R. § 438.404;

(C) Any appeal resolution notice required to be sent by the ~~MCE~~CE and DBM by contract or 42 C.F.R. § 438.404 or 438.408; or

(D) Any other notice required to be sent by the ~~MCE~~CE and DBM by ~~contract~~Contract or any state or federal law or regulation.

(3) OHCA's decision not to delegate the notices of action required by 42 C.F.R. Part 431 Subpart E applies to any ~~managed care entity~~CE or DBM under ~~any managed care contract~~Contract for professional services unless and until this ~~section~~Section is revoked.

(4) The random review system required of a state by 42 C.F.R. § 438.228 does not apply to OHCA, because OHCA has not delegated responsibility for the relevant notices of action.

(5) For any notices of action for which OHCA retains responsibility under this ~~section~~Section, OHCA will ensure the notice conforms to federal regulations at 42 C.F.R. Part 431, Subpart E, and any applicable requirements under 42 C.F.R. § 438.228. OHCA will send such notices of action by electronic or postal means at least ten (10) days before the date of action, except as permitted when:

(A) OHCA has factual information confirming the death of a beneficiary;

(B) OHCA receives a clear written statement signed by a member that they no longer wish to receive services or that gives information that requires termination or reduction of services and indicates that the member understands that supplying the information will result in termination or reduction of services;

(C) The member has been admitted to an institution where they are ineligible for further services;

(D) The member's whereabouts are unknown and the post office returns, indicating no forwarding address, OHCA mail sent directly to the member; ~~and~~or

(E) The ~~MCE~~CE and DBM establishes the fact that the member has been accepted for Medicaid services by another local jurisdiction, state, territory, or commonwealth.

(6) For any notices of action for which OHCA retains responsibility under this Section, OHCA will ensure the notice contains:

(A) A statement of the action OHCA intends to take and the effective date of such action;

(B) A clear statement of the specific reasons supporting the intended action, the specific regulations that support or require the action, and an explanation of the member's rights to request a hearing; and

(C) An explanation of the circumstances under which benefits continue if a hearing is requested.

(7) For any notices of action for which OHCA retains responsibility under this ~~section~~Section, OHCA will allow the member a reasonable time, not to exceed ninety (90) days from the date the notice is mailed, to request a ~~State~~state fair hearing.

317:2-3-9. Exhaustion of ~~managed care entity~~CE or DBM appeals

(a) **Deemed exhaustion of ~~M~~CE or DBM appeals.** If the ~~MCE~~CE and DBM fails to adhere to any timing or notice requirements as detailed in 42 C.F.R. § 438.408, the member is deemed to have exhausted the ~~MCE's~~CE's or DBM's appeal process, and the member or the member's authorized representative may request a ~~State~~state fair hearing.
(b) **Actual exhaustion of ~~MCE~~CE or DBM appeals.** Except as allowed in (a), a member or the member's authorized representative may request a ~~State~~state fair hearing only after receiving notice from the ~~MCE~~CE and DBM upholding an adverse benefit determination and only within one hundred twenty (120) days after the date of the notice of appeal resolution.
(c) **Exhaustion of ~~MCE~~CE or DBM appeals, determination.** OHCA has sole authority to decide whether ~~MCE~~CE and DBM appeals have been exhausted for any member. Documentation, as submitted to OHCA by the ~~MCE~~CE and DBM within fifteen (15) calendar days of the request for ~~State~~state fair hearing, will serve as evidence to deemed exhaustion, actual exhaustion, or no exhaustion of the ~~MCE~~CE and DBM appeals process.

317:2-3-10. Provider complaint system and appeal requests
(a) A participating provider or nonparticipating provider may file a complaint whenever:
(1) The provider is not satisfied with the ~~MCE's~~CE's or DBM's policies and procedures; or
(2) The provider is not satisfied with a decision made by the ~~MCE~~CE and DBM that does not impact the provision of services to members.
(b) The ~~MCE~~CE and DBM will establish and operate a provider complaint system. Such system will:
(1) Use written policies and procedures for receiving, tracking, dating, storing, responding to, reviewing, reporting, and resolving provider complaints;
(2) Track receipt and resolution of provider complaints, including requests for reconsideration or appeals;
(3) Demonstrate sufficient ability to receive provider complaints by telephone, in writing, or in person;
(4) Designate staff to receive, process, and resolve provider complaints;
(5) Thoroughly investigate each provider complaint;
(6) Ensure an escalation process for provider complaints;
(7) Furnish the provider timely written notification of resolution or results; and
(8) Maintain a tracking system capable of generating reports to OHCA on provider complaint volume and resolution.
(c) The ~~MCE~~CE and DBM will operate a reconsideration process whereby providers may request the ~~MCE~~CE and DBM reconsider a decision the ~~MCE~~CE and DBM has made or intends to make that is adverse to the provider, including, at minimum, reconsiderations of provider audit findings, reconsiderations of provider agreement termination, and reconsiderations of denied claims.
(1) **Request for reconsideration, denied claims.** The ~~MCE~~CE and DBM will ask that the provider submits a request for reconsideration of a denied claim within six (6) months after the provider receives notice of the denied claim.
(2) **Request for reconsideration, all other reasons**. The ~~MCE~~CE and DBM will ask that the provider submits a request for reconsideration within fifteen (15) days after the date the provider receives notice of audit findings, termination of provider agreement, or other actions the ~~MCE~~CE and DBM permits for reconsideration requests.
(3) **Desk review.** The ~~MCE~~CE and DBM will conduct the reconsideration through a desk review of the request and all related and available documents.
(4) **Reconsideration resolution.** The ~~MCE~~CE and DBM will resolve all requests for reconsideration within ~~twenty (20) calendar days of the date the MCE receives the request for~~

~~reconsideration~~the timeframes established by the OHCA. The ~~MCE~~CE and DBM will send a reconsideration resolution notice to the provider within ~~three (3) days of the MCE finalizing the resolution~~five (5) calendar days of resolution of the consideration.

(5) **Notice of ~~Reconsideration Resolution~~reconsideration resolution**. The ~~MCE~~CE and DBM will send a reconsideration resolution notice that contains, at a minimum:

(A) The date of the notice;

(B) The action the ~~MCE~~CE has made or intends to make;

(C) The reasons for the action;

(D) The date the action was made or will be made;

(E) The citation to statute, regulation, policy, or procedure, if any, upon which the action was based;

(F) An explanation of the provider's ability to submit an appeal request to the ~~MCE~~CE and DBM within thirty (30) calendar days of the date recorded on the notice;

(G) The address and contact information for submitting an appeal;

(H) The procedures by which the provider may request an appeal regarding the ~~MCE's~~CE's or DBM's action;

(I) The specific change in federal or state law, if any, that requires the action;

(J) The provider's ability to submit a ~~State~~state fair hearing request following completion of the provider appeal process, or, in cases of an action based on a change in law, the circumstances under which a ~~State~~state fair hearing will be granted; and

(K) Any other information required by state or federal statute or regulation, by contract, or by contract-related manual.

(d) The ~~MCE~~CE and DBM will operate an appeals process whereby a provider may request an appeal of a reconsideration resolution when the underlying matter is based on the ~~MCE's~~CE or DBM's provider audit findings~~,~~ or for-cause or immediate termination of the provider agreement~~, or a denied claim~~.

(1) **Request for appeal.** The ~~MCE~~CE and DBM will require the provider to submit a request for appeal in writing within thirty (30) calendar days after the provider receives notice reconsideration resolution.

(2) **Panel review.** The ~~MCE~~CE and DBM will conduct the appeal through a panel review including a hearing and review of the request, all related and available documents, and all documents created for or used in connection with the request for reconsideration.

(A) The panel will consist of three (3) or five (5) reviewers, who are employees or officers of the ~~MCE~~CE and DBM.

(B) Panel members will not have been directly involved with the reconsideration desk review and will not be a subordinate of someone involved directly with the reconsideration desk review.

(C) The panel review hearing will provide the provider or an authorized representative of the provider with a reasonable opportunity to be heard in person or by telecommunications.

(D) The review panel will accept and document any exhibit offered prior to the hearing or during the hearing, so long as the exhibit directly relates to the matter of the appeal.

(E) When the appeal is based on a claim denied on the basis of medical necessity, the following requirements apply:

(i) Medical or dental review staff of the ~~MCE~~CE and DBM will be licensed or credentialed health care clinicians with relevant clinical training or experience; and

(ii) All ~~MCEs~~CEsor DBMs will use medical or dental review staff for such appeals and will not use any automated claim review software or other automated functionality for such appeals.

(3) **Appeal resolution.** The ~~MCE~~CE and DBM will resolve all appeals within ~~forty-five (45) calendar days of the date the MCE receives the request for appeal~~the timeframes established by the OHCA. The ~~MCE~~CE and DBM will send an appeal resolution notice to the provider within ~~three (3) business~~five (5) calendar days of the ~~MCE~~CE and DBM finalizing the resolution.

(4) **Notice of ~~Appeal Resolution~~appeal resolution.** The ~~MCE~~CE and DBM will send an appeal resolution notice that contains, at a minimum:

(A) The date of the notice;

(B) The date of the appeal resolution; and

(C) For decisions not wholly in the provider's favor:

~~(i) An explanation of the provider's ability to request a State fair hearing within thirty (30) calendar days of the date recorded on the notice;~~

~~(ii) How to request a State fair hearing, including the OHCA address and contact information for submitting a request;~~

~~(iii) Details on the right to be represented by counsel at the State fair hearing; and~~

~~(iv) Any other information required by state or federal statute or regulation, by contract, or by contract-related manual.~~

(i) An explanation of the provider's ability to request and OHCA administrative appeal within thirty (30) calendar days of the date recorded on the notice;

(ii) How to request an OHCA administrative appeal, including the OHCA address and contact information for submitting a request;

(iii) Details on the right to be represented by counsel at the OHCA administrative appeal.

(D) Any other information required by state or federal statute or regulation, by Contract, or by Contract-related manual.

(5) **Documentation.** The ~~MCE~~CE and DBM will furnish to OHCA documentation including all information specified ~~at OAC 317:2-3-13(c)(2)~~within the Contract within fifteen (15) calendar days of a provider's request for ~~a State fair hearing~~an OHCA administrative appeal.

(6) **State fair hearing for providers.** There are no state fair hearings provided for providers under a CE or DBM, per OAC 317:2-3-13.

317:2-3-11. Recordkeeping

In compliance with 42 C.F.R. § 438.3(h) and (u), the ~~M~~CE or DBM will maintain records of each grievance and appeal for ten (10) years after the later of the final date of the contract period or the date of completion of any ~~M~~CE or DBM audit by the State, the Centers for Medicare and Medicaid Services (CMS), the Office of the Inspector General, or the Comptroller General. Such records will be part of OHCA's ongoing monitoring and will be used to update and revise OHCA's ~~managed care~~SoonerSelect quality strategy. The record will conform with the content requirements at 42 C.F.R. § 438.416.

317:2-3-12. State fair hearing for members

(a) **Right to ~~State~~state fair hearing.** With regard to grievances or appeals first filed with the ~~MCE~~CE and DBM, a member may request a ~~State~~state fair hearing under 42 C.F.R. 431 Subpart E only after receiving notice from the ~~MCE~~CE and DBM upholding an adverse benefit determination. The member will have one-hundred twenty (120) days from the date of the adverse benefit determination notice to request a ~~State~~state fair hearing. Refer to 42 C.F.R. §§ 438.402(c)(1)(i) and 438.408(f)(1).

(b) **~~MCE~~CE or DBM policies and procedures.** The ~~MCE~~CE and DBM will implement established policies and procedures that allow a member described in (a) to initiate a ~~State~~state fair hearing

process after having exhausted the ~~MCE's~~CE or DBM's appeals process or after the member is deemed to have exhausted the process due to the ~~MCE's~~CE or DBM's failure to adhere to notice and timing requirements.

(c) **Member's request for a ~~State~~state fair hearing.** The ~~MCE~~CE and DBM will allow the member to request a ~~State~~state fair hearing either through an established ~~MCE~~CE and DBM process or through an established OHCA process. Any ~~MCE~~CE and DBM process will ensure that notice of the request for ~~State~~state fair hearing is communicated in writing to the OHCA contracting officer within twenty-four (24) clock-hours of receiving the request.

(d) **~~MCE~~CE or DBM documentation obligation.** The ~~MCE~~CE and DBM will provide documentation to the member, the member's authorized representative, OHCA, and the Office of Administrative Hearings.

(1) **Timing.** The ~~MCE~~CE and DBM will provide the ~~documentation~~support documentation (summary) described in this subsection~~:~~ within fifteen (15) calendar days after notification of the request for state fair hearing.

~~(A) Within twenty-four (24) clock-hours after receiving notification of the request for State fair hearing relating to a step therapy request; or~~

~~(B) Within fifteen (15) calendar days after notification of the request for State fair hearing in all other circumstances.~~

(2) **Information.** ~~Documentation~~Support documentation (summary) will include, at minimum, the following information:

(A) The name and address of the member and, if applicable, the member's authorized representative;

(B) A summary statement concerning why the member has filed a request for ~~State~~state fair hearing;

(C) A brief chronological summary of the ~~MCE's~~CE or DBM's action in relationship to the matter underlying the member's request for ~~State~~state fair hearing;

(D) The member's appeal request, along with any supporting documentation, if received by the ~~MCE~~CE and DBM;

(E) Any applicable correspondence between the ~~MCE~~CE and DBM and the member, including system notes entered by one (1) or more ~~MCE~~CE and DBM employees based on one (1) or more telephone conversations with the member;

(F) All exhibits offered at any hearing held with the ~~MCE~~CE and DBM;

(G) All documents the ~~MCE~~CE and DBM used to reach its decision;

(H) A statement of the legal basis for the ~~MCE's~~CE or DBM's decision;

(I) A citation of the applicable policies and/or legal authorities relied upon by the ~~MCE~~CE or DBM in making its decision;

(J) A copy of the notice which notified the member of the decision in question;

(K) The names and titles of any ~~MCE~~CE or DBM employees who will serve as witnesses at the ~~State~~state fair hearing; and

(L) Any other information requested by the member, the member's authorized representative, OHCA, or the Office of Administrative Hearings when the information relates to the ~~State~~state fair hearing or any matter giving rise to the ~~State~~state fair hearing.

(e) **~~MCE~~CE or DBM staffing.** The ~~MCE~~CE or DBM will maintain a sufficient level of staffing to competently perform the functions, requirements, roles, and duties involved in ~~State~~state fair hearing support, including but not limited to documentation, summarization of the arguments presented, and ensuring timely notice and delivery of documents to all parties.

(f) **Performance targets**. OHCA may set performance targets related to ~~State~~state fair hearing

requests that are resolved upholding the ~~MCE's~~CE or DBM's original determination when and as OHCA deems necessary or appropriate.

(g) **Post-transition obligations**. After termination or expiration of the ~~managed care contract~~Contract, the ~~MCE~~CE or DBM will remain responsible for ~~State~~state fair hearings related to dates of service prior to the ~~contract~~Contract termination or expiration, including but not limited to the provision of records and representation at ~~State~~state fair hearings.

(h) **Cost of services.** If the ~~State~~state fair hearing officer reverses the ~~MCE's~~CE or DBM's decision to deny authorization of services and the member received the disputed services while the ~~State~~state fair hearing was pending, the ~~MCE~~CE or DBM will pay for those disputed services.

317:2-3-13. State fair hearing for providers

~~(a) **Right to State fair hearing.** With regard to provider audit findings, for-cause and immediate termination of the provider's agreement, and claims denial, a provider may request a State fair hearing within thirty (30) calendar days of the MCE's notice of appeal resolution when that resolution does not favor the provider.~~

~~(b) **Information for providers.** As a part of the MCE's provider complaint system, the MCE will provide information to providers on how to request a State fair hearing via filing the appropriate form with the OHCA Docket Clerk.~~

~~(c) **MCE documentation obligation.** The MCE will provide documentation to the provider, OHCA, and the Office of Administrative Hearings.~~

~~(1) **Timing.** The MCE will provide the documentation described in this subsection within fifteen (15) calendar days after notification of the request for State fair hearing.~~

~~(2) **Information.** Documentation will include, at minimum, the following information:~~

~~(A) The name and address of the provider;~~

~~(B) A summary statement concerning why the provider has filed a request for State fair hearing;~~

~~(C) A brief chronological summary of the MCE's action in relationship to the matter underlying the provider's request for State fair hearing;~~

~~(D) The provider's appeal request, along with any supporting documentation, if received by the MCE;~~

~~(E) Any applicable correspondence between the MCE and the provider, including system notes entered by one or more MCE employees based on one or more telephone conversations with the provider;~~

~~(F) All exhibits offered at any hearing held with the MCE;~~

~~(G) All documents the MCE used to reach its decision;~~

~~(H) A statement of the legal basis for the MCE's decision;~~

~~(I) A citation of the applicable policies and/or legal authorities relied upon by the MCE in making its decision;~~

~~(J) A copy of the notice which notified the provider of the decision in question;~~

~~(K) The names and titles of any MCE employees who will serve as witnesses at the State fair hearing; and~~

~~(L) Any other information requested by the provider, OHCA, or the Office of Administrative Hearings when the information relates to the State fair hearing or any matter giving rise to the State fair hearing.~~

(a) There are no state fair hearings provided for providers under a CE or DBM. The CE or DBM shall provide the following:

(1) A provider complaint system;

(2) A provider reconsideration system whereby providers may request the CE or DBM to reconsider the decision the CE or DBM has made or intends to make that is adverse to the provider. This shall include, at minimum, reconsiderations for Program Integrity provider audit findings and provider agreement termination.

(3) Provider appeal to the CE or DBM:

(A) The CE or DBM shall implement and operate a system for provider appeals of the CE or DBM's audit findings related to Program Integrity efforts and for cause and immediate provider agreement termination.

(B) The CE or DBM shall operate a process whereby providers may appeal a decision the CE or DBM has made or intends to make that is adverse to the provider.

(b) For decisions not wholly in the provider's favor an OHCA administrative appeal will be provided, per OAC 317:2-3-10 (d)(4)(C).

317:2-3-14. Administrative Law Judge (ALJ) jurisdiction

The ALJ has jurisdiction of the following matters:

(1) **Member ~~State~~state fair hearing.** The ALJ has jurisdiction to hear any ~~State~~state fair hearing arising from a member's ~~MCE~~CE or DBM appeal of an adverse benefit determination.

(2) ~~**Provider State fair hearing.** The ALJ has jurisdiction to hear any State fair hearing arising from a provider's appeal of audit findings, for-cause or immediate termination of the provider's contract with the MCE, or claims denial.~~ **Provider OHCA administrative appeal.** The ALJ has jurisdiction to hear any OHCA administrative appeal arising from a decision that was not wholly in the provider's favor.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 55. MANAGED CARE

SUBCHAPTER 1. GENERAL PROVISIONS

317:55-1-1. Purpose; use of manuals

The purpose of this Chapter is to provide detailed rules which govern the delivery of health care services provided by ~~managed care organizations~~contracted entities or dental benefits managers as required by the "Ensuring Access to Medicaid Act", ~~2021 Okla. Sess. Law Serv. Ch. 542 (S.B. 131)~~, Title 56 of the Oklahoma Statutes, Sections 4002-4004 and 42 Code of Federal Regulations (C.F.R.), Part 438. The Oklahoma Health Care Authority may also develop manuals and medical guidelines that formalize terms, conditions, and applicable policy of awarded contracts.

317:55-1-2. Monitoring system for all managed care programs [REVOKED]

~~In accordance with 42 C.F.R. § 438.66, the Oklahoma Health Care Authority will monitor each managed care organization or dental benefits manager to assess its ability and capacity to comply with program- and contract-specific requirements and to assess its ability to perform satisfactorily in all major operational areas.~~

317:55-1-3. Definitions

~~The following words and terms, when used in this Chapter, will have the following meaning, unless the context clearly indicates otherwise:~~

~~**"1115 waiver"** means the demonstration waiver, as amended and including all active special terms and conditions (STCs) at a specific point in time, that authorizes Oklahoma Health Care Authority (OHCA) to operate a program in which one or more requirements of Title XIX of the Social Security Act (Act) are waived based on the waiver authority of section 1115 of the Act.~~

~~**"1915(c) waiver"** means any waiver, authorized by section 1915(c) of the Act, that allows specific coverage of home- and community-based services to a limited group of Medicaid-eligible individuals as an alternative to institutional care.~~

~~**"Accountable care organization"** or **"ACO"** means a group of clinicians, hospitals, or other health care providers who come together voluntarily to give coordinated high-quality care to a designated group of patients.~~

~~**"Act"** means the Social Security Act.~~

~~**"Adult"** means an individual twenty-one (21) years of age or older, unless otherwise specified by statute, regulation, and/or policy adopted by the OHCA. For eligibility criteria policy for children and adults, please refer to Oklahoma Administrative Code (OAC) 317:35-5-2.~~

~~**"Adverse determination"** means a determination by a health carrier, including an managed care organization (MCO) or dental benefits manager (DBM), or its designee that an admission, availability of care, continued stay or other health care service that is a covered benefit has been reviewed and, based upon the information provided, does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness, and the requested service or payment for services is therefore denied, reduced or terminated.~~

~~**"Alternative benefit plan"** means the benefit package delivered to expansion adults which is developed by OHCA and approved by the Centers for Medicare and Medicaid Services (CMS) in accordance with the requirements of Subpart C of 42 C.F.R. Part 440.~~

~~**"American Indian/Alaska Native"** or **"AI/AN"** means any individual as defined in 25 U.S.C. §§ 1603(13), 1603(28) or 1679(a) or who has been determined eligible as an Indian under 42 C.F.R. § 136.12.~~

DRAFT

"**Appeal**" means a review by an MCO or DBM of an adverse benefit determination.

"**Authorized representative**" means a competent adult who has the managed care enrollee's signed, written authorization to act on the managed care enrollee's behalf during the grievance, appeal, and State fair hearing process. The written authority to act will specify any limits of the representation.

"**Capitation payment**" means a payment, based on an actuarially sound capitation rate for the provision of Oklahoma Medicaid State Plan services under a managed care contract, that OHCA makes periodically to the MCO or DBM behalf of each enrollee enrolled in that MCO or DBM, regardless of whether the enrollee actually receives services during the period covered by the payment.

"**Capitation rate**" means the actuarially sound per enrollee, per month amount, including any adjustments, that OHCA agrees to pay an MCO or DBM for the provision of State Plan services.

"**Child**" means an individual under twenty-one (21) years of age, unless otherwise specified by statute, regulation, and/or policy adopted by the OHCA. For eligibility criteria policy for children and adults, please refer to OAC 317:35-5-2.

"**Children's Health Insurance Program**" or "**CHIP**" means a federal Medicaid program authorized under Title XXI of the Social Security Act.

"**Choice counseling**" means the provision of information and services designed to assist eligibles in making enrollment decisions related to the managed care program. Choice counseling includes answering questions and identifying factors to consider when choosing among MCOs or DBMs, as well as when choosing a patient-centered medical home provider or dental home provider. Choice counseling does not include making recommendations for or against enrollment into a specific MCO or DBM.

"**Chronic condition**" means a condition that is expected to last one (1) year or more and requires ongoing medical attention and/or limits activities of daily living (ADL).

"**Civil monetary damage**" means a damage imposed by OHCA which the MCO must pay for acting or failing to act in accordance with 42 C.F.R. § 438.700 et seq. Amounts may not exceed those specified in 42 C.F.R. § 438.704.

"**Claims denial error rate**" means the rate of claims denials that are overturned on appeal.

"**Clean claim**" means a properly completed billing form with coding based on Current Procedural Terminology (CPT), 4th Edition or a more recent edition, the Tenth Revision of the International Classification of Diseases or a more recent revision, or Healthcare Common Procedure Coding System (HCPCS), where applicable, to provide information specifically required in the OHCA Provider Billing and Procedure Manual.

"**C.F.R.**" means the Code of Federal Regulations.

"**Contract**" means the risk contract or the written and executed agreement between OHCA and a health plan or managed care organization or dental benefit manager for health plan or managed care services and includes the solicitation, the bid, the contract addenda, appendices, attachments, and amendments, and any documents incorporated into the contract by reference or otherwise, as well as any document or information subject to the rules on legally binding procurement in Chapter 10 of these rules.

"**Copayment**" means a fixed amount that an enrollee pays for a covered health care service when the enrollee receives the service.

"**Cost sharing**" means the State's requirement that an enrollee bear some of the cost of their care through mechanisms such as copayments, deductibles, and other similar charges.

"**Deemed newborn**" means children born to SoonerCare enrolled mothers and determined eligible under 42 C.F.R. § 435.117.

"**Dental benefits manager**" or "**DBM**" means a health plan under contract with the OHCA to

manage and deliver dental benefits and services to enrollees and designated as a pre-paid ambulatory health plan (PAHP) under 42 C.F.R. Part 438.

"**Dental home**" or "**DH**" means the care coordinated delivery system as defined within the contract between OHCA and a DBM.

"**Disenrollment**" means OHCA's removal of an enrollee from participation in a specific MCO or DBM or from participation in the managed care program.

"**Dual eligible individuals**" means individuals eligible for both Medicaid and Medicare.

"**Eligible**" means an individual who has been deemed eligible for Medicaid in the State of Oklahoma and is eligible for participation in the managed care program but who is not yet enrolled in an MCO or DBM.

"**Emergency services**" means medical services provided for a medical condition, including injury, manifesting itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in placing the individual's health, or the health of an unborn child, in serious jeopardy, serious impairment to bodily functions or serious dysfunction of any bodily organs or parts.

"**Enrollee**" means an individual who has been deemed eligible for Medicaid in the State of Oklahoma, who has been deemed eligible for enrollment in a managed care program, and who is currently enrolled in a managed care program.

"**Enrollee handbook**" means a guidebook prepared as a model by OHCA and modified and distributed by the MCO or DBM to its enrollees. The enrollee handbook is designed to help the enrollee understand the MCO or DBM, the managed care program, and the rights and responsibilities that come with enrollment in the program.

"**Enrollment**" means the OHCA process by which an eligible becomes an enrollee with an MCO or DBM.

"**Enrollment activities**" means activities that OHCA performs or conducts related to distributing, collecting, or processing enrollment materials, taking enrollments by technological device or in person, or enrolling or disenrolling eligibles into any MCO or DBM.

"**Essential community provider**" means a provider defined by 45 C.F.R. § 156.235.

"**Essential hospital services**" means tertiary care hospital services to which the MCO must provide access, including but not limited to neonatal, perinatal, pediatric, trauma and burn services.

"**Expansion adult**" means an individual nineteen (19) or older and under age sixty-five (65), with income at or below one hundred thirty-eight percent (138%) of the federal poverty level (FPL) determined eligible in accordance with 42 C.F.R. § 435.119), and who are not categorically related to the aged, blind, and disabled.

"**Former foster children**" or "**FFC**" means individuals under age twenty-six (26) determined eligible in accordance with 42 C.F.R. § 435.150 who were in foster care under the responsibility of the State or an Indian Tribe within Oklahoma and enrolled in SoonerCare on the date of attaining age eighteen (18) or aging out of foster care.

"**Foster children (FC)**" means children in foster care under the responsibility of the State, including children and youth who are in State custody due to abuse or neglect.

