OKLAHOMA HEALTH CARE AUTHORITY
REGULAR BOARD MEETING
January 22, 2020 at 3:00 P.M.
Variety Care - Britton
721 W. Britton Rd., OKC, OK

A G E N D A

1. Call to Order / Determination of Quorum……Stan Hupfeld, Chair

2. Consent Agenda……..Stan Hupfeld, Chair

    a) Approval of the November 20, 2019 OHCA Board Meeting Minutes

3. Welcome and Comments……Lou Carmichael
   Variety Care Chief Executive Officer

4. Chief Executive Officer's Report…….Kevin Corbett, Chief Executive Officer

    a) In Memoriam of Trevlyn Cross

5. Chief of Staff's Report…….....Ellen Buettner, Chief of Staff

6. Chief Operating Officer's Report……....Melody Anthony, Chief Operating Officer
   State Medicaid Director

7. Discussion of Report from the……..……..Phil Kennedy
   Compliance Advisory Committee Chair, Compliance Advisory Committee

8. Discussion of Report from the Legislative……...……Alex Yaffe, Vice-Chair
   Advisory Committee Chair, Legislative Advisory Committee

9. Discussion of Report of Administrative……..…….…….....Jean Hausheer, MD
   Rules Advisory Committee and Possible Action Chair, Administrative Rules Advisory Committee
   Regarding Agency Rulemaking (Attachment "A")

    a) Consideration and Vote of Agency Recommended Rulemaking Pursuant to Article I of the Administrative Procedures Act. OHCA Requests the Adoption of the Following Permanent Rules (see Attachment "A"):

        i. Eligibility Redetermination as Indicated by Returned Mail: AMENDING agency rules at ***OAC 317:35-5-26*** and ADDING agency rules at ***OAC 317:35-5-67***
        ii. Certified Community Behavioral Health Clinics (CCBHC) Project: ADDING agency rules at ***OAC 317:30-5-263 through 317:30-5-268***
        iii. Board Organization and Policy Revisions: AMENDING agency rules at ***OAC 317:31-1-4, 317:1-1-6, and 317:1-1-7***
        iv. Claim Inquiry Procedures: AMENDING agency rules at ***OAC 317:30-3-20***
        v. Expedited Appeals: AMENDING agency rules at ***OAC 317:2-1-2.5***
        vi. Free-Standing Birthing Centers: REVOKING agency rules at ***OAC 317:30-5-890, 317:30-5-890.1, 317:30-5-891, 317:30-5-892, and 317:30-5-893***
        vii. The Oklahoma Office of Juvenile Affairs (OJA) Targeted Case Management (TCM) Services Revisions: ADDING agency rules at ***OAC 317:30-5-971.1*** and AMENDING ***OAC 317:30-5-970 through 317:30-5-974***
        viii. Nursing Licensure Revisions: AMENDING agency rules at ***OAC 317:30-5-240.3, 317:30-5-375, 317:30-5-376, 317:30-5-390, 317:30-5-391, 317:30-5-763, and***

317:30-5-1043

ix. Indian Health Services, Tribal Programs, and Urban Indian Clinics (I/T/Us) Obstetrical (OB) Services: AMENDING agency rules at ***OAC 317:30-5-1095 and 317:30-5-1099***
x. Programs of All-Inclusive Care for the Elderly (PACE): AMENDING agency rules at ***OAC 317:35-5-63 and 317:35-18-3***
xi. Title XXI Parity Compliance: AMENDING agency rules at ***OAC 317:35-22-2***
xii. Nursing Home Supplemental Payment Program Revocation: REVOKING agency rules at ***OAC 317:2-1-16***
xiii. Nursing Home Supplemental Payment Program Revocation: REVOKING agency rules at ***OAC 317:30-5-136***
xiv. Defunding Statutory Rape Cover-Up Act: ADDING agency rules at ***OAC 317:30-3-19.6***

10. Discussion of Report from the Pharmacy Advisory Committee and Possible Action Regarding Drug Utilization Board Recommendations ……Randy Curry Chair, Pharmacy Advisory Committee

    a) Consideration and Vote Regarding Recommendations Made by the Drug Utilization Review Board Pursuant to 63 O.S. § 5030.3 To Add the Following Drugs to the Utilization and Scope Prior Authorization Program under OAC 317:30-5-77.2(e):

        i) Vyndaqel® (tafamidis meglumine) and Vyndamax™ (tafamidis)
        ii) Recarbio™ (imipenem/clastatin/relebactam) and Xenleta™ (Lefamulin)
        iii) Turalio™ (Pexidartinib)
        iv) Elzonris® (tagraxofusp-erzs) and Inrebic® (Fedratinib)
        v) Aemcolo™ (rifamycin), Motegrity™(prucalopride), Zelnorm™ (tegaserod), and Ibsrela®(tenapanor)
        vi) Bevyxxa® (betrixaban)
        vii) Avaclyr™(acyclovir 3% ophthalmic ointment)

11. Discussion and Possible Action……Stan Hupfeld, Chair
    Possible Executive Session as Recommended by the Chief of Legal Services and Authorized by the Open Meeting Act, 25 O.S. § 307(B)(4) and (7), To Discuss Confidential Legal Matters, Including Pending State and Federal Litigation.

12. Adjournment……Stan Hupfeld, Chair

NEXT BOARD MEETING
March 18, 2020
Oklahoma Health Care Authority
Oklahoma City, OK

MINUTES OF A SPECIAL BOARD MEETING
OF THE HEALTH CARE AUTHORITY BOARD
November 20, 2019
Oklahoma Health Care Authority Boardroom
Oklahoma City, Oklahoma

Manner and Time of Notice of Meeting: A statutorily required public meeting notice was placed on the front door of the Oklahoma Health Care Authority on November 19, 2019 at 12:55 p.m. Advance public meeting notice was provided to the Oklahoma Secretary of State. In addition to the posting of the statutory public notice, the agency placed its agenda on its website on November 15, 2019 at 2:32 p.m.

Pursuant to a roll call of the members, a quorum was declared to be present, and Chairman Hupfeld called the meeting to order at 1:00 p.m.

BOARD MEMBERS PRESENT: Chairman Hupfeld, Vice Chairman Yaffe, Member Boyd, Member Case, Member Curry, Member Hausheer, Member Kennedy, Member Nuttle, Member Shamblin

OTHERS PRESENT:

Amy Bradt, OHCA
Josh Richards, OHCA
April Anonsen, OHCA
Kambra Reddick, OHCA
Will Widman, DXC
Aaron Morris, OHCA
Judith Ursitti, RBT
Harvey Reynolds, OHCA
Suzie Megehee, OHCA
Shelly Patterson, OHCA
Carmen Johnson, OHCA
Kimberly Jones, OHCA
Gwendolyn Caldwell, PhRMA
Jarna Morgan, ODOC
Christina Foss, OHCA
Camille Peck, OKDHS
Carolyn Reconnu-Shoffner, OHCA
Katelyn Burns, OHCA
Kerri Wade, OHCA
Jim Dunlap, PhRMA
Rick Snyder, OHA
Annie Baghdayan, BCBA (OLBAB)
David Ward, OHCA
Tanesha Hooks, OHCA
Sandra Puebla, OHCA
Annette Mays, OAHC

OTHERS PRESENT:

Jill Ratterman, OHCA
Melanie Lawrence, OHCA
Jimmy Witcosky, OHCA
Tri Van, PMC
Marcus McEntire, OK House of Representatives
Lisa Spain, DXC
Brenda Teel, Chickasaw Nation
Bert Bailey, OHCA
Josh Bouye, OHCA
Gloria LaFitte, OHCA
Princess Rockmore, OHCA
Lisa Montgomery, OHCA
Matt Robison, OSMA
Tyler Talley, eCap
Caitlin Owen, ODOC
Melissa Amaranto, OKDHS
Jonathan Cannon, OHCA
Bethany Holderread, OU COP
Stephanie Mavredes, OHCA
Braden Mitchell, OHCA
Kyle Janzen, OHCA
Dwyna Vick, OHCA
Courtney Barrett, OHCA
Rachel Peterson, OHCA
Marilyn Stark, OK House of Representatives

ITEM 2 / PUBLIC COMMENT ON THIS MEETING'S AGENDA ITEMS BY ATTENDEES WHO GAVE 24 HOUR PRIOR WRITTEN NOTICE
Stanley Hupfeld, OHCA Board Chairman

Speakers:
- Judith Ursitti, RBT

ITEM 3 / DISCUSSION AND POSSIBLE VOTE ON APPROVAL OF CONSENT AGENDA WHICH INCLUDES:

a) Approval of the Minutes from September 18, 2019 OHCA board meeting
b) Approval of Expenditure of Funds Contracts
    i. Asset Verification System Services
    ii. Independent Verification & Validation

iii. Medicaid Consulting Services
iv. Medicaid Information Technology Architecture RFP
v. Information Technology Consulting Contract
vi. Sickle Cell Disease Consulting
vii. Health Information Exchange Contract Increase
viii. Ground Emergency Medical Transportation
ix. PeopleSoft Statewide Contract

MOTION: Member Hausheer moved for approval of the items listed in the Consent Agenda, except item 3b.iii, as published. The motion was seconded by Member Kennedy.

FOR THE MOTION: Chairman Hupfeld, Vice-Chairman Yaffe, Member Boyd, Member Case, Member Curry, Member Nuttle, Member Shamblin

MOTION: Member Hausheer moved for approval of item 3b.iii as published. The motion was seconded by Member Kennedy.

FOR THE MOTION: Chairman Hupfeld, Vice-Chairman Yaffe, Member Boyd, Member Case, Member Curry, Member Nuttle, Member Shamblin

ITEM 4 / CHIEF EXECUTIVE OFFICER'S REPORT
Kevin Corbett, Chief Executive Officer

Mr. Corbett presented the member moment video of member Kayla and mother Wanda Felty to the board. Following the video Mr. Corbett spoke about the agency's four focus areas, including member first outcomes, Fiscal Responsibility, High Performing Teams, and Operational outcomes. OHCA has engaged with a number of partners, stakeholders, and constituents to understand lessons learned and best in class solutions. Mr. Corbett gave a brief update regarding the Medicaid Consultant contract and possible award date, as well as the Health Information Exchange contract. The Medicaid Consultant contract will be awarded for one year, with an option to be extended. For more information regarding the Medicaid Consultant contract, see item 3b.iii in the board packet.

During Mr. Corbett's report, Chairman Hupfeld asked Vice-Chairman Yaffe to introduce Rep. Marcus McEntire and Rep. Marilyn Stark

ITEM 5 / CHIEF OF STAFF'S REPORT
Ellen Buettner, Chief of Staff

Ms. Buettner followed up on the High Performing Team goal, adding that her team has been working with each division to ensure that each team has optimal organizational structure and ensure an appropriate compensation system is in place. OHCA Executive Leadership team has also engaged in coaching sessions to better communication within the team. Ms. Buettner introduced Jennifer Lamb-Hornsby, new Director of Organizational Development, and Christina Foss, Legislative Liaison.

Ms. Buettner stated the Legislature is working on scheduling budget hearings with State Agencies. OHCA has not received a date, but she will updated the board as soon as the hearing is set.

ITEM 6 / CHIEF OPERATING OFFICER'S REPORT
Melody Anthony, Chief Operating Officer/State Medicaid Director

Ms. Anthony provided a brief overview of SoonerCare, which included information on the Oklahoma Health Care Authority, current Medicaid program, SoonerCare programs, partial benefit programs, program areas, behavioral health programs, external partner shared programs, quality of care in SoonerCare programs, and health services initiatives. For more detailed information, see item 6 in the board packet.

ITEM 7 / DISCUSSION OF REPORT FROM THE COMPLIANCE ADVISORY COMMITTEE
Phil Kennedy, Chair of Compliance Advisory Committee

Member Kennedy gave a brief update regarding the items discussed during the November 8th, 2019 Committee meeting. Items discussed during the committee were the OHCA financials, current Audits, and cyber security. OHCA had a positive

$4.7 million state dollar variance through September. Revenues were under budget, with drug rebates being $2.4 million below budget. Medicare Refunds were over budget by $300,000 state dollars and taxes and fees were over budget by $1.2 million state dollars. Medicaid Program variance is a positive $5.1 variance and Administration is under budget by $0.5 million state dollars. As of September 30, 2019, OHCA is owed $5 million by other state agencies. OHCA staff will continue to monitor these accounts.

ITEM 8A-Bi-vi / DISCUSSION OF REPORT FROM THE ADMINISTRATIVE RULES ADVISORY COMMITTEE AND POSSIBLE ACTION REGARDING AGENCY RULEMAKING

Jean Hausheer, M.D., Chair of Administrative Rules Advisory Committee

Action Item – a) Consideration and Vote upon a Declaration of a Compelling Public Interest for the promulgation of *all Emergency Rules* in item nine in accordance with 75 Okla. Stat. § 253.

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

The following emergency rule HAS previously been approved by the board and the Governor under emergency rulemaking. It has been revised for additional emergency rulemaking.

i. Registered Behavior Technicians (RBT) as Qualifed Providers of Applied Behavior Analysis Services: ADDING agency rules at ***Oklahoma Administrative Code (OAC) 317:30-3-65.12*** and AMENDING agency rules at ***OAC 317:30-5-355.1, 317:30-5-357, 317:30-5-376, 317:30-5-664.1, 317:30-5-1076, 317:30-5-1090 and 317:30-5-1154***

The following emergency rules HAVE NOT previously been approved by the Board

ii. Diabetes Self-Management Training (DSMT) Services: AMENDING agency rules at ***OAC 317:30-5-42.1*** and ADDING agency rules at ***OAC 317:30-5-1080 through 317:30-5-1084***

iii. Suspension of Eligibility During Incarceration for Specific Medicaid Populations, as Required by Federal Law: ADDING agency rules at ***OAC 317:35-6-45***

iv. Newly Required Drug Utilization Review Board (DUR) Activities To Better Monitor Opioid Prescription and Dispensation: AMENDING agency rules at ***OAC 317:30-5-86***

v. Step Therapy Protocol Exceptions: AMENDING agency rules at ***OAC 317:2-1-2*, *317:2-1-13*, *OAC 317:30-5-77.2*, *and 317:30-5-77.3*;** REVOKING agency rules at ***OAC 317:2-1-6*;** ADDING agency rules at ***OAC 317:2-1-18 and OAC 317:30-5-77.4*.**

vi. Removal of Prescription Limits for Frequently Monitored Prescription Drugs and Medication-Assisted Treatment (MAT) Drugs: AMENDING agency rules at ***OAC 317:30-3-5, 317:30-5-72 and 317:30-5-77.1***

MOTION:	Member Case moved for approval of Item 8a as published. The motion was seconded by Vice-Chairman Yaffe.
FOR THE MOTION:	Chairman Hupfeld, Member Boyd, Member Curry, Member Hausheer, Member Kennedy, Member Nuttle, Member Shamblin
MOTION:	Vice-Chairman Yaffe moved for approval of Item 8bi-vi as published. The motion was seconded by Member Boyd
FOR THE MOTION:	Chairman Hupfeld, Member Case, Member Curry, Member Hausheer, Member Kennedy, Member Nuttle, Member Shamblin

ITEM 9 / DISCUSSION OF REPORT FROM THE PHARMACY ADVISORY COMMITTEE AND POSSIBLE ACTION REGARDING DRUG UTILIZATION BOARD RECOMMENDATIONS

Randy G. Curry, D.Ph., Chair of Pharmacy Advisory Committee

Action Item – a) Consideration and Vote Regarding Recommendations Made by the Drug Utilization Review Board Pursuant to 63 O.S. § 5030.3 to Add the Following Drugs to the Utilization and Scope Prior Authorization Program under OAC 317:30-5-77.2(e).

i. Zolgensma® (Onasemnogene Abeparvovec-xioi)

ii. Bryhali™ (Halobetasol Propionate 0.01% Lotion), Duobrii™ (Halobetasol Propionate/Tazarotene 0.01%/0.045% Lotion), and Lexette™ (Halobetasol Propionate 0.05% Foam)
iii. Sorilux® (calcipotriene 0.005% foam)
iv. Herzuma® (Trastuzumab-pkrb), Kanjinti™ (Trastuzumab-anns), Ontruzant® (Trastuzumab-dttb), Piqray® (Alpelisib), Talzenna® (Talazoparib), and Trazimera™ (Trastuzumab-qyyp)
v. Nubeqa® (Darolutamide)

MOTION: Member Curry moved for approval of Item 9ii-v as published. The motion was seconded by Member Hausheer.

FOR THE MOTION: Chairman Hupfeld, Vice-Chairman Yaffe, Member Boyd, Member Case, Member Kennedy, Member Nuttle, Member Shamblin

MOTION: Member Curry moved for approval of Item 9i as published. The motion was seconded by Member Case.

FOR THE MOTION: Chairman Hupfeld, Vice-Chairman Yaffe, Member Boyd, Member Hausheer, Member Kennedy, Member Nuttle, Member Shamblin

***ITEM 10 / CONSIDERATION AND VOTE UPON THE OKLAHOMA HEALTH CARE AUTHORITY BOARD MEETING DATES, TIMES AND LOCATIONS FOR CALENDAR YEAR 2020.**
Stanley Hupfeld, OHCA Board Chairman

Member Hausheer proposed that all board meetings start at 3pm.

MOTION: Member Hausheer moved to approve the board meeting dates, updated time, and updated locations. The motion was seconded by Vice-Chairman Yaffe

FOR THE MOTION: Chairman Hupfeld, Member Boyd, Member Case, Member Curry, Member Kennedy, Member Nuttle, Member Shamblin

ITEM 11 / ELECTION OF THE OKLAHOMA HEALTH CARE AUTHORITY 2020 BOARD OFFICERS
Stanley Hupfeld, OHCA Board Chairman

MOTION: Member Case moved for approval of Stanley Hupfeld as Chairman. The motion was seconded by Vice-Chairman Yaffe.

FOR THE MOTION: Member Boyd, Member Curry, Member Hausheer, Member Kennedy, Member Nuttle, Member Shamblin

ABSTAINED: Chairman Hupfeld

MOTION: Member Case moved for approval of Alex Yaffe as Vice-Chairman. The motion was seconded by Member Nuttle.

FOR THE MOTION: Chairman Hupfeld, Member Boyd, Member Curry, Member Hausheer, Member Kennedy, Member Shamblin

ABSTAINED: Vice-Chairman Yaffe

ITEM 12 / PROPOSED EXECUTIVE SESSION AS RECOMMENDED BY THE CHIEF OF LEGAL SERVICES AND AUTHORIZED BY THE OPEN MEETINGS ACT, 25 OKLAHOMA STATUTES §307(B) (4).
Stanley Hupfeld, OHCA Board Chairman

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

FOR THE MOTION: Chairman Hupfeld, Member Boyd, Member Case, Member Curry, Member Kennedy, Member Nuttle, Member Shamblin

ITEM 13 / ADJOURNMENT

MOTION: Member Hausheer moved for approval for adjournment. The motion was seconded by Member Nuttle.

FOR THE MOTION: Chairman Hupfeld, Vice-Chairman Yaffe, Member Boyd, Member Case, Member Curry, Member Kennedy, Member Shamblin

Meeting adjourned at 3:11 p.m., 11/20/2019

NEXT BOARD MEETING
January 22, 2020
Oklahoma Health Care Authority
Oklahoma City, OK

Martina Ordonez
Board Secretary

Minutes Approved: _____

Initials: _____

Oklahoma HealthCare Authority

SOONERCARE CHOICE PATIENT CENTERED MEDICAL HOME (PCMH) REDESIGN OHCA BOARD MEETING JANUARY 22, 2020

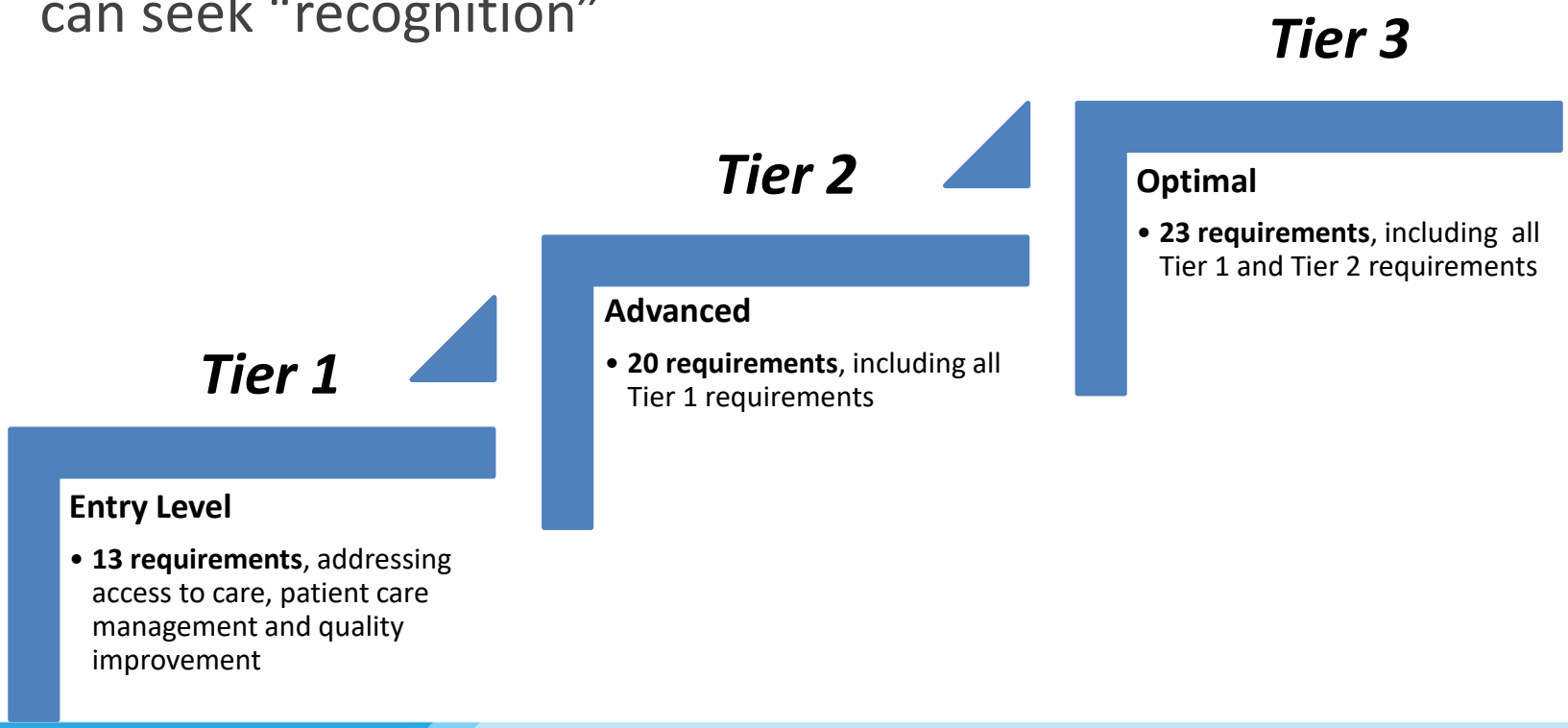
Melody Anthony, State Medicaid Director

SOONERCARE CHOICE TODAY?

- SoonerCare Choice is the state's Medicaid managed care program
- SoonerCare Choice members can select a "Patient Centered Medical Home" (PCMH) for their primary care
- PCMH providers can be family practitioners, pediatricians, general internists or qualified mid-level practitioners
- In November, SoonerCare Choice enrollment was 527,191*(83.4 percent children/adolescents and 16.6 percent adults)*

CURRENT PCMH PROGRAM

- The PCMH program was introduced in 2009 and has been updated over time
- The current design has three tiers, or levels, for which providers can seek "recognition"



CURRENT PCMH PROGRAM *cont'd*

Access to Care Requirements (Examples)

Entry Level	Advanced	Optimal
• 20 office hours per week (minimum) • Open slots for urgent same-day appointments • 24/7 phone coverage	• **30 office hours** per week (minimum) • Open slots for urgent same-day appointments • 24/7 phone coverage	• **30 office hours** per week (minimum) • Open slots for urgent same-day appointments • 24/7 phone coverage • **4 hours of "after-hours"** office availability (minimum)

CURENT PCMH PROGRAM *cont'd*

- PCMH Providers are paid three ways:
  - Monthly "case management" fee paid for each SoonerCare Choice member on the provider's panel that has established a relationship (range from $3.63 to $8.82, depending on practice type and tier level)
  - Fee-for-service payments (medical claims) for patient visits
  - "SoonerExcel" incentive payments for meeting/ exceeding program quality targets (e.g., reducing emergency room visits)

PCMH REDESIGN – OVERVIEW

- For the "nuts and bolts" of the redesign we want to:
  - Build on the progress made since 2009
  - Take note of national "best practices"
- For example:
  - SoonerCare Choice PCMH providers have gradually moved from Entry Level to Optimal in greater and greater numbers
  - Nationally, the trend is toward defining a single, enhanced "tier" with standards that all providers must meet
  - The trend also is to reward providers who demonstrate excellent/ improved quality of care
  - Our approach is to establish a single tier, based on the current Optimal tier + several new requirements
  - We also will pay additional for several optional activities and demonstrated high/ improved quality

REDESIGN CONSIDERATIONS

- General questions about the current program?
- Do we have the right goals for the redesign, from the member's perspective?
  - Raising standards for all providers
  - Improving access to care
  - Improving quality of care
  - Measuring and rewarding excellence
- What else should we be thinking about?

