Oklahoma Health Care Authority
MEDICAL ADVISORY COMMITTEE
November 5, 2026
1:00 – 3:00 PM
Charles Ed McFall Board Room

AGENDA

Please access via zoom:
https://www.zoomgov.com/webinar/register/WN_opTNGqIMQzyjw4uO5ONwXA

Telephone: 1-669-254-5252 **Webinar ID: 161 208 4309**

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

II. Action Item: Approval of Minutes of September 3rd, 2026: **Medical Advisory Committee Meeting**

III. Public Comments (2 minute limit)

IV. MAC Member Comments/Discussion

V. Proposed Rule Changes:Presentation, Discussion, and Vote: **Heather Cox, Deputy State Medicaid Director**

- **A.** APA WF 26-11 Inpatient Psychiatric and Substance Use Disorder Services
- **B.** APA WF 26-15 Determination of Qualifying Categorical Relationships

VI. Medicaid Directors Update: **Melissa Miller, State Medicaid Director**

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

VIII. Next MAC Meeting: **Chairman, Jason Rhynes, O.D.**

January 7, 2027
March 4, 2027
May 6, 2027
July 1, 2027
September 2, 2027
November 4, 2027

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

Oklahoma Health Care Authority
MEDICAL ADVISORY COMMITTEE
MINUTES of September 3, 2026, Meeting
4345 N. Lincoln Blvd., Oklahoma City, OK 73105

1. **Welcome, Roll Call, and Public Comment Instructions:**
   Chairman, Dr. Jason Rhynes called the meeting to order at 1:00 PM.

   Delegates present were: Mr. Nick Barton, Dr. David Evans (virtual), Ms. Wanda Felty, Dr. Arlen Foulks (Virtual) Dr. Terry Mills, Dr. Daniel Post, Ms. Skye Cooper, Ms. Miranda Hooper and Dr. Jason Rhynes providing a quorum.

   Alternates present were: Ms. Eve Switzer, Ms. Janet Cizek

   Ex-officio members present:

   ***Delegates absent without an alternate were*:**, Mr. Coble, and Mr. Smith

   Ex-officio members not present: Madison Miller & Tracey Ellis

2. **Approval of March July 30th, 2026, Minutes**
   Medical Advisory Committee
   The motion to approve the minutes was by Dr. Daniel Post, seconded by Ms. Wanda Felty and passed unanimously.

3. **Public Comments:**

4. **MAC Member Comments/Discussion:**

   Ms. Felty introduced Sky Collins and Miranda Hooper as representation for the Member Advisory Task Force (MATF).

   Mr. Barton Highlighted the unique role and government-to-government relationship between the ITU Health System and the Healthcare Authority, which allows issues to be addressed directly, particularly regarding tribal member access. A consultation meeting took place on the preceding Tuesday, noted that the Healthcare Authority is currently experiencing "growing pains" and operating under new leadership and updated federal guidance, resulting in ongoing agency struggles raising awareness regarding increasingly dated contracts sitting in the queue and introduced the proposal of backdating contracts to the original date of application to mitigate the impact of administrative delays.

   Ms. Felty noted a local out of Stillwater provider specializing in mental/behavioral health reported severe payment delays from OHCA. Due to ongoing payment backlogs, the provider is actively considering stopping services to that population entirely. Ms. Felty Highlighted the urgency of

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addressing these financial processing delays, expressing concern that the system cannot afford to lose providers during a period of significant administrative transitions.
Dr. Post introduced Erin Palmer and Highlighted an issue where office staff accidentally selected an incorrect diagnosis code from a drop-down list (entering M99.00 for a skull diagnosis instead of M99.01 for a cervical diagnosis, despite accurate clinical notes). Dr. Post noted that medical doctors are given a 5-day window for prior authorization revisions, whereas chiropractors are restricted to a 24-hour window, resulting in a claim denial and stressed the inequity of applying different consideration timelines across provider types.