"**Fraud**" means intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable federal or State law.

"**Grievance**" means an enrollee's expression of dissatisfaction about any matter other than an adverse benefit determination. Grievances may include, but are not limited to, the quality of care or services provided, aspects of interpersonal relationships such as rudeness of a provider or employee or failure to respect the enrollee's rights regardless of whether remedial action is requested. A

~~grievance includes an enrollee's right to dispute an extension of time to make an authorization decision when proposed by the MCO or DBM.~~

~~"**Grievance and appeal system**" means the processes the MCO or DBM must implement in accordance with 42 C.F.R. Part 438, Subpart F, to handle enrollee grievances and appeals, as well as the processes to collect and track information about them.~~

~~"**Health care services**" means all Medicaid State Plan services provided, according to contract, by the MCO or DBM in any setting. Health care services may include but are not limited to medical care, behavioral health care, dental care, and pharmacy services.~~

~~"**Health plan**" means the same in these rules as at 36 O.S. § 4405.1.~~

~~"**Implementation**" means the process by which OHCA and the MCO or DBM performs actions and responsibilities to actively implement a managed care program or contract for the first time. Implementation also means, depending on its use, the moment in time that such actions and responsibilities are fully completed.~~

~~"**Implementation period**" means the period of time, as defined in contract, during which implementation occurs.~~

~~"**Indian health care provider**" or "**IHCP**" means a health care program operated by the Indian Health Service (IHS) or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (otherwise known as an I/T/U) as those terms are defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. § 1603).~~

~~"**Initial enrollment**" means an eligible's enrollment in an MCO or DBM during the initial enrollment period.~~

~~"**Initial enrollment period**" means the first period of time, as defined in contract, prior to or immediately following managed care program or contract implementation, when eligibles can first enroll in an MCO or DBM for the managed care program.~~

~~"**Managed care organization**" or "**MCO**" means a health plan designated as a managed care organization pursuant to 42 C.F.R. 438.2 and under contract with OHCA to participate in the managed care program and to deliver health care services to enrollees.~~

~~"**Managed care program**" or "**managed care**" or "**MCP**" means a health care delivery system organized to manage cost, utilization, and quality that is operated by a state as authorized under sections 1915(a), 1915(b), 1932(a), or 1115(a) of the Social Security Act and relevant state law.~~

~~"**Manual**" or "**guide**" means any document, outside of the Medicaid State Plan, any Medicaid waiver, and the rules, that is created by or for OHCA for use in interpreting or implementing contractual terms. "Manual" is synonymous with guide, guidebook, companion guide, manual, reference book, dictionary, handbook, model, instructions, primer, workbook, or any other words denoting a document that is handled as a matter of convenience.~~

~~"**Material change**" means, but not limited to, any change in the overall business operations such as policy, process or protocol which affects, or can reasonably be expected to affect, more than five percent (5%) of enrollees or participating providers of the MCO or DBM.~~

~~"**Medical necessity**" means a standard for evaluating the appropriateness of services as established under OAC 317:30-3-1.~~

~~"**National Provider Identifier (NPI)**" means a unique identification number for covered health care providers. Covered health care providers and all MCOs, DBMs, and health care clearinghouses must use an NPI in the administrative and financial transactions adopted under the Health Insurance Portability and Accountability Act (HIPAA). The NPI is a ten-position, intelligence-free numeric identifier (ten-digit number). This means that the numbers do not carry other information about healthcare providers, such as the state in which they live or their medical specialty. The NPI must be used in lieu of legacy provider identifiers in the HIPAA standards transactions.~~

~~"**Non-participating provider**" means a physician or other provider who has not contracted with~~

~~or is not employed by the MCO or DBM to deliver services under the managed care program.~~

~~**"Non-urgent sick visit"** means medical care given for an acute onset of symptoms which is not emergent or urgent in nature but which requires face-to-face medical attention within seventy-two (72) hours of enrollee notification of a non-urgent condition, as clinically indicated. Examples of non-urgent sick visits include cold symptoms, sore throat, and nasal congestion.~~

~~"**Open enrollment**" means an eligible's selection of and enrollment in an MCO or DBM during the open enrollment period.~~

~~"**Open enrollment period**" means the annual period of time, as defined by contract, when managed care enrollees and eligibles can enroll in and select an MCO or DBM for the managed care program.~~

~~"**Parent and caretaker relative**" means an individual determined eligible under 42 C.F.R. § 435.110.~~

~~"**Participating provider**" means a physician or other provider who has a contract with or is employed by an MCO or DBM to provide health care services to enrollees under the capitated managed care delivery model of the managed care program.~~

~~**"Patient-centered medical home"** or **"PCMH"** means, in this chapter, the care coordinated delivery system as defined within the contract between OHCA and an MCO.~~

~~"**Pregnant women**" means women determined eligible for SoonerCare under 42 C.F.R. § 435.116.~~

~~"**Presumptive eligibility**" means limited period of managed care program eligibility for individuals who are categorically related to certain eligibility groups listed in OAC 317:35-6-38(a)(1)(A)(i) through (vi) and are also determined by a qualified hospital, on the basis of preliminary information provided by the applicant on a completed HPE application, to be eligible for managed care program services.~~

~~"**Primary care dentist**" or "**PCD**" means a provider under contract with a DBM to provide primary health care services, as contracted, and case management, including all medically necessary referrals for specialty services and prior authorizations. In these rules, "dental home provider" or "DH provider" bears the same meaning as "primary care dentist" or "PCD".~~

~~"**Primary care provider**" or "**PCP**" means a provider under contract with an MCO to provide primary health care services, as contracted, and case management, including securing all medically necessary referrals for specialty services and prior authorizations. In these rules, "patient-centered medical home provider" or "PCMH provider" bears the same meaning as "primary care provider" or "PCP".~~

~~"**Prior authorization**" or "**PA**" means a requirement that an enrollee, through the enrollee's provider, obtain the MCO's or DBM's approval before a requested medical service is provided or before services by a non-participating provider are received. Prior authorization is not a guarantee of claims payment; however, failure to obtain prior authorization may result in denial of the claim or reduction in payment of the claim.~~

~~"**Provider**" means a health care services provider licensed or certified in this State.~~

~~"**Provider agreement**" means an agreement between the MCO or DBM and a participating provider that describes the conditions under which the participating provider agrees to furnish covered health care services to enrollees.~~

~~"**Risk contract**" means a contract between OHCA and an MCO, prepaid inpatient health plan (PIHP), or prepaid ambulatory health plan (PAHP), as those terms are defined at 42 C.F.R. § 438.2, under which the contractor assumes risk for the cost of the services covered under the contract and incurs loss if the cost of furnishing the services exceeds the payments under the contract.~~

~~"**SoonerCare**" means the Oklahoma Medicaid program.~~

~~"**Soon-To-Be-Sooner**" means Oklahoma's separate CHIP providing coverage to unborn children~~

~~of families earning up to and including one hundred eighty-five percent (185%) of the FPL.~~

~~"**Specialty Children's Plan**" means the single statewide managed care plan, as contracted with a single MCO, that will coordinate and deliver health care services, as defined by contract, in a highly coordinated manner to the specialty population. The specialty population includes Medicaid eligibles who are FFC, select juvenile justice involved Office of Juvenile Affairs (OJA), in foster care (FC), children with an open prevention services case (PSC) through case workers or receiving adoption assistance (AA).~~

~~**"State Plan"** means an agreement between OHCA and CMS describing how Oklahoma administers its Medicaid and CHIP programs.~~

~~"**Steady state enrollment**" means the period of time, as defined by contract, when an individual, who first became an eligible during steady state operations or who became eligible again during steady state operations after more than two (2) months lapse of eligibility, can first enroll in and select an MCO or DBM for the managed care program.~~

~~"**Steady state operations**" or "**steady state**" means the period of time, as defined by contract, after initial implementation and prior to contract termination, during which all managed care program elements are expected to be operational.~~

~~"**Third party liability**" or "**TPL**" means all or part of the expenditures for a managed care enrollee's medical assistance furnished under the Oklahoma Medicaid State Plan that may be the liability of a third-party individual, entity or program.~~

~~"**Value-added benefit**" means any benefit or service offered by an MCO or DBM when that benefit or service is not a covered benefit per the State Plan. These benefits are subject to change annually as determined by the MCO or DBM and OHCA.~~

~~"**Value-based payment arrangement**" means a payment arrangement between an MCO or DBM and its participating providers when payment is intentionally aligned with quality measures OHCA applies to the MCO or DBM.~~

~~"**Value-based purchasing**" means the provisions of a contract for managed care services when those provisions intentionally align OHCA payments to the MCO or DBM under contract with quality measures or other performance factors OHCA may apply to the MCO or DBM.~~

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

"**1115(a) IMD waiver**" means the 1115(a) Institutions for Mental Disease (IMD) demonstration waiver for individuals with Serious Mental Illness/Serious Emotional Disorder (SMI/SED) and Substance Use Disorder (SUD), as amended and including all active special terms and conditions (STCs) at a specific point in time, that authorizes Oklahoma Health Care Authority (OHCA) to operate a program in which one (1) or more requirements of Title XIX of the Social Security Act (Act) are waived based on the waiver authority of Section 1115 of the Act.

"**1915(c) waiver**" means any waiver, authorized by Section 1915(c) of the Act, that allows specific coverage of home and community-based services to a limited group of Medicaid-Eligible individuals as an alternative to institutional care.

"Abuse" means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care (as defined at 42 C.F.R. § 455.2). It also includes Eligible and Health Plan Enrollee practices that result in unnecessary cost to the Medicaid program.

"**Accountable care organization**" or **"ACO"** means a network of physicians, hospitals, and other health care providers that provide coordinated care to Medicaid members.

"Accrediting entity" means an entity recognized by CMS under 45 C.F.R. § 156.275. Current CMS-recognized accrediting entities include Accreditation Association for Ambulatory Health Care

(AAAHC), National Committee for Quality Assurance (NCQA) and Utilization Review Accreditation Commission (URAC). To the extent CMS recognizes additional accrediting entities, OHCA will also permit the CE or DBM to achieve accreditation from such entity to meet the requirements.

"Act" means the Social Security Act.

"Activities of daily living (ADL)" means activities that reflect the Health Plan Enrollee's ability to perform self-care tasks essential for sustaining health and safety such as: bathing; eating; dressing; grooming; transferring (includes getting in and out of the tub, bed to chair, etc.); mobility; toileting and bowel/bladder control. The services help with proper medical care, self-maintenance skills, personal hygiene, adequate food, shelter, and protection.

"Administrative remedies" means an action taken by the OHCA in response to the DBM's failure to comply with a requirement or performance standard. Remedies, include but are not limit to, liquidated damages, capitation payment suspension, auto-assignment suspension, contract termination, and any other remedies outlined in the Contract.

"**Adult**" means an individual twenty-one (21) years of age or older, unless otherwise specified by statute, regulation, and/or policy adopted by the OHCA. For eligibility criteria policy for children and adults, please refer to Oklahoma Administrative Code (OAC) 317:35-5-2.

"**American Indian/Alaska Native"** or "**AI/AN**" means any individual as defined in 25 U.S.C. §§ 1603(13), 1603(28) or 1679(a) or who has been determined Eligible as an Indian under 42 C.F.R. § 136.12.

"**Appeal**" means a review by an CE or DBM of an adverse benefit determination.

"Applicant" means an individual who seeks SoonerCare coverage.

"**Authorized representative**" means a competent adult who has the Enrollee's signed, written authorization to act on the Enrollee's behalf during the grievance, appeal, and state fair hearing process. The written authority to act will specify any limits of the representation.

"Behavioral health services" means a wide range of diagnostic, therapeutic and rehabilitative services used in the treatment of mental illness, substance abuse, and co-occurring disorders.

"Business days" means Monday through Friday and is exclusive of weekends and State of Oklahoma holidays.

"Calendar days" means all seven (7) days of the week, including State of Oklahoma holidays.

"Capitated contract" means a contract between OHCA and a contracted entity for the delivery of services to Medicaid members in which OHCA pays a fixed, per-member per-month rate based on actuarial calculations.

"Capitation payment" means a payment OHCA will make periodically to the CE or DBM on behalf of each Health Plan Enrollee enrolled under the SoonerSelect program and based on the actuarially sound capitation rate for the provision of services under the State Plan. OHCA shall make the payment regardless of whether the Health Plan Enrollee receives services during the period covered by the payment.

"Capitation rate" means the per Health Plan Enrollee, per-month amount, including any adjustments, that is paid by OHCA to the CE or DBM for each Health Plan Enrollee enrolled in the SoonerSelect program for the provision of services during the payment period.

"Care coordination/care management" means a process that assesses, plans, implements, coordinates, monitors, and evaluates the options and services required to meet the Health Plan Enrollee's needs using advocacy, communication, and resource management to promote quality and cost-effective interventions and outcomes. Based on the needs of the Health Plan Enrollee, the care manager arranges services and supports across the continuum of care, while ensuring that the care provided is person-centered.

"Care manager" means the CE's staff primarily responsible for delivering services to Health

Plan Enrollees in accordance with its OHCA-approved risk stratification level framework, and meets the qualifications specified in the Contract.

"Care plan" means a comprehensive set of actions and goals for the Health Plan Enrollee developed by the care manager based on the unique needs of Health Plan Enrollee(s). The CE shall develop and implement care plans for all Health Plan Enrollees with a special health care need determined through the comprehensive assessment to need a course of treatment or regular care monitoring and in accordance with Section 1.8.3: "Care Plans" of the Contract.

"Case file" means an electronic record that includes Enrollee information regarding the management of health care services including but not limited to: Enrollee demographics; comprehensive assessment (if applicable); care plan; reassessments; referrals and authorizations and Enrollee case notes.

"CEO" means Chief Executive Officer.

"Certified community behavioral health clinic (CCBHC or CCBH)" means entities designed to provide a comprehensive range of mental health and substance use disorder services as defined under the Excellence in Mental Health Act and certified by the Oklahoma Department of Mental Health and Substance Abuse Services.

"**C.F.R.**" means the Code of Federal Regulations.

"**Child"** means an individual under twenty-one (21) years of age, unless otherwise specified by statute, regulation, and/or policy adopted by the OHCA. For eligibility criteria policy for children and adults, please refer to OAC 317:35-5-2.

"**Children's Health Insurance Program**" or **"CHIP"** means a Medicaid program authorized under Title XXI of the Social Security Act.

"Children's Specialty Plan" or **"Children's Specialty Program"** means the single statewide health care plan that covers all Medicaid services other than dental services and is designed to provide care to children in foster care children, former foster care children up to twenty-five (25) years of age, juvenile justice involved children, and children receiving adoption assistance.

"Child welfare services" means the Oklahoma Human Services (OKDHS) division responsible for administering Oklahoma's child welfare services.

"**Choice counseling**" means the provision of information and services designed to assist Eligibles in making enrollment decisions as described in 42 C.F.R § 438.2.

"**Chronic condition**" means a condition that is expected to last one (1) year or more and requires ongoing medical attention and/or limits activities of daily living (ADL).

"**Civil monetary damage**" means a damage imposed by OHCA which the CE must pay for acting or failing to act in accordance with 42 C.F.R. § 438.700 et seq. Amounts may not exceed those specified in 42 C.F.R. § 438.704.

"**Clean claim**" means a properly completed billing form with coding based on Current Procedural Terminology (CPT), fourth edition or a more recent edition, the tenth revision of the International Classification of Diseases (ICD) or a more recent revision, or Healthcare Common Procedure Coding System (HCPCS), where applicable, to provide information specifically required in the OHCA Provider Billing and Procedure Manual.

"**CMS"** means Centers for Medicare & Medicaid Services.

"Commercial plan" means an organization or entity that undertakes to provide or arrange for the delivery of health care services to Medicaid members on a prepaid basis and is subject to all applicable state and federal laws and regulations.

"Continuity of care period" means the ninety (90) day period immediately following an Enrollee's enrollment with the CE or DBM whereby established Enrollee and provider relationships, current services and existing prior authorizations and care plans shall remain in place.

"**Contract**" mean a result of receiving an award from OHCA and successfully meeting all

Readiness Review requirements, the agreement between the Contractor and OHCA where the Contractor will provide Medicaid services to SoonerSelect Enrollees, comprising of the Contract and any Contract addenda, appendices, attachments, or amendments thereto, and be paid by OHCA as described in the terms of the agreement.

"Contract year" means the period during which the Contract is in effect. The initial Contract year shall be from date of award through the end of the state fiscal year. Each subsequent Contract year shall be based on state fiscal year.

"Contracted entity" or **"CE"** means an organization or entity that enters into or will enter into a capitated contract with the Oklahoma Health Care Authority (OHCA) for the delivery of services that will assume financial risk, operational accountability, and statewide or regional functionality in this act in managing comprehensive health outcomes of Medicaid members. This includes an accountable care organization, a provider-led entity, a commercial plan, a dental benefit manager, or any other entity as determined by the OHCA.

"**Contractor"** means a contracted entity with which OHCA has entered into a binding agreement for the purpose of procuring services to SoonerSelect program Enrollees as specified in the Contract. The term "Contractor" includes all such Contractor's affiliates, agents, subsidiaries, any person with an ownership or control interest, officers, directors, manager, employees, independent contractors, and related parties working for or on behalf of the Contractor and other parties.

"**Copayment**" means a fixed amount that an Enrollee pays for a covered health care service when the Enrollee receives the service.

"Corrective action plan" or **"CAP"** means the detailed written plan that may be required by OHCA to correct or resolve a deficiency, event, or breach.

"Cost sharing" means the state's requirement that an Enrollee bear some of the cost of their care through mechanisms such as copayments, deductibles, and other similar charges.

"Critical incident" means any actual or alleged event or situation that creates a significant risk of substantial or serious harm to the physical or mental health, safety, or well-being of a SoonerSelect program Health Plan Enrollee.

"**Deemed newborn**" means children born to SoonerCare enrolled mothers and determined Eligible under 42 C.F.R. § 435.117.

"**Dental benefits manager**" or "**DBM**" means an entity that meets the definition of a Prepaid Ambulatory Health Plan (PAHP) as per 42 C.F.R. § 438.2 and is under contract with the OHCA to manage and deliver all services described in this SoonerSelect Dental Contract and who handles claims payment and prior authorizations and coordinates dental care with participating providers and Enrollees. Also referred to as a "Contractor".

"Dental related emergency services" means services provided to a SoonerSelect Dental Enrollee that are necessary for the treatment of any condition requiring immediate attention for the relief of pain, hemorrhage, acute infections, or traumatic injury to the teeth, supporting structures (periodontal membrane, gingival, alveolar bone), jaws, and tissue of the oral cavity.

"**Disenrollment**" means OHCA's removal of an Enrollee from participation in a specific CE or DBM or from participation in the SoonerSelect program.

"Dual eligible individuals" means individuals eligible for both Medicaid and Medicare.

"**Eligible**" means an individual who has been deemed Eligible for the SoonerSelect program but who is not yet enrolled in a CE or DBM.

"Emergency medical condition" means a medical condition, including injury, manifesting itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in placing the individual's health, or the health of an unborn child, in serious jeopardy, serious impairment to bodily functions or serious dysfunction of any

bodily organs or parts.

"**Emergency services**" means medical services provided for a medical condition, including injury, manifesting itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in placing the individual's health, or the health of an unborn child, in serious jeopardy, serious impairment to bodily functions or serious dysfunction of any bodily organs or parts.

"Encounter data" means information relating to the receipt of any item(s) or service(s) by an Enrollee under the Contract that is subject to the requirements of 42 C.F.R. §§ 438.242 and 438.818.

"**Enrollee**" means an individual who has been deemed Eligible for Medicaid in the State of Oklahoma, who has been deemed Eligible for enrollment in the SoonerSelect program, and who is currently enrolled in the SoonerSelect program.

"**Enrollee handbook**" means a guidebook that explains the SoonerSelect program that the Contactor shall distribute to every Enrollee. It shall be designed to help the Enrollee understand the CE or DBM, the SoonerSelect program and the rights and responsibilities that come with membership in the program.

"**Enrollment"** means the OHCA process by which an Eligible becomes an Enrollee with an CE or DBM.

"**Essential community provider**" means a provider defined by 45 C.F.R. § 156.235.

"**Expansion adult**" means an individual nineteen (19) or older and under age sixty-five (65), with income at or below one hundred thirty-eight percent (138%) of the federal poverty level (FPL) determined Eligible in accordance with 42 C.F.R. § 435.119~~)~~, and who are not categorically related to the aged, blind, and disabled.

"Excluded populations" means populations that are excluded from participation in the SoonerSelect program as specified in the Contract.

"Federally Qualified Health Center (FQHC)"or **"Health Centers"** or **"Centers"** means an organization that qualifies for reimbursement under Section 330 of the Public Health Service Act. FQHCs qualify to receive enhanced reimbursements from Medicare and Medicaid, must serve an underserved population or area, offer a sliding fee scale, provide comprehensive services, have an ongoing quality assurance program, and have a governing board of directors.

"Former foster care children" or "**FFC**" means individuals under age twenty-six (26) determined Eligible in accordance with 42 C.F.R. § 435.150 who were in foster care under the responsibility of the State or an Indian Tribe within Oklahoma and enrolled in SoonerCare on the date of attaining age eighteen (18) or aging out of foster care.

"Foster care" means planned, goal-directed service that provides twenty-four (24) hour a day substitute temporary care and supportive services in a home environment for children birth to eighteen (18) years of age in OKDHS custody.

"**Foster children (FC)"** means children in foster care under the responsibility of the State, including children and youth who are in State custody due to abuse or neglect.

"FPL" means federal poverty level.

"**Fraud**" means intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable federal or state law.

"**Grievance**" means an Enrollee's expression of dissatisfaction about any matter other than an adverse benefit determination. Grievances may include, but are not limited to, the quality of care or services provided, aspects of interpersonal relationships such as rudeness of a provider or employee or failure to respect the Enrollee's rights regardless of whether remedial action is requested. A grievance includes an Enrollee's right to dispute an extension of time proposed by the CE or DBM to

make an authorization decision.

"**Grievance and appeal system**" means the processes the CE or DBM must implement in accordance with 42 C.F.R. Part 438, Subpart F, to handle Enrollee grievances and appeals, as well as the processes to collect and track information about them.

"**Health care services**" means all services outlined in the Oklahoma Medicaid State Plan, the Alternative Benefit Plan, and the 1115(a) IMD Waiver that are provided, according to contract, by the CE or DBM in any setting. Health care services may include but are not limited to medical care, behavioral health care, dental care, and pharmacy services.

"**Health plan**" means the same in these rules as at 36 O.S. § 4405.1.

"Hospitalization" means care in a hospital that requires admission as an inpatient and usually requires an overnight stay.

"**Implementation**" means the process by which OHCA and the CE or DBM performs actions and responsibilities to actively implement a managed care program or contract for the first time. Implementation also means, depending on its use, the moment in time that such actions and responsibilities are fully completed.

"**Indian health care provider**" or "**IHCP**" means a health care program operated by the Indian Health Service (IHS) or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (otherwise known as an I/T/U) as those terms are defined in Section 4 of the Indian Health Care Improvement Act (25 U.S.C. § 1603).

"**Initial enrollment**" means an Eligible's enrollment in an CE or DBM during the initial enrollment period.

"Intermediate sanction(s)" means the sanctions described in 42 C.F.R § 438.702, which the OHCA may impose for the contracted entities non-compliance for any of the conditions in 42 C.F.R. § 438.700.

"Juvenile justice involved" means any person in custody or under the supervision of the Oklahoma Office of Juvenile Affairs (OJA) for whom OJA is required to provide services by law or court order.

"**Manual**" or "**guide**" means any document, outside of the Medicaid State Plan, any Medicaid waiver, and the rules, that is created by or for OHCA for use in interpreting or implementing contractual terms. "Manual" is synonymous with guide, guidebook, companion guide, manual, reference book, dictionary, handbook, model, instructions, primer, workbook, or any other words denoting a document that is handled as a matter of convenience.

"**Medical necessity**" or **"medically necessary"** means a standard for evaluating the appropriateness of services as established under OAC 317:30-3-1.

"National provider identifier (NPI)" means a unique identification number for covered health care providers. Covered health care providers and all CEs, DBMs, and health care clearinghouses must use an NPI in the administrative and financial transactions adopted under the Health Insurance Portability and Accountability Act (HIPAA). The NPI is a ten-position, intelligence-free numeric identifier (ten-digit number). This means that the numbers do not carry other information about healthcare providers, such as the state in which they live or their medical specialty. The NPI must be used in lieu of legacy provider identifiers in the HIPAA standards transactions.

"Non-compliance remedy" means an action taken by OHCA in response to the Contractor's failure to comply with a contract requirement or performance standard.

"**Non-participating provider**" means a physician or other provider who has not contracted with or is not employed by the CE or DBM to deliver services under the SoonerSelect program.

"Non-urgent sick visit" means medical care given for an acute onset of symptoms which is not emergent or urgent, but which requires face-to-face medical attention within seventy-two (72) hours of Enrollee notification of a non-urgent condition, as clinically indicated. Examples of non-urgent

sick visits include cold symptoms, sore throat, and nasal congestion.

"OAC" means Oklahoma Administrative Code.

"OHCA" means the Oklahoma Health Care Authority.

"OJA" means the Office of Juvenile Affairs.

"OKDHS" means the Oklahoma Department of Human Services which is also referenced in rules as Department of Human Services (DHS) and Office of Human Services (OHS).

"**Open enrollment period**" means the annual period of time, as defined by contract, when Enrollees and Eligibles can enroll in and select an CE or DBM for the SoonerSelect program.

"O.S." means Oklahoma Statutes.

"**Parent and caretaker relative**" means an individual determined Eligible under 42 C.F.R. § 435.110.

"**Participating provider**" means a physician or other provider who has a contract with or is employed by a CE or DBM to provide health care services to Enrollees under the SoonerSelect Medical or Dental program.

"Post-stabilization care services" means covered services related to an emergency medical condition that are provided after a Health Plan Enrollee is stabilized to maintain the stabilized condition or under the circumstances described in 42 C.F.R. § 438.114(e), to improve or resolve the Health Plan Enrollee's condition.

"**Pregnant women**" means women determined Eligible for SoonerCare under 42 C.F.R. § 435.116.

"Prepaid Ambulatory Health Plan" or **"PAHP"** means a DBM and/or an entity as per 42 C.F.R. § 438.2 that:

(A) Provides services to Enrollees under contract with the state, and on the basis of capitation payments, or other payment arrangements that do not use State Plan payment rates;

(B) Does not provide or arrange for, and is not otherwise responsible for the provision of any inpatient hospital or institutional services for its Enrollees; and

(C) Does not have a comprehensive risk contract.

"Prepaid dental plan" means a contractual arrangement in accordance with 36 O.S. § 6142, whereby any prepaid dental plan organization undertakes to provide payment of dental services directly, or to arrange for prepaid dental services, or to pay or make reimbursement for any dental services not provided for by other insurance.

"Prepaid dental plan organization" means any person who undertakes to conduct one (1) or more prepaid dental plans providing only dental services in accordance with 36 O.S. § 6142.