SOONERCARE CHOICE MOVING FORWARD

- Goals for the PCMH Redesign
  - Raising standards for all providers
  - Improving access to care
  - Improving quality of care
  - Measuring and rewarding excellence

The PCMH Redesign ultimately is about improving the member's experience

PCMH REDESIGN – APPROACH

Required or Optional	Standards
New Requirement	Screening for Substance Use and Social Determinants of Health (social service needs)
New Requirement	Outreach to patients due for well-care screenings, with the OHCA's support
New Requirement	Linking to State Health Information Exchange (HIE), when established
New Requirement	Reviewing information about the patients in PCMH practice and undertaking quality improvement as appropriate
Optional	Accreditation from NCQA, The Joint Commission or AAAHC OR Use of OHCA-sanctioned comprehensive assessment with required screens (medical, BH, SUD, SDOH), problem lists, risk stratification and care plan or referral to appropriate OHCA program (Non-HAN/HMP providers)
Optional	Extended office hours: 31 – 39 hours OR 40+ hours
Optional	Onsite behavioral health care manager OR Formal referral arrangement to a behavioral health practice and/or use of Trauma Informed Care assessment
Optional	Use of integrated care plans for co-managed members within OHCA-sanctioned Health Neighborhood (to be established by HANs)

PCMH REDESIGN – APPROACH *cont'd*

- **Rewarding Quality**
  - Providers will be evaluated across a series of quality measures focused on member care
  - Providers will receive additional payment (through the case management fee) for exceeding targets or showing significant improvement

Evaluation Area	Measures
Preventive Care/Wellness	• Adolescent well-care visits • Developmental screening (first three years of life) • Tobacco cessation counseling • Body Mass Index screening
Behavioral Health	• Metabolic monitoring of children on anti-psychotics • Adult patients using high dose opioids
Chronic Conditions	• HbA1C testing in adults with diabetes

PCMH REDESIGN – APPROACH *cont'd*

Child/Adolescent Measures

Measure	National Benchmark Rate*	Current SoonerCare Choice Rate**	PMPM Add-on Threshold**	Improvement versus Prior Year & Minimum to Qualify**	
Adolescent Well Care Visits	53.0%	45.7%	54.0%	+3.0% points	47.0%
Developmental Screening First 3 Years	42.2%	18.1%	30.0%	+3.0% points	20.0%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children***	74.3%	5.2%	35.0%	+3.0% points	15.0%
Metabolic Monitoring for Children and Adolescents on Anti-Psychotics	29.8%	TBD	TBD	TBD	TBD

* National Medicaid HMO rate as reported by NCQA except Developmental Screening, which is national Medicaid median

* Current rate is CY 2018 and will be updated with CY 2019 data; thresholds will be adjusted, as appropriate

** SoonerCare Choice rate is based on administrative data only, while national rate includes medical record data; this accounts for the significant discrepancy

PCMH REDESIGN – APPROACH *cont'd*

Adult Measures

Measure	National Benchmark Rate*	Current SoonerCare Choice Rate**	PMPM Add-on Threshold**	Improvement versus Prior Year & Minimum to Qualify**	
5 A's Tobacco Cessation Counseling	N/A	N/A	60 paid claims	20 paid claims	20 paid claims
Adult BMI Assessment***	86.6%	20.8%	40.0%	+3.0% points	25.0%
Adult patients using High Dose Opioids	6.5 per 1,000	25.6 per 1,000	15.0 per 1,000	- 3.0 points	20.0 per 1,000
Diabetes Care – HbA1c Testing	87.8%	76.3%	82.0%	+3.0% points	77.0%

* National Medicaid HMO rate as reported by NCQA

* Current rate is CY 2018 and will be updated with CY 2019 data; thresholds will be adjusted, as appropriate

** SoonerCare Choice rate is based on administrative data only, while national rate includes medical record data; this accounts for the significant discrepancy

PCMH REDESIGN – APPROACH *cont'd*

- **Reporting on Quality**
  - Providers will receive quarterly reports showing how well they are doing, versus their peers in the same region and statewide
  - The reports will address:
    - Member conditions/needs
    - Member access to primary care services
    - Overall member utilization and expenditures
  - Providers will be encouraged to use the information to identify areas for improvement

PCMH REDESIGN – SHARING DATA *cont'd*

Practice Summary

PCMH Region: **Greer, Harmon and Jackson Counties**

Your Practice Serves: **Adults and Children**

Number of Clinicians in Your Practice: **3**

Total Practices Serving Adults and Children in Region: **18**

Total Practices Serving Adults and Children Statewide: **342**

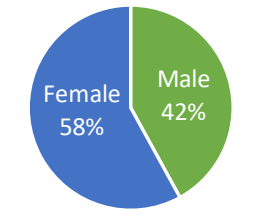
Total Clinicians Serving Adults and Children in Region: **56**

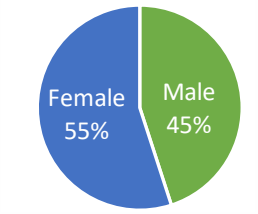
Total Clinicians Serving Adults and Children Statewide: **876**

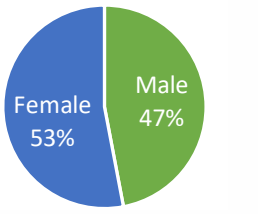
SoonerCare Choice Enrollment Summary

	Your Practice	Your PCMH Region	Statewide
Average Monthly Enrollment	2,434	2,124	2,763
Enrollment per Clinician	811	683	1,079

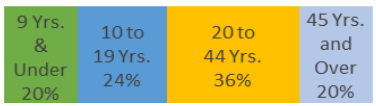
Distribution by Gender

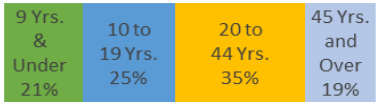




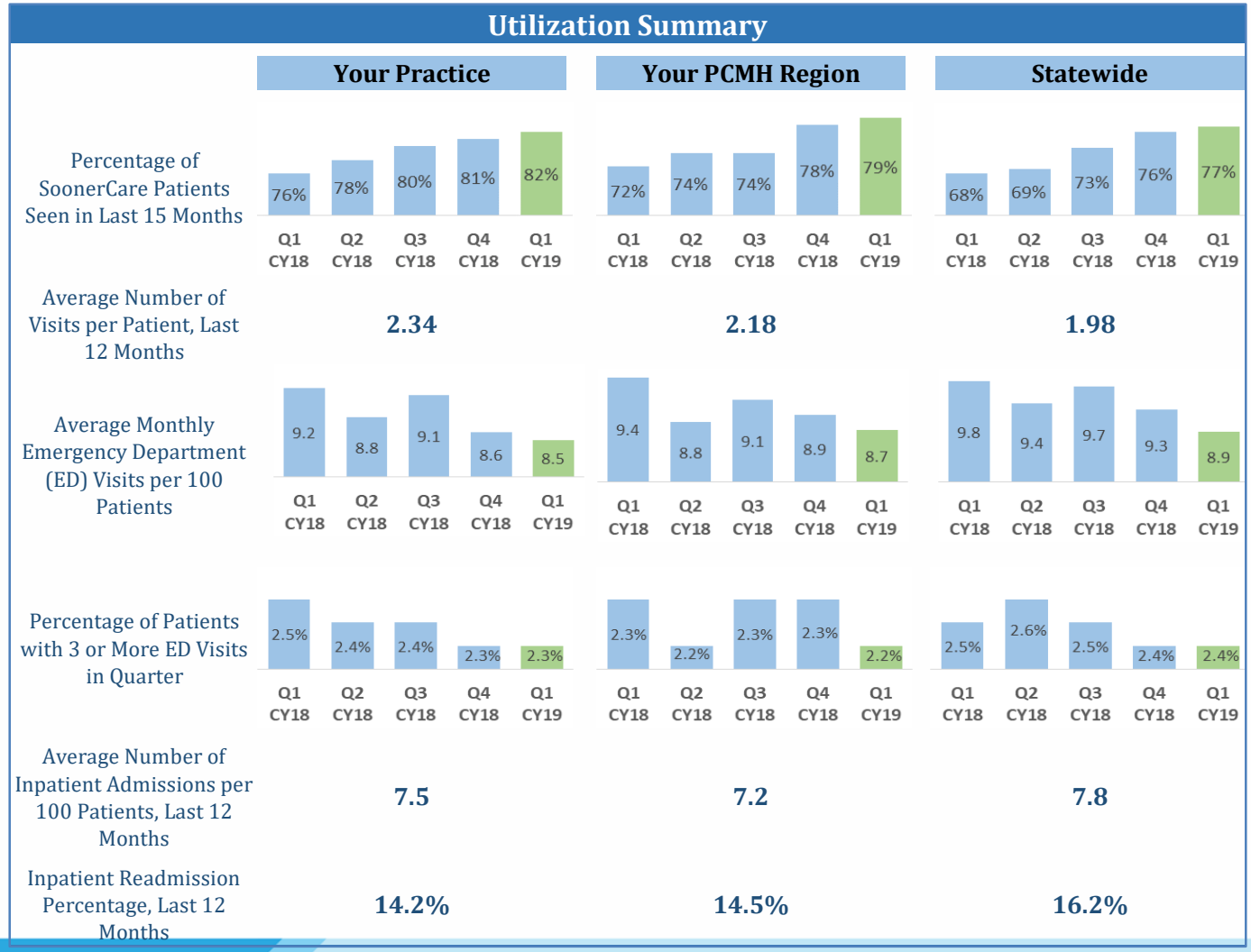


Distribution by Age





PCMH REDESIGN – SHARING DATA *cont'd*

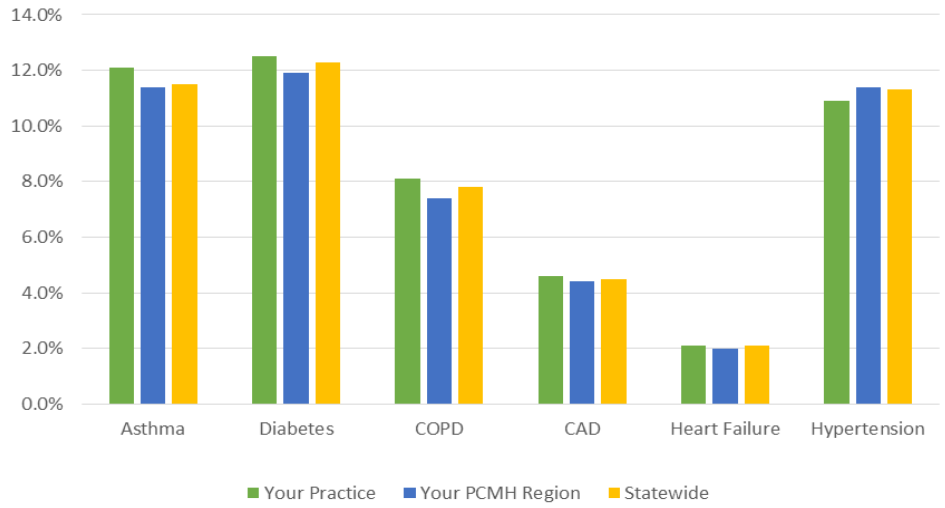


PCMH REDESIGN – SHARING DATA *cont'd*

Summary: Chronic Conditions

Percentage of Patients with Chronic Conditions

Condition	Your Practice	Your PCMH Region	Statewide
Asthma	**12.1%**	**11.4%**	**11.5%**
Diabetes	**12.5%**	**11.9%**	**12.3%**
Chronic Obstructive Pulmonary Disease (COPD)	**8.1%**	**7.4%**	**7.8%**
Coronary Artery Disease (CAD)	**4.6%**	**4.4%**	**4.5%**
Heart Failure	**2.1%**	**2.0%**	**2.1%**
Hypertension	**10.9%**	**11.4%**	**11.3%**



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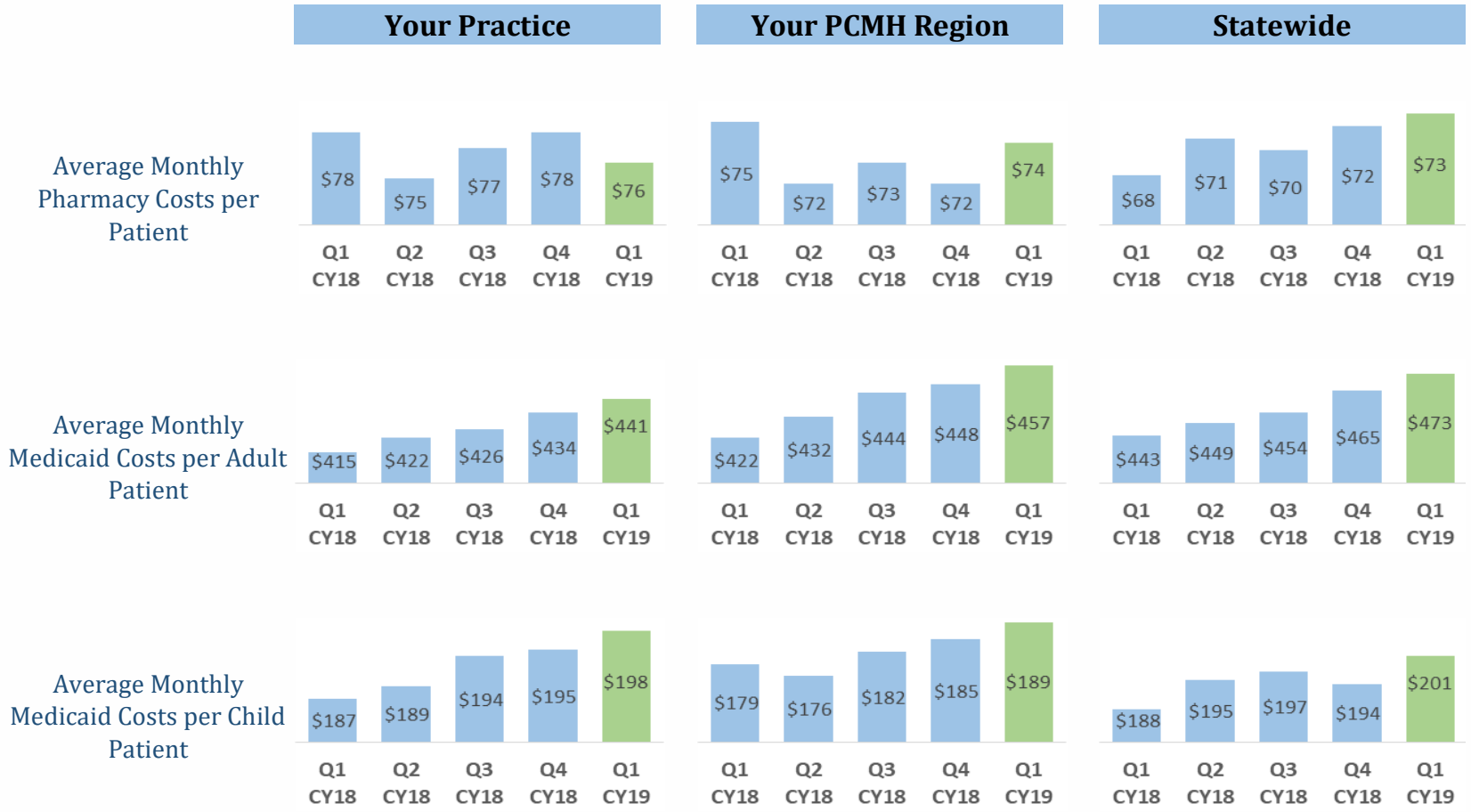
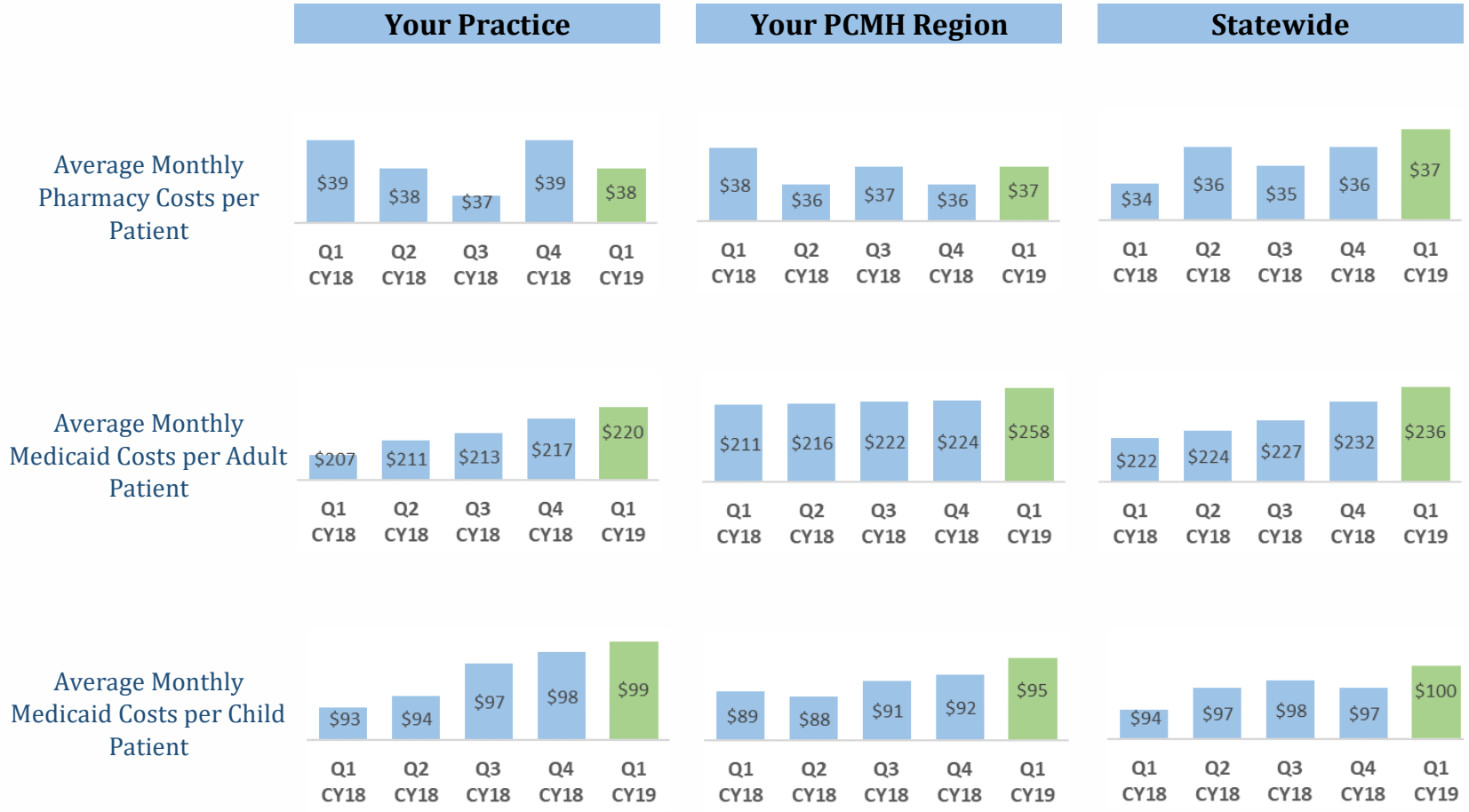
PCMH REDESIGN – SHARING DATA *cont'd*

Cost Summary (All Claims - PCMH-Submitted and Others)



PCMH REDESIGN – SHARING DATA *cont'd*

Cost Summary (PCMH-Submitted Claims Only)



PCMH REDESIGN – SHARING DATA *cont'd*

PCMH Practice X: Enrollment and "Add-On" Care Standard Summary				
Enrollment Summary				
	January, 2019	**February, 2019**	**March, 2019**	**Quarterly Total**
Total Enrollment	2,381	2,404	2,518	7,303
Payment-Qualifying Enrollment (Patients Seen in Last 15 Months)	1,952	1,971	2,077	6,000
Qualifying Add-On Activity				
Optional PCMH Care Standards				**Qualified for Payment**
1. Comprehensive Assessment and Care Planning				
A. NCQA, The Joint Commission or AAAHC Accreditation				Yes
B. OHCA-Sanctioned Comprehensive Assessment and Care Planning				N/A
2. Extended Hours				
A. Extended Hours: 31 - 39 Hours per Week				No
B. Extended Hours: 40 or More Hours per Week				No
3. Behavioral Health Care Management				
A. On-Site Behavioral Health Care Manager				No
B. Formal Referral Arrangement for Behavioral Health				Yes
C. Standarized Trauma Screening				No
4. HAN-Affiliated and Participate in Health Neighborhood				No

PCMH REDESIGN – SHARING DATA *cont'd*

Performance Measure	PCMH Performance		Threshold Qualification		Improvement Qualification		
	Current Period Results	Change from Previous Period	Established Threshold	Meets Threshold	Minimum Rate	Minimum Rate of Improvement	Meets Improvement Targets
Adolescent Well Care Visits	55.0%	+2.5 % Pts	45.7%	Yes	47.0%	+3.0 % Pts	N/A
Developmental Screening First 3 Years	26.2%	+4.6 % Pts	30.0%	No	20.0%	+3.0 % Pts	Yes
Weight Assessment and Counseling	37.5%	+2.4 % Pts	35.0%	Yes	15.0%	+3.0 % Pts	N/A
Metabolic Monitoring for Children and Adolescents on Anti-Psychotics	TBD	TBD	TBD	TBD	TBD	TBD	TBD
5 A's Tobacco Cessation Counseling	12 Claims	+4 Claims	60 Claims	No	20 Claims	+20 Claims	No
Adult BMI Assessment	41.0%	+2.4 % Pts	40.0%	Yes	25.0%	+3.0 % Pts	N/A
Adult Patients Using High Dose Opioids	29.0 per 1,000	-3.4 % Pt	15.0 per 1,000	No	20.0 per 1,000	-3.0 % Pts	No
Diabetes Care - HbA1c Testing	66.8%	+2.7 % Pts	82.0%	No	77.0%	+3.0 % Pts	No

PCMH REDESIGN – SHARING DATA *cont'd*

Payment Summary

PCMH Practice X: Payment Summary		
Total Qualifying Member Months		**6,000**
Monthly Base Rate	**$**	**7.11**
Qualifying Activities		
Accreditation	$	0.50
Formal Referral for Behavioral Health	$	0.25
Value-Based Payments		
Adolescent Well Care Visits	$	0.20
Developmental Screening First 3 Years	$	0.20
Weight Assessment and Counseling - Children and Adolescents	$	0.20
Adult BMI Assessment	$	0.20
PMPM Total	**$**	**8.66**
Total Payments in the Previous Three Months	**$**	**51,960**

PCMH REDESIGN – APPROACH *cont'd*

Transition to New System - Timeline

2019	OHCA finalizes new PCMH program standards with stakeholder participation
April 2020	Target date for federal approval
June 2020	OHCA reports 2019 performance measure results
Summer 2020	PCMH providers apply to participate in new program and identify add-on activities
October 2020	New program takes effect Providers must undertake add-on activities within nine months

PCMH REDESIGN – SUMMARY

- The PCMH redesign will succeed if it advances our member-centered goals
  - Raising standards for all providers
  - Improving access to care
  - Improving quality of care
  - Measuring and rewarding excellence

COMMENTS & QUESTIONS

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Approved SPAs

SPA WF #	SPA Title	Purpose	Approval/Effective Dates	Coinciding Rules?
OK SPA 14-0014	Copay Increase – Submitted in MMDL Portal	SPA updated the State's Medicaid Premiums and Cost Sharing requirements.	CMS approved SPA – 10.04.19 Effective date – 07.01.14	Yes; WF # 14-05
OK SPA 19-0006	RBMS Group Home Provider Rates Increase	DHS request for SPA to increase the reimbursement rates for Residential Behavior Management Services (RBMS) Group Home providers.	CMS approved SPA – 10.18.19 Effective date – 09.01.19	Yes; WF # 18-26
OK SPA 19-0014	Increase Enhanced Payments to University Affiliated Physicians (OU and OSU) (previously 18-04)	SPA increased the 140% for University Affiliated Physicians (OU/OSU) to 175%. This strengthened our efforts to financially support the State Medical Schools; ultimately improving access to Physicians.	CMS approved SPA – 10.07.19 Effective date – 07.01.19	No
OK SPA 19-0016	FQHC and RHC Limitations	SPA notates limit of 4 visits per adult member per month in the State Plan and establishes that reimbursement is made for one encounter per member per day in these settings (with certain exemptions).	CMS approved SPA – 12.10.19 Effective date – 09.01.19	Yes; WF # 18-30
OK SPA 19-0018	TFC Policy Revisions (QBHA II)	In collaboration with DHS and in response to the Co-Neutral's focus on efforts to place children in a more home like or family setting vs. congregate care, current therapeutic foster care (TFC) rules and State Plan were revised to establish provider requirements as well as a reimbursement rate for qualified behavioral health assistant (QBHA) II.	CMS approved SPA – 10.18.19 Effective date – 09.01.19	Yes; WF # 19-05
OK SPA 19-0020	Payment to State-owned PRTFs	SPA reinstated the cost-based reimbursement to a State-owned Psychiatric Residential Treatment Facilities (PRTF) rendering inpatient psychiatric services to individuals under the age of twenty-one (21).	CMS approved SPA – 11.20.19 Effective date – 07.01.19	No

OK SPA 19-0023	RHC Reimbursement Methodology	SPA revised the reimbursement methodology for Rural Health Clinics (RHC).	CMS approved SPA – 10.08.19 Effective date – 07.01.19	No
OK SPA 19-0025	Nursing Facility Rebasing	Annual SPA that rebases nursing facility rates which increased the nursing facility pool amounts and base rate components for nursing facilities serving adults and AIDS patients.	CMS approved SPA – 11.19.19 Effective date – 07.01.19	No
OK SPA 19-0031A	Nursing Facilities (NFs) Personal Needs Allowance	Per SB 280, SPA increased the post-eligibility treatment of income personal needs allowance (PNA) for residents of nursing homes and intermediate care facilities for individuals with intellectual disabilities (ICFs/IID) to seventy-five dollars ($75.00) per month per resident.	CMS approved SPA – 12.02.19 Effective date – 10.01.19	No
OK SPA 19-0031B	FOE & Nursing Facility Rate Increase	Per SB 280 & 1044, SPA increased the nursing facility pool amounts and base rate components for nursing facilities serving adults and AIDS patients. Additionally, this SPA revises the Pay-for-Performance (PFP) program, formerly known as the Focus on Excellence (FOE) program.	CMS approved SPA – 12.04.19 Effective date – 10.01.19	Yes; WF # 19-13A & B
OK SPA 19-0034	Outpatient Services Rate Increase	Per SB 1044, SPA updates the fee-for-service (FFS) rate schedule to include a five percent (5%) increase to outpatient services.	CMS approved SPA – 10.28.19 Effective date – 10.01.19	No
OK SPA 19-0036	State Plan Personal Care Services Rate Increase	Per SB 1044, SPA increased the rate for State Plan personal care services by four percent (4%).	CMS approved SPA – 11.25.19 Effective date – 10.01.19	No
OK SPA 19-0038	Standard Behavioral Health Case Management Units Increase	ODMHSAS request for SPA to increase the behavioral health standard targeted case management units.	CMS approved SPA – 11.04.19 Effective date – 11.01.19	Yes; WF # 19-16

Title XXI SPA WF #	SPA Title	Purpose	Approval/Effective Dates	Coinciding Rules?
CHIP SPA OK-19-0041	Change to Premium Assistance Authority, Discontinuation of Premium Assistance in the Individual Market, and Other Updates	CHIP SPA clarified that the State no longer provides premium assistance for families with children receiving coverage through the individual market. Additionally, the State is made a technical correction to update the premium assistance authority from 2105(c)(10) to 2105(c)(3), which more accurately reflects that the premium assistance program is mandatory for those who are eligible.	CMS approved SPA – 10.31.19 Effective date – 07.01.19	Yes; WF # 13-16

January Board
Proposed Rule Changes

Face-to-face tribal consultations regarding the following proposed changes were held on Tuesday, November 6, 2018, Tuesday, January 8, 2019, Tuesday, June 18, 2019, Tuesday, September 3, 2019, and Tuesday, November 5, 2019 in the Charles Ed McFall Boardroom of the Oklahoma Health Care Authority (OHCA). The proposed rules were presented to the Medical Advisory Committee on Thursday, January 17, 2019, Thursday, May 6, 2019, Thursday, September 5, 2019 and Thursday, January 9, 2020. Additionally, the proposed permanent rules were presented at a public hearing on Wednesday, January 15, 2020 at 1:00 p.m. in the OHCA Board Room.