5. <u>Proposed rule changes: Presentation, discussion and vote:</u>
Heather Cox, Deputy State Medicaid Director

A. **APA WF #26-04 HR1 Reduced Retroactive Eligibility & 6-Month Redeterminations —**
The rule change motion to approve as by Ms. Wanda Felty and seconded by Dr. Daniel Post and passes unanimously.

B. **APA WF #26-06 HR1 Work Requirements —**
The rule change motion to approve as by Ms. Wanda Felty and seconded by Dr. Eve Switzer and passes unanimously.

C. **APA WF #26-12 Obstetrical Unbundling —**
The rule change motion to approve as by Dr. Daniel Post and seconded by Dr. Terry Mills and passes unanimously.

6. <u>Medicaid Director Update:</u>
Melissa Miller, State Medicaid Director

Ms. Miller discussed a timeline and notification process noting that in late august, members with the expansion group were notified of their subjection to work requirements. Members will complete their renewal process at their currently scheduled annual renewal date for Calendar Year (CY) 2027 (12 months from the last renewal). If the Oklahoma Health Care Authority (OHCA) can verify an exemption using existing, available data resources, the process will remain largely unchanged for members. If automated data is insufficient, individuals must supply additional documentation to obtain an exception or prove compliance. Members have **30 days** to demonstrate compliance or an

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exception following an initial adverse action. Fir more detailed information see agenda item 6 in the MAC Agenda.

7. Member Advisory Task Force: Report and update:

Wanda Felty, Co-chair to MATF

Ms. Felty discussed the purpose and reporting structure for the Member Advisory Task Force (MATF). **Geographic Reach:** Includes members from McLean County, Muscogee County, Tulsa, Brady, Custer, Oklahoma, Cleveland, Canadian, Wagoner, and lateral areas (with only two counties having dual-attending representatives), with diverse perspectives & populations represented such as; Children's Health, Developmental Disability Waivers (Medicaid, Mental and behavioral health services, Tribal health combined with SoonerCare, Dual-eligible (Medicare and Medicaid), Private Duty Nursing (PDN), Post-adoption long-term coverage (eligible up to age 26), Expansion populations (family members who eventually applied for themselves), Maternity health coverage, Blended families (e.g., children on SoonerSelect alongside a child who is aged, blind, or disabled). The MATF Operates under formal bylaws with rolling membership. Leadership follows a co-chair structure representing both the healthcare authority and members, supported by a vice-chair position that rolls into the co-chair role. TEFRA allows children under 18 to access SoonerCare services regardless of parents' income or resources, provided they meet a high level of institutional care (hospital, nursing facility, or intermediate care facility for individuals with intellectual disabilities). Key Concerns & Feedback Raised include Renewal Challenges: The application and renewal process begins a significant time in advance and lacks transparency (particularly regarding "rule one"). Staffing Shortages**:** Concerns were raised regarding a shortage of staff (managed jointly by Oklahoma Human Services and the Healthcare Authority) to handle calls and guide individuals through renewals. Process Delays**:** While the renewal process used to be faster, it is slowing down—likely due to a surge in people accessing SoonerCare through TEFRA—making it increasingly challenging. Legislative Request: A formal request was made to consider seeking additional funding from the legislature specifically dedicated to TEFRA staff positions. Acknowledgment**:** The speaker expressed appreciation to the Oklahoma Family Network for providing a helpful "cheat sheet" to assist in reporting back to the group.

8. New Business:

Chairman, Jason Rhynes

No new business was discussed.

9. Adjourn

Chairman, Jason Rhynes

Dr. Rhynes asked for a motion to adjourn. Motion was provided by Dr. Daniel Post and seconded by Ms. Wanda Felty there was no dissent and the meeting was adjourned at 2:10pm.

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November 5, 2026, Medical Advisory Committee
Proposed Rule Amendment Summaries

All proposed rules were previously presented at Tribal Consultation. The permanent rules were subject to a 30-day public comment period from October 1 through November 2, 2026.

The Agency requests an effective date of September 1, 2027, for all permanent rules, contingent upon legislative and gubernatorial approval.