"**Presumptive eligibility**" means a period of temporary SoonerCare eligibility for individuals who are categorically related to certain eligibility groups listed in OAC 317:35-6-38(a)(1)(A)(i) through (vi) and are also determined by a qualified entity, on the basis of applicant self-attested income information, to meet the eligibility requirements for a Modified Adjusted Gross Income (MAGI) eligibility group.

"Primary care" means the provision of integrated, equitable, and accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community.

"**Primary care dentist**" or "**PCD**" means a dental care professional providing comprehensive dental care for a Dental Health Plan Enrollee.

"**Primary care provider**" or "**PCP**" means the following:

(A) Family medicine physicians in an outpatient setting when practicing general primary care;

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(B) General pediatric physicians and adolescent medicine physicians in an outpatient setting when practicing general primary care;

(C) Geriatric medicine physicians in an outpatient setting when practicing general primary care;

(D) Internal medicine physicians in an outpatient setting when practicing general primary care (excludes internists who subspecialize in areas such as cardiology, oncology, and other common internal medicine subspecialties beyond the scope of general primary care);

(E) Obstetrics and gynecology physicians in an outpatient setting when practicing general primary care;

(F) Providers such as nurse practitioners and physicians' assistants in an outpatient setting when practicing general primary care; or

(G) Behavioral health providers, including psychiatrists, providing mental health and substance use disorder services when integrated into a primary care setting.

"**Prior authorization**" or "**PA**" means a requirement that an Enrollee, through the Enrollee's provider, obtain the CEs or DBM's approval before a requested medical service is provided or before services by a non-participating provider are received. Prior authorization is not a guarantee of claims payment; however, failure to obtain prior authorization may result in denial of the claim or reduction in payment of the claim.

"Protected health information" or **"PHI"** means information considered to be individually identifiable health information, per 42 C.F.R.§ 160.103.

"**Provider**" means a health care services provider licensed or certified in this State.

"**Provider agreement**" means an agreement between the CE or DBM and a participating provider that describes the conditions under which the participating provider agrees to furnish covered health care services to Enrollees.

"Provider-led entity" means an organization or entity that meets the criteria of at least one (1) of the following:

(A) A majority of the entity's ownership is held by Medicaid providers in this state or is held by an entity that directly or indirectly owns or is under common ownership with Medicaid providers in the state; or

(B) A majority of the entity's governing body is composed of individuals who:

(i) Have experience serving Medicaid members and:

(I) Are licensed in the state as physicians, physician assistants, nurse practitioners, certified nurse-midwives, or certified registered nurse anesthetists;

(II) At least one (1) board member is a licensed behavioral health provider; or

(III) Are employed by a hospital or other medical facility licensed by the state and operating in the state or an inpatient or outpatient mental health or substance abuse treatment facility or program licensed or certified by the state and operating in the state.

(ii) Represent the providers or facilities including, but not limited to, individuals who are employed by a statewide provider association; or

(iii) Are nonclinical administrators of clinical practices serving Medicaid members.

"Quality Assessment and Performance Improvement" or **"QAPI"** means a process designed to address and continuously improve CE and DBM quality metrics.

"**Risk contract**" means a contract between OHCA and a CE, prepaid inpatient health plan (PIHP), or prepaid ambulatory health plan (PAHP), as those terms are defined at 42 C.F.R. § 438.2, under which the Contractor assumes risk for the cost of the services covered under the contract and incurs loss if the cost of furnishing the services exceeds the payments under the Contract.

"Rural area" means a county with a population of less than fifty thousand (50,000) people.

"Rural Health Clinic" or **"RHC"** means clinics meeting the conditions to qualify for RHC reimbursement as stipulated in Section 330 of the Public Health Services Act.

"**SoonerCare**" means the Oklahoma Medicaid program.

"SoonerSelect" means the CEs and DBMs with whom the OHCA contracts with to provide SoonerCare covered medical, dental, pharmacy, and behavioral health benefits.

"**Soon-To-Be-Sooner**" means Oklahoma's separate CHIP providing coverage to unborn children of families earning up to and including one hundred eighty-five percent (185%) of the FPL.

"State Plan" means an agreement between OHCA and CMS describing how Oklahoma administers its Medicaid and CHIP programs.

"**Steady state operations**" or "**steady state**" means the time period beginning ninety (90) days after initial program implementation.

"**Third party liability**" or "**TPL**" means all or part of the expenditures for an Enrollee's medical or dental assistance furnished under the Oklahoma Medicaid State Plan that may be the liability of a third-party individual, entity, or program.

"Urban area" means a county with a population of fifty thousand (50,000) people or more.

"U.S.C." means United States Code.

"**Value-added benefit**" means any benefit or service offered by a CE or DBM when that benefit, or service is not a covered benefit per the State Plan. These benefits are subject to change annually as determined by the CE or DBM and OHCA.

"**Value-based payment arrangement**" means a payment arrangement between a CE or DBM and its participating providers when payment is intentionally aligned with quality measures OHCA applies to the CE or DBM.

"Waste" means the overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to the Medicaid program; generally, not considered to be caused by criminally negligent actions but rather the misuse of resources.

317:55-1-4. Eligible entities

Eligible entities. The OHCA shall enter into a capitated contract for the delivery of statewide Medicaid services. Eligible entities include an accountable care organization, a provider-led entity, a commercial plan, or any other entity as determined by OHCA. The CE or DBM shall meet the following requirements:

(1) **Licensure and certificate of authority.**

(A) The CE must be licensed as a Health Maintenance Organization (HMO) pursuant to 36 O.S. § 6901 et seq.

(B) The CE must furnish OHCA with a certificate of authority, to operate as an HMO, prior to contract implementation.

(C) The DBM must be licensed and authorized, as prepaid dental health plan, and able to transact dental business in the State of Oklahoma in accordance with 36 O.S. § 6141 et seq.

(D) The DBM must furnish OHCA with a certificate of authority for accident and health insurance or pre-paid dental prior to contract implementation in accordance with 36 O.S. § 703.

(E) Any changes to the certificate of authority, for CE and DBM, must be reported immediately to the OHCA.

(2) **Accreditation.** The CE or DBM shall seek accreditation from a private independent accrediting entity within eighteen (18) months of initial enrollment implementation. When undergoing accreditation, the CE or DBM shall submit reports documenting the status of the accreditation process as required in the Contract and reporting manual.

(A) **Accreditation review.** The CE or DBM shall authorize the accrediting entity to provide the OHCA a copy of the CE's or DBM's most recent accreditation review including:

(i) Accreditation status, survey type, and level (as applicable);

(ii) Accreditation results, including recommended actions or improvements, corrective action plans, and summaries of findings; and

(iii) Expiration date of the accreditation.

(B) **Reaccreditation.** The CE and DBM shall undergo reaccreditation in accordance with the timeframes required by the accrediting entity and federal regulations.

(C) **Health Equity Accreditation for CE.** The CE must earn Health Equity Accreditation from an accrediting entity in accordance with the contract terms.

(D) **Failure to achieve or maintain accreditation for a CE.** Failure to achieve or maintain accreditation shall be considered a breach of the CE Contract and may result in intermediate sanctions/penalties or termination in accordance with OAC 317:55-5-10(e)

(E) **Failure to achieve or maintain accreditation for a DBM.** Failure to achieve or maintain accreditation shall be considered a breach of the DBM Contract and may result in administrative remedies, including liquidated damages or termination, in accordance with OAC 317:50-5-11 and 317:55-5-12.

317:55-1-5. Program administration requirements

(a) **Compliance**. The CE or DBM shall comply with all applicable state and federal laws and regulations, including, but not limited to, 42 C.F.R. Part 438, and HIPAA privacy and security law, as defined in Section 3009 of the Public Health Service Act.

(b) **Subcontracting.** The CE or DBM shall seek approval from the OHCA prior to the effective date of any subcontract for performance of certain Contract responsibilities.

(1) The CE or DBM shall maintain ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its Contract with OHCA, notwithstanding any relationship(s) with any subcontractors. The CE or DBM shall actively monitor subcontractors to ensure their compliance with the Contract and verify the quality of their services.

(2) The CE or DBM is prohibited from entering into any subcontract for the performance of any duty under the Contract in which such services are to be transmitted or performed outside of the United States.

(c) **Staffing.** The CE or DBM shall have sufficient staff to operate efficiently and meet all Contract obligations and standards. Additionally, the CE or DBM shall ensure staff and subcontractor staff receive detailed training on the requirements, policies, and procedures of the SoonerSelect program. All CE or DBM staff, including subcontractor staff, shall receive initial and ongoing training and education necessary to fulfill their job responsibilities under the Contract.

(d) **Policies and procedures.** The CE or DBM and any subcontractor shall:

(1) Develop and maintain written policies and procedures describing in detail how the CE or DBM and any subcontractor will fulfill the responsibilities outlined in the Contract.

(2) Submit all policies and procedures for OHCA's review and approval prior to adoption and implementation.

(3) Submit an annual certification in which the CE or DBM attests to the creation of updated policies and procedure.

(e) **Readiness review.**

(1) In accordance with 42 C.F.R. § 438.66(d)(1), the CE or DBM is required to participate, submit documentation, and satisfactorily pass the readiness review process in the following situations:

(A) Prior to initial implementation;
(B) When the specific CE or DBM has not previously contracted with the state; or
(C) When the CE or DBM, which is currently contracted with the state, will begin to provide, or arrange for covered benefits to new eligibility groups.

(2) All readiness review activities shall be completed to the satisfaction of OHCA and CMS pursuant to the Contract and/or any other policy guidelines/memorandum before being eligible to receive enrollment of Eligibles.

(3) Additionally, the state will conduct a desk review / optional on-site review of new subcontracts executed during the Contract term, or when the subcontract undertakes new eligibility groups or services. CEs, DBMs, and their subcontractors must adhere to all the contractual obligations found at 42 C.F.R. Part 438.

(f) **Marketing**. The CE or DBM must provide each Enrollee with an Enrollee handbook within ten (10) days and identification card within seven days (7) days after receiving notice of the Enrollee's enrollment or within ten (10) days of the Enrollee's request for the Enrollee handbook. The CE or DBM shall not falsify or misrepresent information that furnishes to an Enrollee, Eligible or provider. All marketing activities and materials shall comply with applicable laws and regulations regarding marketing by the Contractor and Contract terms. The OHCA shall approve all marketing materials, which must comply with federal funding requirements, including 42 C.F.R. § 438.10 and 42 C.F.R. § 438.104.

(g) **Accessibility**. The CE or DBM shall ensure Enrollees and providers have continuous access to information as determined by OHCA and that complies with the requirements at Section 508 of the Rehabilitation Act of 1973, Pub. L. No. 93-112, and the Oklahoma Electronic and Information Technology Accessibility law, 2004 HB 2197. To ensure ongoing accessibility standards are met, the CE or DBM shall:

(1) Provide its URL to the OHCA and any changes to the URL shall be approved by the OHCA.
(2) Assign and maintain a point of contact to assist the OHCA with interfacing/exchanging data in the CE's or DBM's system.

(h) **Disaster preparation and data recovery**. The CE and DBM shall submit to the OHCA and maintain a written disaster plan for information resources that will ensure service continuity as required by the Contract.

(i) **System performance.** The CE and DBM shall meet performance requirements pursuant to the Contract.

(j) **Call center standards.** The CE and DBM shall provide assistance to Enrollees and providers through a toll-free call-in system that meets the performance standards and requirements outlined in the Contract.

(k) **Failure to comply.** If the CE or DBM fails to comply with OAC 317:55-1-5, the OHCA may impose any or all the CE intermediate sanctions, found at OAC 317:55-5-10 and the CE Contract, or DBM administrative remedies, found at OAC 317:55-5-11 and the DBM Contract.

SUBCHAPTER 3. GENERAL PROGRAM INFORMATION

PART 1. ELIGIBILITY, ENROLLMENT AND CONTINUITY OF CARE

317:55-3-1. ~~**Mandatory populations**~~**Mandatory, voluntary, and excluded populations**

~~(a) **Mandatory MCO enrollment.** Per 56 O.S. § 4002.3, eligibles in the following categories will be mandatorily enrolled in the MCP and with an MCO:~~

~~(1) Expansion adults;~~
~~(2) Parents and caretaker relatives;~~

~~(3) Pregnant women;~~
~~(4) Deemed newborns;~~
~~(5) Children; and~~
~~(6) All other populations requiring mandatory coverage pursuant to in 42 C.F.R. Part 435, Subpart B (§§ 435.100 435.172), unless otherwise covered by SoonerCare.~~

~~(b) **Mandatory Specialty Children's Plan enrollment.** Per 56 O.S. § 4002.3, eligibles in the following categories, upon entering custody of the State, will be mandatorily enrolled in the MCP and with the MCO under contract to provide the Specialty Children's Plan:~~

~~(1) Foster children (FC); and~~
~~(2) Certain children in the custody of OJA.~~

~~(c) **Mandatory Specialty Children's Plan enrollment, opt out.** Per 56 O.S. § 4002.3, eligibles in the following categories will be mandatorily enrolled in the MCP and with the MCO under contract to provide the Specialty Children's Plan, if they do not select a different MCO during initial enrollment, open enrollment, or steady state enrollment:~~

~~(1) Former foster care (FFC); and~~
~~(2) Children receiving adoption assistance (AA).~~

~~(d) **Mandatory DBM enrollment.** Per 56 O.S. § 4002.3, the following eligibles will be mandatorily enrolled in the MCP and with a DBM:~~

~~(1) Expansion adults;~~
~~(2) Parents and caretaker relatives;~~
~~(3) Pregnant women;~~
~~(4) Deemed newborns;~~
~~(5) Former foster children;~~
~~(6) Certain children in the custody of OJA;~~
~~(7) Foster care children;~~
~~(8) Children receiving adoption assistance; and~~
~~(9) Children.~~

(a) **Mandatory populations.** The following SoonerCare Eligibles will be mandatorily enrolled with a CE and DBM under the SoonerSelect Dental and Medical program:

(1) Expansion adults;
(2) Parents and caretaker relatives;
(3) Pregnant women;
(4) Deemed newborns;
(5) Former foster children;
(6) Juvenile justice involved children;
(7) Foster care children;
(8) Children receiving adoption assistance; and
(9) Children.

(b) **Voluntary populations.** SoonerCare Eligible individuals may voluntarily choose to enroll in the SoonerSelect Dental and Medical program through an opt-in process if they are American Indians and/or Alaskan Natives. AI/AN populations will have the option to:

(1) Voluntarily enroll in the DBM and/or CE through an opt-in process;
(2) Enroll in a DBM and/or CE at each open enrollment period, regardless of initial selection or past disenrollment from the DBM and/or CE;
(3) When enrolled, AI/AN populations may:
(A) Receive services from an IHCP;
(B) Choose the IHCP as the Enrollee's provider, if the provider has the capacity to provide such services;

(C) Obtain services covered under the Contract from out-of-network IHCPs when the Enrollee is otherwise Eligible to receive the IHCP's services;
(D) Self-refer for services provided by IHCPs to AI/AN Enrollees;
(E) Obtain services covered under the Contract from out-of-network IHCPs when the AI/AN Enrollee is otherwise Eligible to receive the IHCP's services; and
(F) Disenroll from any DBM and/or CE at any time without cause.

(c) **Excluded populations.** The following individuals are excluded from enrollment in the SoonerSelect program:
(1) Dual-eligible individuals;
(2) Individuals enrolled in the Medicare Savings Program, including Qualified Medicare Beneficiaries (QMB), Specified Low Income Medicare Beneficiaries (SLMB), Qualified Disabled Workers (QDW) and Qualified Individuals (QI);
(3) Persons with a nursing facility or ICF-IID level of care, except for Enrollees with a pending level of care determination;
(4) Individuals during a period of presumptive eligibility;
(5) Individuals infected with tuberculosis Eligible for tuberculosis-related services under 42 C.F.R. § 435.215;
(6) Individuals determined Eligible for SoonerCare on the basis of needing treatment for breast or cervical cancer under 42 C.F.R. § 435.213;
(7) Individuals enrolled in a § 1915(c) Waiver;
(8) Undocumented persons Eligible for emergency services only in accordance with 42 C.F.R. § 435.139;
(9) Insure Oklahoma Employee Sponsored Insurance (ESI) dependent children in accordance with the Oklahoma Medicaid State Plan;
(10) Coverage of Pregnancy-Related Services under Title XXI for the benefit of unborn children ('Soon- to-be-Sooners'), as allowed by 42 C.F.R. § 457.10; and
(11) Individuals determined Eligible for Medicaid on the basis of age, blindness, or disability.

(d) **Additional eligibility criteria.** For additional eligibility criteria, refer to Chapter 35 Medical Assistance for Adults and Children Eligibility Manual, Subchapter 5 Eligibility and Countable Income.

317:55-3-2. ~~Excluded populations~~Enrollment and disenrollment process

~~(a) Per 56 O.S. § 4002.3, individuals in the following categories will be excluded from enrollment in a MCP contracted with one (1) or more MCOs:~~
~~(1) Dual eligible individuals;~~
~~(2) Individuals enrolled in the Medicare Savings Program, including Qualified Medicare Beneficiaries (QMB), Specified Low Income Medicare Beneficiaries (SLMB), Qualified Disabled Workers (QDW) and Qualified Individuals (QI);~~
~~(3) Persons with a nursing facility or intermediate care facility for individuals with intellectual disabilities (ICF/IID) level of care, except that enrollees who are transitioning into long-term care will remain enrolled in any MCO for up to sixty (60) days while the enrollee's level of care determination is pending. Prior to disenrollment from an MCO, such excepted enrollees will receive a facility's pre-admission screening and resident review (PASRR) process. If OHCA approves the PASRR and designates the nursing facility or ICF/IID level of care, reimbursement will be made to the facility and the enrollee will be disenrolled from their MCO;~~
~~(4) Individuals during a period of presumptive eligibility;~~
~~(5) Individuals infected with tuberculosis eligible for tuberculosis-related services under 42 C.F.R. § 435.215;~~

~~(6) Individuals determined eligible for SoonerCare on the basis of needing treatment for breast or cervical cancer under 42 C.F.R. § 435.213;~~
~~(7) Individuals enrolled in a 1915(c) waiver;~~
~~(8) Undocumented persons eligible for emergency services only in accordance with 42 C.F.R. § 435.139;~~
~~(9) Insure Oklahoma employee sponsored insurance (ESI) dependent children in accordance with the Oklahoma Title XXI State Plan;~~
~~(10) Coverage of pregnancy-related services under Title XXI for the benefit of unborn children (Soon- to-be-Sooners), as allowed by 42 C.F.R. § 457.10; and~~
~~(11) Individuals determined eligible for Medicaid on the basis of age, blindness or disability.~~
~~(b) Per 56 O.S. § 4002.3, eligibles in the following categories will be excluded from enrollment in a MCP contracted with one (1) or more DBMs:~~
~~(1) Dual eligible individuals;~~
~~(2) Individuals enrolled in the Medicare Savings Program, including QMB, SLMB, QDW and QI;~~
~~(3) Persons with a nursing facility or ICF-IID level of care, except that enrollees who are transitioning into long-term care will remain enrolled in any DBM for up to sixty (60) days while the enrollee's level of care determination is pending. Prior to disenrollment from a DBM, such excepted enrollees will receive a facility's PASRR process. If OHCA approves the PASRR and designates the nursing facility or ICF/IID level of care, reimbursement will be made to the facility and the enrollee will be disenrolled from the DBM.~~
~~(4) Individuals during a period of presumptive eligibility;~~
~~(5) Individuals infected with tuberculosis eligible for tuberculosis-related services under 42 C.F.R. § 435.215;~~
~~(6) Individuals determined eligible for SoonerCare on the basis of needing treatment for breast or cervical cancer under 42 C.F.R. § 435.213;~~
~~(7) Individuals enrolled in a §1915(c) waiver;~~
~~(8) Undocumented persons eligible only for emergency services in accordance with 42 C.F.R. § 435.139;~~
~~(9) Insure Oklahoma Employee Sponsored Insurance (ESI) dependent children in accordance with the Oklahoma Title XXI State Plan;~~
~~(10) Coverage of Pregnancy-related services under Title XXI for the benefit of unborn children (Soon-to-be-Sooners), as allowed by 42 C.F.R. § 457.10; and~~
~~(11) Individuals determined eligible for Medicaid on the basis of age, blindness or disability.~~

(a) **Enrollment process.** The OHCA beneficiary support system will provide choice counseling to all potential Enrollees at the time of initial enrollment, during the annual open enrollment period and for Enrollees who disenroll from a CE or DBM for good cause as described in the Contract and in this Section. The OHCA, or its designee, will provide information about individual CE or DBM benefit structures, services, and network providers, as well as information about other Medicaid programs as requested by the Eligible to assist the Eligible in making an informed selection.

(1) **Selection/auto assignment.** During the application process, at OHCA's discretion, an Applicant may have up to sixty (60) days to select a contracted CE and DBM of their choice. Applicants who are Eligible to choose a CE and DBM and fail to make an election on the SoonerCare application, within the allotted timeframe, will be assigned to the CE and DBM that is due next to receive an auto assignment.

(2) **Exemptions to auto-assignments**

(A) The OHCA will not make auto-assignments to the CE if:

(i) The CE's maximum enrollment has been capped and actual enrollment has reached

ninety-five percent (95%) of the cap;

(ii) The CE has been excluded from receiving new enrollment due to the application of non-compliance remedies; or

(iii) The CE has failed to meet readiness review requirements.

(B) The OHCA will not make auto-assignments to the DMB if:

(i) The DBM's maximum enrollment has been capped and actual enrollment has reached ninety-five percent (95%) of the cap;

(ii) The DBM has been excluded from receiving new enrollment due to the imposition of administrative remedies; or

(iii) The DBM has failed to meet readiness review requirements.

(3) **Enrollment effective date**

(A) Eligibles, with the exception of deemed newborns, who select or are assigned to a CE and/or DBM from the first day of the month through the fifteenth day of the month shall be enrolled effective on the first day of the following month.

(B) Eligibles who select or are assigned to a CE and/or DBM on the sixteenth (16^{th}) day of the month through the last day of the month will be enrolled effective on the first day of the second following month.

(C) Prior to these enrollment dates, most Eligibles will be covered by a fee-for-service payment structure administered by OHCA.

(D) Deemed newborns eligible for the CE and/or DBM shall be enrolled effective as of the date of birth, if the newborn's mother also is enrolled in the SoonerSelect program.

(E) Notwithstanding the foregoing, the effective date of enrollment with the CE or DBM shall be the date recorded on the outbound ANSI ASC X 12 834 electronic transaction sent by OHCA.

(4) **Enrollment lock-in period.** An Enrollee may, within the first ninety (90) days of initial enrollment, request to change enrollment without cause from the CE and/or DBM, or during the ninety (90) days following the date OHCA sends the Enrollee notice of initial enrollment, whichever is later. Enrollees will also be permitted to change CEs and/or DBMs, without cause, at least once every twelve (12) months during the open enrollment period. After the disenrollment period from the CE or DBM has lapsed, the Enrollee will remain enrolled with the CE or DBM until the next annual open enrollment period, unless:

(A) The SoonerSelect Medical Enrollee:

(i) Is disenrolled due to loss of SoonerCare eligibility;

(ii) Becomes a foster child under custody of the state;

(iii) Becomes juvenile justice involved under the custody of the state;

(iv) Is a former foster care or child receiving adoption assistance and opts to enroll in the SoonerSelect Children's Specialty program;

(v) Demonstrates good cause under the following conditions:

(I) The Enrollee moves out of the service area;

(II) The Enrollee requires specialized care for a chronic condition and the Enrollee or Enrollee's representative, the CE, OHCA and receiving CE agree that assignment to the receiving CE is in the Enrollee's best interest;

(III) The plan does not cover the service the Enrollee seeks, because of moral or religious objections;

(IV) The Enrollee needs related services to be performed at the same time; not all related services are available within the CE's network; and the Enrollee's primary care provider or another provider determines that receiving the services separately would subject the Enrollee to unnecessary risk;

(V) For other reasons, including a filed and prevailed grievance related to poor quality of care, lack of access to services covered under the Contract, or lack of access to providers experienced in dealing with the Enrollee's oral health care needs or other matters deemed sufficient to warrant disenrollment; and

(VI) The Enrollee has been enrolled in error, as determined by the OHCA.

(vi) Experiences a temporary loss of eligibility or enrollment which caused the Enrollee to miss the annual disenrollment period, then the Enrollee may disenroll without cause upon reenrollment; or

(vii) The OHCA has imposed intermediate sanctions on the CE and allows Enrollees to disenroll without cause.

(B) The SoonerSelect Dental Enrollee:

(i) Is disenrolled due to loss of SoonerCare eligibility;

(ii) Demonstrates good cause under the following conditions:

(I) The Enrollee moves out of the service area;

(II) The plan does not cover the service the Enrollee seeks, because of moral or religious objections;

(III) The Enrollee needs related services to be performed at the same time; not all related services are available within the DBM's network; and the Enrollee's primary care dental provider or another provider determines that receiving the services separately would subject the Enrollee to unnecessary risk;

(IV) For other reasons, including a filed and prevailed grievance related to poor quality of care, lack of access to services covered under the Contract, or lack of access to providers experienced in dealing with the Enrollee's oral health care needs or other matters deemed sufficient to warrant disenrollment; and

(V) The Enrollee has been enrolled in error, as determined by the OHCA.

(iii) Experiences a temporary loss of eligibility or enrollment which caused the Enrollee to miss the annual disenrollment period, then the Enrollee may disenroll without cause upon reenrollment; or

(iv) The DBM is terminated.

(5) **Annual and special enrollment periods.** Sixty (60) days prior to the start of the Enrollee's annual open enrollment period, the Enrollee shall be notified of the option to maintain enrollment with the current CE and/or DBM or to enroll with a different CE and/or DBM. OHCA, at its sole discretion, may schedule a special open enrollment period, under the following circumstances:

(A) In the event of the early termination of a CE or DBM under the process described in the Contract; or

(B) The loss of a major participating provider(s) places the CE or DBM at risk of failing to meet service accessibility standards and the CE or DBM does not have an acceptable plan for mitigating the loss or finding of non-compliance.

(6) **Enrollment caps.** OHCA, at its sole discretion, may impose a cap on the CE or DBM's enrollment, in response to a request by the CE or DBM or as part of a corrective action in accordance to the respective Contract.

(b) **Disenrollment**. The OHCA shall have sole authority to grant or deny a disenrollment request from the Enrollee, and/or CE or DBM.

(1) **CE or DBM-requested disenrollment**. Pursuant to 42 C.F.R. § 438.56(b)(2), the CE or DBM cannot request a disenrollment based on adverse change in the member's health status or utilization of medically necessary services, diminished mental capacity, or uncooperative or disruptive behavior resulting from their special needs, except when their continued Enrollment

with the Contractor seriously impairs the Contractor's ability to furnish services to either this particular Enrollee or other Enrollees.

(A) The CE may only request disenrollment of the Enrollee only for good cause. The following actions, if found by OHCA, comprise good cause:

(i) The Enrollee requires specialized care for a chronic condition and the Enrollee or Enrollee's representative, the CE, OHCA and receiving CE agree that assignment to the receiving CE is in the Enrollee's best interest;

(ii) The Enrollee has been enrolled in error, as determined by OHCA;

(iii) The Enrollee has exhibited disruptive behaviors to the extent the CE cannot effectively manage their care, and the CE has made all reasonable efforts to accommodate the Enrollee; or

(iv) The Enrollee has committed fraud, including but not limited to, loaning an identification (ID) card for use by another person.