The proposed permanent rules were posted on the OHCA public website for a comment period from December 16, 2019 through January 15, 2020.

The following permanent rule HAS previously been approved by the Board and the Governor under EMERGENCY rulemaking. This rule HAS BEEN revised for PERMANENT rulemaking:

A. **APA WF # 19-04 Eligibility Redetermination as Indicated by Returned Mail —** AMENDING agency rules at ***OAC 317:35-5-26*** and ADDING agency rules at ***OAC 317:35-5-67*** to comply with 42 Code of Federal Regulations (CFR) § 435.916(d), which requires a prompt redetermination of eligibility whenever information is received about a change in a member's circumstances that may affect eligibility. The proposed policy outlines that a member's eligibility will be terminated if his or her mail is returned to the agency as unforwardable, with address unknown, and after the Oklahoma Health Care Authority (OHCA) has made reasonable but unsuccessful attempts to verify the member's current address. Per 42 CFR §§ 431.213 and 431.231, advance notice is not required to be given to the member when eligibility is terminated due to returned mail; however, notice will be sent to the member by mail and by email, (if the agency has an email address on file). Additionally, notice will be posted to the member's online SoonerCare account. If the member's whereabouts become known within the eligibility period, eligibility will be reinstated. Rules and procedures for terminating eligibility due to returned mail are employed by other states' Medicaid agencies, including those of Alabama, Arizona, Ohio, New Jersey, New York, Oregon, and Colorado.
Budget Impact: Agency staff has determined the proposed rule change will not result in any additional costs and/or savings to the agency.

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

B. **APA WF # 19-02 Certified Community Behavioral Health Clinics (CCBHC) Project —** ADDING agency rules at ***OAC 317:30-5-263 through 317:30-5-268*** to sustain the CCBHC project beyond its demonstration period in Oklahoma. The services provided include nine types of behavioral health treatment services with an emphasis on the provision of 24-hour crisis care, utilization of evidence based practices, care coordination, and integration with physical health. The proposed new rules will outline CCBHC member eligibility, provider participation requirements, and program scope.
Budget Impact: The proposed rule change will not result in any additional costs and/or savings to the agency. Budget allocation for implementation and enforcement of the proposed rule, was approved during promulgation of the

emergency rule on May 21, 2019.

C. **APA WF # 19-11 Board Organization and Policy Revisions —** AMENDING agency rules at ***317:31-1-4, 317:1-1-6, and 317:1-1-7*** to comply with Oklahoma Senate Bill (SB) 456, which directed the reorganization of the OHCA Board. The seven-member Board was replaced with a nine-member Board. Further revisions establish that the chair and vice-chair elections are held at the last regular meeting before January 1 of each year. Other revisions are needed to correct outdated language.
Budget Impact: Budget neutral

The following PERMANENT rules HAVE NOT previously been approved by the Board:

D. **APA WF # 19-21 Claim Inquiry Procedures —** AMENDING agency rules at ***OAC 317:30-3-20*** to add necessary policy revisions due to a new streamlined electronic process developed by OHCA for providers. The revisions will outline how providers can request a review of submitted claims and how to submit supporting documentation for their request through the OHCA provider portal. The electronic review process will replace the previous manual process of submitting paper forms and documentation to a post office box.
Budget Impact: Budget neutral

E. **APA WF # 19-22 Expedited Appeals —** AMENDING agency rules at ***OAC 317:2-1-2.5*** to specify that requests for expedited appeal hearings should be sent to the Administrative Law Judge (ALJ) with a copy sent to the OHCA. Additionally, the appeal hearing request shall specify the services denied and the specific reason(s) why a regular 30-day appeal will seriously jeopardize the life or health of the member requesting an expedited appeal hearing.
Budget Impact: Budget neutral

F. **APA WF # 19-23 Free-Standing Birthing Centers —** REVOKING agency rules at ***OAC 317:30-5-890, 317:30-5-890.1, 317:30-5-891, 317:30-5-892, and 317:30-5-893*** as this type of provider no longer exists in Oklahoma.
Budget Impact: Budget neutral

G. **APA WF # 19-30 The Oklahoma Office of Juvenile Affairs (OJA) Targeted Case Management (TCM) Services Revisions —** ADDING agency rules at ***OAC 317:30-5-971.1*** and AMENDING ***OAC 317:30-5-970 through 317:30-5-974*** to increase the maximum eligible age for individuals who are involved in or at serious risk of involvement with the juvenile justice system and who are eligible for TCM services from eighteen (18) to under twenty-one (21). Additionally, the proposed revisions will align and reorganize TCM policy with the current evidence-based practices used by OJA.
Budget Impact: The estimated budget impact for State Fiscal Year (SFY) 2021 will be an increase in the total amount of $1,703,215; with $578,752 in state share. The estimated budget impact for SFY 2022 will be an increase in the total amount of $2,270,953; with $771,670 in state share. The state share will be paid by OJA.

H. **APA WF # 19-31 Nursing Licensure Revisions —** AMENDING agency rules at ***OAC 317:30-5-240.3, 317:30-5-375, 317:30-5-376, 317:30-5-390, 317:30-5-391, 317:30-5-763, and 317:30-5-1043*** to comply with 59 Oklahoma Statues (O.S.) § 567.21, which allows Oklahoma to enter into the enhanced Nurse Licensure Compact (eNLC). The eNLC is an agreement between states that allows a nurse's licensure to be portable to other member-states of the Compact. These revisions amend references that narrowly tie a

nurse's license to the Oklahoma Board of Nursing and align SoonerCare rules with the eNLC.
Budget Impact: Budget neutral

I. **APA WF # 19-33 Indian Health Services, Tribal Programs, and Urban Indian Clinics (I/T/Us) Obstetrical (OB) Services —** AMENDING agency rules at ***OAC 317:30-5-1095 and 317:30-5-1099*** to clarify how I/T/U OB providers should bill for OB care. I/T/Us have the option of either billing for OB encounters or a bundled rate for total OB care. The clarification will require I/T/Us to be specific when choosing a billing method as they are only allowed to choose one of the billing methods.
Budget Impact: Budget neutral

J. **APA WF # 19-36 Programs of All-Inclusive Care for the Elderly (PACE) —** AMENDING agency rules at ***OAC 317:35-5-63 and 317:35-18-3*** to bring the OHCA into compliance with Senate Bill (SB) 888 and federal regulations by adding language to clarify PACE participant enrollment and voluntary disenrollment process and criteria. Revisions will also add language to allow PACE providers to either be a non-profit or a for-profit entity to align with the Social Security Act sections 1894(a)(3)(B) and 1934(a)(3)(B).
Budget Impact: Budget neutral

K. **APA WF # 19-38 Title XXI Parity Compliance —** AMENDING agency rules at ***OAC 317:35-22-2*** to remove the two visit limitation for pregnant women covered under the Title XXI State Plan. All visits shall require medical review to deem whether the medical visit affects fetal effect. The revisions are needed to comply with Parity federal regulations which instruct the State to provide equivalent services to all children covered under the Plan.
Budget Impact: The estimated budget impact for SFY 2021 will be an increase in the total amount of $337,260; with $107,957 in state share.

L. **APA WF # 19-39A Nursing Home Supplemental Payment Program Revocation —** REVOKING agency rules at ***OAC 317:2-1-16*** to remove rule sections that were created for the nursing home supplemental payment program, a program that was never implemented; the Centers for Medicare and Medicaid Services (CMS) did not ultimately approve the proposal.
Budget Impact: Budget neutral

M. **APA WF # 19-39B Nursing Home Supplemental Payment Program Revocation —** REVOKING agency rules at ***OAC 317:30-5-136*** to remove rule sections that were created for the nursing home supplemental payment program, a program that was never implemented; the Centers for Medicare and Medicaid Services (CMS) did not ultimately approve the proposal.
Budget Impact: Budget neutral

N. **APA WF # 19-40 Defunding Statutory Rape Cover-Up Act —** ADDING agency rules at ***OAC 317:30-3-19.6*** to comply with House Bill (HB) 2591 which creates the Defunding Statutory Rape Cover-Up Act. The new law requires the OHCA to deny an application for a new or renewed provider agreement, or terminate an existing agreement, if a provider is investigated and found by a court to have failed to report statutory rape. The new rule outlines how an individual can report a complaint on a provider, and the actions OHCA can take if the complaint has been found valid.
Budget Impact: Budget neutral

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

SUBCHAPTER 5. ELIGIBILITY AND COUNTABLE INCOME

PART 3. NON-MEDICAL ELIGIBILITY REQUIREMENTS

317:35-5-26. Residence requirements; residents of public institutions; homeless persons; and residents of IHS, BIA or Tribal controlled dormitories

(a) **Residence.** To be eligible for SoonerCare services, the applicant must be residing in the State of Oklahoma with intent to remain at the time the medical service is received. A durational residence requirement is not imposed.

(1) Temporary absence from the State, with subsequent returns to the State, or intent to return when the purposes of the absence have been accomplished, does not interrupt continuity of Oklahoma residence.

(2) Oklahoma residence does not include transients or visitors passing through the state but does not preclude persons who do not have a fixed address if intent is established.

(3) Intent to remain or return is defined as a clear statement of plans to remain or return in addition to other evidence and/or corroborative statements of others.

(4) When a non-resident makes application for SoonerCare benefits, the local office provides services necessary to make available to the applicant any SoonerCare services for which he/she might be eligible from his/her state of residence. The local office contacts the state or county of the applicant's residence to explore possible eligibility for medical benefits from the state and to obtain information needed for the determination of medical eligibility for the services received while in Oklahoma.

(5) If a member's whereabouts are unknown, as indicated by the return of unforwardable agency mail, refer to OAC 317:35-5-67.

(b) **Individuals residing in institutions (correctional facilities and institutions for mental disease).** The SoonerCare program will only pay for services rendered to adults (21 through 64 years of age) who are inpatients in an institution for mental disease (IMD), juveniles in the custody of the Office of Juvenile Affairs who are inmates in a state-owned and operated facility, or inmates in a correctional facility, when these individuals are admitted as an inpatient to a hospital, nursing facility, juvenile psychiatric facility or an intermediate care facility for the mentally retarded and meet all other eligibility requirements.

(c) **Homeless individuals.** Individuals are not required to have a

fixed address in order to be eligible for assistance. Individuals who lack a fixed or regular residence, who have temporary accommodations, i.e., supervised shelters, residence of other individuals, a hallway, bus station, car or other similar places, are considered as "homeless".

(d) **Individuals residing in IHS, BIA or Tribal controlled dormitories.** Individuals that reside in a facility which provides students boarding and lodging on a temporary residential basis for the purpose of attending a Bureau-operated or Indian-controlled contract or public school are considered Oklahoma residents for SoonerCare eligibility purposes.

PART 7. APPLICATION AND ELIGIBILITY DETERMINATION PROCEDURES

317:35-5-67. Returned mail

If the member's whereabouts are unknown, as indicated by the return of unforwardable agency mail directed to the member, and the Oklahoma Health Care Authority has made reasonable attempts to verify the member's current address, the member's eligibility will be discontinued. Notice thereof will be sent to the member by mail and by electronic notice. If the member's whereabouts become known within the eligibility period, eligibility shall be reinstated in accordance with Section 431.231(d) of Title 42 of the Code of Federal Regulations. If the member's whereabouts become known after the eligibility period, a new application will be required.

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 24. CERTIFIED COMMUNITY BEHAVIORAL HEALTH CLINICS

317:30-5-263. Definitions

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

"Advanced practice registered nurse (APRN)" means a registered nurse in good standing with the board of nursing in the state in which services are provided, who has completed an accredited graduate level advanced practice registered nursing education program approved by the board of nursing in the state in which services are provided, and possesses a current national certification by a national certifying body recognized by the board of nursing in the state in which services are provided. APRN services are limited to the scope of their practice as defined in Title 59 of the Oklahoma Statutes (O.S.) § 567.3a and corresponding rules and regulations at Oklahoma Administrative Code (OAC) 485:10-5-1 through 485:10-16-9.

"Behavioral health rehabilitation (BHR) services" means goal-oriented outpatient interventions that target the maximum reduction of mental and/or behavioral health impairments and strive to restore the members to their best possible mental and/or behavioral health functioning.

"Centers for Medicare and Medicaid Services (CMS)" means the federal agency within the United States Department of Health and Human Services (HHS) that administers the Medicare program and works in partnership with state governments to administer Medicaid.

"Certified alcohol and drug counselor (CADC)" means an individual with an Oklahoma certification as an alcohol and drug counselor.

"Certified behavioral health case manager (CM)" means an individual who is certified by the ODMHSAS as a behavioral health case manager pursuant to OAC, Title 450, Chapter 50. Refer to OAC 317:30-5-240.3(h).

"Certified community behavioral health clinics (CCBHC)" means a service delivery model designed to provide a comprehensive range of mental health and/or substance abuse rehabilitative services. Services are furnished by an interdisciplinary and mobile mental health team that functions interchangeably.

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

"Facility-based crisis stabilization (FBCS)" means emergency psychiatric and substance abuse services aimed at resolving crisis situations. The services provided are emergency stabilization, which includes a protected environment, chemotherapy, detoxification, individual and group treatment, and medical

assessment.

"Family support and training provider (FSP)" means an individual who provides a system of care that is child-centered with the needs of the child and family dictating the types and mix of services provided, to assist in keeping the family together and preventing an out-of-home placement. FSP providers must:

(A) Have a high school diploma or equivalent;

(B) Be twenty-one (21) years of age and have a successful experience as a family member of a child or youth with serious emotional disturbance, or have lived experience as the primary caregiver of a child or youth 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 with Child Welfare/Child Protective Services involvement;

(C) Successfully complete family support training according to a curriculum approved by the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) and pass the examination with a score of eighty percent (80%) or better;

(D) Pass Oklahoma State Bureau of Investigation (OSBI) background check;

(E) Have treatment plans be overseen and approved by a licensed behavioral health professional (LBHP) or licensure candidate; and

(F) 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.

"Illness/wellness management and recovery (IMR/WMR)" means evidence-based practice models designed to help people who have experienced psychiatric symptoms. Elements include: developing personalized strategies for managing their mental illness and moving forward with their lives; setting and pursuing personal goals; learning information and skills to develop a sense of mastery over their psychiatric illness; and helping clients put strategies into action in their everyday lives.

"Institution for mental disease (IMD)" means a hospital, nursing facility, or other institution of more than sixteen (16) beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services, as defined by 42 C.F.R. § 435.1010.

"Intermediate care facility for individuals with intellectual disabilities (ICF/IID)" means a facility which primarily provides health-related care and services above the level of custodial care to intellectually disabled individuals but does not provide the level of care available in a hospital or skilled nursing facility.

"Licensed behavioral health professional (LBHP)" means any of the following practitioners:

(A) 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 medical resident in psychiatry;

(B) A practitioner with a current license to practice in the state in which services are provided, within one (1) of the following areas of practice:

(i) Psychology;

(ii) Social work (clinical specialty only);

(iii) Professional counselor;

(iv) Marriage and family therapist;

(v) Behavioral practitioner; or

(vi) Alcohol and drug counselor.

(C) An APRN, certified in a psychiatric mental health specialty, and licensed as a registered nurse with a current certification of recognition from the board of nursing in the state in which services are provided; or

(D) A physician assistant (PA) with a current license to practice 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.

"Licensure candidate" means a practitioner who is actively and regularly receiving board approved supervision, and extended supervision by a fully licensed clinician if the board's supervision requirement is met but the individual is not yet licensed, to become licensed in a specific area of practice as outlined in (B)(i) through (vi) above. The supervising LBHP responsible for the member's care must:

(A) Staff the member's case with the candidate;

(B) Be personally available, or ensure the availability of an LBHP to the candidate for consultation while they are providing services;

(C) Agree with the current plan for the member;

(D) Confirm that the service provided by the candidate was appropriate; and

(E) Show that the member's medical record meet the requirements for reimbursement 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.

"OAC" means Oklahoma Administrative Code, the publication authorized by Section 256 of Title 75 of the Oklahoma Statutes known as The Oklahoma Administrative Code, or, prior to its publication, the compilation of codified rules authorized by 75 O.S. § 256(A)(1)(a) and maintained in the Office of Administrative Rules.

"ODMHSAS" means the Oklahoma Department of Mental Health and Substance Abuse Services.

"OHCA" means the Oklahoma Health Care Authority.

"O.S." means Oklahoma Statutes.

"Peer recovery support specialist (PRSS)" means an individual certified by ODMHSAS as a peer recovery support specialist pursuant to requirements found in OAC 450:53.

"Program of All-Inclusive Care for the Elderly (PACE)" means a home and community based acute and long-term care services program for eligible individuals who meet the medical requirements for nursing facility care and can be served safely and appropriately in the community.

"Psychiatric residential treatment facility (PRTF)" means a non-hospital facility contracted with the OHCA to provide inpatient psychiatric services to SoonerCare-eligible members under the age of twenty-one (21), as defined by 42 C.F.R. § 483.352.

"Psychosocial rehabilitation services (PSR)" means face-to-face Behavioral Health Rehabilitation services which are necessary to improve the member's ability to function in the community. They are performed to improve the skills and abilities of members to live independently in the community, improve self-care and social skills, and promote lifestyle change and recovery practices.

"Qualified behavioral health aide (QBHA)" means a behavioral health aide who must meet requirements described in OAC 317:30-5-240.3.

"Registered nurse (RN)" means an individual who is a graduate of an approved school of nursing and is appropriately licensed in the state in which he or she practices.

"Serious emotional disturbance (SED)" means a condition experienced by persons from birth to eighteen (18) who have a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria outlined in OAC 317:30-5-240.1.

"Serious mental illness (SMI)" means a condition experienced by persons age eighteen (18) and over that have a diagnosable mental, behavior, or emotional disorder that causes serious functional impairment that substantially interferes with or limits one or more major life activities. Specific diagnostic criteria is outlined in OAC 317:30-5-240.1.

"System of care values" means a philosophy, which embraces a family-driven, child-centered model of care that integrates and coordinates the efforts of different agencies and providers to individualize care in the least restrictive setting that is clinically appropriate.

"Wellness recovery action plans (WRAP)" means a self- management and recovery system designed to:

(A) Decrease intrusive or troubling feelings and behaviors;

(B) Increase personal empowerment;

(C) Improve quality of life; and

(D) Assist people in achieving their own life goals and dreams.

"Wraparound approach" means a team-based planning and implementation process to improve the lives of children with complex needs and their families by developing individualized plans

of care. The key characteristics of the process are that the plan is developed by a family centered team, is individualized based on the strengths and culture of the child and his or her family, and is driven by needs rather than services.

317:30-5-264. Purpose

Certified community behavioral health clinic is a service delivery model designed to provide a comprehensive range of mental health and substance use disorder services. Services are furnished by an interdisciplinary and mobile mental health team that functions interchangeably to provide the rehabilitation and treatment designed to enable the member to live successfully in the community.

317:30-5-265. Eligible providers

(a) **Agency requirements.** CCBHCs are responsible for providing services to qualifying individuals within the provider's specified service area. Qualifying providers must:

(1) Be certified by the ODMHSAS as a community mental health center under OAC 450:17 and have provider specific credentials from ODMHSAS for CCBHCs (OAC 450:17-5-170 et seq.);

(2) Be under the direction of a licensed physician;

(3) Provide mobile crisis care twenty-four (24) hours, seven (7) days a week and have a twenty-four (24) hours, seven (7) days a week walk-in crisis clinic or a psychiatric urgent care, or have an agreement in place with a State-sanctioned alternative;

(4) Actively use an Office of National Coordinator (ONC) certified Electronic Health Record (EHR) as demonstrated on the ONC Certified Health IT Product List;

(5) Have a contract with a Health Information Exchange (HIE) and demonstrate staff use of obtaining and sending data through the HIE as well as policy stating frequency of use and security protocols; and

(6) Report on encounter, clinical outcomes, and quality improvement. This includes meeting all federal and State specifications of the required CMS quality measure reporting, as well as performance improvement reports outlining activities taken to improve outcomes.

(b) **Interdisciplinary team.** CCBHCs will utilize an interdisciplinary team of professionals and paraprofessionals to identify an individual's strengths and needs, create a unified plan to empower a person toward self-management, and coordinate the individual's varied healthcare needs. CCBHC teams will vary in size depending on the size of the member panel and acuity of the member. The treatment team includes the member, the family/caregiver of child members, the adult member's family to the extent the member does not object, and any other person the member chooses. Each CCBHC shall maintain a core staff comprised of employed and, if needed, contracted staff, as appropriate to the needs of the member as stated in the member's individual service plan.

(1) Teams shall at a minimum, include the following positions:

(A) Licensed psychiatrist;
(B) Licensed nurse care manager (RN or licensed practical nurse);
(C) Consulting primary care physician, APRN, or physician assistant (PA);
(D) At least one (1) LBHP and may include additional LBHPs and licensure candidates (see OAC 317:30-5-263);
(E) Peer recovery support specialist (see OAC 317:30-5-263);
(F) Family support provider for child members (see OAC 317:30-5-263);
(G) Certified behavioral health case manager II or certified alcohol and drug counselor (see OAC 317:30-5-263); and
(H) Qualified behavioral health aide.

(2) Optional team members may include the following:
(A) Certified behavioral health case manager I (see OAC 317:30-5-263);
(B) Licensed nutritionist;
(C) Occupational therapist; and/or
(D) Occupational therapist assistant under the supervision of a licensed occupational therapist.

317:30-5-266. Covered services

CCBHCs provide a comprehensive array of services that create access, stabilize people in crisis, and provide the needed treatment and recovery support services for those with the most serious and complex mental health and substance use disorders. CCBHCs integrate additional services to ensure an approach to health care that emphasizes recovery, wellness, trauma-informed care, and physical-behavioral health integration. Initial screening, assessment, and diagnosis must be completed in order to receive a covered service. Services must be medically necessary and recommended by an LBHP or licensure candidate (see OAC 317:30-5-263). Services are covered when provided in accordance with a person-centered and family-centered service plan. Coverage includes the following services:

(1) **Crisis assessment and intervention services.**
(A) **Service requirements.** This service is an immediately available service designed to meet the psychological, physiological, and environmental needs of individuals who are experiencing mental health and/or substance use disorder crises. Services include the following:
(i) Twenty-four (24) hours mobile crisis teams [see OAC 317:30-5-241.4(a) for service definition]. Reimbursement is triggered by the LBHP/licensure candidate crisis assessment;
(ii) Emergency crisis intervention service [see OAC 317:30-5-241.4(a) for service definition]; and
(iii) Facility-based crisis stabilization [see OAC 317:30-5-241.4(b) for service definition], provided directly by the CCBHC or by a State-sanctioned alternative.

(B) **Qualified professionals.** Twenty-four (24) hours mobile crisis intervention is provided by either a team consisting of an LBHP/licensure candidate and a CM II or CADC, or just an LBHP/licensure candidate. Emergency crisis intervention is provided by an LBHP/licensure candidate. Facility-based crisis stabilization is provided by a team, directed by a physician, and consisting of an LBHP/licensure candidate, licensed nurses, CM II or CADC, and PRSS staff.

(2) **Behavorial health integrated (BHI) services.**

(A) **Service requirements.** This service includes activities provided that have the purpose of coordinating and managing the care and services furnished to each member, assuring a fixed point of responsibility for providing treatment, rehabilitation, and support services. This service includes, but is not limited to:

(i) Care coordination for primary health care, specialty health care, and transitional care from emergency departments, hospitals, and PRTFs;

(ii) Ensuring integration and compatibility of mental health and physical health activities;

(iii) Providing on-going service coordination and linking members to resources;

(iv) Tracking completion of mental and physical health goals in member's comprehensive care plan;

(v) Coordinating with all team members to ensure all objectives of the comprehensive care plan are progressing;

(vi) Appointment scheduling;

(vii) Conducting referrals and follow-up monitoring;

(viii) Participating in hospital discharge processes; and

(ix) Communicating with other providers and members/family.

(B) **Qualified professionals.** This service is performed by an LBHP/licensure candidate, nurse, CM II or CADC, and/or PRSS staff.

(3) **Person-centered and family-centered treatment planning.**

(A) **Service requirements.** This service is a process in which the information obtained in the initial screenings and assessments are used to develop a treatment plan that has individualized goals, objectives, activities, and services that will enable the member to improve. For children assessed as SED with significant behavioral needs, treatment planning is a wraparound process consistent with System of Care values. A wraparound planning process supports children and youth in returning to or remaining in the community.

(B) **Qualified professionals.** This service is conducted by LBHPs/licensure candidates, nurses, CM II or CADC, and/or PRSS staff. Treatment planning must include the member and involved practitioners.

(4) **Psychotherapy (individual / group / family).**

(A) **Service requirements.** See OAC 317:30-5-241.2 for service

definitions and requirements. Fee-for-service billing limitations do not apply.

(B) **Qualified professionals.** This service is conducted by an LBHP/licensure candidate.

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

(A) **Service requirements.** This service includes:

(i) A review and educational session focused on the member's response to medication and compliance with the medication regimen and/or medication administration;

(ii) Prescription administration and ordering of medication by appropriate medical staff;

(iii) Assisting the member in accessing medications;

(iv) Monitoring medication response and side effects; and

(v) Assisting members with developing the ability to take medications with greater independence.

(B) **Qualified professionals.** This service is performed by an RN, APRN, or a physician assistant (PA) as a direct service under the supervision of a physician.

(6) **Psychosocial rehabilitation services (PSR).**

(A) **Service requirements.** PSR services are face-to-face behavioral health rehabilitation (BHR) services which are necessary to improve the member's ability to function in the community. They are performed to improve the skills and abilities of members to live independently in the community, improve self-care and social skills, and promote lifestyle change and recovery practices. Rehabilitation services may be provided individually or in group sessions through the format of curriculum-based education and skills training. This service is generally performed with only the member and the qualified provider, but may include a member and the member's family/support system when providing educational services from a curriculum that focuses on the member's diagnosis, symptom management, and recovery. A member who, at the time of service, is not able to cognitively benefit from the treatment due to active hallucinations, substance abuse, or other impairments, is not suitable for this service. Family involvement is allowed for support of the member and education regarding his/her recovery but does not constitute family therapy, which requires a licensed provider. Eligibility requirements and billing limits found in OAC 317:30-5-241.3 do not apply.