The following **PERMANENT** rules are being presented to the Medical Advisory Committee for the first time:

APA WF #26-11 Active Treatment for Children — The proposed revisions clarify administrative requirements for discharge and transition planning for children receiving inpatient psychiatric care. The revisions establish clearer expectations for collaboration with individuals involved in the child's care and related documentation requirements. These changes are intended to improve continuity of care and reduce unnecessary psychiatric readmissions.

Budget Impact: Budget neutral

APA WF #26-15 TEFRA Revisions — The proposed policy changes will allow qualified non-physician providers, including advanced practice registered nurses and physician assistants, to complete required assessment forms for Medicaid eligibility under the Tax Equity and Fiscal Responsibility Act (TEFRA). TEFRA allows OHCA to provide coverage to certain children who have a disability and require an institutional level of care, but who wish to receive services in the community. Certain non-physician providers are qualified to care for TEFRA members and assess their needs and may improve access to TEFRA assessments, especially in rural areas.

Budget Impact: Budget neutral

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 6. INPATIENT PSYCHIATRIC AND SUBSTANCE USE DISORDER SERVICES

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

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

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

(2) **"Discharge/transition planning"** means a patient-centered, interdisciplinary process that begins with an initial assessment of the member's needs at the time of admission and continues throughout the member's stay. Active collaboration with the member, family~~,~~ and/or guardian, outpatient practitioners, and involved agencies must occur throughout treatment to support continuity of care after discharge.~~and all involved outpatient practitioners and agencies should be ongoing throughout treatment so that effective connections remain intact.~~ Needed services may ~~consist of~~include the wraparound process through Systems of Care, counseling, case management, medication management, outpatient behavioral health services, and other community-based supports in the member's community. ~~The linkages with these supports should be made prior to discharge to allow for a smooth transition.~~

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

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

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

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

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

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

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(b) Inpatient psychiatric programs must provide "active treatment". Families and/or guardians must be notified of the dates and times of treatment team meetings and be welcomed to attend. Family members must attend family therapy weekly for continued SoonerCare reimbursement. Reasons for exceptions to this requirement must be well-documented in the member's treatment plan. Family therapy attendance by family members is not a requirement for individuals in the age range of eighteen (18) up to twenty-one (21). Active treatment also includes ongoing assessment, diagnosis, intervention, evaluation of care and treatment, and planning for discharge and aftercare under the direction of a physician.
(c) For individuals ages eighteen (18) up to twenty-one (21), the active treatment program must be appropriate to the needs of the member and be directed toward restoring and maintaining optimal levels of physical and psychiatric-social functioning. The services and the IPC must be recovery-focused, trauma-informed, specific to culture, age, and gender, and provided face to face. Services, including type and frequency, will be specified in the IPC.
(d) A treatment week consists of seven (7) calendar days. In an Acute setting, the treatment week begins the day of admission. In Acute II and PRTF, the treatment week starts on Sunday and ends on Saturday. Active treatment service components are provided as per item (e) below if the services are provided within a seven (7) day treatment week. A chart outlining active treatment component requirements and timelines may also be found at www.okhca.org. If a member has a length of stay of less than seven (7) days, the treatment week is considered a partial treatment week. Active treatment requirements, when provided during a partial treatment week, are delivered as per item (f) below. An hour of treatment must be sixty (60) minutes. When appropriate to meet the needs of the child, the sixty (60) minute timeframe may be split into sessions of no less than fifteen (15) minutes each, on the condition that the active treatment requirements are fully met by the end of the treatment week.
(e) For individuals under age eighteen (18), the components of active treatment consist of face-to-face integrated therapies that are provided on a regular basis and will remain consistent with the member's ongoing need for care. The services and IPC must be recovery-focused, trauma-informed, and specific to culture, age, and gender. Individuals receiving services in an Acute setting must receive seventeen (17) hours of documented active treatment services each week, with seven (7) of those hours dedicated to core services as described in (1) below. Individuals in Acute II and PRTFs must receive fourteen (14) hours of documented active treatment services each week, with four and a half (4.5) of those hours dedicated to core services as described in (1) below. Upon fulfilling the core service hours requirement, the member may receive either the elective services listed in (2) below or additional core services to complete the total required hours of active treatment. The following components meet the minimum standards required for active treatment, although an individual child's needs for treatment may exceed this minimum standard:

(1) **Core services.**

(A) **Individual treatment provided by the physician, Advanced Practice Registered Nurse (APRN), or Physician Assistant (PA).** Individual treatment provided by the physician, APRN with psychiatric certification or PA is required three (3) times per week for Acute and one (1) time a week in Acute II and PRTFs. Individual treatment provided by the physician, APRN with psychiatric certification or PA will never exceed ten (10) calendar days between sessions in Acute II and PRTFs, and never exceed seven (7) calendar days in a specialty Acute II and specialty PRTF. Individual treatment provided by the physician, APRN with psychiatric certification or PA may consist of therapy or medication management intervention for Acute, Acute II, and PRTF programs.

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

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

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

(E) **Transition/discharge planning.** Transition/discharge planning must be provided one (1) hour per week in Acute and thirty (30) minutes per week in Acute II and PRTFs. Transition/discharge planning must include development and documentation of a discharge plan that addresses the member's needed follow-up and aftercare services, including referrals for medication management, outpatient behavioral health counseling, case management, and other community-based supports, as clinically appropriate. The discharge plan must include specific appointment information, including the time, date, provider name, address, and telephone number, when available, and a summary of the member's condition at discharge. Transition/discharge planning can be provided by any level of inpatient staff.

(2) **Elective services.**

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

(B) **Group rehabilitative treatment.** Examples of educational and supportive services,

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

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

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

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

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

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

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

(1) **Individual treatment provided by the physician, APRN or PA.**

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

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(B) In Acute II and PRTFs, one (1) visit during admission week is required. In PRTFs, one (1) visit during the admission week is required, then once a week thereafter. Individual treatment provided by the physician, APRN with psychiatric certification or PA will never exceed ten (10) days between sessions in Acute II and PRTFs, never exceed seven (7) days in specialty Acute II and specialty PRTFs. The completion of a psychiatric evaluation or a combined psychiatric evaluation and a history and physical (H&P) evaluation may count as the first visit if the evaluation was personally rendered by the psychiatrist, APRN with psychiatric certification or PA. If the member is admitted on the last day of the admission week, then the member must be seen by a physician, APRN with psychiatric certification or PA within sixty (60) hours of admission time.

(2) **Individual therapy.**

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

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

(3) **Family therapy.**

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

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

(4) **Process group therapy.**

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

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

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

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

SUBCHAPTER 5. ELIGIBILITY AND COUNTABLE INCOME

PART 1. DETERMINATION OF QUALIFYING CATEGORICAL RELATIONSHIPS

317:35-5-4.1. Special level of care and cost effectiveness application procedures for Tax Equity and Fiscal Responsibility Act (TEFRA)

(a) In order for a child to be eligible for TEFRA, he/she must require a level of care provided in an acute care hospital for a minimum of sixty (60) days, or a nursing facility (NF) or intermediate care facility for individuals with intellectual disabilities (ICF/IID) for a minimum of thirty (30) days. It must also be appropriate to provide care to the child at home. The level of care determination is made by LOCEU. The level of care certification period may be for any number of months that the LOCEU determines appropriate. At the time of application, an assessment form is provided to the applicant for completion by the child's ~~physician~~qualified health care provider acting within their statutory scope of practice. Once completed by the ~~physician~~qualified provider and returned to the Oklahoma Health Care Authority, the assessment form is forwarded to the LOCEU along with the request for a disability determination (if needed).

(b) The estimated cost of caring for the child at home must not exceed the estimated cost of treating the child within an institution at the appropriate level of care, i.e., hospital, NF, or ICF/IID. The initial cost analysis is established by LOCEU based on the information provided by the TEFRA-1 Assessment form and medical information used in the relationship to disability determination.

(c) The level of care determination and cost effectiveness analysis are reported by LOCEU annually.

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