(B) The DBM may only request disenrollment of the Enrollee only for good cause. The following actions, if found by OHCA, comprise good cause:

(i) The Enrollee has been enrolled in error, as determined by OHCA;

(ii) The Enrollee has exhibited disruptive behaviors to the extent the DBM cannot effectively manage their care, and the DBM has made all reasonable efforts to accommodate the Enrollee; or

(iii) The Enrollee has committed fraud, including but not limited to, loaning an ID card for use by another person.

(2) **Enrollee-requested disenrollment.** Enrollees shall seek redress through the CE's or DBM's grievance process before OHCA will make a determination on an Enrollee's request for disenrollment. The CE or DBM shall accept Enrollee requests for disenrollment orally or in writing. The CE or DBM shall complete a review of the request within ten (10) days of the Enrollee filing the grievance. If the Enrollee remains dissatisfied with the result of the grievance process, the CE or DBM shall refer the disenrollment request to OHCA. The Contractor shall send records gathered during the grievance process to OHCA to facilitate OHCA's decision-making process. Disenrollment requests will be adjudicated by OHCA and, if approved, will become effective on a date established by OHCA.

(A) The Enrollee may request disenrollment from the CE or DBM as allowed by 42 C.F.R. § 438.56(c).

(B) An Enrollee may request disenrollment from the CE or DBM at any time based on any cause listed at 42 C.F.R. § 438.56(d)(2).

(C) An Enrollee may request disenrollment at any time in accordance with (a)(4)(A)(v)(I)-(VI) and (B)(ii)(I)-(V) of this Section and the applicable Contract.

(3) **Disenrollment by OHCA.** The CE or DBM shall report to OHCA, within five (5) business days of learning of any change in an Enrollee's status affecting the Enrollee's eligibility.

(A) The OHCA will initiate disenrollment of SoonerSelect Medical Enrollees under the following circumstances:

(i) Loss of eligibility for Medicaid;

(ii) Transition to a SoonerCare eligibility group excluded from the SoonerSelect Medical program;

(iii) Enrollee becomes enrolled in Medicare;

(iv) Death;

(v) Enrollee becomes a foster child under the custody of the state;

(vi) Enrollee becomes juvenile justice involved under the custody of the state;

(vii) The Enrollee becomes an inmate of a public institution;

(viii) The Enrollee commits fraud or provides fraudulent information; or
(ix) Disenrollment is ordered by a hearing officer or court of law.

(B) The OHCA will initiate disenrollment of SoonerSelect Dental Enrollees under the following circumstances:
(i) Loss of eligibility for Medicaid;
(ii) Transition to a SoonerCare eligibility group excluded from the SoonerSelect Dental program;
(iii) Enrollee becomes enrolled in Medicare;
(iv) Death;
(v) The Enrollee becomes an inmate of a public institution;
(vi) The Enrollee commits fraud or provides fraudulent information; or
(vii) Disenrollment is ordered by a hearing officer or court of law.

(4) **Disenrollment effective date**. Consistent with 42 C.F.R. § 438.56(e), except as provided for below, and unless OHCA determines that a delay would have an adverse effect on an Enrollee's health, it is OHCA's intent that a disenrollment shall be effective no later than the first day of the second following month.

(A) Grievance resolution for poor quality of care, lack of access to services covered under the Contract or lack of access to providers experienced in dealing with the Enrollee's health care needs or other matters deemed sufficient to warrant disenrollment under (b)(2) of this Section must be completed within this timeframe. If the CE fails to complete the grievance process in time to permit disenrollment by OHCA, the disenrollment shall be considered approved for the effective date that would have been established had the CE complied with this timeframe. Disenrollment for any of the following reasons shall be effective as of the date that the Enrollee's SoonerSelect Medical program eligibility status changes:
(i) Loss of eligibility for Medicaid;
(ii) Transition to a SoonerCare eligibility group excluded from the SoonerSelect program;
(iii) Enrollee becomes a foster child under the custody of the state;
(iv) Enrollee becomes JJ Involved under the custody of the state;
(v) Enrollee becomes eligible for Medicare;
(vi) Death;
(vii) Enrollee becomes an inmate of a public institution;
(viii) Enrollee commits fraud or provides fraudulent information;
(ix) Disenrollment is ordered by a hearing officer or court of law; or
(x) Enrollee requiring long-term care.
(I) Enrollees requiring long-term care in a nursing facility or ICF-IID shall be disenrolled from the CE when the level of care determination is finalized.
(II) For additional information regarding nursing facility and ICF-IID stays, refer to the Contract.

(B) Grievance resolution for poor quality of care, lack of access to services covered under the Contract or lack of access to providers experienced in dealing with the SoonerSelect Dental Enrollee's oral health care needs, or other matters deemed sufficient to warrant disenrollment under (b)(2) of this Section must be completed within this timeframe. If the Contractor fails to complete the grievance process in time to permit disenrollment by OHCA, the disenrollment shall be considered approved for the effective date that would have been established had the Contractor complied with this timeframe. Disenrollment for any of the following reasons shall be effective as of the date that the SoonerSelect Dental Enrollee's SoonerSelect Dental program eligibility status changes:

(i) Loss of eligibility for Medicaid;
(ii) Transition to a SoonerCare eligibility group excluded from the SoonerSelect Dental program;
(iii) SoonerSelect Dental Enrollee becomes eligible for Medicare;
(iv) Death;
(v) SoonerSelect Dental Enrollee becomes an inmate of a public institution;
(vi) SoonerSelect Dental Enrollee commits Fraud or provides fraudulent information;
(vii) Disenrollment is ordered by a hearing officer or court of law; or
(viii) SoonerSelect Dental Enrollees requiring long-term care in a nursing facility or ICF-IID shall be disenrolled from the Contractor when the level of care determination being done by the SoonerSelect or SoonerSelect Children's Specialty CEs is complete.

(C) Notwithstanding the foregoing, the effective date of disenrollment from the Contractor shall be the date recorded on the outbound ANSI ASC X 12 834 electronic transaction sent by OHCA.

(c) **Retroactive dual eligibility.** Dual eligibles are excluded from the SoonerSelect program. SoonerSelect Enrollees who become dual eligible individuals will be disenrolled as of their Medicare eligibility effective date.

(1) In the event a SoonerSelect Enrollee becomes retroactively Medicare eligible, the CE or DBM shall recover claims payments made to providers during the months of retroactive Medicare eligibility.

(2) The CE or DBM shall also notify the provider of the requirement to submit the claim to Medicare for reimbursement.

(3) OHCA will recoup the capitation payments paid for months of retroactive Medicare eligibility.

(d) **Re-enrollment following loss of eligibility.** Enrollees who lose and regain eligibility for SoonerSelect Medical or Dental program within a period of sixty (60) days or less will be re-enrolled automatically with their prior CE and/or DBM unless the CE and/or DBM is otherwise suspended or excluded from receiving new Enrollees. Re-enrolled Enrollees will have the right to change CE/DBM in accordance with this Section and the Contract.

(e) **Eligibles voluntarily opting out of SoonerSelect Children's Specialty Program.** FFC and children receiving adoption assistance shall be enrolled in the SoonerSelect Children's Specialty Program. These Eligibles may opt-out of enrollment in the Children's Specialty Program; however, the legal guardian of the Eligible will be required to enroll the Eligible with a CE.

(f) **Non-discrimination**. The CE or DBM may not refuse an assignment or seek to disenroll an Enrollee or otherwise discriminate against Eligible to enroll on the basis of race, color, national origin, sex, sexual orientation, gender identity, health status, need for medical services, or disability and may not use any policy or practice that has the effect of discriminating on the basis of race, color or national origin, sex, sexual orientation, gender identity, or disability. The Contractor also may not discriminate against an Enrollee on the basis of expectations that the Enrollee will require frequent or high-cost care, or on the basis of health status or need for health care services or due to an adverse change in the Enrollee's health in enrollment, disenrollment, or re-enrollment. If the CE or DBM fails to comply with OAC 317:55-3-2, the OHCA may impose any or all the CE intermediate sanctions, found at OAC 317:55-5-10 and the CE Contract, or DBM administrative remedies, found at OAC 317:55-5-11 and the DBM Contract.

317:55-3-3. ~~Voluntary enrollment and disenrollment~~Enrollee rights

~~(a) Per 56 O.S. § 4002.3, AI/AN populations that are eligible for SoonerCare will have the option to:~~

~~(1) Voluntarily enroll in the MCP through an opt-in process;~~

~~(2) Enroll in an MCO or DBM at each open enrollment period, regardless of initial selection or past disenrollment from the MCP;~~
~~(3) Receive services from an IHCP;~~
~~(4) Choose the IHCP as the enrollee's PCMH provider or DH provider, if the provider has the capacity to provide such services;~~
~~(5) Obtain services covered under the contract from out-of-network IHCPs when the enrollee is otherwise eligible to receive the IHCP's services;~~
~~(6) Self-refer for services provided by IHCPs to AI/AN enrollees;~~
~~(7) Obtain services covered under the contract from out-of-network IHCPs when the AI/AN enrollee is otherwise eligible to receive the IHCP's services; and~~
~~(8) Disenroll from any MCO or DBM at any time without cause.~~
~~(b) Children receiving prevention services from child welfare services have the option to enroll in the MCO contract to provide health care services under the Specialty Children's Plan.~~
(a) In accordance with 42 C.F.R. § 438.100, state and federal regulations, and all contractual requirements, the CE and DBM shall allow the Enrollee the right to:
(1) Receive information on the SoonerSelect program and the CE or DBM;
(2) Receive information on all available treatment options and alternatives;
(3) Participate in decisions regarding their healthcare;
(4) Free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation; and
(5) Request and receive a copy of their medical records in accordance with all HIPAA rules.
(b) Each Enrollee is free to exercise their rights without the CE or DBM treating them adversely.
(c) The CE or DBM may not otherwise discriminate against Enrollees on the basis of race, color, national origin, sex, sexual orientation, gender identity, health status, need for medical services, or disability and may not use any policy or practice that has the effect of discriminating on the basis of race, color or national origin, sex, sexual orientation, gender identity, or disability. If the CE or DBM fails to comply with OAC 317:55-3-3, the OHCA may impose any or all the CE intermediate sanctions, found at OAC 317:55-5-10 and the CE Contract, or DBM administrative remedies, found at OAC 317:55-5-11 and the DBM Contract.

PART 3. ~~SCOPE AND ADMINISTRATION~~ACCESS TO COVERED SERVICES AND PROVIDER NETWORK STANDARDS

317:55-3-10. ~~Grievances and appeals~~Covered services

~~(a) **Filing**. Grievances and appeals are to be initially filed with each enrollee's MCO or DBM. Grievances may be filed with the enrollee's MCO or DBM at any time, either orally or in writing. A provider or an authorized representative may file an appeal, grievance, or request for a State fair hearing on behalf of an enrollee, provided that the provider or authorized representative has obtained the enrollee's written consent.~~
~~(b) **Levels of appeal**. Pursuant to 42 C.F.R. § 438.402, MCOs and DBMs will only have one (1) level of appeal. Enrollees and providers may file an appeal to OHCA seeking the review of a final adverse benefit determination rendered by an MCO or DBM.~~
~~(c) **Governing rules.** The provisions at OAC 317:2-1-1 et seq. will govern any enrollee or provider right to file a grievance, complaint, appeal or request for a State fair hearing pursuant to 56 O.S. § 4002-4004, 42 C.F.R. Parts 431 or 438, or the managed care contract.~~
(a) **Amount, duration, and scope of services.** The CE or DBM must ensure members have timely access to all medically necessary services, as applicable, covered by SoonerCare under the Medicaid

State Plan, the Alternative Benefit Plan (ABP), and the 1115(a) IMD Waiver. The CE or DBM must ensure:

(1) Services are sufficient in amount, duration, and scope to reasonably be expected to achieve the purpose for which the services are provided;

(2) The amount, duration, and scope of a required service is not arbitrarily denied or reduced solely because of the diagnosis, type of illness, or condition;

(3) PA is available for services on which the CE or DBM has placed a pre-identified limitation to ensure the limitation may be exceeded when medically necessary.

(A) The CE or DBM may propose to impose alternative PA requirements, subject to OHCA's review and approval, except for those benefits identified as exempt from PA. The CE or DBM may be less restrictive on the requirements of a PA than OHCA but may not impose greater restrictions.

(B) PA shall be processed in accordance with timeliness requirements specified in the Contract.

(4) Coverage decisions are based on the coverage and medical necessity criteria published in Title 317 of the Oklahoma Administrative Code and practice guidelines/manual; and

(5) If a member is unable to obtain medically necessary services offered by SoonerCare from a CE or DBM network provider, the CE or DBM must adequately and timely cover the services out of network, until the CE or DBM is able to provide the services from a network provider.

(b) **Emergency services**. The CE or DBM shall provide emergency services to Enrollees in accordance with the respective CE or DBM Contract.

(c) **Post-stabilization services.** In accordance with the provisions set forth at 42 C.F.R. § 422.113(c), the CE shall provide post-stabilization care services are:

(1) Obtained within or outside the CE network that are:

(A) Pre-approved by a CE or representative; or

(B) Not pre-approved by a CE or representative but administered to maintain the Enrollee's stabilized condition within one (1) hour of a request to the CE for pre-approval of further post-stabilization care services.

(2) Administered to maintain, improve, or resolve the Enrollee's stabilized condition without preauthorization, and regardless of whether the Enrollee obtains the services within the CE network when the CE:

(A) Did not respond to a request for pre-approval within one (1) hour;

(B) Could not be contacted; or

(C) Representative and the treating physician could not reach agreement concerning the Enrollee's care and a CE physician was not available for consultation.

(3) In accordance with 42 C.F.R. §§ 438.114(e) and 422.113(c)(2)(iv), the CE shall limit charges to Enrollees for post-stabilization care services to an amount no greater than what the CE would charge the Enrollee if they obtained the services through the CE. Additionally, the CE's financial responsibility for post-stabilization care services if not pre-approved ends when:

(A) A CE physician with privileges at the treating hospital assumes responsibility for the Enrollee's care;

(B) A CE physician assumes responsibility for the Enrollee's care through transfer;

(C) A CE representative and the treating physician reach an agreement concerning the Enrollee's care; or

(D) The Enrollee is discharged.

(d) **Continued services to Enrollees.** The CE and DBM shall take all the necessary steps to ensure continuity of care when Enrollees transition to the CE or DBM from another CE/DBM or SoonerCare program. The CE and DBM shall ensure that established Enrollee and provider

relationships, current services and existing PAs and care plans will remain in place during the continuity of care period in accordance with the requirements outlined in this Section.

(1) Transition to the CE/DBM shall be as seamless as possible for Enrollees and their providers.

(2) The CE shall take special care to provide continuity of care for newly enrolled Enrollees who have physical health conditions, behavioral health conditions and/or functional needs and are under the care of existing treatment providers and whose health could be placed in jeopardy, or who could be placed at risk of hospitalization or institutionalization, if covered services are disrupted or interrupted.

(3) The DBM shall take special care to provide continuity of care for newly enrolled SoonerSelect Dental Enrollees who have oral health care needs and are under the care of existing treatment providers and whose health could be placed in jeopardy, or who could be placed at risk of hospitalization, if covered services are disrupted or interrupted.

(4) The DBM shall work with SoonerSelect and SoonerSelect Children's Specialty CEs to transition and coordinate care after a dental related emergency service pursuant to the Contract.

(5) The CE/DBM shall make transition of care policies available to Enrollees and provide instructions to Enrollees on how to access continued services during the continuity of care period.

(6) The CE/DBM shall ensure that all Enrollees are held harmless by providers for payment for any existing covered services, other than required cost sharing, during the continuity of care period.

(e) **Non discrimination.** The CE or DBM shall not discriminate an Enrollee on the basis of the Enrollee's health or need for medical services.

(f) **Failure to comply.** If the CE or DBM fails to comply with OAC 317:55-3-10, the OHCA may impose any or all the CE intermediate sanctions, found at OAC 317:55-5-10 and the CE Contract, or DBM administrative remedies, found at OAC 317:55-5-11 and the DBM Contract.

317:55-3-11. ~~Intermediate sanctions~~Cost sharing

~~(a) **Intermediate sanctions obligation.** OHCA will establish intermediate sanctions that it may impose on an MCO if OHCA makes any of the determinations specified in 42 C.F.R. § 438.700(b)-(d).~~

~~(b) **Adoption of intermediate sanctions.** OHCA adopts the intermediate sanctions as provided at 42 C.F.R. § 438.702.~~

~~(c) **Imposition of sanctions.** If OHCA makes a determination per 42 C.F.R. §§ 438.700 or 438.706 and thereby imposes intermediate sanctions as listed at 42 C.F.R. §§ 438.702 or 438.706, OHCA will consider the totality of and follow all relevant regulations at 42 C.F.R. Part 438, Subpart I.~~

~~(d) **Required imposition of temporary management.** In accordance with 42 C.F.R. § 438.706(b), OHCA will impose the intermediate sanction of temporary management, regardless of any other sanction that may be imposed, if OHCA finds that an MCO has repeatedly failed to meet substantive requirements in sections 1903(m) or 1932 of the Act or 42 C.F.R. Part 438. In this situation, OHCA will also grant enrollees the right to terminate enrollment without cause, as described in 42 C.F.R. § 438.702(a)(3), and must notify the affected enrollees of their right to terminate enrollment. Notwithstanding any other Section of these rules, OHCA will not delay imposition of temporary management to provide a hearing before imposing this sanction. OHCA will continue this sanction until the MCO can ensure that the sanctioned behavior will not recur.~~

~~(e) **Retained authority.** OHCA retains authority to impose additional sanctions under State statutes or State regulations that address areas of noncompliance specified in 42 C.F.R. § 438.700, as well as additional areas of noncompliance. Nothing in 42 C.F.R. Part 438, Subpart I, prevents OHCA from exercising that authority.~~

(f) **Notice.** Before imposing an intermediate sanction, OHCA will give the affected MCO timely written notice that explains the basis and nature of the sanction and any other appeal rights that OHCA elects to provide.

(g) **Right to request fair hearing.** Though not required under federal regulation, OHCA provides each MCO the right, upon notice of a sanction other than optional or required temporary management, to request a fair hearing before an administrative law judge (ALJ) retained by OHCA. The cost of actions necessary to process an MCO's request will be paid by OHCA.

(1) An MCO must file any request for fair hearing within thirty (30) days after receiving the notice.

(2) The ALJ has jurisdiction to hear any request under this section. The ALJ will review the appeal for legal authority and jurisdiction. If legal authority and jurisdictional requirements are met, the ALJ will conduct an administrative hearing according to the hearing practices of OAC 317:2-1-5, provide proposed findings of fact and conclusions of law to the parties, and send written notice to the parties of the final order sustaining or denying imposition of the sanction.

(3) At the ALJ's discretion, the ALJ will:

(A) Establish a scheduling order;

(B) Establish reasonable procedures such as authorizing pleadings to be filed by facsimile or electronic mail;

(C) Rule on all interlocutory motions;

(D) Require briefing of any or all issues;

(E) Conduct hearings in a forum and manner as determined by the ALJ;

(F) Rule on the admissibility of all evidence;

(G) Question witnesses;

(H) Impose appropriate sanctions against any person failing to obey an order of the ALJ or authorized under the rules in this section which will include:

(i) Refusing to allow the person to assert or oppose designated claims or defenses, or prohibiting that person from introducing designated matters in evidence;

(ii) Excluding all testimony of an unresponsive or evasive witness; or

(iii) Expelling the person from further participation in the hearing;

(I) Take official notice of any material fact not appearing as evidence in the record, if the fact is among traditional matters of judicial notice;

(J) Administer oaths or affirmations;

(K) Determine the location of the hearing and manner in which it will be conducted;

(L) Allow either party to request that the hearing be recorded by a court reporter with costs to be borne by the requesting party. The original of such transcription, if ordered, will be given to the ALJ with a copy to be given to the requesting party;

(M) Recess and reconvene the hearing;

(N) Set and/or limit the time frame of the hearing;

(O) Make proposed findings of facts and conclusions of law; and

(P) Sustain or deny OHCA's imposition of the sanction(s).

The CE or DBM shall ensure that all Enrollees are held harmless by providers for payment for any existing covered services, other than required cost sharing, during the continuity of care period. The CE or DBM shall not impose premiums or charges on Enrollees that are in excess of those permitted in the SoonerCare program in accordance with OAC 317:30-3-5 and the Oklahoma Medicaid State Plan. If the CE or DBM fails to comply with OAC 317:55-3-11, the OHCA may impose any or all the CE intermediate sanctions, found at OAC 317:55-5-10 and the CE Contract, or DBM administrative remedies, found at OAC 317:55-5-11 and the DBM Contract.

In accordance with Section 1916(e) of the Act, a provider participating in the SoonerSelect

program may not deny care or services to an eligible individual based on such individual's inability to pay the co-payment. An enrollee's assertion of the inability to pay the co-payment establishes this inability.

This rule does not change the fact that a member is liable for these charges, and it does not preclude the provider from attempting to collect the co-payment.

Providers will be required to refund any co-payment amounts the provider collected from the member in error and/or above the family's aggregate cost sharing maximum.

317:55-3-12. ~~Non-compliance damages and remedies~~Provider contracting and network requirements

~~If OHCA finds an MCO or DBM to be in violation of the provisions of 56 O.S. §§ 4002-4004, rules promulgated thereto, or the terms and conditions of the contract, OHCA may enforce any damages or remedies for non-compliance as required by CMS, as provided for in the contract, or as permitted by State or Federal law.~~

(a) **Provider contracts**. A CE or DBM must provide or arrange for the delivery of covered health care services described in OAC 317:55-3-5 through a provider agreement with SoonerCare-contracted providers. All provider agreements must be in writing and in accordance with the Contract and 42 C.F.R. §§ 434.6 and 438.6. The CE's or DBM's execution of a provider agreement does not terminate the CE's or DBM's legal responsibility to the OHCA to ensure all the CE's and DBM's activities and obligations are performed in accordance with Okla. Admin. Code § 317, as applicable, the CE's or DBM's Contract with the OHCA, and all applicable federal, state, and local regulations. The CE or DBM shall maintain, and have available, written policies and procedures on:

(1) Participating provider selection;

(2) Retention and termination of a provider's participation with the CE or DBM;

(3) Responding to changes in the CE'S or DBM'S network of participating providers that affect access and ability to deliver services in a timely manner; and

(4) Access standards.

(b) **Provider network.**

(1) The CE and DBM must maintain, in accordance with 42 C.F.R. § 438.206(b)(1), a network of appropriate participating providers that is supported by a signed provider agreement and is sufficient to provide adequate access and availability to all services covered under the Contract with the OHCA, including those with limited English proficiency or physical or mental disabilities.

(2) The CE and DBM must ensure that all requirements found at 42 C.F.R. § 438.3(q)(1) and (q)(3) are met.

(3) The CE and DBM must meet and require its participating providers to meet state standards for timely access to care and services, in accordance with 42 C.F.R. § 438.206(c) and all contractual requirements.

(4) The OHCA shall monitor and review the CE's and DBM's compliance with all standards as part of all ongoing oversight activities.

(c) **Credentialing and recredentialing.**

(1) All CE and DBM must utilize the same single Credential Verification Organization (CVO) that is certified by a CMS-approved accrediting organization and approved by OHCA as part of its provider credentialing and recredentialing process. The CE and DBM credentialing and re-credentialing processes shall comply with relevant state and federal regulations, including, but not limited to, 42 C.F.R. §§ 438.12, 438.206(b)(6), and 438.214, and all applicable contractual requirements.

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(2) The CE and DBM must ensure that providers have been properly credentialed to ensure provider facilities, organizations, and staff meet all qualifications and requirements for participation in the Oklahoma Medicaid program. All applications must be credentialed and the CE's or DBM's claim systems must be able to recognize the provider as a SoonerSelect program network provider, within all applicable timeframes as outlined within the Contract with the OHCA.

(3) The recredentialing process must take into consideration provider performance data including Enrollee grievance and appeal, quality of care, and utilization management.

(4) The CE and DBM must review and approve the credentials of all applicable licensed and unlicensed participating and contracted providers who participate in the CE's or DBM's provider network at least once every three (3) years.

(5) If the CE or DBM fails to comply with the credentialing and recredentialing standards per OAC 317:55-5-12(c), the OHCA may impose any or all the CE intermediate sanctions, found at OAC 317:55-5-10 and the CE Contract, or DBM administrative remedies, found at OAC 317:55-5-11 and the DBM Contract.

(d) **Non-discrimination against providers.**

(1) The CE's and DBM's written policies and procedures shall not discriminate against providers that serve high-risk populations or specialize in conditions that require costly treatment, per 42 C.F.R. §§ 438.12(a)(2) and 438.214(a).

(2) In accordance with 56 O.S. § 4002.4(B), shall not exclude essential community providers, providers who receive directed payments in accordance with 42 C.F.R. Part 438, and such other providers, as directed by OHCA from execution of provider agreements.

317:55-3-13. ~~Termination of managed care contract~~Time, distance, and access standards

~~(a) **Termination of an MCO, permitted by 42 C.F.R. § 438.708**. Members impacted by the contract termination of an MCO will be enrolled with a different MCO or be provided Medicaid benefits through options as prescribed in the Oklahoma Medicaid State Plan. OHCA may terminate a contract with an MCO if OHCA determines that the MCO:~~

~~(1) Failed to carry out the substantive terms of the contract; or~~

~~(2) Failed to meet applicable requirements of sections 1903(m), 1905(t), or 1932 of the Act.~~

~~(b) **Termination permitted by contract, MCO or DBM**. Grounds for termination include:~~

~~(1) **Mutual consent.** OHCA and the MCO or DBM may terminate the contract by a mutually written agreement. The MCO or DBM does not have the right to appeal the termination. Enrollees impacted by the contract termination will be enrolled with a different MCO or DBM of their choosing or, if no choice is made, a default MCO or DBM.~~

~~(2) **Termination for convenience**. OHCA may terminate a contract for convenience, in whole or part, with a sixty (60) day written notice to the MCO or DBM if the State determines that termination is in the State's best interest. Any partial termination of the contract will not be construed as a waiver of, and will not affect, the rights and obligations of any party regarding portions of the contract that remain in effect. Upon receipt of notice of such termination, the MCO or DBM will immediately comply with the notice terms and take all necessary steps to minimize the incurrence of costs allocable to the work affected by the notice.~~

~~(3) **Termination for unavailability of funds.** OHCA may terminate a contract for lack of the availability of funds with written notice to the managed care. OHCA will give written notice to the MCO or DBM, effective the close of business on the day specified. OHCA is the final authority on the availability of funds, and the MCO or DBM does not have the right to appeal this termination.~~

~~(4) **Termination for lack of authority.** In the event that the State is determined, in whole or~~

part, to lack Federal or State approval or authority to contract with an MCO or DBM, OHCA may terminate the contract immediately, effective on the close of business on the day specified. The MCO or DBM does not have the right to appeal this termination.