(B) **Qualified professionals.** This service is solely restorative in nature and may be performed by a behavioral health CM II, CADC, LBHP, or licensure candidate, following development of a service plan and treatment curriculum approved by an LBHP or licensure candidate. The behavioral health CM II and CADC must have immediate access to an LBHP who can provide clinical oversight and collaborate with the qualified PSR provider in the provision of services.

(7) **Psychoeducation and counseling.**

(A) **Service requirements.** This service is designed to restore, rehabilitate, and support the individual's overall health and wellness. Services are intended for members to provide purposeful and ongoing psychoeducation and counseling that are specified in the individual's person-centered, individualized plan of care. Components include:

(i) Delivery of manualized wellness management interventions via group and individual work such as WRAP or IMR/WMR; and

(ii) Emotional support, education, resources during periods of crisis, and problem-solving skills.

(B) **Qualified professionals.** This service is provided by a licensed nurse, licensed nutritionist, or CM II or CADC within the scope of their licensure, certification, and/or training.

(8) **Peer recovery support services.**

(A) **Service requirements.** See OAC 317:30-5-241.5(d) for service requirements.

(B) **Qualified professionals.** PRSS must be certified through ODMHSAS pursuant to OAC 450:53.

(9) **Family support and training.**

(A) **Service requirements.** See OAC 317:30-5-241.5(c) for service requirements.

(B) **Qualified professionals.** Family support providers must be trained/credentialed through ODMHSAS.

(10) **Screening, assessment, and service planning.**

(A) **Service requirements.** See OAC 317:30-5-241.1 for service requirements. Service billing limitations found in OAC 317:30-5-241.1 do not apply.

(B) **Qualified professionals.** Screenings can be performed by any qualified team member as listed in OAC 317:30-5-265(b). Assessment and service planning can only be performed by an LBHP or licensure candidate.

(11) **Occupational therapy.**

(A) **Service requirements.** This service includes the therapeutic use of everyday life activities (occupations) with an individual or groups for the purpose of participation in roles and situations in home, school, workplace, community, and other settings for the purpose of promoting health and wellness. Occupational therapy services are provided to those who have developed an illness, injury, disease, disorder, condition, impairment, disability, activity limitation, or participation restrictions. Occupational therapy addresses the physical, cognitive, psychosocial, sensory, and other aspects of performance in a variety of contexts to support engagement in everyday life activities that affect health, well-being, and quality of life.

(B) **Qualified professionals.** This service is solely restorative in nature and provided by a qualified

occupational therapist who is contracted with the OHCA or an occupational therapist assistant who is working under the supervision of a licensed occupational therapist (see OAC 317:30-5-295).

(C) **Coverage limitations.** In order to be eligible for SoonerCare reimbursement, occupational therapy services must be prior authorized and/or prescribed by a physician or other licensed practitioner of the healing arts, in accordance with State and federal law, including, but not limited to, OAC 317:30-5-296, OAC 317:30-5-1020, and 42 C.F.R. § 440.110.

317:30-5-267. Reimbursement

(a) In order to be eligible for payment, CCBHCs must have an approved provider agreement on file with the OHCA. Through this agreement, the CCBHC assures that OHCA's requirements are met and assures compliance with all applicable federal and state Medicaid law, including, but not limited to, OHCA administrative rules, ODMHSAS administrative rules, the Code of Federal Regulations, and the Oklahoma State Medicaid Plan. These agreements are renewed annually with each provider.

(b) Reimbursement is made using a provider-specific prospective payment system (PPS) rate developed based on provider-specific cost report data. The PPS rate varies by category and level of service intensity and is paid when a CCBH program delivers at least one (1) CCBHC covered service, and when a valid individual procedure code is reported for the calendar month. Care coordination services do not trigger a PPS payment when billed alone in a calendar month. For reimbursement purposes, members are categorized as follows, and are assigned to special populations by the State:

(1) Standard population;

(2) Special population 1. This population includes individuals eighteen (18) years of age and over with SMI and complex needs including those with co-occurring substance use disorder (SUD). Individuals between eighteen (18) and twenty-one (21) years of age can be served in either special population 1 or 2 depending on the member's individualized needs; and

(3) Special population 2. This population includes children and youth [ages six (6) through twenty-one (21)] with SED and complex needs, including those with co-occurring mental health and SUD.

(c) Payments for services provided to non-established clients will be separately billable. Non-established CCBH clients are those who receive crisis services directly from the CCBHC without receiving a preliminary screening and risk assessment by the CCBHC and those referred to the CCBHC directly from other outpatient behavioral health agencies for pharmacologic management.

(d) Additional reimbursement may be made to the CCBHC once in the same calendar month as the PPS payment for care coordination provided by CCBHC staff to members who are involved in a drug court or other specialty court program. Physician services provided to these members by the CCBHC are reimbursable using the SoonerCare

fee schedule.
(e) Reimbursement rates will be reviewed bi-annually and updated as necessary by the Medicare Economic Index (MEI).

317:30-5-268. Limitations

(a) The following are non-billable opportunities for CCBHCs serving eligible members:
(1) Employment services;
(2) Personal care services;
(3) Childcare
(4) Respite services; and
(5) Care coordination.

(b) The following SoonerCare members are not eligible for CCBHC services:
(1) Members receiving care in an IM);
(2) Members residing in a nursing facility or ICF/IID;
(3) Inmates of a public correctional institution; and
(4) SoonerCare members being served by a PACE provider.

(c) SoonerCare members receiving services from a CCBHC are not eligible for enrollment in a SoonerCare behavioral health home.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 1. ADMINISTRATIVE OPERATIONS

SUBCHAPTER 1. ORGANIZATION AND ADMINISTRATION

317:1-1-4. Organization and meetings

(a) The Authority Board consists of ~~seven (7)~~nine (9) members. Section 5007 of Title 63 of the Oklahoma Statutes (O.S.) provides for their appointment and service.

(b) A chair and a ~~Vice-Chair~~vice-chair shall be elected by a majority of the members of the Board. The terms of office of the ~~Chair and Vice-Chair~~chair and vice-chair shall be one (1) year beginning ~~July~~January 1 of each year. A member elected to serve as ~~Chair or Vice-Chair~~chair or vice-chair may be elected to serve more than one (1) term. Elections will be held at the last regular meeting before ~~July~~January 1. However, in the event the last regular meeting before ~~July~~January 1 shall be canceled for any reason, the election may be held at a specially-scheduled meeting or, if it is not possible to schedule a special meeting, at the next ~~regularily-scheduled~~regularly-scheduled meeting. In the event an election ~~can not~~cannot be conducted prior to ~~July~~January 1 of any year, the ~~Chair and Vice-Chair~~chair and vice-chair who are in office ~~June 30~~December 31 shall continue their terms until an election is held.

(c) The chair will preside over meetings and perform other duties as required by the Authority ~~[65:5008(A)]~~.

(d) A majority of the members of the Board shall constitute a quorum for the transaction of business and for taking any official action. Any action or decision of the Board requires an affirmative vote of at least a majority of the members present ~~[63:5007(D)]~~[63 O.S. § 5007(D)].

(e) All meetings of the Authority Board will be conducted in accordance with the Open ~~Meetings~~Meeting Act, ~~Sections 301 through 314 of Title 25 of the Oklahoma Statutes~~25 O.S. §§ 301 - 314.

317:1-1-6. ~~Cancellation~~Emergency cancellation of meetings

The ~~Chairman~~chair, or the vice-chair in the chair's absence, shall have the power to cancel or reschedule any regular or special meeting of the Authority due to anticipated lack of quorum, inclement weather, or other emergency. Notice ~~of cancellation of said meeting~~thereof shall be ~~posted~~filed with the Secretary of State and publicly posted as soon as reasonably possible ~~and in the same manner as the agenda~~.

317:1-1-7. Minutes of the Authority

A summary shall be made of all proceedings before the Authority which shall show those members present and absent, all matters considered, all actions taken, and the vote of each member on any motion, and shall be made public~~, as prescribed in OAC 317:1-1-10(e)~~on the Authority's website.

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

SUBCHAPTER 3. GENERAL PROVIDER POLICIES

PART 1. GENERAL SCOPE AND ADMINISTRATION

317:30-3-20. Claim inquiry procedures (excluding nursing homes and hospitals)

A medical provider may request a review of ~~the decision of~~ the amount paid or the non-payment of medical services provided to an eligible member. If the medical provider does not agree with the ~~original payment from the Fiscal Agent~~adjudication of the original claim, he/she may submit ~~a written explanation on HCA-17 (Claim Inquiry Form) as to why the adjustment is being requested and what action is to be taken, a copy of the paid remittance statement and/or detailed explanation of the paid information and a copy of the original claim with the corrections to be made for consideration of additional payment. The claim should be submitted in accordance with the instructions in the OHCA Provider Billing and Procedures Manual~~an electronic request for review on the Oklahoma Health Care Authority (OHCA) provider portal in accordance with the instructions in the Provider Billing and Procedures Manual, available on OHCA's website, www.okhca.org. Documentation, including but not limited to, supporting medical documentation and/or proof of timely filing as outlined in Oklahoma Administrative Code (OAC) 317:30-3-11, must be included with each submission.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY

CHAPTER 2. GRIEVANCE PROCEDURES AND PROCESS

317:2-1-2.5. Expedited appeals

(a) An Appellant may request an expedited hearing~~ request may be granted within three (3) working days of the request for hearing~~, if the time otherwise permitted for a hearing as described in ~~OAC~~ Oklahoma Administrative Code (OAC) 317:2-1-2(a)(8) could jeopardize the Appellant's life or health or ability to attain, maintain, or regain maximum function. Any request for expedited consideration should be made to the Administrative Law Judge (ALJ), with a copy to the Oklahoma Health Care Authority (OHCA) Legal division and shall be ruled upon within three (3) working days of the date of the request. The request shall specify the reason for the appeal and the specific basis for the Appellant's assertion that a delay will jeopardize the Appellant's life or health.

(b) If ~~OHCA~~the ALJ determines that ~~the request meets the criteria for~~ an expedited hearing is warranted, ~~it~~he or she shall:

(1) ~~Initiate the hearing process as described in~~Schedule the matter for hearing pursuant to OAC 317:2-1-5~~;~~. Telephonic hearings may be scheduled as appropriate under the particular facts of the case; and

(2) ~~All matters relating to the hearing must be heard and disposed of~~Issue a preliminary or final decision as expeditiously as possible, but no later than three (3) working days after ~~OHCA has received the request for an~~the close of the expedited hearing.

(c) If ~~OHCA~~the ALJ determines that the request does not meet the criteria for ~~an~~ expedited ~~hearing~~consideration, ~~it~~he or she shall:

(1) ~~Initiate the ordinary hearing process~~Schedule the appeal for hearing within the ordinary timeframe, in accordance with OAC 317:2-1-2(a)(8); and

(2) Notify the Appellant of the denial orally or through ~~an electronic~~a written notice as described in OAC 317:35-5-66. If oral notification is provided, ~~OHCA~~the ALJ ~~will follow up with~~shall issue a written ~~notice~~notification within three (3) calendar days of the denial.

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 87. BIRTHING CENTERS

317:30-5-890. Eligible providers [REVOKED]

~~Eligible providers are birthing centers that are currently licensed by the Oklahoma State Health Department and meet the requirements listed in (1)-(5) of this subsection:~~

~~(1) Have a current written agreement with a board certified Obstetrician-Gynecologist (OB-GYN) to provide coverage for consultation, collaboration or referral services as defined by the American College of Nurse-Midwives.~~

~~(2) Have a current medical director who is a board certified OB-GYN and is responsible for establishing patient protocols and other functions as defined in requirements for state licensure. This individual may, or may not, be the physician providing individual patient coverage for consultation, collaborative or referral service.~~

~~(3) Have a written agreement with a referral hospital which is a Class II hospital. Class II hospital is defined as a facility with 24 hour availability of OB-GYN and capability of performing a C-section within 30 minutes of the decision to operate. The 30 minute timeframe is subject to each hospital's unique circumstance, logistical issues that include, but are not limited to, obtaining informed consent, transporting the patient, and any other potential problems that may arise.~~

~~(4) Must be accredited by the Commission for the Accreditation of Freestanding Birth Centers.~~

~~(5) Have a current contract on file with the Oklahoma Health Care Authority.~~

317:30-5-890.1 Definitions [REVOKED]

~~The following words or terms, when used in this Part, shall have the following meaning, unless the context clearly indicates otherwise:~~

~~"**Birthing center**" means a freestanding facility, place or institution, which is maintained or established primarily for the purpose of providing services of a certified midwife or licensed medical doctor to assist or attend a woman in delivery and birth, and where a woman is scheduled in advance to give birth following a normal, uncomplicated, low-risk pregnancy.~~

~~"**Certified Nurse Midwife**" means a person educated in the discipline of nursing and midwifery, certified by the American~~

~~College of Nurse-Midwives (ACNM) and licensed by the state to engage in the practice of midwifery and as a registered nurse.~~

~~**"Low-risk"** means a normal, uncomplicated prenatal course as determined by adequate prenatal care and prospects for a normal, uncomplicated birth as defined by generally accepted criteria of maternal and fetal health.~~

~~**"Newborn"** means an infant during the first 28 days following birth.~~

317:30-5-891. Coverage by category [REVOKED]

~~(a) **Adults.** Payment is made for birthing center services for adults and includes admission to the birthing center of low-risk, uncomplicated pregnancies, with an anticipated spontaneous vaginal delivery for the period of labor and delivery.~~

~~(b) **Newborn.** Coverage for newborns within scope of practice as defined by state law.~~

~~(c) **Individuals eligible for Part B of Medicare.** Birthing center services provided to Medicare eligible recipients should be billed directly to the fiscal agent.~~

317:30-5-892. Reimbursement [REVOKED]

~~(a) Payment rates are based on a geographic adjustment made for centers in rural and urban areas. A birthing center will be designated as an urban or rural entity based on the definition of urban and rural counties used by the Medicare program for reimbursement purposes. The urban areas (counties) are those inside the Metropolitan Statistical Areas (MSA) and the rural areas (counties) are those outside the MSA.~~

~~(1) Urban areas:~~

~~(A) Canadian~~
~~(B) Cleveland~~
~~(C) Comanche~~
~~(D) Creek~~
~~(E) Garfield~~
~~(F) Logan~~
~~(G) McClain~~
~~(H) Oklahoma~~
~~(I) Osage~~
~~(J) Pottawatomie~~
~~(K) Rogers~~
~~(L) Sequoyah~~
~~(M) Tulsa~~
~~(N) Wagoner~~

~~(2) Rural areas:~~

~~(A) Adair~~
~~(B) Alfalfa~~
~~(C) Atoka~~

~~(D) Beaver~~
~~(E) Beckham~~
~~(F) Blaine~~
~~(G) Bryan~~
~~(H) Caddo~~
~~(I) Carter~~
~~(J) Cherokee~~
~~(K) Choctaw~~
~~(L) Cimarron~~
~~(M) Coal~~
~~(N) Cotton~~
~~(O) Craig~~
~~(P) Custer~~
~~(Q) Delaware~~
~~(R) Dewey~~
~~(S) Ellis~~
~~(T) Garvin~~
~~(U) Grady~~
~~(V) Grant~~
~~(W) Greer~~
~~(X) Harmon~~
~~(Y) Harper~~
~~(Z) Haskell~~
~~(AA) Hughes~~
~~(BB) Jackson~~
~~(CC) Jefferson~~
~~(DD) Johnston~~
~~(EE) Kay~~
~~(FF) Kingfisher~~
~~(GG) Kiowa~~
~~(HH) Latimer~~
~~(II) Leflore~~
~~(JJ) Lincoln~~
~~(KK) Love~~
~~(LL) McCurtain~~
~~(MM) McIntosh~~
~~(NN) Major~~
~~(OO) Marshall~~
~~(PP) Mayes~~
~~(QQ) Murray~~
~~(RR) Muskogee~~
~~(SS) Noble~~
~~(TT) Nowata~~
~~(UU) Okfuskee~~
~~(VV) Okmulgee~~
~~(WW) Ottawa~~
~~(XX) Pawnee~~

~~(YY) Payne~~
~~(ZZ) Pittsburg~~
~~(AAA) Pontotoc~~
~~(BBB) Pushmataha~~
~~(CCC) Roger Mills~~
~~(DDD) Seminole~~
~~(EEE) Stephens~~
~~(FFF) Texas~~
~~(GGG) Tillman~~
~~(HHH) Washington~~
~~(III) Washita~~
~~(JJJ) Woods~~
~~(KKK) Woodward~~

~~(b) Payment to a birthing center on behalf of a Medicaid client is an all-inclusive facility payment and represents payment in full for the birthing center services. Separate payment will be made for the midwife or physician obstetrical care, delivery and postpartum care as appropriate.~~

~~(1) Urban Birthing Center: Unit 1, Limit 1 each 9 months.~~
~~(2) Rural Birthing Center: Unit 1, Limit 1 each 9 months.~~

317:30-5-893. Billing [REVOKED]

~~Billing for birthing center services will be on HCFA-1500. Claims must be submitted in accordance with guidelines found at OAC 317:30-3-11 and 317:30-3-11.1.~~

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 97. TARGETED CASE MANAGEMENT SERVICES FOR MEMBERS UNDER ~~AGE 18~~TWENTY-ONE YEARS OF AGE AT RISK OF INVOLVEMENT WITH OR IN THE TEMPORARY CUSTODY OR SUPERVISION OF THE OKLAHOMA OFFICE OF JUVENILE AFFAIRS (OJA)

317:30-5-970. Eligible providers

~~(a) **Case management agencies.** Services are provided by case management agencies established for the purpose of providing case management services. Medicaid Office of Juvenile Affairs Targeted Case Management (OJATCM) services must be made available to all eligible recipients and must be delivered by provider agencies on a statewide basis with procedures that assure 24 hour availability, the protection and safety of recipients, continuity of services without duplication, and compliance with federal and State mandates and regulations related to servicing the targeted population are met in a uniform and consistent manner. The agency must demonstrate that their staff has:~~

~~(1) experience working with the target population.~~
~~(2) a minimum of five years experience in providing all core elements of case management services including:~~
~~(A) individualized strengths and needs assessment;~~
~~(B) needs-based service planning;~~
~~(C) service coordination and monitoring; and~~
~~(D) on-going assessment and treatment plan revision.~~
~~(3) adequate administrative capacity to fulfill State and federal requirements.~~
~~(4) a financial management capacity and system that provides documentation of services and costs.~~
~~(5) a capacity to document and maintain individual case records in accordance with State and federal requirements.~~
~~(6) ability to meet all State and federal laws governing the participation of providers in the State Medicaid program including, but not limited to, the ability to meet federal and State requirements for documentation, billing and audits.~~
~~(7) statutory authority to care for, supervise and provide services to the targeted population on a statewide basis.~~
~~(8) a minimum of five years experience in providing case management services that coordinate and link the community resources required by the target population.~~
~~(9) a minimum of five years experience in meeting the case management and service needs of the target population, including the statewide contract management/oversight and administration of services funded through the Oklahoma Children's Initiative.~~
~~(10) responsibility for planning and coordinating statewide~~

~~juvenile justice and delinquency prevention services in accordance with Title 10, Section 7302-3.1A. of Oklahoma Statutes.~~

~~(b) **Provider agreement.** A Provider Agreement between the Oklahoma Health Care Authority and the provider agency for OJATCM services must be in effect before reimbursement can be made for compensable services.~~

~~(c) **Qualifications of individual case managers.** A targeted case manager for the OJATCM program must:~~

~~(1) be employed by the provider agency or its contractor.~~

~~(2) posses a minimum of a bachelor's degree is a behavioral science or a bachelor's degree and one year of professional experience in juvenile justice or a related field.~~

~~(3) possess knowledge of laws, rules, regulations, legislation, policies and procedures as they pertain to:~~

~~(A) the State administration of juvenile justice and the investigation of juvenile delinquency;~~

~~(B) community resources;~~

~~(C) human developmental stages and related dysfunctions;~~

~~(D) social work theory and practices;~~

~~(E) emotional, physical and mental needs of children and families;~~

~~(F) sensitivity to cultural diversity; and~~

~~(G) clinical and counseling techniques and treatment of juvenile delinquency.~~

~~(4) possess skill in:~~

~~(A) crisis intervention;~~

~~(B) gathering necessary information to determine the needs of the child;~~

~~(C) casework management;~~

~~(D) courtroom testimony, terminology and procedures;~~

~~(E) effective communication;~~

~~(F) developing, evaluating and modifying an intervention plan on an ongoing basis;~~

~~(G) establishing and maintaining constructive relationships with children and their families;~~

~~(H) helping families become and maintain as functional family units; and~~

~~(I) working with courts and law enforcement entities.~~

~~(d) **Provider selection.** Provision of case management services must not restrict an individual's free choice of providers. Eligible recipients must have free choice of providers of case management as well as providers of other medical care under the plan.~~

(a) **Case management agency qualifications**. As the provider agency, the Oklahoma Office of Juvenile Affairs (OJA) must meet applicable state and federal laws governing the participation of providers in the Medicaid program. The Office of Juvenile Affairs Targeted Case Management (OJATCM) program must:

(1) Be available to all eligible members;

(2) Be delivered on a statewide basis with procedures that assure twenty-four (24) hour availability, the protection and safety of recipients, and continuity of services without duplication;
(3) Ensure compliance with federal and state mandates and regulations related to serving the targeted population are met in a consistent and uniform manner;
(4) Meet applicable state and federal laws governing the participation of providers in the Medicaid program, including, but not limited to, the ability to meet federal and state requirements for documentation billing and audits;
(5) Demonstrate that its staff has experience working with the target population and a minimum of five (5) years' experience in providing all core elements of case management including:
(A) Individual strengths and needs assessment;
(B) Needs-based service planning;
(C) Service coordination and monitoring; and
(D) Ongoing assessment and treatment plan revision.
(6) Have adequate administrative capacity to fulfill state and federal requirements;
(7) Have financial management capacity and systems that provide documentation of services and costs in accordance with Generally Accepted Government Auditing Standards (GAGAS);
(8) Have the capacity to document and maintain individual case records in accordance with state and federal requirements;
(9) Have a minimum of five (5) years' experience in providing and meeting the case management and service needs of the target population;
(10) Have responsibility for planning and coordinating statewide juvenile justice and delinquency prevention services in accordance with Title 10A of the Oklahoma Statutes (O.S.), Section (§) 2-2-102; and
(11) Have the ability to evaluate the effectiveness, accessibility, and quality of targeted case management (TCM) services on a community-wide basis.

(b) Interagency agreement. An agreement between the Oklahoma Health Care Authority (OHCA) and OJA for TCM services must be in effect before Medicaid reimbursement can be made for compensable services.

(c) Case manager qualifications. A targeted case manager for the OJATCM program must:
(1) Be employed by OJA;
(2) Possess a minimum of a bachelor's degree in a behavioral science, or a bachelor's degree and one (1) year of professional experience in juvenile justice or a related field;
(3) Possess knowledge of:
(A) Laws, regulations, legislation, policies, and procedures as they pertain to the State's administration of juvenile justice and the investigation of juvenile delinquency;
(B) Community resources;
(C) Human developmental stages, developmental disorders, and

social work theory and practices;
(D) Adverse childhood experiences and the impact of trauma on the developing brain;
(E) The risk and protective factors of child delinquency;
(F) Solution-focused practices and the critical role protective factors play in intervention planning;
(G) Sensitivity of cultural diversity; and
(H) Clinical and counseling techniques and treatment of juvenile delinquency;
(4) Possess skills in:
(A) Crisis intervention;
(B) Gathering necessary information to determine the needs of the child;
(C) Casework management;
(D) Courtroom testimony, terminology, and procedures;
(E) Effective communication;
(F) Developing, evaluating, and modifying, as appropriate, intervention planning on an ongoing basis;
(G) Establishing and maintaining supportive relationships with children and their families;
(H) Assisting children and families to access needed resources and supports; and
(I) Working with courts and law enforcement entities; and
(5) Have the ability to access multi-disciplinary staff, when needed. This includes, at a minimum, medical professionals and a child protective services social worker.

317:30-5-971. Coverage by category

~~Payment is made for case management service as set forth in this Section.~~

~~(1) **Adults.** There is no coverage for adults.~~

~~(2) **Children.** Payment is made for services to persons under age 18 as follows:~~

~~(A) **Description of case management services.** The target group for case management services are persons under age 18 who are in temporary custody or supervision of the Office of Juvenile Affairs (OJA), who are placed in own home or out-of-home care or Medicaid eligible recipients under age 18 whose behavior places them at risk of coming into the custody or supervision of OJA.~~

~~(i) Services are provided to assist a client in gaining access to needed medical, social, educational and other services. Major components of the services include working with the client in gaining access to appropriate community resources. The case manager may also provide referral, linkage and advocacy. Case management is designed to assist individuals in accessing services. The client has the right to refuse case management and cannot be restricted from services because of a refusal for Case Management Services.~~

~~(ii) Case management does not include:~~

~~(I) Physically escorting or transporting a client to scheduled appointments or staying with the client during an appointment;~~

~~(II) Monitoring financial goals;~~

~~(III) Providing specific services such as shopping or paying bills; or~~

~~(IV) Delivering bus tickets, food stamps, money, etc.~~

~~(B) **Non-Duplication of services.** To the extent any eligible recipients in the identified target population are receiving OJATCM services from another provider agency as a result of being members of other covered target groups, the provider agency assures that case management activities are coordinated to avoid unnecessary duplication of service.~~

~~(C) **Providers.** Case management services must be provided by case management agencies.~~

~~(3) **Individuals eligible for Part B of Medicare.** Case Management Services provided to Medicare eligible recipients are filed directly with the fiscal agent.~~

The target group includes individuals under twenty-one (21) years of age involved in, or at serious risk of involvement with, the juvenile justice system, as provided in Article II of the Oklahoma Juvenile Code. The target group includes individuals, under twenty-one (21) years of age, who have been temporarily placed in OJA custody or supervision or who are voluntarily supervised by OJA to prevent further involvement with the juvenile justice system. The target group may include individuals, under twenty-one (21) years of age, who are assessed as at risk of abuse or neglect as defined in Title 10A of the Oklahoma Statutes (O.S.), Section (§) 1-1-105. The target group does not include those who are involuntarily in secure custody of law enforcement or judicial systems, except individuals who meet Medicaid criteria for inpatient care as defined in § 435.1010 of Title 42 of the Code of Federal Regulations.

(1) **Adults.** There is no coverage for adults age twenty-one (21) and older.

(2) **Children.** Payment is made for services to members under the age twenty-one (21).

317:30-5-971.1 Description of targeted case management (TCM) services.

(a) **Definition.** In accordance with Section (§) 440.169(b) of Title 42 of the Code of Federal Regulations (C.F.R.), TCM services are defined as services furnished to assist individuals, eligible under the Oklahoma Medicaid State Plan, in gaining access to needed medical, social, educational, and other services. TCM includes providing services that are directly related to identifying the individual's needs and care, for the purposes of helping the individual access services; identifying needs and supports to

assist the individual in obtaining services; providing case managers with useful feedback, and alerting case managers to changes in the individual's needs [42 C.F.R. 440.169(e)]. TCM includes the following assistance:

(1) Comprehensive assessment and periodic reassessment of an individual's needs, to determine the need for any medical, educational, social, or other services.

(A) All members are assessed using comprehensive, evidence-based, risk/needs assessment tools at the beginning of case assignment.

(B) Comprehensive, evidence-based, risk/needs assessment tools are used to measure multiple areas or domains in the lives of the members and then linking that information to case planning.

(C) Any area showing a moderate to high-risk/need/strength score could result in additional goals and action steps documented within the individualized treatment plan.

(D) In addition to the initial assessment, each member is assessed, at least once every six (6) months. Assessment activities include:

(i) Taking member history;

(ii) Identifying and documenting the member's needs; and

(iii) Gathering information from family members, medical providers, social workers, educators (if necessary), and other applicable sources to form a complete assessment of the member.

(E) Should behavior shifts or life-changing events occur prior to six (6) months, the member is reassessed and the individualized treatment service plan is adjusted to reflect identified needs. Any needed changes in services, service providers, treatment type, frequency, or duration may be adjusted at this time.

(2) Development (and periodic revision) of a specific individualized treatment service plan is based on the information collected through the assessment that:

(A) Specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;

(B) Includes activities such as ensuring the active participation of the individual, and working with his or her authorized health care decision maker and others to develop those goals; and

(C) Identifies a course of action to respond to the assessed needs of the individual.

(3) Referral and related activities (such as scheduling appointments for the member) to help the individual obtain needed services, including activities that help link the member with medical, social, educational providers, or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the

treatment service plan.

(4) Monitoring and follow-up activities necessary to ensure the individualized treatment service plan is implemented and adequately addresses the individual's needs.

(A) The targeted case manager visits with the child at least once each month, face to face, and/or weekly (via telephone) to review progress as outlined within the individualized treatment service plan. The targeted case manager must visit with the parent or legal guardians monthly. The targeted case manager maintains consistent contact with the service providers to remain up to date on the child's treatment and progress.

(B) The frequency and type of visits may be adjusted or revised to better meet the needs of the child.

(C) Monitoring and follow-up activities may be conducted as frequently as necessary, including at least one (1) annual monitoring, to determine whether the following conditions are met:

(i) Services are being furnished in accordance with the member's treatment service plan;

(ii) Services in the treatment service plan are adequate; and

(iii) Changes in the needs or status of the member are reflected in the treatment service plan. Monitoring and follow-up activities include making necessary adjustments in the treatment service plan and service arrangements with providers.

(b) **Non-covered services.** TCM does not include:

(1) Physically escorting or transporting a member to scheduled appointments or staying with the member during an appointment;

(2) Monitoring financial goals;

(3) Providing specific services such as shopping or paying bills; and/or

(4) Delivering bus tickets, nutritional services, money, etc.

(c) **Non-duplication of services.** Consistent with 42 C.F.R. § 441.18(a)(4), payment for case management or TCM services shall not duplicate payments made to public agencies or private entities under the Oklahoma Medicaid State Plan or other program authorities.

(d) **Individuals eligible for Part B of Medicare.** Case management services provided to Medicare eligible recipients are filed directly with the fiscal agent.

317:30-5-972. Reimbursement

~~Office of Juvenile Affairs Targeted Case Management (OJATCM) services will be reimbursed pursuant to the methodology described in the Oklahoma Title XIX State Plan.~~

(a) Targeted case management (TCM) services will be reimbursed pursuant to the methodology described in the Oklahoma Medicaid

State Plan.
(b) The reimbursement methodology is based upon qualifying costs for the eligible population from the Cost Allocation Plan. The TCM unit rate is a prospective flat rate based on a qualifying TCM contact with the member in the target population or with some other person on behalf of the member during the claim period.

317:30-5-973. Billing

~~Billing for case management services is on Form HCFA-1500. Claims must be submitted in accordance with guidelines found at OAC 317:30-3-11 and 317:30-3-11.1.~~

Billing for case management services must be submitted, ensuring no duplication of services, and in accordance with state and federal requirements, reflective of guidelines found at Oklahoma Administrative Code (OAC) 317:30-3-11, 317:30-3-11.1, and 317:30-3-20.

317:30-5-974. Documentation of records

~~All case management services rendered must be reflected by documentation in the records. All units of Medicaid OJATCM services provided are documented by the case manager on the monthly Record of Contact form.~~

(a) The Oklahoma Office of Juvenile Affairs (OJA) must maintain case records that document for all members receiving targeted case management (TCM) as follows:

(1) The name of the member;
(2) The dates of the case management services;
(3) The name of the OJA as the provider agency (if applicable) and the person providing the case management service;
(4) The nature, content, units of the case management services received, and whether goals specified in the treatment service plan have been achieved;
(5) Whether the member has declined services in the treatment service plan;
(6) The need for, and occurrences of, coordination with other case managers;
(7) A timeline for obtaining needed services; and
(8) A timeline for reevaluation of the plan.

(b) All case management services rendered must be reflected by documentation in the records. All TCM units provided to the member must be documented by the case manager on the electronic case management system designated by OJA.

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 21. OUTPATIENT BEHAVIORAL HEALTH AGENCY SERVICES

317:30-5-240.3. Staff ~~Credentials~~credentials

(a) **Licensed ~~Behavioral Health Professional~~behavioral health professional (LBHPs).** LBHPs are defined as ~~follows~~any of the following practitioners:

(1) ~~Allopathic or Osteopathic Physicians~~ 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) ~~Practitioners~~A practitioner with a current license to practice in the state in which services are provided, ~~issued by one (1) of the licensing boards~~within one (1) of the areas of practice listed in (A) through (F). The exemptions from licensure under 59 O.S. § 1353(4) ~~(Supp. 2000)~~ and (5), 59 O.S. § 1903(C) and (D) ~~(Supp. 2000)~~, 59 O.S. § 1925.3(B) ~~(Supp. 2000)~~ and (C), and 59 O.S. § 1932(C) ~~(Supp. 2000)~~ and (D) do not apply to ~~Outpatient Behavioral Health Services~~outpatient behavioral health services.

(A) Psychology~~,~~;
(B) Social ~~Work~~work (clinical specialty only)~~,~~;
(C) Professional ~~Counselor,~~counselor;
(D) Marriage and ~~Family Therapist,~~family therapist;
(E) Behavioral ~~Practitioner, or~~practitioner; or
(F) Alcohol and ~~Drug Counselor~~drug counselor.

(3) ~~Advanced Practice Nurse (certified in a psychiatric mental health specialty),~~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~~physician assistant who is licensed and in good standing in ~~this~~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~~candidates.** Licensure candidates are practitioners actively and regularly receiving ~~board approved~~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 ~~licensing boards~~areas of practice listed in (2)(A) through (F) above. The supervising LBHP responsible for the

member's care must:

(1) ~~staff~~Staff the member's case with the candidate~~,~~;

(2) ~~be~~Be personally available, or ensure the availability of an LBHP to the licensure candidate for consultation while they are providing services~~,~~;

(3) ~~agree~~Agree with the current plan for the member~~, and~~;

(4) ~~confirm~~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~~alcohol and drug counselors (CADCs).** CADCs are defined as having a current certification as a CADC in the state in which services are provided.

(d) **Multi-~~Systemic Therapy (MST) Providers~~systemic therapy (MST) provider.** ~~Masters~~Master's level therapist who works on a team established by ~~OJA~~the Oklahoma Juvenile Affairs Office (OJA) which may include ~~Bachelor~~bachelor's level staff.

(e) **Peer ~~Recovery Support Specialist~~recovery support specialist (PRSS).** The ~~Peer Recovery Support Specialist~~PRSS must be certified by ODMHSAS pursuant to requirements found in OAC 450:53.

(f) ~~**Family Support and Training Provider (FSP).** FSPs are defined as follows:~~

~~(1) Have a high school diploma or equivalent;~~

~~(2) be 21 years of age and have successful experience as a family member of a child or youth with serious emotional disturbance, or a minimum of 2 years' experience working with children with serious emotional disturbance or be equivalently qualified by education in the human services field or a combination of work experience and education with one year of education substituting for one year of experience (preference is given to parents or care givers of child with SED);~~

~~(3) successful completion of ODMHSAS Family Support Training;~~

~~(4) pass background checks;~~

~~(5) service plans must be overseen and approved by an LBHP or Licensure Candidate; and~~

~~(6) must function under the general direction of an LBHP, or 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.~~**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) **~~Behavioral Health Aide (BHA).~~** ~~BHAs are defined as follows:~~

~~(1) Behavioral Health Aides must have completed 60 hours or equivalent of college credit; or~~

~~(2) may substitute one year of relevant employment and/or responsibility in the care of children with complex emotional needs for up to two years of college experience; and~~

~~(3) must have successfully completed the specialized training and education curriculum provided by the ODMHSAS; and~~

~~(4) must be supervised by a bachelor's level individual with a minimum of two years case management or care coordination experience; and~~

~~(5) service plans must be overseen and approved by an LBHP or Licensure Candidate; and~~

~~(6) must 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.~~**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; 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~~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~~licensure candidate, CADC or have and maintain a current certification as a ~~Case Manager~~case manager II (CM II) or ~~Case Manager~~case manager I (CM I) from ODMHSAS. The requirements for obtaining these certifications are as follows:

(1) ~~Certified Behavioral Health Case Manager II (CM II)~~The CM II must meet the requirements in (A), (B), (C) or (D) below:

(A) Possess a ~~Bachelor's or Master's~~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~~bachelor's or master's degree in education; and complete web-based training for behavioral health case management and behavioral health rehabilitation as specified by ODMHSAS; and complete one (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) ~~Possess a current license as a registered nurse in the State of Oklahoma~~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~~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 ~~US Psychiatric Association (USPRA)~~USPRA must also complete the behavioral health rehabilitation web-based training as specified by ODMHSAS.

(D) Possess a ~~Bachelor's or Master's~~bachelor's or master's degree in any field and proof of active progression toward obtaining a clinical licensure ~~Master's or Doctoral~~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) ~~Certified Behavioral Health Case Manager~~The CM I meets the requirements in either (A) or (B) and (C):

(A) ~~completed 60~~Completed sixty (60) college credit hours; or

(B) ~~has~~Possesses a high school diploma with ~~36~~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~~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) Wraparound ~~Facilitator Case Manager~~facilitator case manager is ~~a~~an LBHP, ~~Licensure Candidate~~licensure candidate or CADC that meets the qualifications for CM II and has the following:

(A) ~~successful~~Successful completion of the ODMHSAS training for wraparound facilitation within six (6) months of employment; and

(B) ~~participate~~Participate in ongoing coaching provided by ODMHSAS and employing agency; and

(C) ~~successfully~~Successfully complete wraparound credentialing process within nine (9) months of beginning process; and

(D) ~~direct~~Direct supervision or immediate access and a minimum of one (1) hour weekly clinical consultation with a ~~Qualified Mental Health Professional~~qualified mental health professional, as required by ODMHSAS.

(4) Intensive ~~Case Manager~~case manager is ~~a~~an LBHP, ~~Licensure Candidate~~licensure candidate, or CADC that meets the provider qualifications of a ~~Case Manager~~CM II and has the following:

(A) A minimum of two (2) years ~~Behavioral Health Case Management~~behavioral health case management experience, crisis diversion experience, and

(B) ~~must~~Must have attended the ODMHSAS six (6) hours ~~Intensive~~intensive case management training.

PART 37. ADVANCED PRACTICE REGISTERED NURSE

317:30-5-375. Eligible providers

~~The Advanced Practice Nurse must be a registered nurse in good standing with the Oklahoma Board of Nursing, and have acquired knowledge and clinical skills through the completion of a formal program of study approved by the Oklahoma Board of Nursing Registration and have obtained professional certification through the appropriate National Board recognized by the Oklahoma Board of Nursing. Advanced Practice Nurse services are limited to the scope of their practice as defined in 59 O.S. 567.3a and corresponding rules and regulations at OAC 485:10-5-1 through 10-16-9. Rules regarding Certified Nurse Midwives are referenced in OAC 317:30-5-225. Advanced Practice Nurses who practice in states other than Oklahoma must be appropriately licensed in the state in which they practice. In addition, all providers must have a current contract on file with the Oklahoma Health Care Authority.~~

(a) The advanced practice registered nurse (APRN) must:

(1) Be licensed and in good standing in the state in which services are provided;

(2) Have completed an accredited graduate level advanced practice registered nursing education program approved by the board of nursing in the state in which services are provided; and

(3) Possess a current national certification by a national certifying body recognized by the board of nursing in the state in which services are provided.

(b) APRN services are limited to the scope of practice defined in 59 O.S. § 567.3a and corresponding administrative rules at Oklahoma Administrative Code (OAC) 485:10-5-1 through 485:10-16-9. Rules regarding certified nurse midwives are referenced in OAC 317:30-5-225. APRNs who practice in states other than Oklahoma must be appropriately licensed in the state in which they practice. In addition, all providers must have a current contract on file with the Oklahoma Health Care Authority.

317:30-5-376. Coverage by category

Payment is made to ~~Advanced Practice Nurse~~advanced practice registered nurses (APRNs) as set forth in this Section.

(1) **Adults.** Payment for adults is made for primary care health services, within the scope of practice of ~~Advanced Practice Nurse~~an APRN and within the scope of the Oklahoma Health Care Authority (OHCA) medical programs.

(2) **Children.** Payment for children is made for primary care health services, within the scope of practice of ~~Advanced Practice Nurse~~an APRN, to ~~children and adolescents under 21~~members under twenty-one (21) years of age, including ~~EPSDT~~Early and Periodic Screening, Diagnostic and Treatment (EPSDT) screening services ~~and within the scope of the Oklahoma Health Care Authority medical programs~~.

(A) Payment is made to eligible providers for ~~Early and Periodic Screening, Diagnosis and Treatment of individuals~~

~~under age 21~~EPSDT services to members under twenty-one (21) years of age. Specific guidelines for the EPSDT program including the periodicity schedule are found in ~~OAC~~Oklahoma Administrative Code (OAC) 317:30-3-65 through ~~317:30-3-65.11~~317:30-3-65.12.

(B) Comprehensive screening examinations are to be performed by a provider qualified under State law to furnish primary health care services.

(3) **Individuals eligible for Part B of Medicare.** Payment is made utilizing the Medicaid allowable for comparable services.

PART 39. SKILLED NURSING SERVICES

317:30-5-390. Home and Community-Based Services ~~Waivers~~waivers for adults with an intellectual disability or certain adults with related conditions

(a) **Introduction to waiver services.** Each Home and Community-Based Services (HCBS) ~~Waiver~~waiver that includes services for adults with an intellectual disability or certain adults with related conditions allows payment for home health care services as defined in the waiver approved by the Centers for Medicare and Medicaid Services.

(1) Home health care services are skilled nursing services provided to a member by a registered nurse (RN) or a licensed practical nurse (LPN) that include:

(A) ~~direct~~Direct nursing care;

(B) ~~assessment~~Assessment and documentation of health changes;

(C) ~~documentation~~Documentation of significant observations;

(D) ~~maintenance~~Maintenance of nursing plans of care;

(E) ~~medication~~Medication administration;

(F) ~~training~~Training of the member's health care needs;

(G) ~~preventive~~Preventive and health care procedures; and

(H) ~~preparing~~Preparing, analyzing, and presenting nursing assessment information regarding the member.

(2) The first ~~36~~thirty-six (36) visits provided by the home health care agency are covered by the Oklahoma Medicaid State Plan.

(b) **Eligible providers.** Skilled nursing services providers must enter into contractual agreements with the Oklahoma Health Care Authority (OHCA) to provide HCBS for adults with an intellectual disability or certain adults with related conditions.

(1) Individual providers must be currently licensed ~~in Oklahoma as a:~~and in good standing in the state in which services are provided as a:

(A) ~~registered nurse~~RN; or

(B) ~~licensed practical nurse~~LPN.

(2) Agency providers must:

(A) ~~have~~Have a current Medicaid HCBS home health care agency contract; or

(B) ~~be~~Be certified by the Oklahoma State Department of Health (OSDH) as a home health care agency.

317-30-5-391. Coverage for ~~Skilled Nursing Services~~skilled nursing services

(a) All ~~Skilled Nursing Services~~skilled nursing services must be ordered and prescribed by a physician, supported by a nursing plan of care, included in the individual plan as described in ~~OAC~~Oklahoma Administrative Code (OAC) 340:100-5-53 and reflected in the ~~Plan of Care~~plan of care approved in accordance with OAC 340:100-3-33 and ~~OAC~~ 340:100-3-33.1. For purposes of this Section, a physician is defined as all licensed medical and osteopathic physicians, physician assistants (PAs) and advanced practice registered nurses (APRNs) in accordance with the rules and regulations covering the OHCA's medical care program. Arrangements for waiver ~~Skilled Nursing Services~~skilled nursing services are made through the personal support team with the specific involvement of the assigned Oklahoma Department of Human Services (OKDHS) Developmental Disabilities Services Division (DDSD) registered nurse (RN). The DDSD RN develops a nursing service support plan subject to review and authorization by the DDSD state nursing director or designee.

(b) Skilled ~~Nursing Services~~nursing services are rendered in such a manner as to provide the service recipient as much autonomy as possible.

(1) Skilled ~~Nursing Services~~nursing services must be flexible and responsive to changes in the service recipient's needs.

(2) Providers are expected to participate in annual personal support team meetings and other team meetings as required.

(3) Appropriate supervision of ~~Skilled Nursing Services~~skilled nursing services including services provided by licensed practical nurses (LPNs) is provided pursuant to State law and regulatory board requirements.

(4) Individual service providers must be RNs or LPNs currently licensed ~~to practice in the State of Oklahoma~~ and in good standing in the state in which services are provided.

PART 85. ADVANTAGE PROGRAM WAIVER SERVICES

317:30-5-763. Description of services

Services included in the ADvantage ~~Program~~program are:

(1) **Case management.**

(A) Case management services, regardless of payment source, assist a member to gain access to medical, social, educational, or other services that may benefit him or her to maintain health and safety. Case managers:

(i) ~~initiate~~Initiate and oversee necessary assessments and reassessments to establish or reestablish waiver program eligibility;

(ii) ~~develop~~Develop the member's comprehensive person-

centered service plan, listing only the services necessary to prevent institutionalization of the member, as determined through the assessments;

(iii) ~~initiate~~Initiate the addition of necessary services or deletion of unnecessary services, as dictated by the member's condition and available support; and

(iv) ~~monitor~~Monitor the member's condition to ensure delivery and appropriateness of services and initiate person-centered service plan reviews. Case managers submit an individualized Form 02CB014, Services Backup Plan, on all initial service plans, annually at reassessment, and on updates as appropriate throughout the year, reflecting risk factors and measures in place to minimize risks. When a member requires hospital or nursing facility (NF) services, the case manager:

(I) ~~assists~~Assists the member in accessing institutional care and, as appropriate, periodically monitors the member's progress during the institutional stay;

(II) ~~helps~~Helps the member transition from institution to home by updating the person-centered service plan;

(III) ~~prepares~~Prepares services to start on the date the member is discharged from the institution; and

(IV) ~~must~~Must meet ADvantage ~~Program~~program minimum requirements for qualification and training prior to providing services to ADvantage members.

(B) Providers of ADvantage services for the member or for those who have an interest in or are employed by an ADvantage provider for the member must not provide case management or develop the person-centered service plan, except when the ADvantage Administration (AA) demonstrates the only willing and qualified entity to provide case management and/or develop person-centered service plans in a geographic area, also provides other ADvantage services. Prior to providing services to members receiving Consumer-Directed Personal Assistance Services and Supports (CD-PASS), case manager supervisors, and case managers are required to receive training and demonstrate knowledge regarding the CD-PASS service delivery model, "Independent Living Philosophy," and demonstrate competency person-centered planning.

(C) Providers may only claim time for billable case management activities, described as:

(i) ~~any~~Any task or function, per Oklahoma Administrative Code (OAC) 317:30-5-763(1)(A) that only an ADvantage case manager can perform on behalf of the member, because of skill, training, or authority can perform on behalf of a member; and

(ii) ~~ancillary~~Ancillary activities, such as clerical tasks, including, but not limited to, mailing, copying, filing, faxing, driving time, or supervisory and

administrative activities are not billable case management activities. The administrative cost of these activities and other normal and customary business overhead costs are included in the reimbursement rate for billable activities.

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

(i) ~~Standard rate. case~~Case management services are billed using a standard rate for reimbursement for billable service activities provided to a member who resides in a county with a population density greater than twenty-five (25) persons per square mile.

(ii) ~~Very rural/difficult service area rate. case~~Case management services are billed using a very ~~rural/difficult~~rural/outside providers' service area rate for billable service activities provided to a member who resides in a county with a population density equal to, or less than twenty-five (25) persons per square mile. Exceptions are services to members who reside in Oklahoma Department of Human Services ~~(DHS)~~ (OKDHS) Aging Services identified zip codes in Osage County adjacent to the metropolitan areas of Tulsa and Washington counties. Services to these members are prior authorized and billed using the standard rate.

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

(2) **Respite.**

(A) Respite services are provided to members who are unable to care for themselves. Services are provided on a short-term basis due to the primary caregiver's absence or need for relief. Payment for respite care does not include room and board costs unless more than seven (7) hours are provided in a NF. Respite care is only utilized when other sources of care and support are exhausted. Respite care is only listed on the service plan when it is necessary to prevent institutionalization of the member. Units of services are limited to the number of units approved on the service plan.

(B) In-home respite services are billed per ~~fifteen-minute (15-minute) units~~fifteen (15) minute unit of service. Within any ~~one-day (1-day)~~one (1) day period, a minimum of eight (8) units [two (2) hours] must be provided with a maximum of twenty-eight (28) units [seven (7) hours] provided. The service is provided in the member's home.

(C) Facility-based extended respite is filed for a per diem rate when provided in a NF. Extended respite must be at least eight (8) hours in duration.

(D) In-home extended respite is filed for a per diem rate. A minimum of eight (8) hours must be provided in the member's home.

(3) **Adult day health (ADH) care.**

(A) ADH is furnished on a regularly-scheduled basis for one (1) or more days per week in an outpatient setting. It provides both health and social services necessary to ensure the member's optimal functioning. Most assistance with activities of daily living (ADLs), such as eating, mobility, toileting, and nail care are integral services to ADH care service and are covered by the ADH care basic reimbursement rate.

(B) ADH care is a ~~fifteen-minute (15-minute)~~fifteen (15) minute unit of service. No more than ~~eight (8) hours, thirty-two (32) units [eight (8) hours]~~eight (8) hours, [thirty-two (32) units] are authorized per day. The number of units of service a member may receive is limited to the number of units approved on the member's approved service plan.

(C) Physical, occupational, and speech therapies are only provided as an enhancement to the basic ADH care service when authorized by the service plan and are billed as a separate procedure. ADH care therapy enhancement is a maximum of one (1) session unit per day of service.

(D) Meals provided as part of this service do not constitute a full nutritional regimen. One (1) meal, that contains at least one-third (1/3) of the current daily dietary recommended intake (DRI), as established by the Food and Nutrition Board of the ~~Institute of Medicine of the~~ National ~~Academy~~Academies of Sciences, Engineering, and Medicine, is provided to those participants who are in the center for four (4) or more hours per day, and does not constitute a full nutritional regimen. Member's access to food at any time must also be available in addition to the required meal and is consistent with an individual not receiving Medicaid-funded services and supports.

(E) Personal-care service enhancement in ADH is assistance in bathing, hair care, or laundry service, authorized by the person-centered service plan and billed as separate procedures. This service is authorized when an ADvantage ~~Waiver~~waiver member who uses ADH requires assistance with bathing, hair care, or laundry to maintain health and safety. Assistance with bathing, hair care, or laundry service is not a usual and customary ADH care service. ADH personal care enhancement is a maximum of one (1) unit per day of bathing, hair care, or laundry service.

(F) ~~DHS~~OKDHS Home and Community-Based Services (HCBS) ~~Waiver~~waiver settings have qualities defined in ~~federal~~

~~regulation, per Section (§) 441.301 (c)(4) of Title 42 of Code of Federal Regulations (CFR)~~Home and Community-Based Services: Waiver Requirements, 42 Code of Federal Regulations, Section (§) 441.301 (c)(4) based on the individual's needs, defined in the member's authorized service plan.

(i) The ADH center is integrated and supports full access of ADvantage members to the greater community, including opportunities to:

(I) ~~seek~~Seek employment and work in competitive integrated ADH Center, not a requirement for persons that are retirement age;

(II) ~~engage~~Engage in community life;

(III) ~~control~~Control personal resources; and

(IV) ~~receive~~Receive services in the community, to the same degree as individuals not receiving ADvantage Program or other Medicaid HBCS ~~Waiver~~waiver services.

(ii) The ADH is selected by the member from all available service options and given the opportunity to visit and understand the options.

(iii) The ADH ensures the member's rights of privacy, dignity, respect, and freedom from coercion and restraint.

(iv) The ADH optimizes the member's initiative, autonomy, and independence in making life choices including, but not limited to:

(I) ~~daily~~Daily activities;

(II) ~~the~~The physical environment; and

(III) ~~with whom to interact~~Social interactions.

(v) The ADH facilitates the member's choice regarding services and supports including the provider.

(vi) Each member has the freedom and support to control his or her own schedules, activities, and access to food at any time.

(vii) Each member may have visitors whenever he or she chooses.

(viii) The ADH center is physically accessible to the member.

(G) ADH centers that are presumed not to be HCBS settings per 42 ~~CFR~~C.F.R. § 441.301(c)(5)(v) include, ADH centers:

(i) in a publicly- or privately-owned facility providing inpatient treatment;

(ii) on the grounds of or adjacent to a public institution; and

(iii) with the effect of isolating individuals from the broader community of individuals not receiving ADvantage ~~Program~~program or another Medicaid HCBS;

(H) When the ADH is presumed not HCBS, according to 42 ~~CFR~~C.F.R. § 441.301(c)(5)(v), it may be subject to heightened scrutiny by AA, ~~OHCA~~the Oklahoma Health Care

Authority (OHCA), and the Centers for Medicare and Medicaid Services (CMS). The ADH must provide evidence that the ADH portion of the facility has clear administrative, financial, programmatic, and environmental distinctions from the institution and comply with additional monitoring by the AA.