(5) **Termination for default.** OHCA may terminate the contract, in whole or in part, whenever the MCO has failed to carry out the terms of the contract or meet the applicable readiness requirements of §§ 1932, 1903(m) or 1905(t) of the Act.

(6) **Termination for financial instability.** In the event that OHCA, in its sole discretion, deems an MCO or DBM to be financially unstable to the point of threatening the ability of OHCA to obtain the services provided for under this contract, or to conduct business in the normal course, makes a general assignment for the benefit of creditors or suffers or permits the appointment of a receiver for its business or its assets, then OHCA may, at its option, immediately terminate the contract effective on the close of business on the date specified. In the event OHCA elects to terminate the contract under this provision, the MCO or DBM will be notified in writing specifying the date of termination. In the event of the filing of a petition in bankruptcy court by or against a principal subcontractor, the MCO or DBM will immediately advise OHCA. The MCO or DBM will ensure that all tasks related to the subcontract are performed in accordance with the terms of the contract.

(7) **Termination for debarment.** Section 1932(d)(1) of the Act prohibits affiliations with individuals debarred by federal agencies. The MCO will not knowingly have an individual or affiliate, as defined in Section 1932(d)(1)(C), who has been debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.

(c) **Notice and pre-termination hearing**. Prior to terminating an MCO's contract for default, financial instability, or debarment, OHCA will provide the MCO a pre-termination hearing. OHCA will:

(1) Give the MCO written notice of the intent to terminate, the reason for termination, and the time and place of the hearing. The notice will detail how the MCO has failed to carry out the terms of the contract and/or failed to comply with the requirements of 1932, 1903(m) and 1905(t) of the Act. A time period will be provided, if applicable, in which the MCO is allowed to cure the default prior to the pre-termination hearing. If the MCO cures the default within the specified timeframe, no further action is required;

(2) After the hearing, the MCO will receive written notice of the decision affirming or reversing the proposed termination of the contract. In the event the decision is affirmed the notice is to include the effective date of the termination; and

(3) Upon affirmation of a decision, OHCA will give enrollees of the MCO written notice, comporting with the content requirements of 42 C.F.R § 438.10, of the termination and information identifying options for receiving Medicaid services following the effective date of termination. This notice will be provided within five (5) business days of the affirming decision.

(d) **Hearing timing**. Though not required under federal regulation, OHCA provides each MCO the right, upon notice of a termination, to request a fair hearing before an administrative law judge (ALJ) retained by OHCA. The cost of actions necessary to process an MCO's request will be paid by OHCA.

(1) An MCO will file any request for fair hearing within thirty (30) days after receiving the notice.

(2) The ALJ has jurisdiction to hear any request under this section. The ALJ will review the appeal for legal authority and jurisdiction. If legal authority and jurisdictional requirements are met, the ALJ will conduct an administrative hearing according to the hearing practices of OAC

~~317:2-1-5, provide proposed findings of fact and conclusions of law to the parties, and send written notice to the parties of the final order sustaining or denying imposition of the sanction.~~

~~(3) At the ALJ's discretion, the ALJ will:~~

~~(A) Establish a scheduling order;~~

~~(B) Establish reasonable procedures such as authorizing pleadings to be filed by facsimile or electronic mail;~~

~~(C) Rule on all interlocutory motions;~~

~~(D) Require briefing of any or all issues;~~

~~(E) Conduct hearings in a forum and manner as determined by the ALJ;~~

~~(F) Rule on the admissibility of all evidence;~~

~~(G) Question witnesses;~~

~~(H) Impose appropriate sanctions against any person failing to obey an order of the ALJ or authorized under the rules in this section which will include:~~

~~(i) Refusing to allow the person to assert or oppose designated claims or defenses, or prohibiting that person from introducing designated matters in evidence;~~

~~(ii) Excluding all testimony of an unresponsive or evasive witness; or~~

~~(iii) Expelling the person from further participation in the hearing;~~

~~(I) Take official notice of any material fact not appearing as evidence in the record, if the fact is among traditional matters of judicial notice;~~

~~(J) Administer oaths or affirmations;~~

~~(K) Determine the location of the hearing and manner in which it will be conducted;~~

~~(L) Allow either party to request that the hearing be recorded by a court reporter with costs to be borne by the requesting party. The original of such transcription, if ordered, will be given to the ALJ with a copy to be given to the requesting party;~~

~~(M) Recess and reconvene the hearing;~~

~~(N) Set and/or limit the time frame of the hearing;~~

~~(O) Make proposed findings of facts and conclusions of law; and~~

~~(P) Sustain or deny OHCA's imposition of the termination(s).~~

(a) The CE and DBM must meet all time and distance standards as established by the OHCA in accordance with 42 C.F.R. § 438.68. The time and distance standards will apply to all geographic areas in which the CE or DBM operates, with standards varying for urban and rural areas, which will include, at a minimum:

(1) Anticipated enrollment;

(2) Expected utilization of services;

(3) Characteristics and health care needs of all covered populations;

(4) Provider-to-Enrollee ratios;

(5) Travel time or distance to providers;

(6) Percentage of contracted providers that are accepting new patients;

(7) Ability to communicate with limited English proficiency Enrollees;

(8) Ability to ensure physical access, reasonable accommodations, and accessible equipment for Enrollees with physical or mental disabilities;

(9) Maximum wait times; and

(10) Hours of operations.

(b) The standards listed in (a)(1) – (10) of this Section apply to the following medical provider types, in accordance with 42 C.F.R. § 438.68(b) and specified in the Medical and Children's Specialty Program Contract:

(1) Adult and pediatric PCPs;

(2) Obstetrics and Gynecology (OB/GYN) providers;

(3) Adult and pediatric mental health providers;
(4) Adult and pediatric substance use disorder (SUD) providers;
(5) Adult and pediatric specialists;
(6) Hospitals;
(7) Pharmacies; and
(8) Essential community providers.

(c) The standards listed in (a)(1) – (10) of this Section apply to the following dental provider types, in accordance with 42 C.F.R § 438.68(b) and specified in the DBM Contract:
(1) General dentistry providers;
(2) Pediatric specialty dental providers;
(3) Specialty dental providers; and
(4) Essential community providers.

(d) If the CE or DBM fails to comply with the standards as set forth in this Section, the OHCA may impose any or all the CE intermediate sanctions, found at OAC 317:55-5-10 and the CE Contract, or DBM administrative remedies, found at OAC 317:55-5-11 and the DBM Contract.

317:55-3-14. ~~Record retention~~Primary care requirements

~~In addition to the requirements found at OAC 317:30-3-15 and 317:30-5-70.2, the MCO or DBM and its affiliates, subcontractors, and employees must retain records in compliance with the provisions and spirit of 42 C.F.R. §§ 438.3(h) and (u), to the extent applicable.~~

(a) **Primary care spending/expenses.** No later than the end of the fourth (4th) year of the initial contracting period, each CE shall be currently spending not less than eleven percent (11%) of its total health care expenses on primary care services.

(b) **Primary care expenditure reporting requirements.**
(1) The CEs must submit a primary care implementation plan which describes the CEs strategies for increasing the percentage of total medical expenditures allocated to primary care over the initial four (4) year contract period.
(2) The plan shall include target annual percentage increases over the previous year baseline data that demonstrate the CEs ability to achieve eleven percent (11%) by the end of year four (4).

(c) **Primary care expenditure calculations.**
(1) CEs shall submit data on an annual basis for primary care and total medical expenditures made through paid claims amounts and non-claims payments to the OHCA, in the manner and timeline prescribed in the SoonerSelect Contract.
(2) The OHCA will consider non-claims-based investments into primary care including but not limited to investments in electronic health record (EHR) systems, health information exchange (HIE) costs, care coordination activities and systems, and recruitment/retention incentives for primary care providers in rural and medically underserved areas.
(3) Other non-claims-based investments may be reviewed and approved by the OHCA.
(4) The OHCA may impose a cap on the amount of non-claims-based investment considered in the primary care expenditure calculation.

317:55-3-15. Provider agreement/contract termination

(a) The CE and DBM and all participating providers have the right to terminate the Contract entered into with each other via a provider agreement.
(b) The CE and DBM and all participating providers may terminate the provider agreement for cause with thirty (30) days advance written notice and without cause with sixty (60) days advance written notice to the other party.

(c) The CE and DBM shall terminate its provider agreement with a participating provider immediately if any of the following circumstances occur:

(1) In order to protect the health and safety of all Enrollees;

(2) If a credible allegation of fraud results in a conviction of credible allegation on the participating provider;

(3) When the participating provider's licenses, certifications and/or accreditations are modified, revoked or in any other way making it unlawful for the provider to provide services under the Contract; or

(4) If requested by the OHCA.

(d) The OHCA reserves the right to terminate a provider from SoonerCare participation. The OHCA will notify the CE or DBM regarding any termination. The CE and DBM shall be responsible for monitoring all state registries to review any participating providers that are terminated by OHCA and excluded from participation in the CE's or DBM's participating provider network.

317:55-3-16. Non-licensed providers

(a) The CE and DBM must ensure that all non-licensed providers are educated, trained, and qualified to perform all job responsibilities.

(b) Background checks and database screening in accordance with state and federal laws must be completed to ensure the non-licensed provider has not been excluded or debarred from participation in Medicare, Medicaid, or any federal health care program.

(c) All applicable state and federal regulations and contractual requirements must be followed when employing non-licensed providers.

PART 5. ~~REQUIRED FEDERAL AUTHORIZATIONS~~GRIEVANCE, APPEAL AND PROVIDER COMPLAINT SYSTEM

317:55-3-20. ~~Authorizations~~SoonerSelect enrollee grievance and appeal system

~~Prior to the implementation of any MCP authorized under 42 C.F.R. Part 438, OHCA will receive the following authorizations:~~

~~(1) Federal authority through a State Plan Amendment or waiver of the Act;~~

~~(2) CMS approval of each contract in relation to the MCP;~~

~~(3) CMS approval of all contract rates authorized under the MCP; and~~

~~(4) CMS approval of direct payment arrangements authorized under the MCP.~~

(a) The CE or DBM shall have written grievance and appeal policies and procedures for an Enrollee, or an Enrollee's authorized representative, to appeal a CE's or DBM's action and/or file a grievance. The policies must address contractual requirements, including performance standards, and federal funding requirements, including 42 C.F.R. § 438 Subpart F and OAC 317:2-3-3.

(1) Timeframes, pursuant to OAC 317:2-3-2;

(2) Grievances, pursuant to OAC 317:2-3-4;

(3) Appeals, pursuant to OAC 317:2-3-5;

(4) Grievance and appeal notices, pursuant to OAC 317:2-3-8;

(5) State fair hearings, pursuant to OAC 317:2-3-12;

(6) Recordkeeping, pursuant to OAC 317:2-3-11; and

(7) Continuation of benefits, pursuant to OAC 317:2-1-2.6 and 317:2-3-5.1.

(b) If the CE or DBM fails to meet performance standards, the OHCA may impose any or all the CE intermediate sanctions, found at OAC 317:55-5-10 and the CE Contract, or DBM administrative remedies, found at OAC 317:55-5-11 and the DBM Contract.

317:55-3-21. ~~Timing~~ Provider complaint system

~~OHCA may only execute transition to a managed care delivery system ninety (90) days after CMS has approved all contracts entered into between OHCA and all MCOs or DBMs following OHCA's submission of readiness review results to CMS, pursuant to 42 C.F.R. § 438.66.~~

The CE or DBM shall have written provider complaint policies and procedures for an Enrollee, or an Enrollee's authorized representative, to appeal a CE's or DBM's action and/or file a grievance. The policies must address contractual requirements, including performance standards, and federal funding requirements, including 42 C.F.R. Part 438 Subpart F and OAC 317:2-3-10.

(1) Timeframes, pursuant to OAC 317:2-3-2;

(2) Notices, pursuant to OAC 317:2-3-8; and

(3) Recordkeeping, pursuant to OAC 317:2-3-11.

SUBCHAPTER 5. REQUIREMENTS FOR ~~MANAGED CARE ORGANIZATIONS~~ CONTRACTED ENTITIES AND DENTAL BENEFITS MANAGERS

PART 1. ~~ACCREDITATION AND READINESS~~MONITORING, PROGRAM INTEGRITY, DATA, AND REPORTING

317:55-5-1. ~~MCO or DBM accreditation~~Monitoring system for all SoonerSelect programs

~~All MCOs and DBMs will be accredited in accordance with 45 C.F.R. § 165.275 by an accrediting entity recognized by the United States Department of Health and Human Services.~~

(a) In accordance with 42 C.F.R. § 438.66, the OHCA will monitor each CE or DBM to assess its ability and capacity to comply with program and Contract-specific requirements and to assess its ability to perform satisfactorily in all major operational areas.

(b) The CE or DBM shall have a reporting monitoring process for ensuring compliance with all Contract requirements, implementation deadlines for mandates and/or laws as directed by CMS, CDC, or other federal or state government entity. The CE or DBM shall report monthly on its compliance monitoring activities as required by the reporting manual.

317:55-5-2. ~~MCO or DBM readiness~~Program integrity; data and reporting

~~(a) According to 42 C.F.R. § 438.66, during implementation and prior to enrollment effective dates, the MCO or DBM will participate in a readiness review process. To be deemed eligible to effect enrollments, the MCO or DBM will complete all readiness review activities to the satisfaction of OHCA and CMS. The readiness reviews will be conducted through one (1) or more desk reviews and one or more on-site reviews. The MCO or DBM must satisfactorily demonstrate readiness for MCP operations, including but not limited to focus areas identified at 42 C.F.R. § 438.66(b). At any stage(s) of the readiness review process, OHCA may but is not required to provide an MCO or DBM with notice(s) of deficiency and reasonable opportunity(ies) to cure the deficiency. As between the parties to the managed care contract, OHCA has sole authority to determine the readiness of any MCO or DBM.~~

~~(b) As a part of any readiness review, OHCA will ensure the MCO or DBM meets the requirements at 56 O.S. § 4002.10.~~

(a) **Program integrity standards.** The CE and DBM shall comply with all state and federal laws, regulations, and mandates including but not limited to 42 C.F.R. § 438.608. The CE and DBM shall have and implement written policies and procedures that are designed to detect and prevent fraud, waste, and abuse pursuant to the Contract and federal regulations. The CE and DBM shall:

(1) Provide a monthly report (by close of the last calendar day of each month), of all open Program Integrity related audits and investigations related to fraud, waste, and abuse activities

for identifying and collecting potential overpayments, utilization review, and provider compliance.

(2) Refer credible allegations of fraud to OHCA's Legal Division in writing within three (3) business days of discovery.

(3) Suspend all payments to the provider when a credible allegation of fraud exists.

(4) Participate in good faith at monthly Program Integrity meetings held jointly with MFCU and OHCA.

(5) Participate in good faith at monthly meetings with OHCA Program Integrity and Accountability Unit.

(6) Disclose any change in ownership and control information to OHCA within thirty-five (35) calendar days.

(7) Submit to OHCA or HHS, within thirty-five (35) days of request, full and complete information about:

(A) The ownership of any subcontractor with whom the CE/DBM has had business transactions totaling more than twenty-five thousand dollars ($25,000) during the twelve (12-month) period ending on the date of the request; and

(B) Any significant business transactions between the CE/DBM and any wholly owned supplier, or between the provider and any subcontractor, during the five (5-year) period ending on the date of request.

(b) **Data and reporting standards.**

(1) The CE and DBM shall:

(A) Provide information responsive to specific requests made by OHCA, MFCU, or other authorized state and federal authorities (including, but not limited to, requests for records of Health Plan Enrollee and provider interviews), within three (3) business days of said request, unless otherwise agreed upon by OHCA.

(B) Submit weekly encounter data by the deadline established by OHCA and in accordance with OHCA accuracy standards.

(C) Submit a required report timely and/or accurately.

(2) The CE or DBM shall not falsify or misrepresent information that it furnishes to CMS or OHCA.

(c) **Request for information.** The CE or DBM shall provide and prioritize requests for information made by OHCA, MFCU, or other authorized state and federal authorities. The CE or DBM shall respond to urgent requests from OHCA within twenty-four hours (24-hours) and according to guidance and timelines provided by OHCA.

(d) **Record retention.** The CE or DBM shall retain records for a period of ten (10) years as well as comply with all state and federal regulations and contractual requirements.

(e) **Non-compliance actions**. If the CE or DBM fails to submit any OHCA-requested materials, as specified in this Section, without cause as determined by OHCA, on or before the due date, OHCA may impose any or all the CE sanctions, found at OAC 317:55-5-10 and the CE Contract, or DBM administrative penalties, found at OAC 317:55-5-11 and the DBM Contract.

317:55-5-3. Critical incident reporting system

(a) The CE shall ensure that any serious incident that harms or potentially harms the Enrollee's health, safety, or well-being, including incidents of seclusion and restraint, are immediately identified, reported, reviewed, investigated, and corrected, in compliance with state and federal law.

(b) When the Enrollee is in the care of a behavioral health inpatient, PRTF, or crisis stabilization unit, critical incidents shall include, but are not limited to the following:

(1) Suicide death;

(2) Non-suicide death;
(3) Death-cause unknown;
(4) Homicide;
(5) Homicide attempt with significant medical intervention;
(6) Suicide attempt with significant medical intervention;
(7) Allegation of physical, sexual, or verbal abuse or neglect;
(8) Accidental injury with significant medical intervention;
(9) Use of restraints/seclusion (isolation);
(10) AWOL or absence from a mental health facility without permission; or
(11) Treatment complications (medication errors and adverse medication reaction) requiring significant medical intervention.

(c) The CE shall develop and implement a critical incident reporting and tracking system for behavioral health adverse or critical incidents and shall require participating providers to report adverse or critical incidents to the CE, OHS, and the Enrollee's parent or legal guardian.

(d) Participating providers shall contact the CE by phone no later than 5:00pm Central time on the business day following a serious occurrence and disclose, at a minimum:

(1) The name of the Enrollee involved in the serious incident;
(2) A description of the occurrence; and
(3) The name, street address, and telephone number of the facility.

(e) The participating provider must, within three (3) days of the serious occurrence, submit a written facility critical incident report to the CE.

(1) The facility critical incident report must include specific information regarding the incident including the following:
(A) All information listed in OAC 317:55-5-3 (d)(1) through (3);
(B) Available follow-up information regarding the Enrollee's condition;
(C) Debriefings; and
(D) Any programmatic changes that were implemented.

(2) A copy of this report must be maintained in the Enrollee's record, along with the names of the persons at the CE and OHS to whom the occurrence was reported.

(3) A copy of the report must also be maintained in the incident and accident report logs kept by the facility.

(4) The CE shall review the participating provider's report and follow up with the participating provider as necessary to ensure that an appropriate investigation was conducted, and corrective actions were implemented within applicable timeframes.

(f) The CE shall provide appropriate training and take corrective action as needed to ensure its staff and participating providers, as applicable, comply with all critical incident requirements, in the manner and format outlined in the reporting manual.

PART 3. ~~PROVIDER REQUIREMENTS~~NON-COMPLIANCE OF A CE AND/OR DBM AND NOTIFICATIONS

317:55-5-10. ~~Provider contracts and credentialing standards~~Non-compliance of contracted entities

~~(a) All MCOs and DBMs will formally credential and recredential network providers at a frequency required by a single, consolidated provider enrollment and credentialing process established by OHCA in accordance with 42 C.F.R. § 438.214 and in coordination with MCOs and DBMs.~~

~~(b) All MCOs and DBMs will contract to the extent possible and practicable with all essential community providers who receive directed payments in accordance with 42 C.F.R. Part 438 and any~~

~~other providers as specified by OHCA through contract.~~

~~(c) Every MCO and DBM will contract with every participating provider through a written provider agreement that:~~

~~(1) Identifies the contractual obligations between the MCO or DBM and the participating provider; and~~

~~(2) Incorporates any provision required by the contract between OHCA and the MCO or DBM for inclusion in the provider agreement.~~

~~(d) An MCO or DBM or any subcontractor thereof will not enforce with any provider a policy or contract term that requires the provider to contract for all products currently offered or that may be offered in the future by the MCO, DBM, or subcontractor.~~

(a) **Failure to comply**. If the CE fails to fulfill its duties and obligations or meet performance standards under 42 C.F.R. Part 438, 42 U.S.C. § 1396b(m), 42 U.S.C. § 1396u-2, Title 317 of the Oklahoma Administrative Code, or the CE Contract, OHCA will notify the CE of unmet performance expectations, violations or deficiencies, and may impose corrective actions or any sanctions in addition to or instead of any actions or sanctions specified in the Contract.

(b) **Non-material compliance deficiencies.**

(1) If OHCA determines that unmet performance expectations, violations, or deficiencies do not result in a material deficiency or delay in the implementation or operation of services, the CE will have five (5) business days (or the date specified by OHCA) of receipt of notice to provide the OHCA with a written response that:

(A) Explains the reasons for the deficiency;

(B) The CE's plan to address or cure the deficiency; and

(C) The date and time by which the deficiency will be cured.

(D) If the CE disagrees with OHCA's findings, the CE shall provide its reasons for disagreeing with OHCA's findings.

(2) The CE's proposed cure of a non-material deficiency is subject to the approval of OHCA.

(3) The CE's repeated commission of non-material deficiencies or repeated failure to resolve any such deficiencies may be regarded by OHCA as a material deficiency and entitle OHCA to pursue any other remedy provided in the Contract or any other appropriate remedy OHCA may have at law or equity.

(c) **Material compliance deficiencies.**

(1) An item of material non compliance means a specific action of the CE that:

(A) Violates a substantive term of the Contract;

(B) Fails to meet an agreed upon measure of performance; or

(C) Represents a failure of the CE to be reasonably responsive to a reasonable request of OHCA relating to the Services for information, assistance, or support within the timeframe specified by OHCA.

(2) If OHCA determines that unmet performance expectations, violations, or deficiencies result in a material deficiency, The CE may be required to submit a written CAP under the signature of the CE's CEO to correct or resolve a material breach of the Contract.

(A) The CAP must:

(i) Be submitted by the deadline set forth in the OHCA's request for a CAP.

(ii) Be reviewed and approved by the OHCA.

(B) Following the approval of the CAP, the OHCA may:

(i) Condition such approval on completion of tasks in the order or priority that the OHCA prescribes;

(ii) Disapprove portions of the CE's proposed CAP; or

(iii) Require additional or different corrective action(s) or timelines/time limits.

(C) The CE remains responsible for achieving the established performance criteria.

(3) OHCA may apply one (1) or more of the following non-compliance remedies for each item of material non-compliance listed in (2) of this Section.

(A) Conduct accelerated monitoring of the CE;

(B) Require additional, more detailed, financial and/or programmatic reports to be submitted by the CE;

(C) Decline to renew or extend the Contract;

(D) Require forfeiture of all or part of the CE's performance bond or other substitute; or

(E) Terminate the Contract in accordance with OAC 317:55-5-14.

(4) In addition to the non-compliance remedies, the OHCA may impose tailored remedies, including liquidated damages pursuant to (e) of this Section.

(d) **Imposition of intermediate sanctions.** In accordance with 42 C.F.R. § 438.702, if OHCA determines the CE is non-compliant and 42 C.F.R. § 438.700(b) is the basis for the Agency's determination, OHCA may impose the following intermediate sanctions:

(1) Imposition of civil money penalties in the amounts specified in 42 C.F.R. § 438.704;

(2) Grant Enrollee(s) the right to terminate enrollment without cause and notifying the affected Enrollees of their right to disenroll;

(3) Suspend all new enrollment of Enrollee(s), including default enrollment, after the date OHCA notifies the CE of a determination of a violation of any requirement under § 1903(m) or § 1932 of The Act;

(4) Suspend or recoup capitation payments to the CE for Enrollees enrolled after the effective date of the sanction and until OHCA is satisfied that the reason for imposition of the sanction no longer exist and is not likely to recur;

(5) Impose additional sanctions provided for under state statutes or regulations to address noncompliance in accordance with 42 C.F.R. § 438.702(b); and

(6) Appoint temporary management in accordance with 42 C.F.R. § 438.706. The CE shall comply with the contractual requirements found in Section 1.26.3.5 "Intermediate Sanctions" of the Contract.

(7) The CE shall be responsible for all reasonable expenses related to the direct operation of the SoonerSelect program, including but not limited to attorney fees, cost of preliminary or other audits of the CE and expenses related to the management of any office or other assets of the CE.

(e) **Liquidated damages.** OHCA may impose actual, consequential, and liquidated damages in accordance with Tit. 23 O.S. § 21, resulting from the CE's failure to comply with any of the terms of the Contract, Ch. 55, or any applicable state or federal regulations. Consequential and liquidated damages will be assessed if OHCA determines such failure is the fault of the CE, including the CE's subcontractors and/or consultants, and is not materially caused or contributed to by OHCA or its agents.

(f) **Other provisions.** The CE shall be responsible for all reasonable expenses related to the direct operation of the SoonerSelect Medical program, including but not limited to attorney fees, cost of preliminary or other audits of the CE and expenses related to the management of any office or other assets of the CE.

317:55-5-11. ~~Network adequacy standards~~Non-compliance of dental benefit managers

~~In accordance with 42 C.F.R. § 438.604, the MCO or DBM will submit documentation for which OHCA will base its certification to CMS that the MCO or DBM has complied with requirements for availability and accessibility of services, including health professional shortage areas and adequacy of the MCO's or DBM's network, as set forth in 42 C.F.R. §§ 438.206, 438.14 and 438.68.~~

(a) **Failure to comply**. If the DBM fails to fulfill its duties and obligations or meet performance standards under 42 C.F.R. Part 438, 42 U.S.C. § 1396b(m), 42 U.S.C. § 1396u-2, Title 317 of the Oklahoma Administrative Code, or the DBM Contract, OHCA will notify the DBM of unmet performance expectations, violations, or deficiencies, and may impose corrective actions or any sanctions in addition to or instead of any actions or sanctions specified in the Contract.

(b) **Non-material compliance deficiencies.**

(1) If OHCA determines that unmet performance expectations, violations, or deficiencies do not result in a material deficiency or delay in the implementation or operation of services, the DBM will have five (5) business days (or the date specified by OHCA) of receipt of notice to provide the OHCA with a written response that:

(A) Explains the reasons for the deficiency;

(B) The DBM's plan to address or cure the deficiency; and

(C) The date and time by which the deficiency will be cured; or

(D) If the DBM disagrees with OHCA's findings, the DBM shall provide its reasons for disagreeing with OHCA's findings.

(2) The DBM's proposed cure of a non-material deficiency is subject to the approval of OHCA.

(3) The DBM's repeated commission of non-material deficiencies or repeated failure to resolve any such deficiencies may be regarded by OHCA as a material deficiency and entitle OHCA to pursue any other remedy provided in the Contract or any other appropriate remedy OHCA may have at law or equity.

(c) **Material compliance deficiencies.**

(1) An item of material non compliance means a specific action of the DBM that:

(A) Violates a substantive term of the Contract;

(B) Fails to meet an agreed upon measure of performance; or

(C) Represents a failure of the DBM to be reasonably responsive to a reasonable request of OHCA relating to the services for information, assistance, or support within the timeframe specified by OHCA.