(4) **Environmental modifications.**

(A) Environmental modifications are physical adaptations to the home, required by the member's person-centered service plan that are necessary to ensure the member's health, welfare, and safety or enable the member to function with greater independence in the home, and that without such, the member would require institutionalization. Adaptations or improvements to the home but not of direct medical or remedial benefit to the waiver member are excluded.

(B) All services require prior authorization.

(5) **Specialized medical equipment and supplies.**

(A) Specialized medical equipment and supplies are devices, controls, or appliances specified in the person-centered service plan that enable members to increase their abilities to perform ADLs, or to perceive, control, or communicate with the environment in which they live. Necessary items for life support, ancillary supplies, and equipment necessary for the proper functioning of such items, and durable and non-durable medical equipment not available under the Oklahoma Medicaid State Plan are also included. This service excludes any equipment and/or supply items not of direct medical or remedial benefit to the waiver member and necessary to prevent institutionalization.

(B) Specialized medical equipment and supplies are billed using the appropriate HealthCare Common Procedure Code (HCPC). Reoccurring supplies shipped and delivered to the member are compensable only when the member remains eligible for ~~Waiver~~waiver services, continues to reside in the home, and is not institutionalized in a hospital, skilled nursing facility, or nursing home. It is the provider's responsibility to verify the member's status prior to shipping and delivering these items. Payment for medical supplies is limited to the SoonerCare (Medicaid) rate when established, to the Medicare rate, or to actual acquisition cost, plus ~~thirty (30) percent~~thirty percent (30%). All services must have prior authorization.

(6) **Advanced supportive/restorative assistance.**

(A) Advanced supportive/restorative assistance services are maintenance services used to assist a member who has a chronic, yet stable condition. These services assist with ADLs that require devices and procedures related to altered body functions. These services are for maintenance only and are not utilized as treatment services.

(B) Advanced supportive/restorative assistance service is billed per ~~fifteen-minute (15-minute)~~fifteen (15) minute

unit of service. The number of units of service a member may receive is limited to the number of units approved on the person-centered service plan.

(7) **Nursing.**

(A) Nursing services are services listed in the person-centered service plan that are within the scope of the ~~Oklahoma Nursing Practice Act~~state's Nurse Practice Act. These services are provided by a registered nurse (RN), a licensed practical nurse (LPN), or a licensed vocational nurse (LVN) under the supervision of an RN licensed to practice and in good standing in the state in which services are provided. Nursing services may be provided on an intermittent or part-time basis or may be comprised of continuous care. The provision of the nursing service works to prevent or postpone the institutionalization of the member.

(B) Nursing services are services of a maintenance or preventative nature provided to members with stable, chronic conditions. These services are not intended to treat an acute health condition and may not include services reimbursable under either the Medicaid or Medicare ~~Home Health Program~~home health program. This service primarily provides nurse supervision to the personal care assistant or to the advanced supportive/restorative assistance aide and assesses the member's health and prescribed medical services to ensure they meet the member's needs as specified in the person-centered service plan. A nursing assessment/evaluation, on-site visit is made to each member, with additional visits for members with advanced supportive/restorative assistance services authorized to evaluate the condition of the member and medical appropriateness of services. An assessment/evaluation report is forwarded to the ADvantage ~~Program~~program case manager and the skilled nurse in accordance with review schedule determined between the case manager and the skilled nurse and outlined in the member's person-centered service plan, to report the member's condition or other significant information concerning each ADvantage member.

(i) The ADvantage ~~Program~~program case manager may recommend authorization of nursing services as part of the interdisciplinary team planning for the member's person-centered service plan and/or assessment/evaluation of the:

(I) ~~member's~~Member's general health, functional ability, and needs; and/or

(II) ~~adequacy~~Adequacy of personal care and/or advanced supportive/restorative assistance services to meet the member's needs, including providing on-the-job training and competency testing for personal care or advanced supportive/restorative care aides per rules

and regulations for the delegation of nursing tasks established by the ~~Oklahoma Board of Nursing~~board of nursing in the state in which services are provided.

(ii) In addition to assessment/evaluation, the ADvantage ~~Program~~program case manager may recommend authorization of nursing services to:

(I) ~~prepare a one-week (1-week)~~Prepare a one (1) week supply of insulin syringes for a person who is blind and has diabetes and can safely self-inject the medication but cannot fill his or her own syringe. This service includes monitoring the member's continued ability to self-administer the insulin;

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

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

(IV) ~~provide~~Provide nail care for the member with diabetes or member who has circulatory or neurological compromise; and

(V) ~~provide~~Provide consultation and education to the member, member's family, or other informal caregivers identified in the person-centered service plan, regarding the nature of the member's chronic condition. Skills training, including return skills demonstration to establish competency, to the member, family, or other informal caregivers as specified in the person-centered service plan for preventive and rehabilitative care procedures are also provided.

(C) Nursing service includes interdisciplinary team planning and recommendations for the member's person-centered service plan development and/or assessment/evaluation or for other services within the scope of the ~~Oklahoma Nursing Practice Act~~nurse's license, including private duty nursing. Nursing services are billed per ~~fifteen-minute (15-minute)~~fifteen (15) minute unit of service. A specific procedure code is used to bill for interdisciplinary team planning and recommendations for the member's person-centered service plan, but other procedure codes may be used to bill for all other authorized nursing services. A maximum of eight (8) units~~, two (2) hours~~[two (2) hours], per day of nursing for service plan development and assessment evaluation are allowed. An agreement by a provider to perform a nurse evaluation is also an agreement to provide the Medicaid in-home care services for which the provider is certified and

contracted. Reimbursement for a nurse evaluation is denied when the provider that produced the nurse evaluation fails to provide the nurse assessment identified in the Medicaid in-home care services for which the provider is certified and contracted.

(8) **Skilled nursing services.**

(A) Skilled nursing services listed in the person-centered service plan that are within the scope of the state's Nurse Practice Act and are ordered by a licensed physician, osteopathic physician, physician assistant, or an advanced practice nurse and are provided by an RN, LPN, or LVN under the supervision of an RN, licensed to practice and in good standing in the state in which services are provided. Skilled nursing services provided in the member's home or other community setting are services requiring the specialized skills of a licensed nurse. The scope and nature of these services are intended for treatment of a disease or a medical condition and are beyond the scope of ADvantage nursing services. These intermittent nursing services are targeted toward a prescribed treatment or procedure that must be performed at a specific time or other predictable rate of occurrence. The RN contacts the member's physician to obtain necessary information or orders pertaining to the member's care. When the member has an ongoing need for service activities requiring more or less units than authorized, the RN must recommend, in writing, that the service plan be revised.

(B) Skilled nursing services are provided on an intermittent or part-time basis, and billed per ~~fifteen-minute (15-minute) units~~fifteen (15) minute unit of service. Skilled nursing services are provided when nursing services are not available through Medicare or other sources or when SoonerCare plan nursing services limits are exhausted. Amount, frequency, and duration of services are prior-authorized in accordance with the member's person-centered service plan.

(9) **Home-delivered meals.**

(A) Home-delivered meals provide one (1) meal per day. A home-delivered meal is a meal prepared in advance and brought to the member's home. Each meal must have a nutritional content equal to at least one-third (1/3) of the dietary reference intakes as established by the Food and Nutrition Board of the National ~~Academy of Sciences~~Academies of Sciences, Engineering and Medicine. Home-delivered meals are only provided to members who are unable to prepare meals and lack an informal provider to do meal preparation.

(B) Home-delivered meals are billed per meal, with one (1) meal equaling one (1) unit of service. The limit of the number of units a member is allowed to receive is in accordance with the member's person-centered service plan.

The provider must obtain a signature from the member or the member's representative at the time the meal is delivered. In the event the member is temporarily unavailable, such as at a doctor's appointment and the meal is left at the member's home, the provider must document the reason a signature was not obtained. The signature logs must be available for review.

(10) **Occupational therapy services.**

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

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

(11) **Physical therapy services.**

(A) Physical therapy services are those services that maintain or improve physical disability through the evaluation and rehabilitation of members disabled by pain, disease, or injury. Services are provided in the member's home and are intended to help the member achieve greater independence to reside and participate in the community. Treatment involves the use of physical therapeutic means, such as massage, manipulation, therapeutic exercise, cold and/or heat therapy, hydrotherapy, electrical stimulation, and light therapy. Under a physician's order, a licensed physical therapist evaluates the member's rehabilitation potential and develops an appropriate, written, therapeutic

regimen. Under the Oklahoma Physical Therapy Practice Act, a physical therapist may evaluate a member's rehabilitation potential and develop and implement an appropriate, written, therapeutic regimen without a referral from a licensed health care practitioner for a period not to exceed ~~thirty-calendar (30-calendar)~~thirty (30) calendar days. Any treatment required after the ~~thirty-calendar (30-calendar)~~thirty (30) calendar day period requires a prescription from a physician or the physician's assistant of the licensee. The regimen utilizes paraprofessional physical therapy assistant services, within the limitations of his or her practice, working under the supervision of the licensed physical therapist. The regimen includes education and training for informal caregivers to assist with and/or maintain services when appropriate. The licensed physical therapist ensures monitoring and documentation of the member's rehabilitative progress and reports to the member's case manager and physician to coordinate the necessary addition or deletion of services, based on the member's condition and ongoing rehabilitation potential.

(B) Physical therapy services are authorized as ADH care therapy enhancement and are a maximum of one (1) session unit per day of service. Payment is not allowed solely for written reports or record documentation.

(12) **Speech and language therapy services.**

(A) Speech and language therapy services are those that maintain or improve speech and language communication and swallowing disorders/disability through the evaluation and rehabilitation of members disabled by pain, disease, or injury. Services are provided in the member's home and are intended to help the member achieve greater independence to reside and participate in the community. Services involve the use of therapeutic means, such as evaluation, specialized treatment, or development and oversight of a therapeutic maintenance program. Under a physician's order, a licensed speech and language pathologist evaluates the member's rehabilitation potential and develops an appropriate, written, therapeutic regimen. The regimen utilizes ~~Speech Language Pathology Assistant~~speech language pathology assistant services within the limitations of his or her practice, working under the supervision of the licensed ~~Speech and Language Pathologist~~speech and language pathologist. The regimen includes education and training for informal caregivers to assist with, and/or maintain services when appropriate. The ~~Speech and Language Pathologist~~speech and language pathologist ensures monitoring and documentation of the member's rehabilitative progress and reports to the member's case manager and physician to coordinate the necessary addition and/or deletion of

services, based on the member's condition and ongoing rehabilitation potential.

(B) Speech and language therapy services are authorized as ADH care-therapy enhancement and are a maximum of one (1) session unit per day of service. Payment is not allowed solely for written reports or record documentation.

(13) **Hospice services.**

(A) Hospice services are palliative and comfort care provided to the member and his or her family when a physician certifies the member has a terminal illness, with a life expectancy of six (6) months or less, and orders hospice care. ADvantage hospice care is authorized for a ~~six-month (6-month)~~six (6) month period and requires physician certification of a terminal illness and orders of hospice care. When the member requires more than six (6) months of hospice care, a physician or nurse practitioner must have a face-to-face visit with the member ~~thirty-calendar (30-calendar)~~thirty (30) calendar days prior to the initial hospice authorization end-date, and re-certify that the member has a terminal illness, has six (6) months or less to live, and orders additional hospice care. After the initial authorization period, additional periods of ADvantage hospice may be authorized for a maximum of ~~sixty-calendar (60-calendar)~~sixty (60) calendar day increments with physician certification that the member has a terminal illness and six (6) months or less to live. A member's person-centered service plan that includes hospice care must comply with Waiver requirements to be within total person-centered service plan cost limits.

(B) A hospice program offers palliative and supportive care to meet the special needs arising out of the physical, emotional, and spiritual stresses experienced during the final stages of illness, through the end of life, and bereavement. The member signs a statement choosing hospice care instead of routine medical care with the objective to treat and cure the member's illness. Once the member has elected hospice care, the hospice medical team assumes responsibility for the member's medical care for the illness in the home environment. Hospice care services include nursing care, physician services, medical equipment and supplies, drugs for symptom and pain relief, home health aide and personal care services, physical, occupational and speech therapies, medical social services, dietary counseling, and grief and bereavement counseling to the member and/or the member's family.

(C) A hospice person-centered service plan must be developed by the hospice team in conjunction with the member's ADvantage case manager before hospice services are provided. The hospice services must be related to the palliation or management of the member's terminal illness, symptom

control, or to enable the member to maintain ADL and basic functional skills. A member who is eligible for Medicare hospice provided as a Medicare Part A benefit, is not eligible to receive ADvantage hospice services.

(D) Hospice services are billed per diem of service for days covered by a hospice person-centered service plan and while the hospice provider is responsible for providing hospice services as needed by the member or member's family. The maximum total annual reimbursement for a member's hospice care within a ~~twelve-month (12-month)~~twelve (12) month period is limited to an amount equivalent to ~~eighty-five (85) percent~~eighty-five percent (85%) of the Medicare hospice cap payment, and must be authorized on the member's person-centered service plan.

(14) **ADvantage personal care.**

(A) ADvantage personal care is assistance to a member in carrying out ADLs, such as bathing, grooming, and toileting or in carrying out instrumental activities of daily living (IADLs), such as preparing meals and laundry service, to ensure the member's personal health and safety, or to prevent or minimize physical health regression or deterioration. Personal care services do not include service provision of a technical nature, such as tracheal suctioning, bladder catheterization, colostomy irrigation, or the operation and maintenance of equipment of a technical nature.

(B) ADvantage home care agency skilled nursing staff working in coordination with an ADvantage case manager is responsible for the development and monitoring of the member's personal care services.

(C) ADvantage personal care services are prior-authorized and billed per ~~fifteen-minute (15-minute)~~fifteen (15) minute unit of service, with units of service limited to the number of units on the ADvantage approved person-centered service plan.

(15) **Personal emergency response system (PERS).**

(A) PERS is an electronic device that enables members at high risk of institutionalization, to secure help in an emergency. Members may also wear a portable "help" button to allow for mobility. PERS is connected to the person's phone and programmed to signal, per member preference, a friend, relative, or a response center, once the "help" button is activated. For an ADvantage member to be eligible for PERS service, the member must meet all of the service criteria in (i) through (vi). The member:

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

(ii) ~~member lives~~Lives alone and without a regular caregiver, paid or unpaid, and therefore is left alone for long periods of time;

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

(iv) ~~member has~~Has a health and safety plan detailing the interventions beyond the PERS to ensure the member's health and safety in his or her home;

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

(vi) ~~PERS service avoids~~Will likely avoid premature or unnecessary institutionalization ~~of the member~~as a result of PERS.

(B) PERS services are billed using the appropriate ~~Healthcare Common Procedure Coding System (HCPCS)~~HCPC procedure code for installation, monthly service, or PERS purchase. All services are prior authorized per the ADvantage approved service plan.

(16) **CD-PASS.**

(A) CD-PASS are personal services assistance (PSA) and advanced personal services assistance (APSA) that enables a member in need of assistance to reside in his or her home and community of choice, rather than in an institution; and to carry out functions of daily living, self-care, and mobility. CD-PASS services are delivered as authorized on the person-centered service plan. The member becomes the employer of record and employs the PSA and the APSA. The member is responsible, with assistance from ADvantage ~~Program Administrative~~program administrative Financial Management Services (FMS), for ensuring the employment complies with state and federal labor law requirements. The member/employer may designate an adult family member or friend, who is not a PSA or APSA to the member, as an "authorized representative" to assist in executing the employer functions. The member/employer:

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

(ii) ~~is solely responsible to provide instruction and training to the PSA or APSA on tasks and works with the consumer directed agent/case manager (CDA) to obtain ADvantage skilled nursing services assistance with training, when necessary~~Ensures that the PSA or APSA has received sufficient instruction and training. If needed, the member/employer will work with the consumer-directed agent/case manager (CDA) to obtain training assistance from ADvantage skilled nurses. Prior to performing an APSA task for the first time, the APSA must demonstrate competency in the tasks in an on-the-job training session conducted by the member, and the member must document the attendant's competency in performing each task in the APSA's personnel file;

(iii) ~~determines~~Determines where and how the PSA or APSA works, hours of work, what is to be accomplished and, within individual budget allocation limits, wages to be paid for the work;

(iv) ~~supervises~~Supervises and documents employee work time; and

(v) ~~provides~~Provides tools and materials for work to be accomplished.

(B) The services the PSA may provide include:

(i) ~~assistance~~Assistance with mobility and transferring in and out of bed, wheelchair, or motor vehicle, or all;

(ii) ~~assistance~~Assistance with routine bodily functions, such as:

(I) ~~bathing~~Bathing and personal hygiene;

(II) ~~dressing~~Dressing and grooming; and

(III) ~~eating~~Eating, including meal preparation and cleanup;

(iii) ~~assistance~~Assistance with home services, such as shopping, laundry, cleaning, and seasonal chores;

(iv) ~~companion~~Companion assistance, such as letter writing, reading mail, and providing escort or transportation to participate in approved activities or events. "Approved activities or events," means community, civic participation guaranteed to all citizens including, but not limited to, exercise of religion, voting or participation in daily life activities in which exercise of choice and decision making is important to the member, and may include shopping for food, clothing, or other necessities, or for participation in other activities or events specifically approved on the person-centered service plan.

(C) An APSA provides assistance with ADLs to a member with a stable, chronic condition, when such assistance requires devices and procedures related to altered body function if such activities, in the opinion of the attending physician or licensed nurse, may be performed if the member were physically capable, and the procedure may be safely performed in the home. Services provided by the APSA are maintenance services and are never used as therapeutic treatment. Members who develop medical complications requiring skilled nursing services while receiving APSA services are referred to his or her attending physician, who ~~when appropriate, orders~~may order home health services, as appropriate. APSA includes assistance with health maintenance activities that may include:

(i) ~~routine~~Routine personal care for persons with ostomies, including tracheotomies, gastrostomies, and colostomies with well-healed stoma, external, indwelling, and suprapubic catheters that include changing bags and soap and water hygiene around the ostomy or catheter site;

(ii) ~~removing~~Removing external catheters, inspecting skin, and reapplication of same;

(iii) ~~administering~~Administering prescribed bowel program, including use of suppositories and sphincter stimulation, and enemas pre-packaged only without contraindicating rectal or intestinal conditions;

(iv) ~~applying~~Applying medicated prescription lotions or ointments and dry, non-sterile dressings to unbroken skin;

(v) ~~using~~Using a lift for transfers;

(vi) ~~manually~~Manually assisting with oral medications;

(vii) ~~providing~~Providing passive range of motion (non-resistive flexion of joint) therapy, delivered in accordance with the person-centered service plan unless contraindicated by underlying joint pathology;

(viii) ~~applying~~Applying non-sterile dressings to superficial skin breaks or abrasions; and

(ix) ~~using~~Using universal precautions as defined by the Centers for Disease Control and Prevention.

(D) FMS are program administrative services provided to participating CD-PASS members/employers by AA. FMS are employer-related assistance that provides Internal Revenue Service (IRS) fiscal reporting agent and other financial management tasks and functions, including, but not limited to:

(i) ~~processing~~Processing employer payroll, after the member/employer has verified and approved the employee timesheet, at a minimum of semi-monthly, and associated withholding for taxes, or for other payroll withholdings performed on behalf of the member as employer of the PSA or APSA;

(ii) ~~other employer related~~Other employer-related payment disbursements as agreed to with the member/employer and in accordance with the member/employer's individual budget allocation;

(iii) ~~responsibility~~Responsibility for obtaining criminal and abuse registry background checks on prospective hires for PSA or APSA on the member/employer's behalf;

(iv) ~~providing~~Providing orientation and training regarding employer responsibilities, as well as employer information and management guidelines, materials, tools, and staff consultant expertise to support and assist the member successfully perform employer-related functions; and

(v) ~~making~~Making Hepatitis B vaccine and vaccination series available to PSA and APSA employees in compliance with Occupational Safety and Health Administration (OSHA) standards.

(E) The PSA service is billed per ~~fifteen-minute (15-minute)~~fifteen (15) minute unit of service. The number of units of PSA a member may receive is limited to the number of units approved on the person-centered service plan.

(F) The APSA service is billed per ~~fifteen-minute (15-minute)~~fifteen (15) minute unit of service. The number of units of APSA a member may receive is limited to the number of units approved on the person-centered service plan.

(17) **Institutional transition services.**

(A) Institutional transition services are those services necessary to enable a member to leave the institution and receive necessary support through ADvantage waiver services in his or her home and community.

(B) Transitional case management services are services per OAC 317:30-5-763(1) required by the member and included on the member's person-centered service plan that are necessary to ensure the member's health, welfare, and safety, or to enable the member to function with greater independence in the home, and without which, the member would continue to require institutionalization. ADvantage transitional case management services assist institutionalized members who are eligible to receive ADvantage services in gaining access to needed ~~Waiver~~waiver and other State ~~plan~~Plan services, as well as needed medical, social, educational, and other services to assist in the transition, regardless of the funding source for the services to which access is gained. Transitional case management services may be authorized for periodic monitoring of an ADvantage member's progress during an institutional stay and for assisting the member transition from institution to home by updating the person-centered service plan, including necessary institutional transition services to prepare services and supports to be in place or to start on the date the member is discharged from the institution. Transitional case management services may be authorized to assist individuals that have not previously received ADvantage services, but were referred by ~~DHS~~OKDHS AS to the case management provider for assistance in transitioning from the institution to the community with ADvantage services support.

(i) Institutional transition case management services are prior authorized and billed per ~~fifteen-minute (15-minute)~~fifteen (15) minute unit of service using the appropriate HCPC procedure code and modifier associated with the location of residence of the member served, per OAC 317:30-5-763(1)(C).

(ii) A unique modifier code is used to distinguish transitional case management services from regular case management services.

(C) Institutional transition services may be authorized and reimbursed, per the conditions in (i) through (iv).

(i) The service is necessary to enable the member to move from the institution to his or her home.

(ii) The member is eligible to receive ADvantage services outside of the institutional setting.

(iii) Institutional transition services are provided to the member within one-hundred and eighty (180) calendar-days of discharge from the institution.

(iv) Services provided while the member is in the institution are claimed as delivered on the day of discharge from the institution.

(D) When the member receives institutional transition services but fails to enter the waiver, any institutional transition services provided are not reimbursable.

(18) **Assisted living services (ALS).**

(A) ALS are personal care and supportive services furnished to waiver members who reside in a homelike, non-institutional setting that includes twenty-four (24) hour on-site response capability to meet scheduled or unpredictable member needs and to provide supervision, safety, and security. Services also include social and recreational programming and medication assistance, to the extent permitted under State law. The ALS provider is responsible for coordinating services provided by third parties to ADvantage members in the assisted living center (ALC). Nursing services are incidental rather than integral to the provision of ALS. ADvantage reimbursement for ALS includes services of personal care, housekeeping, laundry, meal preparation, periodic nursing evaluations, nursing supervision during nursing intervention, intermittent or unscheduled nursing care, medication administration, assistance with cognitive orientation, assistance with transfer and ambulation, planned programs for socialization, activities, and exercise, and for arranging or coordinating transportation to and from medical appointments. Services, except for planned programs for socialization, activities, and exercise are to meet the member's specific needs as determined through the individualized assessment and documented on the member's person-centered service plan.

(B) The ADvantage ALS philosophy of service delivery promotes member choice, and to the greatest extent possible, member control. A member has control over his or her living space and his or her choice of personal amenities, furnishings, and activities in the residence. The ADvantage member must have the freedom to control his or her schedule and activities. The ALS provider's documented operating philosophy, including policies and procedures, must reflect and support the principles and values associated with the ADvantage assisted living philosophy and approach to service delivery emphasizing member dignity, privacy, individuality, and independence.

(C) ADvantage ALS required policies for admission and termination of services and definitions.

(i) ADvantage-certified assisted living centers (ALC) are required to accept all eligible ADvantage members who choose to receive services through the ALC, subject only to issues relating to, one (1) or more of the following:

(I) ~~rental~~Rental unit availability;

(II) ~~the~~The member's compatibility with other residents;

(III) ~~the~~The center's ability to accommodate residents who have behavior problems, wander, or have needs that exceed the services the center provides; or

(IV) ~~restrictions~~Restrictions initiated by statutory limitations.

(ii) The ALC may specify the number of units the provider is making available to service ADvantage members. At minimum, the ALC must designate ten (10) residential units for ADvantage members. Residential units designated for ADvantage may be used for other residents at the ALC when there are no pending ADvantage members for those units. Exceptions may be requested in writing subject to the approval of AA.

(iii) Mild or moderate~~,~~ cognitive impairment of the applicant is not a justifiable reason to deny ALC admission. Centers are required to specify whether they are able to accommodate members who have behavior problems or wander. Denial of admission due to a determination of incompatibility must be approved by the case manager and the AA. Appropriateness of placement is not a unilateral determination by the ALC. The ADvantage case manager, the member, or member's designated representative, and the ALC in consultation determine the appropriateness of placement.

(iv) The ALC is responsible for meeting the member's needs for privacy, dignity, respect, and freedom from coercion and restraint. The ALC must optimize the member's initiative, autonomy, and independence in making life choices. The ALC must facilitate member choices regarding services and supports, and who provides them. Inability to meet those needs is not recognized as a reason for determining an ADvantage member's placement is inappropriate. The ALC agrees to provide or arrange and coordinate all of the services listed in the Oklahoma State Department of Health (OSDH) regulations, per OAC 310:663-3-3, except for specialized services.

(v) In addition, the ADvantage participating ALC agrees to provide or coordinate the services listed in (I) through (III).

(I) Provide an emergency call system for each participating ADvantage member.

(II) Provide up to three (3) meals per day plus snacks sufficient to meet nutritional requirements, including modified special diets, appropriate to the member's needs and choices; and provide members with twenty-four (24) hour access to food by giving members control in the selection of the foods they eat, by allowing the member to store personal food in his or her room, by allowing the member to prepare and eat food in his or her room, and allowing him or her to decide when to eat.

(III) Arrange or coordinate transportation to and from medical appointments. The ALC must assist the member with accessing transportation for integration into the community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, and control his or her personal resources and receive services in the community to the same degree of access as residents not receiving ADvantage services.

(vi) The provider may offer any specialized service or rental unit for members with Alzheimer's disease and related dementias, physical disabilities, or other special needs the facility intends to market. Heightened scrutiny, through additional monitoring of the ALC by AA, is utilized for those ALC's that also provide inpatient treatment; settings on the grounds of or adjacent to a public institution and/or other settings that tend to isolate individuals from the community. The ALC must include evidence that the ALC portion of the facility has clear administrative, financial, programmatic and environmental distinctions from the institution.

(vii) When the provider arranges and coordinates services for members, the provider is obligated to ensure the provision of those services.

(viii) Per OAC 310:663-1-2, "personal care" is defined as "assistance with meals, dressing, movement, bathing or other personal needs or maintenance, or general supervision of the physical and mental well-being of a person~~,~~ [Title 63 of the Oklahoma Statutes (O.S.), Section (§) 1-1902.17] and includes assistance with toileting." For ADvantage ALS, assistance with "other personal needs" in this definition includes assistance with grooming and transferring. The term "assistance" is clarified to mean hands-on help, in addition to supervision.

(ix) The specific ALS assistance provided along with amount and duration of each type of assistance is based upon the member's assessed need for service assistance and is specified in the ALC's service plan that is incorporated as supplemental detail into the ADvantage

comprehensive person-centered service plan. The ADvantage case manager in cooperation with ALC professional staff, develops the person-centered service plan to meet member needs. As member needs change, the person-centered service plan is amended consistent with the assessed, documented need for change in services.

(x) Placement, or continued placement of an ADvantage member in an ALC, is inappropriate when any one (1) or more of the conditions exist.

(I) The member's needs exceed the level of services the center provides. Documentation must support ALC efforts to provide or arrange for the required services to accommodate participant needs.

(II) The member exhibits ~~behavior~~behaviors or actions that repeatedly and substantially ~~interferes~~interfere with the rights or well-being of other residents, and the ALC documented efforts to resolve behavior problems including medical, behavioral, and increased staffing interventions. Documentation must support the ~~ALC~~ALC's attempted interventions to resolve behavior problems.

(III) The member has a complex, unstable, or unpredictable medical condition and treatment cannot be developed and implemented appropriately in the assisted living environment. Documentation must support the ~~ALC~~ALC's attempts to obtain appropriate member care.

(IV) The member fails to pay room and board charges and/or ~~DHS~~OKDHS determined vendor payment obligation.

(xi) Termination of residence when inappropriately placed. Once a determination is made that a member is inappropriately placed, the ALC must inform the member, the member's representative, ~~when~~if applicable, the AA, and the member's ADvantage case manager. The ALC must develop a discharge plan in consultation with the member, the member's representative, the ADvantage case manager, and the AA. The ALC and case manager must ensure the discharge plan includes strategies for providing increased services, when appropriate, to minimize risk and meet the higher care needs of members transitioning out of the ALC, when the reason for discharge is inability to meet member needs. When voluntary termination of residency is not arranged, the ALC must provide written notice to the member and to the member's representative, with a copy to the member's ADvantage case manager and the AA. The written notice provides intent to terminate the residency agreement and move the member to an appropriate care provider. The thirty (30) calendar-day requirement must not apply when emergency termination of the residency agreement is mandated by the member's

immediate health needs or when the termination of the residency agreement is necessary for the physical safety of the member or other ALC residents. The written involuntary termination of residency notice for reasons of inappropriate placement must include:

(I) ~~a~~A full explanation of the reasons for the termination of residency;

(II) ~~the~~The notice date;

(III) ~~the~~The date notice was given to the member and the member's representative, the ADvantage case manager, and the AA;

(IV) ~~the~~The date the member must leave ALC; and

(V) ~~notification~~Notification of appeal rights and the process for submitting appeal of termination of Medicaid ALS to OHCA.

(D) ADvantage ALS provider standards in addition to licensure standards.

(i) **Physical environment.**

(I) The ALC must provide lockable doors on the entry door of each rental unit and an attached, lockable compartment within each member unit for valuables. Members must have exclusive rights to his or her unit with lockable doors at the entrance of the individual or shared rental unit. Keys to rooms may be held by only appropriate ALC staff as designated by the member's choice. Rental units may be shared only when a request to do so is initiated by the member. Members must be given the right to choose his or her roommate.

(II) The member has a legally enforceable agreement, or lease, with the ALC. The member must have the same responsibilities and protections from eviction as all tenants under the ~~landlord tenant~~landlord-tenant law of the state, county, city, or other designated entity.

(III) The ALC must provide each rental unit with a means for each member to control the temperature in the residential unit through the use of a damper, register, thermostat, or other reasonable means under the control of the member and that preserves privacy, independence, and safety, provided that the OSDH may approve an alternate means based on documentation that the design of the temperature control is appropriate to the special needs of each member who has an alternate temperature control.

(IV) For ALCs built prior to January 1, 2008, each ALC individual residential unit must have a minimum total living space, including closets and storage areas, of two-hundred and fifty (250) square feet; for ALCs built after December 31, 2007, each ALC individual residential unit must have a minimum total living

space, including closets and storage areas, of three-hundred and sixty (360) square feet.

(V) The ALC must provide a private bathroom for each living unit that must be equipped with one (1) lavatory, one (1) toilet, and one (1) bathtub or shower stall.

(VI) The ALC must provide at a minimum; a kitchenette, defined as a space containing a refrigerator, adequate storage space for utensils, and a cooking appliance~~, a~~. A microwave is an acceptable cooking appliance.

(VII) The member is responsible for furnishing the rental unit. When a member is unable to supply basic furnishings defined as a bed, dresser, nightstand, chairs, table, trash can, and lamp, or if ~~member supplied~~ furnishings pose a health or safety risk, the member's ADvantage case manager in coordination with the ALC, must assist the member in obtaining basic furnishings for the rental unit. The member must have the freedom to furnish and decorate the rental unit within the scope of the lease or residency agreement.

(VIII) The ALC must meet the requirements of all applicable federal and state laws and regulations including, but not limited to, state and local sanitary codes, state building and fire safety codes, and laws and regulations governing use and access by persons with disabilities.

(IX) The ALC must ensure the design of common areas accommodates the special needs of the resident population and that the rental unit accommodates the special needs of the member in compliance with the Americans with Disabilities Act accessibility guidelines per ~~28 Code of Federal Regulations, Part 36, Appendix A~~Nondiscrimination on the Basis of Disability By Public Accommodations and in in Commercial Facilities, 28 Code of Federal Regulations, Appendix A, at no additional cost to the member.

(X) The ALC must provide adequate and appropriate social and recreational space for residents and the common space must be proportionate to the number of residents and appropriate for the resident population.

(XI) The ALC must provide appropriately monitored outdoor space for resident use.

(XII) The ALC must provide the member with the right to have visitors of his or her choosing at any time. Overnight visitation is allowed as permissible by the Landlord/Tenant Agreement.

(XIII) The ALC must be physically accessible to members.

(ii) **Sanitation.**

(I) The ALC must maintain the facility, including its individual rental units in a clean, safe, and sanitary manner ~~and be~~, ensuring that they are insect and rodent free, odorless, and in good repair at all times.

(II) The ALC must maintain buildings and grounds in a good state of repair, in a safe and sanitary condition, and in compliance with the requirements of applicable regulations, bylaws, and codes.

(III) The ALC stores clean laundry in a manner that prevents contamination and changes linens at time intervals necessary to avoid health issues.

(IV) The ALC must provide housekeeping in member rental units to maintain a safe, clean, and sanitary environment.

(V) The ALC must have policies and procedures for members' pets.

(iii) **Health and ~~Safety~~safety.**

(I) The ALC must provide building security that protects members from intruders with security measures appropriate to building design, environmental risk factors, and the resident population.

(II) The ALC must respond immediately and appropriately to missing members, accidents, medical emergencies, or deaths.

(III) The ALC must have a plan in place to prevent, contain, and report any diseases considered to be infectious or are listed as diseases that must be reported to the OSDH.

(IV) The ALC must adopt policies for the prevention of abuse, neglect, and exploitation that include screening, training, prevention, investigation, protection during investigation, and reporting.

(V) The ALC must provide services and facilities that accommodate the needs of members to safely evacuate in the event of fires or other emergencies.

(VI) The ALC must ensure staff is trained to respond appropriately to emergencies.

(VII) The ALC must ensure that fire safety requirements are met.

(VIII) The ALC must offer meals that provide balanced and adequate nutrition for members.

(IX) The ALC must adopt safe practices for the preparation and delivery of meals.

(X) The ALC must provide a twenty-four (24) hour response to personal emergencies appropriate to the needs of the resident population.

(XI) The ALC must provide safe transportation to and from ALC sponsored social or recreational outings.

(iv) **Staff to resident ratios.**

(I) The ALC must ensure a sufficient number of trained staff are on duty, awake, and present at all times, twenty-four (24) hours a day, and seven (7) days a week, to meet the needs of residents and to carry out all of the processes listed in the ALC's written emergency and disaster preparedness plan for fires and other disasters.

(II) The ALC must ensure staffing is sufficient to meet ADvantage ~~Program~~program members' needs in accordance with each member's ADvantage person-centered service plan.

(III) The ALC must have plans in place to address situations where there is a disruption to the ALC's regular work force.

(v) **Staff training and qualifications.**

(I) The ALC must ensure staff has qualifications consistent with their job responsibilities.

(II) All staff assisting in, or responsible for, food service must have attended a food service training program offered or approved by OSDH.

(III) The ALC must provide staff orientation and ongoing training to develop and maintain staff knowledge and skills. All direct care and activity staff receive at least eight (8) hours of orientation and initial training within the first month of employment and at least four (4) hours annually thereafter. Staff providing direct care on a dementia unit must receive four (4) additional hours of dementia specific training. Annual first aid and cardiopulmonary resuscitation (CPR) certification do not count toward the four (4) hours of annual training.

(vi) **Staff supervision.**

(I) The ALC must ensure delegation of tasks to non-licensed staff is consistent and in compliance with all applicable state regulations including, but not limited to, the ~~Oklahoma~~state's Nurse Practice Act and OSDH Nurse Aide Certification rules.

(II) The ALC must ensure that, where the monitoring of food intake or therapeutic diets is provided at the prescribed services level, a registered dietitian monitors member health and nutritional status.

(vii) **Resident rights.**

(I) The ALC must provide to each member and each member's representative, at the time of admission, a copy of the resident statutory rights listed in ~~Section 1-1918 of Title 63 of the Oklahoma Statutes~~63 O.S. § 1-1918 amended to include additional rights and the clarification of rights as listed in the ADvantage ~~Member Assurances~~member assurances. A copy of resident rights must be posted in an easily accessible,

conspicuous place in the facility. The facility must ensure that staff is familiar with and observes, the resident rights.

(II) The ALC must conspicuously post for display in an area accessible to residents, employees, and visitors, the ALC's complaint procedures and the name, address, and phone number of a person authorized to receive complaints. A copy of the complaint procedure must also be given to each member, the member's representative, or the legal guardian. The ALC must ensure all employees comply with the ALC's complaint procedure.

(III) The ALC must provide to each member and member's representative, at the time of admission, information about Medicaid grievance and appeal rights, including a description of the process for submitting a grievance or appeal of any decision that decreases Medicaid services to the member.

(viii) **Incident reporting.**

(I) The ALC must maintain a record of incidents that occur and report incidents to the member's ADvantage case manager and to the AA, utilizing the AA Critical Incident Reporting form. Incident reports are also made to Adult Protective Services (APS) and to the OSDH, as appropriate, per ALC licensure rules, utilizing the specific reporting forms required.

(II) Incidents requiring report by licensed ~~ALC~~ALC's are those defined by OSDH, per OAC 310:663-19-1 and listed on the AA Critical Incident Reporting form.

(III) Reports of incidents must be made to the member's ADvantage case manager and to the AA via electronic submission within one (1) business day of the reportable incident's discovery utilizing the AA Critical Incident Reporting form. When required, a follow-up report of the incident must be submitted via electronic submission to the member's ADvantage case manager and to the AA. The follow-up report must be submitted within ~~five-business (5-business)~~five (5) business days of the incident. The final report must be filed with the member's ADvantage case manager and the AA when the investigation is complete, not to exceed ~~ten-business (10-business)~~ten (10) business days after the incident.

(IV) Each ALC having reasonable cause to believe that a member is suffering from abuse, neglect, exploitation, or misappropriation of member property must make a report to APS as soon as the person is aware of the situation per ~~O.S. 43A § 10-104.A~~43A O.S. § 10-104.A. Reports are also made to OSDH, as appropriate, per ALC licensure rules.

(V) The preliminary incident report must at the minimum, include who, what, when, where, and the measures taken to protect the member and resident(s) during the investigation. The follow-up report must, at the minimum, include preliminary information, the extent of the injury or damage, ~~when~~if any, and preliminary investigation findings. The final report, at a minimum, includes preliminary and follow-up information, a summary of investigative actions representing a thorough investigation, investigative findings and conclusions~~ based on findings~~, and corrective measures to prevent future occurrences. When it is necessary to omit items, the final report must include why such items were omitted and when they will be provided.

(ix) Provision of or arrangement for necessary health services. The ALC must:

(I) ~~arrange~~Arrange or coordinate transportation for members to and from medical appointments; and

(II) ~~provide~~Provide or coordinate with the member and the member's ADvantage case manager for delivery of necessary health services. The ADvantage case manager is responsible for monitoring that all health-related services required by the member as identified through assessment and documented on the person-centered service plan, are provided in an appropriate and timely manner. The member has the freedom to choose any available provider qualified by licensure or certification to provide necessary health services in the ALC.

(E) ~~ALS~~ALCs are billed per diem of service for days covered by the ADvantage member's person-centered service plan and during which the ALS provider is responsible for providing ALS for the member. The per diem rate for ADvantage ~~assisted living services~~ALS for a member is one (1) of three (3) per diem rate levels based on a member's need for type of, intensity of, and frequency of service to address member ADLs, instrumental activities of the daily living(IADLs), and health care needs. The rate level is based on the Uniform Comprehensive Assessment Tool (UCAT) assessment by the member's ADvantage case manager employed by a case management agency independent of the ALS provider. The determination of the appropriate per diem rate is made by the AA clinical review staff.

(F) The ALC must notify AA ~~ninety-calendar (90-calendar)~~ninety (90) calendar days before terminating or not renewing the ALC's ADvantage contract.

(i) The ALC must give notice in writing to the member, the member's representative(s), the AA, and the member's ADvantage case manager ~~ninety-calendar (90-~~

~~calendar)~~ninety (90) calendar days before:

(I) ~~voluntary~~Voluntary cessation of the ALC's ADvantage contract; or

(II) ~~closure~~Closure of all or part of the ALC.

(ii) The notice of closure must include:

(I) ~~the~~The proposed ADvantage contract termination date;

(II) ~~the~~The termination reason;

(III) ~~an~~An offer to assist the member secure an alternative placement; and

(IV) ~~available~~Available housing alternatives.

(iii) The facility must comply with all applicable laws and regulations until the closing date, including those related to resident transfer or discharge.

(iv) Following the last move to the last ADvantage member, the ALC must provide in writing to the AA:

(I) ~~the~~The effective date of closure based on the discharge date of the last resident;

(II) ~~a~~A list of members transferred or discharged and where they relocated,; and

(III) ~~the~~The plan for storage of resident records per OAC 310:663-19-3(g), relating to preservation of resident records and the name, address, and phone numbers of the person responsible for the records.

PART 105. RESIDENTIAL BEHAVIORAL MANAGEMENT SERVICES IN GROUP SETTINGS AND NON-SECURE DIAGNOSTIC AND EVALUATION CENTERS

317:30-5-1043. Coverage by category

(a) **Adults.** Residential Behavioral Management Services (RBMS) in group settings are not covered for adults.

(b) **Children.** RBMS in group settings are covered for children as set forth in this subsection.

(1) **Description.** RBMS are provided by Organized Health Care Delivery Systems (OHCDS) for children in the care and custody of the State who have special psychological, behavioral, emotional and social needs that require more intensive care than can be provided in a family or foster home setting. The behavior management services are provided in the least restrictive environment and within a therapeutic milieu. The group setting is restorative in nature, allowing children with emotional and psychological problems to develop the necessary control to function in a less restrictive setting. RBMS are reimbursed in accordance with established rate methodology as described in the Oklahoma Medicaid State Plan. It is expected that RBMS in group settings are an all-inclusive array of treatment services provided in one (1) day. In the case of a

child who needs additional specialized services, under the Rehabilitation Option or by a psychologist, prior authorization by the OHCA or designated agent is required. Only specialized rehabilitation or psychological treatment services to address unique, unusual or severe symptoms or disorders will be authorized. If additional services are approved, the OHCDS collaborates with the provider of such services as directed by the OHCA or its agent. Any additional specialized behavioral health services provided to children in state custody are funded in the normal manner. The OHCDS must provide concurrent documentation that these services are not duplicative. The OHCDS determines the need for RBMS.

(2) **Medical necessity criteria.** The following medical necessity criteria must be met for RBMS.

(A) Any Diagnostic and Statistical Manual of Mental Disorders (DSM) primary diagnosis, with the exception of V codes, with a detailed description of the symptoms supporting the diagnosis. A detailed description of the child's emotional, behavioral and psychological condition must be on file.

(B) The child is medically stable and not actively suicidal or homicidal and not in need of substance abuse detoxification services.

(C) It has been determined by the OHCDS that the current disabling symptoms could not have been or have not been manageable in a less intensive treatment program.

(D) Documentation that the child's presenting emotional and/or behavioral problems prevent the child from living in a traditional family home. The child requires the availability of twenty-four (24) hour crisis response/behavior management and intensive clinical interventions from professional staff.

(E) The agency which has permanent or temporary custody of the child agrees to active participation in the child's treatment needs and planning.

(F) All of the medical necessity criteria must also be met for continued stay in residential group settings.

(3) **Treatment components.**

(A) **Individual plan of care development.** A comprehensive individualized plan of care for each resident shall be formulated by the provider agency staff within thirty (30) days of admission, for intensive treatment services (ITS) level within seventy-two (72) hours, with documented input from the agency which has permanent or temporary custody of the child and when possible, the parent. This plan must be revised and updated at least every three (3) months, every seven (7) days for ITS, with documented involvement of the agency which has permanent or temporary custody of the child. Documented involvement can be written approval of the individual plan of care by the agency which has permanent or

temporary custody of the child and indicated by the signature of the agency case worker or liaison on the individual plan of care. It is acceptable in circumstances where it is necessary to fax a service plan to someone for review and then have him/her fax back his/her signature; however, the provider obtains the original signature for the clinical file within thirty (30) days. No stamped or Xeroxed signatures are allowed. An individual plan of care is considered inherent in the provision of therapy and is not covered as a separate item of behavior management services. The individual plan of care is individualized taking into account the child's age, history, diagnosis, functional levels, and culture. It includes appropriate goals and time limited and measurable objectives. Each member's individual plan of care must also address the provider agency's plans with regard to the provision of services in each of the following areas:

(i) Group therapy;
(ii) Individual therapy;
(iii) Family therapy;
(iv) Alcohol and other drug counseling;
(v) Basic living skills redevelopment;
(vi) Social skills redevelopment;
(vii) Behavior redirection; and
(viii) The provider agency's plan to access appropriate educational placement services. (Any educational costs are excluded from calculation of the daily rate for behavior management services.)

(B) **Individual therapy.** The provider agency must provide individual therapy on a weekly basis with a minimum of one (1) or more sessions totaling one (1) hour or more of treatment per week to children and youth receiving RBMS in group homes. Individual therapy must be age appropriate and the techniques and modalities employed relevant to the goals and objectives of the individual's plan of care. Individual counseling is a face-to-face, one-to-one service, and must be provided in a confidential setting.

(C) **Group therapy.** The provider agency must provide group therapy to children and youth receiving RBMS. Group therapy must be a face-to-face interaction, age appropriate and the techniques and modalities employed relevant to the goals and objectives of the individual's plan of care. The minimum expected occurrence would be one (1) hour per week in group homes. Group size should not exceed six (6) members and group therapy sessions must be provided in a confidential setting. ~~One half hour (30 min)~~Thirty (30) minutes of individual therapy may be substituted for one (1) hour of group therapy.

(D) **Family therapy.** Family therapy is a face-to-face interaction between the therapist/counselor and family, to facilitate emotional, psychological or behavioral changes

and promote successful communication and understanding. The provider agency must provide family therapy as indicated by the resident's individual plan of care. The agency must work with the caretaker to whom the resident will be discharged, as identified by the OHCDS custody worker. The agency must seek to support and enhance the child's relationships with family members (nuclear and appropriate extended), if the custody plan for the child indicates family reunification. The RBMS provider must also seek to involve the child's parents in treatment team meetings, plans and decisions and to keep them informed of the child's progress in the program. Any service provided to the family must have the child as the focus.

(E) **Alcohol and other drug abuse treatment education, prevention, therapy.** The provider agency must provide alcohol and other drug abuse treatment for residents who have emotional or behavioral problems related to substance abuse/chemical dependency, to begin, maintain and enhance recovery from alcoholism, problem drinking, drug abuse, drug dependency addiction or nicotine use and addiction. This service is considered ancillary to any other formal treatment program in which the child participates for treatment and rehabilitation. For residents who have no identifiable alcohol or other drug use, abuse, or dependency, age appropriate education and prevention activities are appropriate. These may include self-esteem enhancement, violence alternatives, communication skills or other skill development curriculums.

(F) **Basic living skills redevelopment.** The provider agency must provide goal-directed activities designed for each resident to restore, retain, and improve those basic skills necessary to independently function in a family or community. Basic living skills redevelopment is age appropriate and relevant to the goals and objectives of the individual plan of care. This may include, but is not limited to food planning and preparation, maintenance of personal hygiene and living environment, household management, personal and household shopping, community awareness and familiarization with community resources, mobility skills, job application and retention skills.

(G) **Social skills redevelopment.** The provider agency must provide goal-directed activities designed for each resident to restore, retain and improve the self-help, communication, socialization, and adaptive skills necessary to reside successfully in home and community based settings. These are age appropriate, culturally sensitive and relevant to the goals of the individual plan of care. For ITS level of care, the minimum skill redevelopment per day is three (3) hours. Any combination of basic living skills and social skills redevelopment that is appropriate to the need and

developmental abilities of the child is acceptable.

(H) **Behavior redirection.** The provider agency must be able to provide behavior redirection management by agency staff as needed twenty-four (24) hours a day, seven (7) days per week. The agency must ensure staff availability to respond in a crisis to stabilize residents' behavior and prevent placement disruption. In addition, ITS group homes will be required to provide crisis stabilization interaction and treatment for new residents twenty-four (24) hours a day, seven (7) days a week.

(4) **Providers.** For eligible RBMS agencies to bill the OHCA for services provided by their staff for behavior management therapies (individual, group, family) as of July 1, 2007, providers must have the following qualifications:

(A) Be licensed in the state in which the services are delivered as a licensed psychologist, social worker (clinical specialty only), professional counselor, marriage and family therapist, or behavioral practitioner, alcohol and drug counselor or under Board approved ~~Supervision~~supervision to be licensed in one (1) of the above stated areas; or

(B) Be licensed as 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~~, AND~~;and

(C) Demonstrate a general professional or educational background in the following areas:

(i) Case management, assessment and treatment planning;

(ii) Treatment of victims of physical, emotional, and sexual abuse;

(iii) Treatment of children with attachment disorders;

(iv) Treatment of children with hyperactivity or attention deficit disorders;

(v) Treatment methodologies for emotionally disturbed children and youth;

(vi) Normal childhood development and the effect of abuse and/or neglect on childhood development;

(vii) Treatment of children and families with substance abuse and chemical dependency disorders;

(viii) Anger management; and

(ix) Crisis intervention.

(D) Staff providing basic living skills redevelopment, social skills redevelopment, and alcohol and other substance abuse treatment, must meet one (1) of the following areas:

(i) Bachelor's or master's degree in a behavioral health related field including but not limited to, psychology, sociology, criminal justice, school guidance and counseling, social work, occupational therapy, family studies, alcohol and drug; or

(ii) ~~A current license as an RN in Oklahoma~~Currently licensed and in good standing as an RN in the state in which services are provided; or

(iii) Certification as an alcohol and drug counselor to provide substance abuse rehabilitative treatment to those with alcohol and/or other drug dependencies or addictions as a primary or secondary DSM diagnosis; or

(iv) Current certification as a behavioral health case manager from the Oklahoma Department of Mental Health and Substance Abuse (ODMHSAS) and meets OHCA requirements to perform case management services, as described in Oklahoma Administrative Code (OAC) 317:30-5-240 through 317:30-5-249.

(E) Staff providing behavior redirection services must have current certification and required updates in nationally recognized behavior management techniques, such as Controlling Aggressive Patient Environment (CAPE) or MANDT. Additionally, staff providing these services must receive initial and ongoing training in at least one (1) of the following areas:

(i) Trauma-informed methodology;

(ii) Anger management;

(iii) Crisis intervention;

(iv) Normal child and adolescent development and the effect of abuse;

(v) Neglect and/or violence on such development;

(vi) Grief and loss issues for children in out of home placement;

(vii) Interventions with victims of physical, emotional and sexual abuse;

(viii) Care and treatment of children with attachment disorders;

(ix) Care and treatment of children with hyperactive, or attention deficit, or conduct disorders;

(x) Care and treatment of children, youth and families with substance abuse and chemical dependency disorders;

(xi) Passive physical restraint procedures; or

(xii) Procedures for working with delinquents or the Inpatient Mental Health and Substance Abuse Treatment of Minors Act.

(F) In addition, behavior management staff must have access to consultation with an appropriately licensed mental health professional.

and family therapist, or behavioral practitioner, alcohol and drug counselor or under Board approved ~~Supervision~~supervision to be licensed in one (1) of the above stated areas; or

(B) Be licensed as 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~~, AND~~;and

(C) Demonstrate a general professional or educational background in the following areas:

(i) Case management, assessment and treatment planning;

(ii) Treatment of victims of physical, emotional, and sexual abuse;

(iii) Treatment of children with attachment disorders;

(iv) Treatment of children with hyperactivity or attention deficit disorders;

(v) Treatment methodologies for emotionally disturbed children and youth;

(vi) Normal childhood development and the effect of abuse and/or neglect on childhood development;

(vii) Treatment of children and families with substance abuse and chemical dependency disorders;

(viii) Anger management; and

(ix) Crisis intervention.

(D) Staff providing basic living skills redevelopment, social skills redevelopment, and alcohol and other substance abuse treatment, must meet one (1) of the following areas:

(i) Bachelor's or master's degree in a behavioral health related field including but not limited to, psychology, sociology, criminal justice, school guidance and counseling, social work, occupational therapy, family studies, alcohol and drug; or

(ii) ~~A current license as an RN in Oklahoma~~Currently licensed and in good standing as an RN in the state in which services are provided; or

(iii) Certification as an alcohol and drug counselor to provide substance abuse rehabilitative treatment to those with alcohol and/or other drug dependencies or addictions as a primary or secondary DSM diagnosis; or

(iv) Current certification as a behavioral health case manager from the Oklahoma Department of Mental Health and Substance Abuse (ODMHSAS) and meets OHCA requirements to perform case management services, as described in Oklahoma Administrative Code (OAC) 317:30-5-240 through 317:30-5-249.