(2) If OHCA determines that unmet performance expectations, violations, or deficiencies result in a material deficiency, the DBM may be required to submit a written CAP under the signature of the DBM's CEO to correct or resolve a material breach of the Contract.

(A) The CAP must:

(i) Be submitted by the deadline set forth in OHCA's request for a CAP.

(ii) Be reviewed and approved by OHCA.

(B) Following the approval of the CAP, the OHCA may:

(i) Condition such approval on completion of tasks in the order or priority that the OHCA prescribes;

(ii) Disapprove portions of the DBM's proposed CAP; or

(iii) Require additional or different corrective action(s) or timelines/time limits.

(C) The DBM remains responsible for achieving the established performance criteria.

(3) OHCA may apply one (1) or more of the administrative remedies found in (f) of this Section for each item of material non-compliance listed in (c)(2) of this Section.

(d) **Liquidated damages.** OHCA may impose actual, consequential, and liquidated damages in accordance with 23 O.S. § 21, resulting from the DBM's failure to comply with any of the terms of the Contract, Ch. 55, or any applicable state or federal regulations. Consequential and liquidated damages will be assessed if OHCA determines such failure is the fault of the DBM, including the CE's subcontractors and/or consultants, and is not materially caused or contributed to by OHCA or its agents.

(e) **Administrative remedies**. OHCA may impose the following remedies:

(1) Conduct accelerated monitoring of the DBM;
(2) Require additional, more detailed, financial and/or programmatic reports to be submitted by the DBM;
(3) Decline to renew or extend the Contract;
(4) Require forfeiture of all or part of the DBM's performance bond or other substitute; or
(5) Terminate the Contract in accordance with OAC 317:55-5-14.
(6) Grant Enrollee(s) the right to terminate enrollment without cause and notifying the affected Enrollees of their right to disenroll;
(7) Suspend all new enrollment of Enrollee(s), including default enrollment, after the date OHCA notifies the CE or DBM of a determination of a violation of any requirement;
(8) Suspend or recoup capitation payments to the DBM for Enrollees enrolled after the effective date of the sanction and until OHCA is satisfied that the reason for imposition of the sanction no longer exist and is not likely to recur; and
(9) Appoint temporary management in accordance with 42 C.F.R. § 438.706. The DBM shall comply with the contractual requirements found in the Contract at Section 1.26.3.5 "Imposition of Liquidated Damages".

(f) **Other provisions.** The DBM shall be responsible for all reasonable expenses related to the direct operation of the SoonerSelect Dental program, including but not limited to attorney fees, cost of preliminary or other audits of the DBM and expenses related to the management of any office or other assets of the DBM.

317:55-5-12. ~~Prior authorization requirements, generally~~Termination of contract

~~The OHCA will establish prior authorization requirements that are consistent with 56 O.S. §§ 4002-4004. MCOs and DBMs may establish prior authorization of benefits to the extent these are consistent with OHCA's policies and rules. The MCO or DBM may propose to impose additional prior authorization requirements, subject to OHCA's review and approval, except for those benefits identified in the Oklahoma Medicaid State Plan, rules, or practices as exempt from prior authorization. The MCO or DBM may be less restrictive on the requirements of a prior authorization than OHCA but may not impose greater restrictions.~~

(a) The Contract may be terminated prior to its scheduled expiration date only for the reasons specified in this Section.
(1) **Termination for mutual consent.** OHCA and the CE or DBM may terminate the contract by mutual written agreement.
(2) **Termination for convenience.** The OHCA may terminate the contract, in whole or in part, for convenience if it is determined that termination is in the state's best interest.
(3) **Termination for default.** OHCA may, at its election, assign Enrollees to another DBM/CE or provide benefits through other State Plan authority if the DBM/CE has breached this contract and is unable or unwilling to cure such breach within the period of time as specified in writing by OHCA.
(4) **Termination for unavailability of funds.** If state, federal, or other funding is not sufficiently appropriated, or is withdrawn, reduced, or limited in any way after the effective date of the contract, OHCA may terminate this contract immediately, effective on the close of business on the day specified. OHCA shall be the final authority as to the availability of funds.
(5) **Termination for lack of authority.** If any necessary federal or state approval or authority to operate the SoonerSelect Medical or Dental program is not granted, or the Oklahoma Legislature prohibits OHCA from contracting with a CE or DBM for the provision of health care for Eligibles or Enrollees, OHCA may terminate this contract immediately, effective on the close of business on the day specified.

(6) **Termination for financial instability.** If the OHCA deems, in its sole discretion, that the CE or DBM is financially unstable to the point of threatening the ability of OHCA to obtain the services provided for under this contract, ceases to conduct business in the normal course, makes a general assignment for the benefit of creditors or suffers or permits the appointment of a receiver for its business or its assets, then OHCA may, at its option, immediately terminate this Contract effective on the close of business on the date specified.

(7) **Termination for debarment.** The CE or DBM will not knowingly have a relationship with an individual or affiliate, as defined in 42 C.F.R. § 438.610.

(b) **Transition period requirements.** A transition period begins upon notification by the OHCA of intent to terminate the contract, notice by the CE or DBM or OHCA of intent not to extend the contract for a subsequent extension period, or if the CE or DBM has no remaining extension periods.

317:55-5-13. Notification of material change

~~An MCO~~A CE or DBM will promptly, within one (1) business day, notify OHCA of all changes materially affecting the delivery of care or the administration of the ~~MCP~~plan.

317:55-5-14. Patient data

~~An MCO~~A CE or DBM will provide patient data to a provider upon request to the extent allowed under federal or ~~State~~state laws, rules, or regulations, including but not limited to the Health Insurance Portability and Accountability Act of 1996.

PART 5. FINANCE

317:55-5-20. ~~Capitation rates~~Financial standards and third-party liability

~~OHCA will contract with an actuary, as defined at 42 C.F.R. § 438.2, to establish actuarially sound capitation rates, as described at 42 C.F.R. §§ 438.3(c), 438.4, and 438.5, for OHCA to pay to MCOs and DBMs.~~

(a) **Financial standards.** The CE or DBM shall comply with Oklahoma Insurance Department requirements for minimum net worth and risk- based capital in accordance with applicable Oklahoma Statutes found in Title 36 Insurance.

(b) **Insolvency protection.** In accordance with the requirements found at 42 C.F.R. §§ 438.106, 438.116, 36 O.S. § 6901, et seq., and all contractual requirements, the CE and DBM will provide satisfactory assurances to the OHCA to ensure that neither Enrollees nor the OHCA is held liable or responsible for any of the following:

(1) Any debts obtained by the CE or DBM;

(2) Covered services that are provided to the Enrollee for which the OHCA does not pay the CE or DBM; or

(3) Payment for covered services that are in excess of the amount that the Enrollee would owe the CE or DBM if those services were covered directly.

(c) **Medical loss ratio.** A CE or DBM will have a medical loss ratio that, at minimum, meets the standards provided by 42 C.F.R. §§ 438.8, 438.74, and applicable Contract. OHCA will monitor compliance with this requirement. If CE or DBM are not compliant with submission of MLR reporting, OHCA will evaluate the CE's or DBM's status for penalties or termination. Monitoring procedures to ensure compliance with MLR reporting include review of timeliness and completeness of reporting requirement and audit of date contained within the report.

(d) **Third-party liability**. Medicaid should be the payer of last resort for all covered services pursuant to federal regulations including but not limited to 42 C.F.R. 433 Subpart D and 42 C.F.R. § 447.20. The OHCA will notify the CE and DBM for any known third-party resources identified or

made available to OHCA at the time of an Applicant's or Eligible's eligibility determination or re-determination. The CE or DBM shall make every reasonable effort to:

(1) Determine the liability of third parties to pay for services rendered to Enrollees;

(2) Avoid costs which may be the responsibility of third parties;

(3) Reduce payments based on payments by a third-party for any part of a service;

(4) Recover any liability from responsible third-party sources, except for estate recovery and third-party subrogation which will remain OHCA's responsibility;

(5) Treat funds recovered from third parties as reductions to claims payments as required in the Contract; and

(6) Report all third-party liability collections as specified by the OHCA, the Contract, and reporting manual.

317:55-5-21. ~~Medical loss ratio~~Payment to CEs and DBMs

~~An MCO or DBM will have a medical loss ratio that, at minimum, meets the standards provided by 42 C.F.R. § 438.8.~~

(a) **Capitation rates.** In consideration for all services rendered by a CE or DBM under a contract with the OHCA, the CE and DBM will receive a monthly capitation payment for each Enrollee pursuant to 42 C.F.R. §§ 438.3(c), 438.4 and any other applicable state and/or federal regulation.

(b) **Capitation reconciliation.** The CE and DBM shall perform monthly reconciliation of enrollment roster data against capitation payments and notify discrepancies to the OHCA on schedule and as defined by the OHCA.

(c) **Denial of payment.** Capitation payments to the CE or DBM will be denied for new Enrollees when, and for so long as, payment for those Enrollees is denied by CMS under 42 C.F.R. § 438.730(e). CMS may deny payment to OHCA for new Enrollees if its determination is not contested timely by the CE. OHCA will define in writing to the CE the conditions for lifting the payment denials.

(d) **Recoupment for Medicare eligible Enrollees.** In the event an Enrollee becomes retroactively Medicare eligible, the CE or DBM shall recover claims payments made to providers during the months of retroactive Medicare eligibility. The CE or DBM shall also notify the provider of the requirement to submit the claim to Medicare for reimbursement. OHCA will recoup the capitation payments paid for months of retroactive Medicare eligibility.

317:55-5-22. ~~Value-based purchasing~~Payment to providers

~~In any contract for managed care services, OHCA may include provisions in which payments OHCA makes to an MCO or DBM are based in whole or in part on quality measures and/or any other performance metric as defined in the contract.~~

(a) **Provider payment.**

(1) The CE and DBM shall establish rates for participating providers that are reasonable to cover access to services.

(2) The CE and DBM shall abide by state and federal requirements related to payment of specific provider types as described in the Contract.

(3) Pursuant to 56 O.S. § 4002.12, the OHCA shall establish minimum rates of reimbursement from CEs to providers who elect not to enter into a value-based payment arrangement or other alternative payment arrangements for health care services rendered to Enrollees.

(4) Applicable exceptions to OAC 317:55-5-22(3) can be found at 56 O.S. § 4002.12(I).

(b) **Non-participating provider payment.** If the CE or DBM is unable to provide covered services to an Enrollee within its network of participating providers, the CE or DBM must adequately and timely arrange for the provision and payment of these services by non-participating providers.

Except as otherwise provided by law and/or specified for IHCPs, FQHCs, RHCs, and CCBHs, the CE or DBM will reimburse non-participating providers for covered services provided to Enrollees at a minimum of ninety percent (90%) of the current Medicaid fee schedule, unless the CE or DBM and the non-participating provider has agreed to a different reimbursement amount.

(c) **Value-based payments.** The CE and DBM shall implement value-based payment strategies and quality improvement initiatives to promote better care, better health outcomes, and lower spending for publicly funded health care services. OHCA will follow the withhold payment schedule and perform annual assessments to ensure CEs and DBMs are adhering to the VBP target requirements in accordance with the Contract. Pursuant to 42 C.F.R. § 438.10(f)(3), if the CE uses physician financial incentive plans, the Contractor must make available information about the incentive program. The CE shall also provide information about any physician incentive plans to OHCA prior to its initial use and prior to any subsequent revisions, and report information to OHCA as specified in the reporting manual. Any such incentive plans must comply with all applicable laws, including, without limitation 42 U.S.C. § 1395mm(i)(8) and 42 C.F.R § 417.479.

317:55-5-23. ~~Special contract provisions related to payment~~Timely claims filing and processing

~~(a) **Federal regulation.** Any special contract provision related to payment, as described at 42 C.F.R. § 438.6, will meet all related standards within the federal regulation.~~

~~(b) **Provider payments.**~~

~~(1) OHCA will establish minimum rates of reimbursement paid by MCOs and DBPs to providers who choose not to enter into value-based payment arrangements for health care items and services furnished by such providers to enrollees.~~

~~(A) For participating providers, the reimbursement rate until July 1, 2026, will be equal to or greater than one hundred percent (100%) of the reimbursement rate for the applicable item or service per the applicable OHCA fee schedule.~~

~~(B) For non-participating providers and subject to CMS approval as a directed payment or otherwise, the reimbursement rate, until July 1, 2026, will be equal to or greater than ninety percent (90%) of the reimbursement rate for the applicable item or service provided by a non-participating provider per the applicable OHCA fee schedule as of January 1, 2021.~~

~~(2) Notwithstanding any other provision of this section, OHCA will comply with payment methodologies required by federal law or regulation for specific types of providers including, but not limited to, Federally Qualified Health Centers (FQHCs), rural health clinics (RHCs), pharmacies, Indian Health Care Providers (IHCPs), and emergency services.~~

~~(c) **Optional value-based payments.** The MCO or DBM will offer optional value-based payment arrangements to all providers. Reimbursement amounts to providers in value-based payment arrangements align with the quality measures OHCA applies to MCOs or DBMs, respectively.~~

(a) **Timely claims filing.** The CE or DBM shall adjudicate provider claims in accordance with timely filing limits specified in OAC 317:30-3-11.

(b) **Timely payment.** The CE or DBM shall meet timely claims payment standards specified in the Contract and 42 C.F.R § 447.45.

317:55-5-24. Hospital readmission damages

The OHCA will establish a hospital readmission damage program to reduce potentially preventable readmissions. The program will use a nationally recognized tool to establish a base measurement year and a performance year and will provide for risk-adjustment based on the population of the state Medicaid program covered by the ~~MCOs or DBMs~~CEs. The program will be

fully described in the ~~managed care contract~~Contract so that the program will be founded on contract-current tools, populations, and other factors.

317:55-5-25. Claims processing and methodology; post payment audits

(a) **Claims payment systems.** The ~~MCO~~CE or DBM will maintain a claims payment system capable of processing and adjudicating claims for payment in an accurate and timely manner and in full compliance with all ~~State and Federal~~state and federal laws.

(b) **Claim filing.** A claim that is filed by a provider within six (6) months of the date the item or service was furnished will be considered timely, per ~~Oklahoma Administrative Code (~~OAC~~)~~ 317:30-3-11.

(c) **Clean claims.** The ~~MCO~~CE or DBM will process a clean claim within the time frame outlined in 36 O.S. § 1219.

(1) The ~~MCO~~CE or DBM will ensure that at least ninety percent (90%) of clean claims received from all providers are paid within fourteen (14) days of receipt.

(2) A clean claim that is not processed within the time frame will bear simple interest at the monthly rate of one and one-half percent (1.5%), which is payable to the provider.

(d) **Additional documentation.** After a claim has been paid but not prior to payment, the ~~MCO~~CE or DBM may request medical records~~,~~ if additional documentation is needed to review the claim for medical necessity.

(e) **Claim denials.**

(1) A claim denial will include the following information:

(A) Detailed explanation of the basis for the denial; and

(B) Detailed description of the additional information necessary to substantiate the claim.

(2) The ~~MCO~~CE or DBM will establish a process for all claim denials by which the provider may identify and provide additional information to substantiate the claim.

(3) A provider will have six (6) months from the receipt of a claim denial to file an appeal per OAC 317:2-3-10.

(f) **Post payment audits.**

(1) In accordance with OAC 317:30-5-70.2, the ~~MCO~~CE or DBM will comply with the post payment audit process established by OHCA.

(2) The ~~MCO~~CE or DBM will adhere to limits set forth by OHCA regarding the percentage of claims that can be subjected to post payment audits.

(3) ~~An MCO~~A CE or DBM who has a claims denial error rate of greater than five percent (5%) will be subject to damages as set forth by OHCA in the ~~managed care contract~~Contract.

317:55-5-26. Prohibited payments

(a) **Overpayment.** The CE or DBM shall report overpayments to OHCA and promptly recover identified overpayments.

(b) **Suspension of payments.** The CE or DBM shall suspend payments to providers for which the state determines there is a credible allegation of fraud in accordance with the Contract and 42 C.F.R. § 455.23.

(c) **Providers ineligible for payment.** The CE or DBM shall ensure that no Medicaid funds are reimbursed to a provider whose payments are suspended or that has been terminated by the OHCA.

(d) **Provider-preventable conditions.** In accordance with 42 C.F.R. §§ 438.3(g), 434.6(a)(12)(i) and 447.26(b), the CE or DBM shall not make any payment to a provider for provider-preventable conditions as defined at 42 C.F.R. § 447.26(b). A list of provider-preventable conditions including health care-acquired conditions (HCACs) and other provider-preventable conditions (OPPCs) for which payment shall not be made can be found at OAC 317:30-3-62 and 30-3-63.

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PART 7. THE ~~MANAGED CARE~~SOONERSELECT QUALITY ADVISORY COMMITTEE

317:55-5-30. ~~Managed care~~SoonerSelect quality advisory committee

(a) The Chief Executive Officer (CEO) of OHCA will establish and appoint members to the ~~MC~~SoonerSelect Quality Advisory Committee (Committee). Committee members serve without compensation and at the pleasure of the CEO. The Committee will consist of:

(1) Participating providers as a majority of the Committee members;

(2) Representatives of hospitals and health systems;

(3) Members of the health care community; and

(4) Members of the academic community with an expertise in health care or other applicable field.

(b) The primary power and duty of the Committee is set forth at 56 O.S. § 4002.13.

(c) Committee meetings will be subject to the Oklahoma Open Meeting Act.

(d) The Committee will select from among its membership a chair and vice chair.

(e) The Committee may meet as often as may be required ~~in order~~ to perform the duties imposed on it.

(f) A quorum of the Committee will be required to approve any final ~~action~~recommendations of the Committee. A majority of the members of the Committee will constitute a quorum.

317:55-5-31. Quality scorecard

(a) Within one (1) year of beginning steady state operations of any ~~MCP~~plan, OHCA will create a quality scorecard, in accordance with 56 O.S. § 4002.11, that compares ~~MCOs~~CEs to one another and DBMs to one another.

(b) OHCA will provide the most recent quarterly scorecard for ~~initial enrollees~~first time Enrollees during choice counseling.

(c) OHCA will provide the most recent quarterly scorecard to all ~~enrollees~~Enrollees at the beginning of each open enrollment period.

(d) OHCA will publish each quarterly scorecard on its website.

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

SUBCHAPTER 3. GENERAL PROVIDER POLICIES

PART 1. GENERAL SCOPE AND ADMINISTRATION

317:30-3-5. Assignment and cost sharing

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(B) Members in nursing facilities (NF) and intermediate care facilities for individuals with intellectual disabilities (ICF/IID).

(C) Home and Community-Based Services (HCBS) waiver members except for prescription drugs.

(D) American Indian and Alaska Native members, per Section 5006 of the American Recovery and Reinvestment Act of 2009 and as established in the federally-approved Oklahoma Medicaid State Plan.

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

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

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

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

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

(C) Services furnished to pregnant women.

(D) Smoking and tobacco cessation counseling and products.

(E) Blood glucose testing supplies and insulin syringes.

(F) Medication-assisted treatment (MAT) drugs.

(G) Vaccine administration.

(H) Preventive services for expansion adults.

(I) Opioid overdose reversal agents.

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

(A) Inpatient hospital stays.

(B) Outpatient hospital visits.

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

(D) Encounters with the following rendering providers:

(i) Physicians;

(ii) Advanced practice registered nurses;

(iii) Physician assistants;

(iv) Optometrists;

(v) Home health agencies;

(vi) Certified registered nurse anesthetists;

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(vii) Anesthesiologist assistants;
(viii) Durable medical equipment providers; and
(ix) Outpatient behavioral health providers.

(E) Prescription drugs.

(F) Crossover claims. Dually eligible Medicare/SoonerCare members must make a co-payment in an amount that does not exceed the federal allowable per visit/encounter for all Part B covered services. This does not include dually eligible HCBS waiver members.

(4) Medicaid premiums and cost sharing incurred by all individuals in the Medicaid household may not exceed an aggregate limit of five percent (5%) of the family's income applied on a monthly basis, as specified by the agency.

(5) Providers will be required to refund any co-payment amounts the provider collected from the member in error and/or above the family's aggregate cost sharing maximum.

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

SUBCHAPTER 7. MEDICAL SERVICES

PART 7. CERTIFICATION, REDETERMINATION AND NOTIFICATION

317:35-7-61.1. Special redetermination procedures for Tax Equity and Fiscal Responsibility Act (TEFRA)

In addition to redetermining the level of care ~~annually~~, the OHCA also conducts an annual cost effectiveness review for all active TEFRA children. If OHCA determines the child does not meet any level of care, is no longer disabled, or the estimated cost of care in the home is greater than the estimated cost of care in an institution, at the appropriate level of care, the case is closed.

SUBCHAPTER 9. ICF/IID, HCBW/IID, AND INDIVIDUALS AGE 65 OR OLDER IN MENTAL HEALTH HOSPITALS

PART 5. DETERMINATION OF MEDICAL ELIGIBILITY FOR ICF/IID, HCBW/IID, AND INDIVIDUALS AGE 65 OR OLDER IN MENTAL HEALTH HOSPITALS

317:35-9-48.1. Determining ICF/IID institutional level of care for TEFRA children

In order to determine ~~ICF/Dis~~intermediated Care Facility for Individuals with Intellectual Disabilities (ICF/IID) level of care for ~~TEFRA~~Tax Equity and Fiscal Responsibility Act (TEFRA) children:

(1) The child must be age ~~18~~eighteen (18) years or younger and expected to meet the following criteria for at least ~~30~~thirty (30) days.

(A) Applicants under age three (3) must:

(i) ~~have~~Have a diagnosis of a developmental disability; and

(ii) ~~have~~Have been evaluated by the SoonerStart Early Intervention Program or other appropriate healthcare provider, and found to have severe ~~dys~~functional deficiencies with findings of at least two (2) standard deviations in at least two (2) total domain areas.

(B) Applicants age three (3) years and older must:

(i) ~~have~~Have a diagnosis of intellectual disability or a developmental disability; and

(ii) ~~have~~Have received a psychological evaluation by a licensed psychologist, ~~or~~ school psychologist certified by the Oklahoma Department of Education (ODE) within the last ~~12~~twelve (12) months, certified psychometrist, psychological technician of a psychologist, or licensed behavioral health professional (LBHP). The evaluation must include intelligence testing that yields a full-scale intelligence quotient, as determined appropriate by the provider, and a full-scale functional or adaptive assessment that yields a composite functional age. Eligibility for TEFRA ICF/IID level of institutional care requires either an IQ of ~~70~~seventy (70) or less, or a full-scale functional assessment indicating a functional age composite that does not exceed fifty (50) percent of the child's chronological age. In no case shall eligibility be granted for a functional age greater than eight (8) years.

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(2) Psychological evaluations are required for children who are approved for TEFRA under ICF/IID level of care. Children under evaluation, including both intelligence testing and adaptive/functional assessment, by a licensed psychologist, ~~or~~ school psychologist certified by the ODE, certified psychometrist, psychological technician of a psychologist, or licensed behavioral health professional (LBHP) at ~~age three, age six,~~application, at two (2) years (but no later than three (3) years) after the initial psychological evaluation, and at two (2) years (but no later than three (3) years) after the second psychological evaluation and, if medically necessary, thereafter, to ascertain continued eligibility for TEFRA under the ICF/IID level of institutional care. ~~The psychological evaluation must be completed and submitted to the LOCEU no later than 90 days following the child's third (3rd) and sixth (6th) birthday, and, if medically necessary, thereafter.~~

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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

317:30-5-240.3. Staff credentials

(a) **Licensed behavioral health professional (LBHPs).** LBHPs are defined as any of the following practitioners:

(1) An allopathic or osteopathic physician with a current license and board certification in psychiatry or board eligible in the state in which services are provided, or a current resident in psychiatry practicing as described in OAC 317:30-5-2.

(2) A practitioner with a current license to practice in the state in which services are provided, within one (1) of the areas of practice listed in (A) through (F). The exemptions from licensure under 59 O.S. § 1353(4) and (5), 59 O.S. § 1903(C) and (D), 59 O.S. § 1925.3(B) and (C), and 59 O.S. § 1932(C) and (D) do not apply to outpatient behavioral health services.

(A) Psychology;
(B) Social work (clinical specialty only);
(C) Professional counselor;
(D) Marriage and family therapist;
(E) Behavioral practitioner; or
(F) Alcohol and drug counselor.

(3) An advanced practice registered nurse (APRN) certified in a psychiatric mental health specialty, and licensed as a registered nurse (RN) with a current certification of recognition from the board of nursing in the state in which services are provided.

(4) A physician assistant who is licensed and in good standing in the state in which services are provided and has received specific training for and is experienced in performing mental health therapeutic, diagnostic, or counseling functions.

(b) **Licensure candidates.** Licensure candidates are practitioners actively and regularly receiving board-approved supervision, and extended supervision by a fully licensed clinician if board's supervision requirement is met but the individual is not yet licensed, to become licensed by one (1) of the areas of practice listed in (2)(A) through (F) above. The supervising LBHP responsible for the member's care must:

(1) Staff the member's case with the candidate;

(2) Be personally available, or ensure the availability of an LBHP to the licensure candidate for consultation while they are providing services;

(3) Agree with the current plan for the member;

(4) Confirm that the service provided by the candidate was appropriate; and

(5) The member's medical record must show that the requirements for reimbursement were met and the LBHP responsible for the member's care has reviewed, countersigned, and dated the service plan and any updates thereto so that it is documented that the licensed professional is responsible for the member's care.

(c) **Certified alcohol and drug counselors (CADCs).** CADCs are defined as having a current certification as a CADC in the state in which services are provided.

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(d) **Multi systemic therapy (MST) provider**. Master's level therapist who works on a team established by the Oklahoma Juvenile Affairs Office (OJA) which may include bachelor's level staff.

(e) **Peer recovery support specialist (PRSS)/Family peer recovery support specialist (F-PRSS).** The PRSS and F-PRSS must be certified by ODMHSAS pursuant to requirements found in OAC 450:53.

~~(f) **Family support and training provider (FSP).** FSPs must:~~

~~(1) Have a high school diploma or equivalent;~~

~~(2) Be twenty-one (21) years of age and have a successful experience as a family member of a child/adolescent with serious emotional disturbance, or a minimum of have lived experience as the primary caregiver of a child/adolescent who has received services for substance use disorder and/or co-occurring substance use and mental health, or have lived experience being the caregiver for a child/adolescent with Child Welfare/Child Protective Services involvement;~~

~~(3) Successfully complete family support training according to a curriculum approved by ODMHSAS and pass the examination with a score of eighty percent (80%) or better;~~

~~(4) Pass Oklahoma State Bureau of Investigation (OSBI) background check;~~

~~(5) Have treatment plans be overseen and approved by a licensed behavioral health professional (LBHP) or licensure candidate; and~~

~~(6) Function under the general direction of an LBHP, licensure candidate or systems of care team, with an LBHP or licensure candidate available at all times to provide back up, support, and/or consultation.~~

~~(g)~~(f) **Qualified behavioral health aide (QBHA)**. QBHAs must:

(1) ~~Have completed sixty (60) hours or equivalent of college credit; or may substitute one (1) year of relevant employment and/or responsibility in the care of children with complex emotional needs for up to two (2) years of college experience~~Possess current certification as a Behavioral Health Case Manager I; ~~and~~

(2) Have successfully completed the specialized training and education curriculum provided by the ODMHSAS; ~~and~~

(3) Be supervised by a bachelor's level individual with a minimum of two (2) years case management or care coordination experience; ~~and~~

(4) Have service plans be overseen and approved by an LBHP or licensure candidate; and

(5) Function under the general direction of an LBHP, or licensure candidate and/or systems of care team, with an LBHP or licensure candidate available at all times to provide back up, support, and/or consultation.

(h) **Behavioral health case manager.** For behavioral health case management services to be compensable by SoonerCare, the provider performing the services must be an LBHP, licensure candidate, CADC or have and maintain a current certification as a ~~case manager~~Behavioral Health Case Manager II (CM II) or ~~case manager~~Behavioral Health Case Manager I (CM I) from ODMHSAS in accordance with requirements found in OAC 450:50. ~~The requirements for obtaining these certifications are as follows:~~

~~(1) The CM II must meet the requirements in (A), (B), (C) or (D) below:~~

~~(A) Possess a bachelor's or master's degree in a behavioral health related field earned from a regionally accredited college or university recognized by the United States Department of Education (USDE) or a bachelor's or master's degree in education; and complete web-based training for behavioral health case~~

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~~management and behavioral health rehabilitation as specified by ODMHSAS; and complete one (1) day of face-to-face behavioral health case management training and two (2) days of face-to-face behavioral health rehabilitation training as specified by ODMHSAS; and pass web-based competency exams in behavioral health case management and behavioral health rehabilitation.~~

~~(B) Be licensed and in good standing as a registered nurse in the state in which services are provided, with experience in behavioral health care; complete web-based training for behavioral health case management and behavioral health rehabilitation as specified by ODMHSAS; complete one (1) day of face-to-face behavioral health case management training and two (2) days of face-to-face behavioral health rehabilitation training as specified by ODMHSAS; and pass web-based competency exams for behavioral health case management and behavioral health rehabilitation.~~

~~(C) Possess a bachelor's or master's degree in any field earned from a regionally accredited college or university recognized by the USDE and a current certification or Children's Certificate in Psychiatric Rehabilitation from the US Psychiatric Rehabilitation Association (USPRA); complete the behavioral health case management web-based training as specified by ODMHSAS; complete one (1) day of face-to-face behavioral health case management training; and pass web-based competency exams for behavioral health case management. Applicants who have not received a certificate in children's psychiatric rehabilitation from the USPRA must also complete the behavioral health rehabilitation web-based training as specified by ODMHSAS.~~

~~(D) Possess a bachelor's or master's degree in any field and proof of active progression toward obtaining a clinical licensure master's or doctoral degree at a regionally accredited college or university recognized by the USDE and complete web-based training for behavioral health case management and behavioral health rehabilitation as specified by ODMHSAS; complete one (1) day of face-to-face behavioral health case management training and two (2) days of face-to-face behavioral health rehabilitation training as specified by ODMHSAS; and pass web-based competency exams in behavioral health case management and behavioral health rehabilitation.~~

~~(2) The CM I meets the requirements in either (A) or (B) and (C):~~

~~(A) Completed sixty (60) college credit hours; or~~

~~(B) Possesses a high school diploma with thirty-six (36) total months of experience working with persons who have a mental illness and/or substance abuse. Documentation of experience on file with ODMHSAS; and~~

~~(C) Completes two (2) days of ODMHSAS specified behavioral health case management training and passes a web-based competency exam for behavioral health case management.~~

~~(3)~~(1) A Wraparound ~~facilitator case manager is~~Facilitator Case Manager must be an LBHP, licensure candidate or CADC that meets the qualifications for CM II and has the following:

(A) Successful completion of the ODMHSAS training for wraparound facilitation within six (6) months of employment; and

(B) Participate in ongoing coaching provided by ODMHSAS and employing agency; ~~and~~

(C) Successfully complete wraparound credentialing process within nine (9) months of beginning process; and

(D) Direct supervision or immediate access and a minimum of one (1) hour weekly clinical consultation with a qualified mental health professional, as required by ODMHSAS.

~~(4)~~(2) An Intensive ~~case manager is~~Case Manager must be an LBHP, licensure candidate, or CADC that meets the provider qualifications of a CM II and has the following:

(A) A minimum of two (2) years behavioral health case management experience~~, crisis diversion experience,~~; and

~~(B) Must have attended the ODMHSAS six (6) hours intensive case management training.~~

(B) Crisis diversion experience.

317:30-5-241.5 Support services

(a) **Program of Assertive Community Treatment (PACT) Services**.

(1) **Definition**. PACT is provided by an interdisciplinary team that ensures service availability 24 hours a day, seven days a week and is prepared to carry out a full range of treatment functions wherever and whenever needed. An individual is referred to the PACT team service when it has been determined that his/her needs are so pervasive and/or unpredictable that it is unlikely that they can be met effectively by other combinations of available community services, or in circumstances where other levels of outpatient care have not been successful to sustain stability in the community.

(2) **Target population**. Individuals 18 years of age or older with serious and persistent mental illness and co-occurring disorders. PACT services are those services delivered within an assertive community-based approach to provide treatment, rehabilitation, and essential behavioral health supports on a continuous basis to individuals 18 years of age or older with serious mental illness with a self-contained multi-disciplinary team. The team must use an integrated service approach to merge essential clinical and rehabilitative functions and staff expertise. This level of service is to be provided only for persons most clearly in need of intensive ongoing services.

(3) **Qualified practitioners**. Providers of PACT services are specific teams within an established organization and must be operated by or contracted with and certified by the ODMHSAS in accordance with 43A O.S. 319 and OAC 450:55. The team leader must be an LBHP or Licensure Candidate.

(4) **Limitations**. PACT services are billable in 15 minute units. A maximum of 105 hours per member per year in the aggregate is allowed. All PACT compensable SoonerCare services are required to be face-to-face. The following services are separately billable: Case management, facility-based crisis stabilization, physician and medical services.

(5) **Service requirements**. PACT services must include the following:

(A) PACT assessments (initial and comprehensive);

(i) **Initial assessment.** is the initial evaluation of the member based upon available information, including self-reports, reports of family members and other significant parties, and written summaries from other agencies, including police, court, and

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outpatient and inpatient facilities, where applicable, culminating in a comprehensive initial assessment. Member assessment information for admitted members shall be completed on the day of admission to the PACT. The start and stop times for this service should be recorded in the chart.

(ii) **Comprehensive assessment.** is the organized process of gathering and analyzing current and past information with each member and the family and/or support system and other significant people to evaluate: 1) mental and functional status; 2) effectiveness of past treatment; 3) current treatment, rehabilitation and support needs to achieve individual goals and support recovery; and 4) the range of individual strengths (e.g., knowledge gained from dealing with adversity or personal/professional roles, talents, personal traits) that can act as resources to the member and his/her recovery planning team in pursuing goals. Providers must bill only the face-to-face service time with the member. Non-face to face time is not compensable. The start and stop times for this service should be recorded in the chart.

(B) Behavioral health service plan (moderate and low complexity by a non-physician treatment planning and review) is a process by which the information obtained in the comprehensive assessment, course of treatment, the member, and/or treatment team meetings is evaluated and used to develop a service plan that has individualized goals, objectives, activities and services that will enable a member to improve. The initial assessment serves as a guide until the comprehensive assessment is completed. It is to focus on recovery and must include a discharge plan. It is performed with the direct active participation by the member. SoonerCare compensation for this service includes only the face to face time with the member. The start and stop times for this service should be recorded in the chart.

(C) Treatment team meetings (team conferences with the member present) is a billable service. This service is conducted by the treatment team, which includes the member and all involved practitioners. For a complete description of this service, see OAC 450:55-5-6 Treatment Team Meetings. This service can be billed to SoonerCare only when the member is present and participating in the treatment team meeting. The conference starts at the beginning of the review of an individual member and ends at the conclusion of the review. Time related to record keeping and report generation is not reported. The start and stop times should be recorded in the member's chart. The participating psychiatrist/physician should bill the appropriate CPT code; and the agency is allowed to bill one treatment team meeting per member as medically necessary.

(D) Individual and family psychotherapy;

(E) Individual rehabilitation;

(F) Recovery support services;

(G) Group rehabilitation;

(H) Group psychotherapy;

(I) Crisis Intervention;

(J) Medication training and support services;

(K) Blood draws and /or other lab sample collection services performed by the nurse.

(b) **Therapeutic Behavioral Services.**

(1) **Definition**. Therapeutic behavioral services include behavior management and redirection and behavioral and life skills remedial training provided by qualified behavioral health aides. The behavioral health aide also provides monitoring and observation of the child's

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emotional/behavioral status and responses, providing interventions, support and social skills redirection when needed. Training is generally focused on behavioral, interpersonal, communication, ~~self help~~self-help, safety and daily living skills.

(2) **Target population**. This service is limited to children with serious emotional disturbance who are in an ODMHSAS contracted systems of care ~~community based~~community-based treatment program, or are under OKDHS or OJA custody residing within a RBMS level of care, who need intervention and support in their living environment to achieve or maintain stable successful treatment outcomes.

(3) **Qualified practitioners**. Qualified Behavioral Health Aides (QBHA) must possess certification as a Behavioral Health Case Manager I and be trained/credentialed through ODMHSAS.

(4) **Limitations**. The ~~Behavioral Health Aide~~QBHA cannot bill for more than one individual during the same time period. Therapeutic behavioral services by a BHA, Treatment Parent Specialist (TPS) or Behavioral Health School Aide (BHSA) cannot be delivered during the same clock time.

(5) **Documentation requirements**. Providers must follow requirements listed in OAC 317:30-5-248.

~~(c) **Family Support and Training.**~~

~~(1) **Definition.** This service provides the training and support necessary to ensure engagement and active participation of the family in the service plan development process and with the ongoing implementation and reinforcement of skills learned throughout the treatment process. Child Training is provided to family members to increase their ability to provide a safe and supportive environment in the home and community for the child. Parent Support ensures the engagement and active participation of the family in the service plan development process and guides families toward taking a proactive role in their child's treatment. Parent Training is assisting the family with the acquisition of the skills and knowledge necessary to facilitate an awareness of their child's needs and the development and enhancement of the family's specific problem-solving skills, coping mechanisms, and strategies for the child's symptom/behavior management.~~

~~(2) **Target population.** Family Support and Training is designed to benefit the SoonerCare eligible child experiencing a serious emotional disturbance who is in an ODMHSAS contracted systems of care community based treatment program, are diagnosed with a pervasive developmental disorder, or are under OKDHS or OJA custody, are residing within a RBMS level of care or are at risk for out of home placement, and who without these services would require psychiatric hospitalization.~~

~~(3) **Qualified practitioners.** Family Support Providers (FSPs) must be trained/credentialed through ODMHSAS.~~

~~(4) **Limitations.** The FSP cannot bill for more than one individual during the same time period.~~

~~(5) **Documentation requirements.** Providers must comply with requirements listed in OAC 317:30-5-248.~~

~~(d)~~(c) **Peer Recovery Support Services (PRSS)**.

(1) **Definition**. Peer recovery support services are an EBP model of care which consists of a qualified ~~peer recovery support specialist provider~~Peer Recovery Support Specialist (PRSS) who assists individuals with their recovery from behavioral health disorders. Recovery Support is a service delivery role in the ODMHSAS public and contracted provider system

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~~throughout the behavioral health care system~~ where the provider understands what creates recovery and how to support environments conducive of recovery. The role is not interchangeable with traditional staff members who usually work from the perspective of their training and/or their status as a licensed behavioral health provider; rather, this provider works from the perspective of their experimental expertise and specialized ~~credential~~ training. They lend unique insight into mental illness and what makes recovery possible because they are in recovery. Family Peer Recovery Support Specialists (F-PRSS) focus on the family unit of a child or adolescent, ensuring the engagement and active participation of the family during treatment and guiding families toward taking a proactive role in their family member's recovery, for the benefit of the SoonerCare eligible child or adolescent. Services may include assisting the family with the acquisition of the skills and knowledge necessary to facilitate an awareness of their child's needs and the development and enhancement of the family's problem-solving skills, coping mechanisms, and strategies for the child's symptom/behavior management.

(2) **Target population**. ~~Children 16~~Members age sixteen (16) years of age and over with SED and/or substance use disorders~~, and~~ adults 18 and over with SMI and/or substance use disorder(s), and family units with a child or adolescent experiencing an SED and/or substance use disorder.

(3) **Qualified professionals**. Peer Recovery Support Specialists (PRSS) and Family Peer Recovery Support Specialists (F-PRSS) must be certified through ODMHSAS pursuant to OAC 450:53. A PRSS may provide services to individuals sixteen (16) years of age or older. An F-PRSS may provide services to families with children and adolescents.

(4) **Limitations**. The PRSS and F-PRSS cannot bill for more than one individual service during the same time period. This service can be an individual or group service. Groups have no restriction on size.

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

(6) **Service requirements**.

(A) PRSS staff utilizing their knowledge, skills and abilities will:

(i) teach and mentor the value of every individual's recovery experience;

(ii) model effective coping techniques and self-help strategies;

(iii) assist members or their family members in articulating personal goals for recovery; and

(iv) assist members or their family members in determining the objectives needed to reach his/her recovery goals.

(B) PRSS staff utilizing ongoing training must:

(i) proactively engage members ~~and possess~~or their family members using communication skills/ability to transfer new concepts, ideas, and insight to others;

(ii) facilitate peer support groups;

(iii)assist in setting up and sustaining self-help (mutual support) groups;

(iv) support members in using a Wellness Recovery Action Plan (WRAP);

(v) assist in creating a crisis plan/Psychiatric Advanced Directive;

(vi) utilize and teach problem solving techniques with members or their family members;

(vii) teach members how to identify and combat negative self-talk and fears;

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(viii) support the vocational choices of members and assist him/her in overcoming job-related anxiety;
(ix) assist in building social skills in the community that will enhance quality of life. Support the development of natural support systems;
(x) assist other staff in identifying program and service environments that are conducive to recovery and;
(xi) attend treatment team and program development meetings to ensure the presence of the member's voice and to promote the use of self-directed recovery tools.

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 3. HOSPITALS

317:30-5-41. Inpatient hospital coverage/limitations

(a) Covered hospital inpatient services are those medically necessary services which require an inpatient stay ordinarily furnished by a hospital for the care and treatment of inpatients and which are provided under the direction of a physician or dentist in an institution approved under OAC: 317:30:5-40.1(a) or (b) Claims for inpatient admissions in acute care or critical access hospitals are reimbursed the lesser of the billed charges or the Diagnosis Related Groups (DRG) amount.

(b) **Inpatient status.** OHCA considers a member an inpatient when ~~the member is admitted to the hospitaland~~a physician writes an order for the member to be admitted to a participating hospital; the member is admitted and is receiving room, board, and professional services provided on a continuous twenty-four (24) hour a day basis; and a member is counted in the midnight census. A length of stay less than twenty-four (24) hours may be considered if the stay meets an inpatient acuity level of care. In situations when a ~~member~~member's inpatient admission occurs and the member dies, is discharged following an obstetrical stay, or is transferred to another facility on the day of admission, the member is also considered an inpatient of the hospital.

(1) **Same day admission.** If a member is admitted and dies before the midnight census on the same day of admission, the member is considered an inpatient.

(2) **Same day admission/discharge - obstetrical and newborn stays.** A hospital stay is considered inpatient stay when a member is admitted and delivers a baby, even when the mother and baby are discharged on the date of admission (i.e., they are not included in the midnight census). This rule applies when the mother and/or newborn are transferred to another hospital.

(3) **Same day admission/discharges other than obstetrical and newborn stays.** In the event a member is admitted as an inpatient, but is determined to not qualify for an inpatient payment based on OHCA ~~criteria,~~review, the hospital may bill on an outpatient claim for the ancillary services provided during that time.

(4) **Discharges and Transfers**. A hospital inpatient is considered discharged from a hospital paid under the DRG-based payment system when:

(A) The patient is formally released from the hospital; or

(B) The patient dies in the hospital; or

(C) The patient is transferred to a hospital that is excluded from the DRG-based payment system, or transferred to a distinct part psychiatric or rehabilitation unit of the same hospital. Such instances will result in two or more claims. Effective January 1, 2007, distinct part psychiatric and rehabilitation units excluded from the Medicare Prospective Payment System (PPS) of general medical surgical hospitals will require a separate provider identification number.

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

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

(1) Covered inpatient services provided to eligible SoonerCare members admitted to in-state

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

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

(A) Laboratory services;

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

(C) Technical component on radiology services;

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

(E) Pre-admission diagnostic testing performed within seventy-two (72) hours of admission; and

(F) Organ transplants.

(3) Charges for services or supplies deemed not medically necessary and/or not separately billable may be recouped upon post payment review of outlier payments.

~~(3)~~(4) Hospitals may submit a claim for payment only upon the final discharge of the patient or upon completion of a transfer of the patient to another hospital.

~~(4)~~(5) Covered inpatient services provided to eligible members of the SoonerCare program, when treated in out-of-state hospitals will be reimbursed in the same manner as in-state hospitals. Refer to OAC 317:30-3-90 and 317:30-3-91.

~~(5)~~(6) Cases which indicate transfer from one (1) acute care hospital to another will be monitored under a retrospective utilization review policy to help ensure that payment is not made for inappropriate transfers.

~~(6)~~(7) The transferring hospital will be paid the lesser of the calculated transfer fee or the DRG base payment amount for a non-transfer.

~~(7)~~(8) If the transferring or discharge hospital or unit is exempt from the DRG, that hospital or unit will be reimbursed according to the method of payment applicable to the particular facility or units.

~~(8)~~(9) Covered inpatient services provided in out-of-state specialty hospitals may be reimbursed at a negotiated rate not to exceed one-hundred percent (100%) of the cost to provide the service. Negotiation of rates will only be allowed when the OHCA determines that the specialty hospital or specialty unit provides a unique (non-experimental) service required by SoonerCare members and the provider will not accept the DRG payment rate. Prior authorization is required.

~~(9)~~(10) New providers entering the SoonerCare program will be assigned a peer group and will be reimbursed at the peer group base rate for the DRG payment methodology or the statewide median rate for per diem methods.

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

~~(11)~~(12) For high-investment drugs, refer to OAC 317:30-5-47.6.

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

SUBCHAPTER 3. GENERAL PROVIDER POLICIES

PART 3. GENERAL MEDICAL PROGRAM INFORMATION

317:30-3-57. General SoonerCare coverage - categorically needy

The following are general SoonerCare coverage guidelines for the categorically needy:

(1) Inpatient hospital services.

(A) Adult coverage for inpatient hospital stays as described at Oklahoma Administrative Code (OAC) 317:30-5-41.

(B) Coverage for members under twenty-one (21) years of age is not limited. All admissions must be medically necessary. All psychiatric admissions require prior authorization for an approved length of stay.

(2) Emergency department services.

(3) Dialysis in an outpatient hospital or freestanding dialysis facility.

(4) Outpatient therapeutic radiology or chemotherapy for proven malignancies or opportunistic infections.

(5) Outpatient surgical services - facility payment for selected outpatient surgical procedures to hospitals which have a contract with the Oklahoma Health Care Authority (OHCA).

(6) Outpatient mental health services for medical and remedial care including services provided on an outpatient basis by certified hospital-based facilities that are also qualified mental health clinics.

(7) Rural health clinic services and other ambulatory services furnished by rural health clinic.

(8) Optometrists' services - only as listed in Subchapter 5, Part 45, Optometrist specific rules of this Chapter.

(9) Maternity clinic services.

(10) Outpatient diagnostic x-rays and lab services. Other outpatient services provided to adults, not specifically addressed, are covered only when prior authorized by the Agency's Medical Authorization Unit.

(11) Medically necessary screening mammography. Additional follow-up mammograms are covered when medically necessary.

(12) Long-term care facility services (other than services in an institution for tuberculosis or mental diseases).

(13) Early and Periodic Screening, Diagnostic and Treatment Services (EPSDT) are available for members under twenty-one (21) years of age to provide access to regularly scheduled examinations and evaluations of the general physical and mental health, growth, development, and nutritional status of infants, children, and youth. Federal regulations also require that diagnosis and treatment be provided for conditions identified during a screening whether or not they are covered under the State Plan, as long as federal funds are available for these services. These services must be necessary to ameliorate or correct defects and physical or mental illnesses or conditions and require prior authorization. EPSDT/OHCA child-health services are outlined in OAC 317:30-3-65.2 through 317:30-3-65.12.

(A) EPSDT screening examinations for eligible children by a medical or osteopathic physician, physician assistant, or advanced practice nurse practitioner.

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(B) Diagnostic x-rays, lab, and/or injections when prescribed by a provider.
(C) Immunizations.
(D) Outpatient care.
(E) Dental services as outlined in OAC 317:30-3-65.8.
(F) Optometrists' services. The EPSDT periodicity schedule provides for at least one (1) visual screening and glasses each twelve (12) months. In addition, payment is made for glasses for children with congenital aphakia or following cataract removal. Interperiodic screenings and glasses at intervals outside the periodicity schedule for optometrists are allowed when a visual condition is suspected. Payment is limited to two (2) glasses per year. Any glasses beyond this limit must be prior authorized and determined to be medically necessary.
(G) Hearing services as outlined in OAC 317:30-3-65.9.
(H) Prescribed drugs.
(I) Outpatient psychological services as outlined in OAC 317:30-5-275 through 317:30-5-278.
(J) Inpatient psychiatric services as outlined in OAC 317:30-5-94 through 317:30-5-97.
(K) Transportation. Provided when necessary in connection with examination or treatment when not otherwise available.
(L) Inpatient hospital services.
(M) Medical supplies, equipment, appliances, orthotics and prosthetics.
(N) EPSDT services furnished in a qualified child health center.

(14) Family planning services and supplies for members of child-bearing age, including counseling, insertion of intrauterine device, implantation of subdermal contraceptive device, and sterilization for members twenty-one (21) years of age and older who are legally competent, not institutionalized and have signed the "Consent Form" at least thirty (30) days prior to procedure. Reversal of sterilization procedures for the purposes of conception is not covered. Reversal of sterilization procedures are covered when medically indicated and substantiating documentation is attached to the claim.

(15) Physicians' services whether furnished in the office, the member's home, a hospital, a long-term care facility, intermediate care facilities for individuals with intellectual disabilities (ICF/IID), or elsewhere. For adults, payment is made for compensable hospital days described at OAC 317:30-5-41. Office visits for adults are limited to four (4) per month except when in connection with conditions as specified in OAC 317:30-5-9(b).

(16) Medical care and any other type of remedial care recognized under state law, furnished by licensed practitioners within the scope of their practice as defined by state law. See applicable provider section for limitations to covered services for:

(A) Podiatrists' services;
(B) Optometrists' services;
(C) Psychologists' services;
(D) Certified registered nurse anesthetists;
(E) Certified nurse midwives;
(F) Advanced practice registered nurses; and
(G) Anesthesiologist assistants.

(17) Freestanding ambulatory surgery centers.

(18) Prescribed drugs not to exceed a total of six (6) prescriptions with a limit of two (2) brand name prescriptions per month. Exceptions to the six (6) prescription limit are:

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(A) Unlimited medically necessary monthly prescriptions for:
(i) Members under the age of twenty-one (21) years; and
(ii) Residents of long-term care facilities or ICF/IID.
(B) Seven (7) medically necessary generic prescriptions per month in addition to the six (6) covered under the State Plan (including three (3) brand name prescriptions) are allowed for adults receiving services under the 1915(c) home and community-based services (HCBS) waivers. These additional medically necessary prescriptions beyond the three (3) brand name or thirteen (13) total prescriptions are covered with prior authorization.

(19) Rental and/or purchase of medical supplies, equipment, and appliances.
(20) Adaptive equipment, when prior authorized, for members residing in private ICF/IID's.
(21) Dental services for members residing in private ICF/IID's in accordance with the scope of dental services for members under age twenty-one (21).
(22) For non-expansion adults, prosthetic devices are limited to catheters and catheter accessories, colostomy and urostomy bags and accessories, tracheostomy accessories, nerve stimulators, hyperalimentation and accessories, home dialysis equipment and supplies, external breast prostheses and support accessories, oxygen/oxygen concentrator equipment and supplies, respirator or ventilator equipment and supplies, and those devices inserted during the course of a surgical procedure. There is no coverage for orthotic devices for adults.
(23) Orthotics and prosthetics, including prosthetic hearing implants and ocular prosthetics, are covered for expansion adult members, above the limitations within (22) of this Section, when prescribed by the treating provider (physician, physician assistant, or an advanced practice registered nurse) and medical necessity is documented in accordance with OAC 317:30-5-211.13.
(24) Standard medical supplies.
(25) Eyeglasses under EPSDT for members under age twenty-one (21). Payment is also made for glasses for children with congenital aphakia or following cataract removal. Payment is limited to two (2) glasses per year. Any glasses beyond this limit must be prior authorized and determined to be medically necessary.
(26) Blood and blood fractions for members when administered on an outpatient basis.
(27) Inpatient services for members age sixty-five (65) or older in institutions for mental diseases, limited to those members whose Medicare, Part A benefits are exhausted for this particular service and/or those members who are not eligible for Medicare services.
(28) Long-term care facility services, limited to members preauthorized and approved by OHCA for such care.
(29) Inpatient psychiatric facility admissions for members are limited to an approved length of stay with provision for requests for extensions.
(30) Transportation and subsistence (room and board) to and from providers of medical services to meet member's needs (ambulance or bus, etc.), to obtain medical treatment.
(31) Extended services for pregnant women including all pregnancy-related and postpartum services to continue to be provided, as though the women were pregnant, for twelve (12) months after the pregnancy ends regardless of the reason, beginning on the last date of pregnancy.
(32) Long-term care facility services for members under twenty-one (21) years of age.
(33) Personal care in a member's home, prescribed in accordance with a plan of treatment and rendered by a qualified person under supervision of a registered nurse (RN).

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(34) Medicare Part A, Part B, and Part C deductibles, coinsurance, and copays.
(35) HCBS for the intellectually disabled.
(36) Home health services can be provided without a PA for the first thirty-six (36) visits. A PA will be required beyond the 36th visit. The visits are limited to any combination of RN and nurse aide visits.
(37) Medically necessary solid organ and bone marrow/stem cell transplantation services for children and adults are covered services based upon the conditions listed in (A)-(D) of this paragraph:

(A) All transplantation services, except kidney and cornea, must be prior authorized;

(B) All transplant procedures are reviewed and prior authorization is based upon appropriate medical criteria;

(C) All organ transplants must be performed at a Medicare approved transplantation center;

(D) Procedures considered experimental or investigational are not covered. For more information regarding experimental or investigational including clinical trials, see OAC 317:30-3-57.1; and

(E) Donor search and procurement services are covered for transplants consistent with the methods used by the Medicare program for organ acquisition costs.

(38) HCBS for intellectually disabled members who were determined to be inappropriately placed in a long-term care facility (Alternative Disposition Plan - ADP).
(39) Case management services for the chronically and/or seriously mentally ill.
(40) Emergency medical services, including emergency labor and delivery for undocumented or ineligible aliens.
(41) Services delivered in Federally Qualified Health Centers (FQHCs). Payment is made on an encounter basis.
(42) Early intervention services for children ages zero (0) to three (3).
(43) Residential behavior management in therapeutic foster care setting.
(44) Case management services through the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS).
(45) HCBS for aged or physically disabled members.
(46) Outpatient ambulatory services for members infected with tuberculosis.
(47) Smoking and tobacco use cessation counseling for children and adults.
(48) Services delivered to American Indians/Alaskan Natives (AI/AN) in Indian Health Services, Tribal Programs, and Urban Indian Clinics (I/T/Us). Payment is made on an encounter basis.
(49) OHCA contracts with designated agents to provide disease state management for individuals diagnosed with certain chronic conditions. Disease state management treatments are based on protocols developed using evidence-based guidelines.
(50) Residential substance use disorder (SUD) services.
(51) Medication-assisted treatment (MAT) services.
(52) Diabetes self-management education and support (DSMES).

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 17. MEDICAL SUPPLIERS

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317:30-5-211.13. Orthotics and prosthetics

(a) Coverage of prosthetics for non-expansion adults is limited to (1) home dialysis equipment and supplies, (2) nerve stimulators, (3) external breast prosthesis and support accessories, and (4) implantable devices inserted during the course of a surgical procedure. Prosthetics prescribed by an appropriate qualified provider and as specified in this section are covered items for non-expansion adults. There is no coverage of orthotics for non-expansion adults.

(1) **Home dialysis.** Equipment and supplies are covered items for members receiving home dialysis treatments only.

(2) **Nerve stimulators.** Payment is made for transcutaneous nerve stimulators, implanted peripheral nerve stimulators, and neuromuscular stimulators.

(3) **Breast prosthesis, bras, and prosthetic garments.**

(A)Payment is limited to:

(i) One (1) prosthetic garment with mastectomy form every twelve (12) months for use in the postoperative period prior to a permanent breast prosthesis or as an alternative to a mastectomy bra and breast prosthesis;

(ii) Two (2) mastectomy bras per year; and

(iii) One (1) silicone or equal breast prosthetic per side every twenty-four (24) months; or

(iv) One (1) foam prosthetic per side every six (6) months.

(B) Payment will not be made for both a silicone and a foam prosthetic in the same twelve (12) month period.

(C) Breast prostheses, bras, and prosthetic garments must be purchased from a Board Certified Mastectomy Fitter.

(D) A breast prosthesis can be replaced if:

(i) Lost;

(ii) Irreparable damaged (other than ordinary wear and tear); or

(iii) The member's medical condition necessitates a different type of item and the physician provides a new prescription explaining the need for a different type of prosthesis.

(E) External breast prostheses are not covered after breast reconstruction is performed except in instances where a woman with breast cancer receives reconstructive surgery following a mastectomy, but the breast implant fails or ruptures and circumstances are such that an implant replacement is not recommended by the surgeon and/or desired by the member.

(4) **Prosthetic devices inserted during surgery**. Separate payment is made for prosthetic devices inserted during the course of surgery when the prosthetic devices are not integral to the procedure and are not included in the reimbursement for the procedure itself.

(b) Orthotics and prosthetics are covered for expansion adults services when:

(1) Orthotics are medically necessary when required to correct or prevent skeletal deformities, to support or align movable body parts, or to preserve or improve physical function.

(2) Prosthetics, including prosthetic hearing implants and ocular prosthetics, are medically necessary as a replacement for all or part of the function of a permanently inoperative, absent, or malfunctioning body part. The member shall require the prosthesis for mobility, daily care, or rehabilitation purposes.

(3) In addition, orthotics and prosthetics must be:

(A) A reasonable and medically necessary part of the member's treatment plan;

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(B) Consistent with the member's diagnosis and medical condition, particularly the functional limitations and symptoms exhibited by the member; and

(C) Of high quality, with replacement parts available and obtainable.

(c) Refer to Oklahoma Administrative Code (OAC) 317:30-5-211.1 for definitions of orthotics and prosthetics.

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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~~The ADvantage Administration (AA) certifies ADvantage Program service providers, except pharmacy providers~~,~~. ~~and they~~Providers must 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~~certification process verifies the provider meets licensure, certification, and training standards, and uses sound business management practices and has a financially stable business, as specified in the waiver document. All providers, except nursing facility (NF) respite; medical equipment and supplies; and environmental modification providers, must ~~obtain programmatic certification~~meet certification requirements to be ADvantage program certified.

(2) ~~The provider financial certification verifies the provider uses sound business management practices and has a financially stable business. All providers, except for~~ NF respite~~;~~, medical equipment and supplies~~;~~ and environmental modification providers~~,~~ will ~~obtain financial certification to be ADvantage program certified~~verify the provider meets licensure and certification standards as applicable.

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

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

(5) All provider service types must agree to and sign the Conditions of Provider Participation and Service Standards.

(6) The Oklahoma Human Services (OKDHS) Community Living, Aging and Protective Services (CAP) does not authorize the member's ~~CD PASS~~CDPASS services provider to also have an active power of attorney for the member.

(7) 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 a member's care provider may occur only when the member is offered provider choice and documentation demonstrates:

(i) No provider included on the Certified Agency Report (CAR) or in the member's service area, has available staffing. Documentation also affirms all area providers attempt to employ staff to serve; or

(ii) 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~~or

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

(B) The service:

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(i) Meets service or support definition as outlined in the federally-approved waiver document;

(ii) Is necessary to avoid institutionalization;

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

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

(v) Is paid at a rate that does not exceed what is paid to a provider of a similar service and does not exceed what OHCA allows for personal care or personal assistance services payment; and

(vi) 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 no more than forty (40) service hours of services in a seven (7) day period;

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

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

(iv) The person-centered service plan as the member's care provider~~.~~; and

(v) Continuing non-reimbursed family responsibilities of primary caregiver and emergency backup caregiver.

(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 case manager must visit the member at least monthly to monitor the continued appropriateness ~~The AA monitors, through quarterly documentation 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, and document findings in the member's electronic record.

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

~~(9)~~ OKDHS CAP periodically performs a ~~programmatic~~provider audit of:

(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~~CDPASS providers.

~~(10)~~(9) When, due to a ~~programmatic~~provider audit, a provider plan of correction (POC) is required, the AA may stop new cases and referrals to the provider, by removing from the CAR, until the POC is approved, implemented, and a follow-up review occurs. Depending on the

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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.

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TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 40. DEVELOPMENTAL DISABILITIES SERVICES

SUBCHAPTER 5. MEMBER SERVICES

PART 9. SERVICE PROVISIONS

317:40-5-101. Architectural modifications (AM)

(a) **Applicability.** The rules in this Section apply to ~~architectural modification (~~AM~~)~~ services authorized by ~~the~~ Oklahoma ~~Department of~~ Human Services (OKDHS) Developmental Disabilities Services ~~Division~~ (DDS~~D~~) through Home and Community Based Services (HCBS) Waivers.

(b) **General information.** Architectural Modification services:

(1) are provided by building contractors who have contractual agreements with the Oklahoma Health Care Authority to provide Home and community Based Services. Providers must meet requirements of the International Code Council (ICC), formerly the Building Official and Code Administrators (BOCA), for building, electrical, plumbing and mechanical inspections;

(2) include the installation of ramps, grab-bars, widening of doorways, modification of a bathroom or kitchen facilities**,** specialized safety adaptations such as scald protection devices, stove guards, and modifications required for the installation of specialized equipment, which are necessary to ensure the health, welfare and safety of the member or that enable the member to function with greater independence in the home;

(3) must be recommended by the member's Team and included in the member's IP. Arrangements for this service must be made through the member's case manager;

(4) are performed on homes of eligible members who have disabilities that limit accessibility or require modifications to ensure health and safety;

(5) are provided based on the:

(A) assessment and Personal Support Team (Team) consideration of the member's unique needs per OAC 317:40-5-101(b);

(B) scope of architectural modifications per OAC 317:40-5-101;

(C) most appropriate and cost effective bid, if applicable, ensuring the quality of materials and workmanship;

(D) lack of a less expensive equivalent, such as assistive technology, that meets the member's needs; and

(E) safety and suitability of the home.

(6) are limited to modifications of two different residences within any seven-year period beginning with the member's first request for an approved architectural modification service;

(7) are provided with assurance of plans for the member to remain in the residence for at least five years;

(8) may be denied when DDS~~D~~ determines the home is unsafe or otherwise unsuitable for architectural modifications.

(A) DDS~~D area office~~ resource development staff with architectural modification experience screens a home for safety and suitability for architectural modifications prior to home acquisition.

(B) Members needing home modification services and provider agencies assisting members to locate rental property identify several homes, when possible, for screening

in order to select a home with the fewest or most cost effective modifications;

(9) are provided to eligible members with the homeowner's signed permission;

(10) are not authorized to modify homes solely for family or staff convenience or for cosmetic preference;

(11) are provided on finished rooms complete with wiring and plumbing;

(12) services that do not meet the requirements of OAC 317:40-5-101 may be approved by the DDS~~D~~ division administrator or designee in exceptional circumstances; and

(13) are authorized in accordance with requirements of The Oklahoma Central Purchasing Act 74 O.S., '§ 85.1 et. Seq., Chapter 15 of Title 580 of the Department of Central Services, and other applicable statutory provisions.

(c) **Assessment and Team process.**

(1) Architectural modification assessments are performed by:

(A) DDS~~D area office~~ resource development staff with architectural modification experience, when the requested architectural modification complies with minimum applicable national standards for persons with physical disabilities as applicable to private homes; or

(B) a licensed occupational therapist or physical therapist, at the request of designated DDS~~D area office~~ resource development staff ~~or area program supervisory staff~~, when the requested architectural modification exceeds or requires a variance to applicable national standards for persons with physical disabilities, or when such expertise is deemed necessary by DDS~~D area office~~ resource development staff ~~or area program supervisory staff~~.

(2) The Team considers the most appropriate architectural modifications based on the:

(A) member's needs;

(B) member's ability to access his or her environment; and

(C) possible use of assistive technology instead of architectural modification.

(3) The Team considers architectural modifications that:

(A) are necessary to ensure the health, welfare, and safety of the member; and

(B) provide the member increased access to the home to reduce dependence on others for assistance in daily living activities.

(d) **Requirements and standards for architectural modification contractors and construction.** All contractors must meet applicable federal, state and local requirements.

(1) Contractors are responsible for:

(A) obtaining all permits required by the municipality where construction is performed;

(B) following all applicable building codes; and

(C) taking and providing pictures to ~~area office~~ resource development staff of each completed architectural modification project within five working days of project completion and prior to payment of the architectural modification claim. ~~Area office resource~~Resource development staff may take pictures of the completed architectural modification projects when requested by the contractor.

(2) Any penalties assessed for failure to comply with requirements of the municipality are the sole responsibility of the contractor.

(3) New contractors must provide three references of previous work completed.

(4) Contractors must provide evidence of:

(A) liability insurance;

(B) vehicle insurance;

(C) worker's compensation insurance or affidavit of exemption; and

(D) lead paint safety certificate.

(5) All modifications meet national standards for persons with physical disabilities as applicable to private homes unless a variance is required by the assessment.

(6) Contractors complete construction in compliance with written assessment recommendations from the:

(A) DDS~~D area office~~ resource development staff with architectural modification experience; or

(B) a licensed professional.

(7) All architectural modifications must be completed by using high standard materials and workmanship, in accordance with industry standard.

(8) Ramps are constructed using the standards in (A) through (G) of this paragraph.

(A) ~~All exterior wooden ramps are constructed of number two pressure treated wood.~~

~~(B)~~ Surface of the ramp has a rough, non-skid texture.

~~(C) Ramps are assembled by the use of deck screws.~~

~~(D) Hand rails on ramps, if required, are sanded and smooth.~~

~~(E)~~(B) Ramps ~~can~~must be constructed of ~~stamped~~aluminum or steel.

~~(F)~~(C) Support legs on ramps are no more than six feet apart.

~~(G) Posts on ramps must be set or anchored in concrete.~~

(9) Roll-in showers are constructed to meet standards in (A) through (E) of this paragraph.

(A) The roll-in shower includes a new floor that slopes uniformly to the drain at not less than one-fourth nor more than one-half inch per foot.

(B) The material around the drain is flush, without an edge on which water can catch before going into the drain.

(C) Duro-rock, rather than sheet rock, is installed around the shower area, at least 24 inches up from the floor, with green board above the duro-rock.

(D) Tile, shower insert, or other appropriate water resistant material is installed to cover the duro-rock and green board.

(E) The roll-in shower includes a shower pan, or liner if applicable.

(F) Roll in showers may also be constructed with a one piece pre-formed material.

(10) DDS~~D area office~~ resource development staff inspect any or all architectural modification work, prior to payment of an architectural modifications claim, to ensure:

(A) architectural modifications are completed in accordance with assessments; and

(B) quality of workmanship and materials used comply with requirements of OAC 317:40-5-101.

(e) **Architectural modifications when members change residences.**

(1) When two or more members share a home that has been modified and the member will no longer be sharing the home, the member whose Plan of Care authorized the modifications is given the first option of remaining in the residence.

(2) Restoration of architectural modifications is performed only for members of the Homeward Bound class when a written agreement between the homeowner and DDS~~D~~ director, negotiated before any architectural modifications begin, describes in full the extent of the restoration. If no written agreement exists between the DDS~~D~~ director and homeowner, OKDHS is not responsible to provide, pay for, or authorize any restorative services.

(f) **Services not covered under architectural modifications.** Architectural modifications do not include adaptations or improvements to the home which are of general utility and are not of direct

medical or remedial benefit to the member, construction, reconstruction, or remodeling of any existing construction in the home, such as floors, sub-floors, foundation work, roof, or major plumbing.

(1) Square footage is not added to the home as part of an architectural modification.

(2) Architectural modifications are not performed during construction or remodeling of a home.

(3) Modifications not authorized by the OKDHS include, but are not limited to:

(A) roofs;

(B) installation of heating or air conditioning units;

(C) humidifiers;

(D) water softener units;

(E) fences;

(F) sun rooms;

(G) porches;

(H) decks;

(I) canopies;

(J) covered walkways;

(K) driveways;

(L) sewer lateral lines or septic tanks;

(M) foundation work;

(N) room additions;

(O) carports;

(P) concrete for any type of ramp, deck, or surface other than a five by five landing pad at the end of a ramp, as described in applicable national standards for persons with physical disabilities as applicable to private homes;

(Q) non-adapted home appliances;

(R) carpet or floor covering that is not part of an approved architectural modification that requires and includes a portion of the floor to be re-covered such as a roll in shower, a door widening; or

(S) a second ramp or roll in shower in a home.

(4) A sidewalk is not authorized unless needed by the member to move between the house and vehicle.

(g) **Approval or denial of architectural modification services.** DDS~~D~~ approval or denial of an architectural modification service is determined in accordance with (1) through (3) of this subsection.

(1) The architectural modification request provided by the DDS~~D~~ case manager to DDS~~D area office~~ resource development staff includes:

(A) documentation from the member's Team confirming the need and basis for architectural modification, including the architectural modification assessment;

(B) documentation of current Team consensus, including consideration of issues per OAC 317:40-5-101;

(C) lease, proof of home ownership, or other evidence that the member is able to live in the modified residence for at least 12 months; and

(D) an assurance by the member or legal guardian, if applicable, that the member plans to reside in the residence for five years.

(2) ~~The DDSD area office:~~

~~(A) authorizes architectural modification services less than $2500 when the plan of care is less than the state office reviewer limit; and~~

~~(B) provides all required information to the DDSD State Office architectural modification programs manager for authorization of services when the plan of care is more than the area office limit or is $2500 or more.~~

~~(3)~~ Architectural modifications may be denied when the requirements of OAC 317:40-5-101 are not met.

(h) **Appeals**. The denial of acquisition of an architectural modification request may be appealed per OAC 340:2-5.

(i) **Resolving problems with services.** If the member, family member, or legal guardian, or Team is dissatisfied with the architectural modification, the problem resolution process per OAC 340:100-3-27 is initiated.

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 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), SoonerCare Provider 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 Provider 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.

(3) If a 340B covered entity fails to pay quarterly adjustments invoiced by OHCA within forty-five (45) days of receipt, it may result in a debt to the State of Oklahoma subject to applicable interest pursuant to prompt payment methodology at OAC 260:10-3-3.

(4) The quarterly adjustments invoiced, including applicable interest, must be paid regardless of any disputes made by the covered entity. If a covered entity fails to pay OHCA the adjustments invoiced within forty-five (45) days of receipt, the adjustments invoiced and applicable interest will be deducted from the facility's payment.

(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.

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CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE

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PART 43. AGENCY COMPANION, SPECIALIZED FOSTER CARE, DAILY LIVING SUPPORTS, GROUP HOMES, AND COMMUNITY TRANSITION SERVICES

317:30-5-423. Coverage limitations

(a) Coverage limitations for residential supports for members with an intellectual disability are:

(1) Description: agency companion services (ACS); Unit: one day; Limitation: 366 units per year;

(2) Description: specialized foster care (SFC); Unit: one day; Limitation: 366 units per year;

(3) Description: daily living supports (DLS); Unit: one day; Limitation: 366 units per year; and

(4) Description: group home services; Unit: one day; Limitation: 366 units per year.

(b) Members may not receive ACS, SFC, DLS and group home services at the same time.

(c) Community transition services (CTS) are limited to ~~$2,400~~$3,000 per eligible member.

(1) CTS is limited to one transition over the member's lifetime. If the member's situation changes after receipt of CTS and hospitalization or readmission to an intermediate care facility for the mentally retarded (ICF/MR) is necessary, CTS is not authorized upon transition back into the community.

(2) Members moving into a group home, SFC, or ACS arrangement in the companion's home are not eligible to receive CTS.

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PART 9. SERVICE PROVISIONS

317:40-5-101. Architectural modifications (AM)

(a) **Applicability.** The rules in this Section apply to ~~architectural modification (~~AM~~)~~ services authorized by ~~the~~ Oklahoma ~~Department of~~ Human Services (OKDHS) Developmental Disabilities Services ~~Division~~ (DDS~~D~~) through Home and Community Based Services (HCBS) Waivers.

(b) **General information.** Architectural Modification services:

(1) are provided by building contractors who have contractual agreements with the Oklahoma Health Care Authority to provide Home and community Based Services. Providers must meet requirements of the International Code Council (ICC), formerly the Building Official and Code Administrators (BOCA), for building, electrical, plumbing and mechanical inspections;

(2) include the installation of ramps, grab-bars, widening of doorways, modification of a bathroom or kitchen facilities**,** specialized safety adaptations such as scald protection devices, stove guards, and modifications required for the installation of specialized equipment, which are necessary to ensure the health, welfare and safety of the member or that enable the member to function with greater independence in the home;

(3) must be recommended by the member's Team and included in the member's IP. Arrangements for this service must be made through the member's case manager;

(4) are performed on homes of eligible members who have disabilities that limit accessibility or require modifications to ensure health and safety;

(5) are provided based on the:

(A) assessment and Personal Support Team (Team) consideration of the member's unique needs per OAC 317:40-5-101(b);

(B) scope of architectural modifications per OAC 317:40-5-101;

(C) most appropriate and cost effective bid, if applicable, ensuring the quality of materials and workmanship;

(D) lack of a less expensive equivalent, such as assistive technology, that meets the member's needs; and

(E) safety and suitability of the home.

(6) are limited to modifications of two different residences within any seven-year period beginning with the member's first request for an approved architectural modification service;

(7) are provided with assurance of plans for the member to remain in the residence for at least five years;

(8) may be denied when DDS~~D~~ determines the home is unsafe or otherwise unsuitable for architectural modifications.

(A) DDS~~D area office~~ resource development staff with architectural modification experience screens a home for safety and suitability for architectural modifications prior to home acquisition.

(B) Members needing home modification services and provider agencies assisting members to locate rental property identify several homes, when possible, for screening

in order to select a home with the fewest or most cost effective modifications;

(9) are provided to eligible members with the homeowner's signed permission;

(10) are not authorized to modify homes solely for family or staff convenience or for cosmetic preference;

(11) are provided on finished rooms complete with wiring and plumbing;

(12) services that do not meet the requirements of OAC 317:40-5-101 may be approved by the DDS~~D~~ division administrator or designee in exceptional circumstances; and

(13) are authorized in accordance with requirements of The Oklahoma Central Purchasing Act 74 O.S., '§ 85.1 et. Seq., Chapter 15 of Title 580 of the Department of Central Services, and other applicable statutory provisions.

(c) **Assessment and Team process.**

(1) Architectural modification assessments are performed by:

(A) DDS~~D area office~~ resource development staff with architectural modification experience, when the requested architectural modification complies with minimum applicable national standards for persons with physical disabilities as applicable to private homes; or

(B) a licensed occupational therapist or physical therapist, at the request of designated DDS~~D area office~~ resource development staff ~~or area program supervisory staff~~, when the requested architectural modification exceeds or requires a variance to applicable national standards for persons with physical disabilities, or when such expertise is deemed necessary by DDS~~D area office~~ resource development staff ~~or area program supervisory staff~~.

(2) The Team considers the most appropriate architectural modifications based on the:

(A) member's needs;

(B) member's ability to access his or her environment; and

(C) possible use of assistive technology instead of architectural modification.

(3) The Team considers architectural modifications that:

(A) are necessary to ensure the health, welfare, and safety of the member; and

(B) provide the member increased access to the home to reduce dependence on others for assistance in daily living activities.

(d) **Requirements and standards for architectural modification contractors and construction.** All contractors must meet applicable federal, state and local requirements.

(1) Contractors are responsible for:

(A) obtaining all permits required by the municipality where construction is performed;

(B) following all applicable building codes; and

(C) taking and providing pictures to ~~area office~~ resource development staff of each completed architectural modification project within five working days of project completion and prior to payment of the architectural modification claim. ~~Area office resource~~Resource development staff may take pictures of the completed architectural modification projects when requested by the contractor.

(2) Any penalties assessed for failure to comply with requirements of the municipality are the sole responsibility of the contractor.

(3) New contractors must provide three references of previous work completed.

(4) Contractors must provide evidence of:

(A) liability insurance;

(B) vehicle insurance;

(C) worker's compensation insurance or affidavit of exemption; and

(D) lead paint safety certificate.

(5) All modifications meet national standards for persons with physical disabilities as applicable to private homes unless a variance is required by the assessment.

(6) Contractors complete construction in compliance with written assessment recommendations from the:

(A) DDS~~D area office~~ resource development staff with architectural modification experience; or

(B) a licensed professional.

(7) All architectural modifications must be completed by using high standard materials and workmanship, in accordance with industry standard.

(8) Ramps are constructed using the standards in (A) through (G) of this paragraph.

(A) ~~All exterior wooden ramps are constructed of number two pressure treated wood.~~

~~(B)~~ Surface of the ramp has a rough, non-skid texture.

~~(C) Ramps are assembled by the use of deck screws.~~

~~(D) Hand rails on ramps, if required, are sanded and smooth.~~

~~(E)~~(B) Ramps ~~can~~must be constructed of ~~stamped~~aluminum or steel.

~~(F)~~(C) Support legs on ramps are no more than six feet apart.

~~(G) Posts on ramps must be set or anchored in concrete.~~

(9) Roll-in showers are constructed to meet standards in (A) through (E) of this paragraph.

(A) The roll-in shower includes a new floor that slopes uniformly to the drain at not less than one-fourth nor more than one-half inch per foot.

(B) The material around the drain is flush, without an edge on which water can catch before going into the drain.

(C) Duro-rock, rather than sheet rock, is installed around the shower area, at least 24 inches up from the floor, with green board above the duro-rock.

(D) Tile, shower insert, or other appropriate water resistant material is installed to cover the duro-rock and green board.

(E) The roll-in shower includes a shower pan, or liner if applicable.

(F) Roll in showers may also be constructed with a one piece pre-formed material.

(10) DDS~~D area office~~ resource development staff inspect any or all architectural modification work, prior to payment of an architectural modifications claim, to ensure:

(A) architectural modifications are completed in accordance with assessments; and

(B) quality of workmanship and materials used comply with requirements of OAC 317:40-5-101.

(e) **Architectural modifications when members change residences.**

(1) When two or more members share a home that has been modified and the member will no longer be sharing the home, the member whose Plan of Care authorized the modifications is given the first option of remaining in the residence.

(2) Restoration of architectural modifications is performed only for members of the Homeward Bound class when a written agreement between the homeowner and DDS~~D~~ director, negotiated before any architectural modifications begin, describes in full the extent of the restoration. If no written agreement exists between the DDS~~D~~ director and homeowner, OKDHS is not responsible to provide, pay for, or authorize any restorative services.

(f) **Services not covered under architectural modifications.** Architectural modifications do not include adaptations or improvements to the home which are of general utility and are not of direct

medical or remedial benefit to the member, construction, reconstruction, or remodeling of any existing construction in the home, such as floors, sub-floors, foundation work, roof, or major plumbing.

(1) Square footage is not added to the home as part of an architectural modification.

(2) Architectural modifications are not performed during construction or remodeling of a home.

(3) Modifications not authorized by the OKDHS include, but are not limited to:

(A) roofs;

(B) installation of heating or air conditioning units;

(C) humidifiers;

(D) water softener units;

(E) fences;

(F) sun rooms;

(G) porches;

(H) decks;

(I) canopies;

(J) covered walkways;

(K) driveways;

(L) sewer lateral lines or septic tanks;

(M) foundation work;

(N) room additions;

(O) carports;

(P) concrete for any type of ramp, deck, or surface other than a five by five landing pad at the end of a ramp, as described in applicable national standards for persons with physical disabilities as applicable to private homes;

(Q) non-adapted home appliances;

(R) carpet or floor covering that is not part of an approved architectural modification that requires and includes a portion of the floor to be re-covered such as a roll in shower, a door widening; or

(S) a second ramp or roll in shower in a home.

(4) A sidewalk is not authorized unless needed by the member to move between the house and vehicle.

(g) **Approval or denial of architectural modification services.** DDS~~D~~ approval or denial of an architectural modification service is determined in accordance with (1) through (3) of this subsection.

(1) The architectural modification request provided by the DDS~~D~~ case manager to DDS~~D area office~~ resource development staff includes:

(A) documentation from the member's Team confirming the need and basis for architectural modification, including the architectural modification assessment;

(B) documentation of current Team consensus, including consideration of issues per OAC 317:40-5-101;

(C) lease, proof of home ownership, or other evidence that the member is able to live in the modified residence for at least 12 months; and

(D) an assurance by the member or legal guardian, if applicable, that the member plans to reside in the residence for five years.

(2) ~~The DDSD area office:~~

~~(A) authorizes architectural modification services less than $2500 when the plan of care is less than the state office reviewer limit; and~~

~~(B) provides all required information to the DDSD State Office architectural modification programs manager for authorization of services when the plan of care is more than the area office limit or is $2500 or more.~~

~~(3)~~ Architectural modifications may be denied when the requirements of OAC 317:40-5-101 are not met.

(h) **Appeals**. The denial of acquisition of an architectural modification request may be appealed per OAC 340:2-5.

(i) **Resolving problems with services.** If the member, family member, or legal guardian, or Team is dissatisfied with the architectural modification, the problem resolution process per OAC 340:100-3-27 is initiated.