(E) Staff providing behavior redirection services must have current certification and required updates in nationally

recognized behavior management techniques, such as Controlling Aggressive Patient Environment (CAPE) or MANDT. Additionally, staff providing these services must receive initial and ongoing training in at least one (1) of the following areas:

(i) Trauma-informed methodology;

(ii) Anger management;

(iii) Crisis intervention;

(iv) Normal child and adolescent development and the effect of abuse;

(v) Neglect and/or violence on such development;

(vi) Grief and loss issues for children in out of home placement;

(vii) Interventions with victims of physical, emotional and sexual abuse;

(viii) Care and treatment of children with attachment disorders;

(ix) Care and treatment of children with hyperactive, or attention deficit, or conduct disorders;

(x) Care and treatment of children, youth and families with substance abuse and chemical dependency disorders;

(xi) Passive physical restraint procedures; or

(xii) Procedures for working with delinquents or the Inpatient Mental Health and Substance Abuse Treatment of Minors Act.

(F) In addition, behavior management staff must have access to consultation with an appropriately licensed mental health professional.

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 110. INDIAN HEALTH SERVICES, TRIBAL PROGRAMS, AND URBAN INDIAN CLINICS (I/T/Us)

317:30-5-1095. I/T/U services not compensable under outpatient encounters

I/T/U services that are not compensable under outpatient encounters include:

(1) group or mass information programs, health education classes, or group education activities, including media productions and publications;

(2) vaccines covered by the Vaccines for Children program [refer to ~~OAC~~Oklahoma Administrative Code 317:30-5-14(a)(1)];

(3) group or sports physicals and medical reports;

(4) drug samples or other prescription drugs provided to the clinic free of charge;

(5) administrative medical examinations and report services; and

(6) gauze, band-aids, or other disposable products used during an office visit~~.~~; and

(7) billing global obstetrical care when performing a cesarean or vaginal delivery only.

317:30-5-1099. I/T/U service limitations and requirements

Service limitations governing the provision of all Oklahoma SoonerCare services will apply pursuant to Chapter 30 of the OHCA rules. In addition, the following limitations and requirements apply to services provided by I/T/U facilities:

(1) **Multiple encounters.** An I/T/U facility may bill for more than one encounter per ~~24~~twenty-four (24) hour period under certain conditions.

(2) **Behavioral Health services.** Behavioral Health Services are limited to those services furnished to members at or on behalf of the I/T/U facility.

(3) **Laboratory procedures.** Laboratory procedures performed by an I/T/U outpatient facility (not an independently certified enrolled laboratory) on the same date of service are considered part of the health care practitioner's service and are included in the I/T/U encounter.

(4) **Obstetrical services.** For OB services provided to a member before, during, and/or after the same pregnancy, ITUs may not bill for individual encounters and the package/bundled rate. Providers may only either:

(A) bill for antepartum visits, postpartum visits, and/or a cesarean or vaginal delivery as individual encounter; or
(B) bill the packaged/bundled rate for total care obstetrics, (which includes antepartum and postpartum visits and delivery). Refer to Oklahoma Administrative Code 317:30-5-22 for more detailed obstetrical care policy.

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

SUBCHAPTER 5. ELIGIBILITY AND COUNTABLE INCOME

PART 7. APPLICATION AND ELIGIBILITY DETERMINATION PROCEDURES

317:35-5-63. Agency responsible for determination of eligibility

(a) **Determination of eligibility by ~~OHCA.~~Oklahoma Health Care Authority (OHCA).** OHCA is responsible for determining eligibility for the following eligibility groups:

(1) children
(2) newborns deemed eligible
(3) pregnant women
(4) pregnancy-related services under Title XXI
(5) parents and caretaker relatives
(6) former foster care children
(7) Oklahoma Cares Breast and Cervical Cancer program
(8) SoonerPlan Family Planning program.
(9) Programs of All-Inclusive Care for the Elderly

(b) **Determination of eligibility by ~~OKDHS.~~DHS.** ~~OKDHS~~DHS is responsible for determining eligibility for the following eligibility groups:

(1) TANF recipients
(2) recipients of adoption assistance or kinship guardianship assistance
(3) state custody
(4) Refugee Medical Assistance
(5) aged
(6) blind
(7) disabled
(8) Tuberculosis
(9) QMBP
(10) QDWI
(11) SLMB
(12) QI-1
(13) Long term care services
(14) alien emergency services.

(c) **Determination of eligibility for programs offered through the Health Insurance Exchange.** Effective October 1, 2013, OHCA assesses applicants who are found to be ineligible for SoonerCare for potential eligibility for affordable insurance programs offered through the Health Insurance Exchange. OHCA does not determine eligibility or ineligibility for those programs. OHCA facilitates the determination for those affordable insurance

programs by forwarding applicants' electronic applications to the Health Insurance Exchange.

SUBCHAPTER 18. PROGRAMS OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)

317:35-18-3. Definitions

The words and terms used in this Subchapter have the following meanings, unless the context clearly indicates otherwise:

(1) **"American Indian/Alaska Native (AI/AN)"** means an individual of Native American descent who has or is eligible for a Certificate of Degree of Indian Blood (CDIB) card;

(2) **"Capitation"** means the per member per month (pmpm) amount that the Oklahoma Health Care Authority pays PACE providers for PACE compensable services.

(3) **"Interdisciplinary Team (IDT)"** means the team of persons who interact and collaborate to assess PACE participants and plan for their care as set forth in 42 CFR 460.102. The IDT may also include the PACE participant's personal representative or advocate.

(4) **"Participant"** means an individual enrolled in a PACE program.

(5) **"Program agreement"** means the three-party agreement between the PACE provider, Centers for Medicare & Medicaid Services (CMS), and OHCA.

(6) **"Provider"** means the non-profit or for-profit entity that delivers required PACE services under an agreement with OHCA and CMS.

(7) **"Service area"** means the geographic area served by the provider agency, according to the program agreement.

(8) **"State Administering Agency (SAA)"** means the Oklahoma Health Care Authority.

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

SUBCHAPTER 22. PREGNANCY RELATED BENEFITS COVERED UNDER TITLE XXI

317:35-22-2. Scope of coverage for Title XXI Pregnancy

(a) Pregnancy related services provided are prenatal, delivery, postnatal care when included in the global delivery fee, and other related services that are medically necessary to optimize pregnancy outcomes within the defined program benefits.

(b) ~~Only two~~Medical visits ~~per month~~ for other related services to evaluate and/or treat conditions that may adversely impact the pregnancy are covered. All visits shall require medical review to deem whether the medical visit is within the scope of coverage.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY

CHAPTER 2. GRIEVANCE PROCEDURES AND PROCESS

317:2-1-16. Nursing Facility Supplemental Payment Program appeals [REVOKED]

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

~~(1) The following are appealable issues of the program: the assessed amount for each component of the intergovernmental transfer (IGT), the Upper Payment Limit (UPL) payment, the UPL Gap payment, and penalties for the non-state government-owned entity (NSGO). This is the final and only process for appeals regarding NFSPP. Suspensions or terminations from the program are not appealable in the administrative process.~~

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

~~(3) To file an appeal, the NSGO (appellant is the NSGO who files an appeal) shall file an LD-2 form within thirty (30) days from the date of the OHCA letter which advises the NSGO of component of IGT, UPL payment, UPL Gap payment and/or a penalty. An IGT that is not received by the date specified by OHCA, or that is not in the total amount indicated on the notice of program reimbursement (NPR) shall be subject to penalty and suspension from the program. Any applicable penalties shall also be deducted from the UPL payment regardless of any appeal action requested by the facility. Any change in the payment amount resulting from an appeals decision in which a recoupment or additional allocation is necessary will be adjusted in the future from any SoonerCare payments.~~

~~(4) The LD-2 shall only be filed by the NSGO or the NSGO's attorney in accordance with (5) below.~~

~~(5) Consistent with Oklahoma rules of practice, the non-state government-owned (NSGO) entity shall be represented by an attorney licensed to practice within the State of Oklahoma. Attorneys not licensed to practice in Oklahoma shall comply with Article II, Section 5 of Title 5 of the Oklahoma Statutes (O.S.), and rules of the Oklahoma Bar Association.~~

~~(6) The hearing will be conducted in an informal manner, without formal rules of evidence or procedure. However, parties who fail to appear at a hearing, after notification of said hearing date, will have their cases dismissed for failure to prosecute.~~

~~(7) The appellant has the burden of proof by the preponderance of the evidence standard as defined by the Oklahoma Supreme Court.~~

~~(8) The docket clerk will send the appellant and any other necessary party a notice which states the hearing location, date, and time.~~

~~(9) The ALJ may:~~

~~(A) Identify and rule on issues being appealed which will be determined at the administrative hearing;~~

~~(B) Require the parties to state their positions concerning appeal issue(s);~~

~~(C) Require the parties to produce for examination those relevant witnesses and documents under their control;~~

~~(D) Rule on whether witnesses have knowledge of the facts at issue;~~

~~(E) Establish time limits for the submission of motions or memoranda;~~

~~(F) Rule on relevant motions, requests, and other procedural items; limiting all decisions to procedure matters and issues directly related to the contested determination resulting from OAC 317:30-5-136;~~

~~(G) Rule on whether discovery requests are relevant;~~

~~(H) Strike or deny witnesses, documents, exhibits, discovery requests, and other requests or motions which are cumulative, not relevant, not material, or used as a means of harassment, unduly burdensome, or not timely filed;~~

~~(I) Schedule pre-hearing conferences to settle, simplify, or identify issues in a proceeding or to consider other matters that may end the appeal;~~

~~(J) Impose appropriate sanctions against any party failing to obey an order of the ALJ;~~

~~(K) Rule on any requests for extension of time;~~

~~(L) Dismiss an issue or appeal if:~~

~~(i) it is not timely filed or is not within the OHCA's jurisdiction or authority;~~

~~(ii) it is moot or there is insufficient evidence to support the allegations;~~

~~(iii) the appellant fails or refuses to appear for a scheduled meeting, conference or hearing; or~~

~~(iv) the appellant refuses to accept a settlement offer which affords the relief the party could reasonably expect if the party prevailed in the appeal;~~

~~(M) Set and/or limit the time frame for the hearing.~~

~~(10) After the hearing:~~

~~(A) The ALJ should attempt to make the final hearing decision within ninety (90) days from the date of the hearing and send a copy of the ALJ's decision to both parties outlining~~

~~their rights to appeal the decision. Any appeal of the final order pursuant to 12 O.S. ' 951 shall be filed with the District Court of Oklahoma County within thirty (30) days.~~

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

~~(11) All orders and settlements are non-precedential decisions.~~

~~(12) The hearing shall be digitally recorded and closed to the public.~~

~~(13) The case file and any audio recordings shall remain confidential.~~

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 9. LONG-TERM CARE FACILITIES

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

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

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

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

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

~~(3) **"Non-state government-owned (NSGO)"** means an entity owned and/or operated by a unit of government other than the state and the application packet is accepted and determined complete by OHCA as a qualified NSGO.~~

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

~~(5) **"Supplemental payment calculation period"** means the State Fiscal Year for which supplemental payment amounts are calculated based on Medicaid paid claims (less leave days) compiled from the state's Medicaid Management Information System (MMIS) at a minimum yearly to a maximum quarterly.~~

~~(6) **"Upper payment limit (UPL)"** means a reasonable estimate of the amount that would be paid for the services furnished by a facility under Medicare equivalent payment.~~

~~(c) **Eligible nursing facilities.** A nursing facility that is owned and as applicable under the operational responsibility of an NSGO,~~

~~is eligible for participation when the following conditions are met:~~

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

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

~~(3) the participating NSGO has completed and submitted the Agreement of Participation application at minimum thirty (30) days prior to the start of the participation quarter and received the application packet is accepted and determined complete by OHCA;~~

~~(4) the facility is an active participant in the Focus on Excellence program and has earned at minimum one-hundred (100) points; does not receive an immediate jeopardy (IJ) scope and severity tag for abuse or neglect on three (3) separate surveys within a twelve (12) month period; and~~

~~(5) the facility and NSGO comply with care criteria requirements. All facilities shall provide supporting documentation (e.g., baselines, written plan, improvement summary, data sources) for the care criteria metrics.~~

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

~~(1) shall provide proof of ownership, if applicable (i.e. Change of Ownership) as licensed operator of the nursing facility;~~

~~(2) shall provide proof of proximity requirements of no greater than one hundred fifty (150) miles of NSGO. Exceptions may be made at the sole discretion of OHCA;~~

~~(3) shall execute a nursing facility provider contract as well as an agreement of participation with the OHCA;~~

~~(4) shall provide OHCA with an executed Management Agreement between the NSGO and the facility manager;~~

~~(5) shall provide and identify the state share dollars' source of the IGT;~~

~~(6) shall pay the calculated IGT to OHCA by the required deadline;~~

~~(7) shall utilize program dollars for health care related expenditures; and~~

~~(8) shall provide per facility, the per patient per Medicaid day (PPMD) IGT within specified timeframe of receipt of the Notice of Program Reimbursement (NPR) as indicated below:~~

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

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

~~(C) For the third year-$8.50 PPMD, or the equivalent of ten percent (10%) of nursing facility budget of the current fiscal year, whichever is less. This amount excludes any IGT for actual administration cost associated with the nursing~~

home UPL supplemental program. Any remaining IGT after administration cost shall be distributed through the rate setting methodology process. Distribution shall occur once escrowed funds reach an amount sufficient to distribute as determined by OHCA.

(e) **Change in ownership.**

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

(2) For a nursing facility that changes ownership on or after the first day of the SoonerCare supplemental payment limit calculation period, the data used for the calculations will include data from the facility for the entire upper payment limit calculation period relating to payments for days of service provided under the prior owner, pro-rated to reflect only the number of calendar days during the calculation period that the facility is owned by the new owner.

(f) **Care Criteria.** Each facility shall be required to participate in the following care criteria components to receive UPL financial reimbursement.

(1) **Component 1- Quality Improvement Plan.** A facility shall hold monthly Quality Improvement Plan meetings. The meetings shall be tailored to identify an improvement plan for quality enhancement focused on nursing facility safety, quality of resident life, personal rights, choice and respect. Consistent with 42 CFR 483.75. Quality indicators shall be identified during the meetings and include the following:

(A) A written plan to include but not limited to the development, implementation and evaluation of the quality enhancement indicator. The plan shall be reviewed monthly for ongoing quality indicator progress, completion of the quality indicator and/or routine updates on the sustainability of current and/or prior indicators achieved.

(B) The design and scope of the plan should include the specific system and service that will be utilized to monitor and track performance improvement, the staff included to improve the quality indicator, resident choice, subjective/objective evidence and ongoing measures taken to ensure stability and enhancement. This may include but not be limited to a written policy, a procedure manual, data collections systems, management practices, resident/staff interviews, and trainings.

(C) Outcomes shall include evidence of improvement, cost expenditures toward improvement goal, how the facility shall continue to monitor the effectiveness of its quality enhancement and how it shall have ongoing sustainability.

(D) Facility shall submit program documentation monthly. The information shall include A-D as well as OHCA required form LTC-19.

(E) The quality improvement plan shall be reviewed monthly by the OHCA quality review team. Payment shall be assessed in increments of 20 percent (20%) per month for a total of 60 percent (60%) per quarter if approved.

(2) **Component 2- Health Improvement Plan.**

(A) A facility shall hold quarterly Health Improvement Plan meetings. The meetings shall be tailored to identify an improvement plan for the quality indicators of urinary tract infection, unintended weight loss, developing or worsening pressure ulcers, and received antipsychotic medication. Meetings include the following:

(i) A written plan to include but not limited to the development, implementation and evaluation of the quality enhancement indicator. The plan shall be reviewed quarterly for ongoing quality indicator progress, completion of the quality indicator and/or routine updates on the sustainability of current and/or prior indicators achieved.

(ii) The design and scope of the plan should include the specific system and service that shall be utilized to monitor and track performance improvement, the staff included to improve the quality indicator, resident choice, subjective/objective evidence and ongoing measures taken to ensure stability and enhancement. This may include but not be limited to a written policy, a procedure manual, data collections systems, management practices, resident/staff interviews, and trainings.

(iii) Outcomes shall include evidence of improvement, cost expenditures toward improvement, how the facility will continue to monitor the effectiveness of its quality enhancement and how it shall have ongoing sustainability.

(iv) Facility shall submit program documentation quarterly. The information will include i-iii as well as OHCA required form LTC-18.

(B) The health improvement plan shall be reviewed quarterly by the OHCA quality review team. Payment shall be assessed in increments of ten percent (10%) by achieving five percent (5%) relative improvement or by achieving the national average benchmark per each of the four (4) components quarterly for a total of forty percent (40%) per quarter if approved.

(3) **Care Criteria Evaluation and Audit.** The care criteria measures may be evaluated at the discretion of OHCA on an annual basis after each fiscal year, following implementation of the

~~program. However, OHCA reserves the right to conduct intermittent evaluations within any given year based on the quality, care and safety of SoonerCare members. The evaluation may be conducted by an independent evaluator. In addition, care criteria metrics may be internally evaluated after each fiscal year at the discretion of OHCA. The OHCA may make adjustments to the care criteria measures based on findings and recommendations as a result of the independent or internal evaluation.~~

~~(g) **Supplemental Payments.**~~

~~(1) The nursing facility supplemental payments to a NSGO under this program shall not exceed Medicare payment principles pursuant to Inpatient Services: Application of Upper Payment Limits, 42 C.F.R., Sec. 447.272. Payments are made in accordance with the following criteria:~~

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

~~(B) The eligible supplemental amount is the difference/gap between the SoonerCare payment and the Medicare equivalent payment as determined based on compliance with the care criteria metrics.~~

~~(2) The amount of the eligible supplemental payment is associated with improvement of care of SoonerCare nursing facility residents as demonstrated through the care criteria. The quality components are evaluated monthly with a quarterly payout. Component 1 is assessed at twenty percent (20%) per month with a possible total achievement of sixty percent (60%) per quarter. Component 2 is assessed at ten percent (10%) per each of the four (4) components with a possible total achievement of 40 percent (40%) per quarter. Facilities will be reimbursed accordingly based on the percentage of care criteria earned.~~

~~(h) **Disbursement of payment.** NSGOs shall secure allowable IGT funds from a NSGO to fund the non-federal share amount. The method is as follows:~~

~~(1) The OHCA or its designee will notify the NSGO of the non-federal share amount to be transferred by an IGT, via electronic communications and NPR, for purposes of seeking federal financial participation (FFP) for the UPL supplemental payment, within twenty-five (25) business days after the end of the quarter. This amount will take into account the percentage of metrics achieved under the care criteria requirement. The NSGO will have five (5) business days to sign the participant agreement and make payment of the state share in the form of an IGT either in person or via mail. The date the NPR is sent by OHCA or its designee to the provider (NSGO) is the official date the clock starts to measure the five (5) business days. In~~

addition, the NSGO shall also be required to remit, upon receipt of the NPR, the applicable PPMD IGT in full, pursuant to (d) (7) above.

(2) If the full IGT and the PPMD IGT are received within five (5) business days, the UPL payment will then be disbursed to the NSGO by OHCA within ten (10) business days in accordance with established payment cycles.

(i) **Penalties.**

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

(2) Any total IGT received after the fifth (5th) business day, but with an OHCA date stamp or mailing postal mark on or prior to five (5) business days from the official date of the receipt of the NPR will not be subject to penalty.

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

(A) A five percent (5%) penalty will be assessed for the total IGT payments received after five (5) business days, but within eight (8) business days of receipt of the NPR. The five percent (5%) penalty will be assessed on the total eligible supplemental payment for the quarter in which the IGT is late and assessed to the specific NSGO as applicable.

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

(C) An NSGO that remits payment of the total IGT under the circumstances listed in (i) (2) or (i) (3) above will receive payment during the next available OHCA payment cycle.

(4) The first violation by an NSGO to remit the full IGT as indicated on the NPR by OHCA or its designee within the defined timeframes shall subject the NSGO to a penalty. The second violation by an NSGO to remit the full IGT indicated on the NPR by OHCA or its designee within the defined timeframes shall subject the NSGO to a penalty and a suspension for two (2) consecutive quarters. The NSGO will not be eligible to participate in the program during suspended quarters. A third violation by an NSGO to remit the full IGT indicated on the NPR

by OHCA or its designee within the defined timeframes shall subject the NSGO to termination from the NFSPP. If the NSGO desires to participate again, it will be required to reapply. Reentry into the program is at the sole discretion of the OHCA. If the NSGO is readmitted to the program, terms of participation may include a probationary period with defined requirements.

(5) If OHCA receives a partial IGT or receives a full IGT after eight (8) business days of the receipt of the NPR, the NSGO shall be deemed to have voluntarily elected to withdraw participation in the NFSPP.

(6) If a nursing facility fails to meet the benchmarks of component 1 and/or component 2 of the care criteria for two (2) consecutive quarters, the facility shall be suspended for two (2) subsequent quarters and will not be eligible to participate in the program during suspended quarters. A facility that has been suspended for a total of four (4) quarters within a two (2) year period due to non-compliance with the Care Criteria shall be terminated from the program, and if the facility wishes to participate again, it will be required to reapply. Reentry into the program is at the sole discretion of the OHCA. If the facility is readmitted to the program, terms of participation may include a probationary period with defined requirements as it relates to care.

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

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

SUBCHAPTER 3. GENERAL PROVIDER POLICIES

PART 1. GENERAL SCOPE AND ADMINISTRATION

317:30-3-19.6. Complaints related to the Defunding Statutory Rape Cover-up Act

(a) In accordance with Title 56 of the Oklahoma Statutes (O.S.) § 1007.4, the Oklahoma Health Care Authority (OHCA) shall investigate complaints made pursuant to the Defunding Statutory Rape Cover-up Act that are submitted in writing to OHCA's Legal Division, and that include:

(1) The name and contact information of the person submitting the complaint;

(2) The name of the health care provider and/or affiliate, as that term is defined by 56 O.S. § 1007.1, who is alleged:

(A) To have been found by a court of law to have failed to report statutory rape; or

(B) To have failed to report statutory rape where the statutory rape resulted in a conviction against the assailant;

(3) The name of the SoonerCare member who allegedly was the victim of statutory rape (if the member is an adult), or of the member's parent(s) or legal guardian (if the member is a minor); and

(4) A short summary of any other relevant information.

(b) A complaint made pursuant to the Defunding Statutory Rape Cover-up Act may result in a denial of an application for a new or renewed provider enrollment contract, pursuant to Oklahoma Administrative Code (OAC) 317:30-3-19.3, or termination of an existing provider agreement, pursuant to OAC 317:30-3-19.5.

(c) A complaint made pursuant to the Defunding Statutory Rape Cover-up Act may also result in a referral to local law enforcement authorities, where appropriate.

Oklahoma Health Care Authority Board Meeting – Drug Summary

Drug Utilization Review Board Meeting – November 13, 2019 and December 11, 2019

Recommendation/ Vote	Drug	Used for	Cost*	Notes
1	Vyndaqel® Vyndamax™	Hereditary ATTR-CM	• $18,750 per 30 days	
2	Recarbio™ Xenleta™	Antibiotics	• N/A • $1,024.50 -$1,434.30	• Complicated UTI or Complicated Intra-abdominal Infection • Community Acquired Bacterial Pneumonia
3	Turalio™	Tenosynovial Giant Cell Tumor	• $19,800 per month	
4	Elzonris® Inrebic®	Blastic Plasmasytoid Dendritic Cell Neoplasm Myelofibrosis	• $25,529.35 per vial (Weight based dosing; cost varies) • $21,000 per month	
5	Aemcolo™ Motegrity™ Zelnorm™ Ibsrela®	Traveler's Diarrhea Constipation (C) Irritable Bowel Syndrome C (IBS-C) IBS-C	• $144.00 per 3 day course • $409.80 per month • $388.80 per month • N/A	
6	Bevyxxa®	Venous Thromboembolism	• $645.00 per course	
7	Avaclyr™	Antiviral	• N/A	Ophthalmic ointment

*Costs do not reflect rebated prices or net costs. Costs based on National Average Drug Acquisition Costs (NADAC) or Wholesale Acquisition Costs (WAC) if NADAC unavailable. N/A = not available at the time of publication.

Recommendation 1: Vote to Prior Authorize Vyndaqel® and Vyndamax™

The Drug Utilization Review Board recommends the prior authorization of Vyndaqel® and Vyndamax™ with the following criteria:

Vyndaqel® (Tafamidis Meglumine) and Vyndamax™ (Tafamidis) Approval Criteria:

1. An FDA approved indication for the treatment of cardiomyopathy of wild type or hereditary transthyretin-mediated amyloidosis (ATTR-CM) in adults to reduce cardiovascular (CV) mortality and CV-related hospitalization; and
2. Diagnosis confirmed by:
    a. Genetic confirmation of transthyretin (*TTR*) mutation (e.g., Val122Ile) or wild-type amyloidosis; and
    b. Cardiac imaging (including ultrasound or MRI) confirming cardiac involvement; and
3. Presence of amyloid deposits confirmed by:
    a. Nuclear scintigraphy; or
    b. Endomyocardial biopsy; and
4. Member must have medical history of heart failure (NYHA Class I to III); and
5. Prescriber must confirm light-chain amyloidosis (AL) has been ruled out; and
6. Vyndaqel® or Vyndamax™ must be prescribed by or in consultation with a cardiologist or geneticist (or an advanced care practitioner with a supervising physician who is a cardiologist or geneticist); and
7. Prescriber must verify Vyndaqel® or Vyndamax™ will not be used concomitantly with Onpattro® (patisiran) or Tegsedi™ (inotersen); and
8. Initial approvals will be for the duration of 6 months. Reauthorization may be granted if the prescriber documents the member is responding well to treatment; and
9. A quantity limit of 4 Vyndaqel® capsules or 1 Vyndamax™ capsule per day will apply.

Recommendation 2: Vote to Prior Authorize Recarbrio™ and Xenleta™

The Drug Utilization Review Board recommends the prior authorization of Recarbrio™ and Xenleta™ with the following criteria:

Recarbrio™ (Imipenem/Cilastatin/Relebactam) Approval Criteria:

1. An FDA approved diagnosis of 1 of the following infections caused by designated susceptible microorganisms:
    a. Complicated intra-abdominal infection (cIAI); or
    b. Complicated urinary tract infection (cUTI), including pyelonephritis; and
2. Member must be 18 years of age or older; and
3. The prescriber must verify that limited or no alternative treatment options are available; and
4. A patient-specific, clinically significant reason why the member cannot use an appropriate penicillin/beta lactamase inhibitor combination (e.g., piperacillin/ tazobactam), a carbapenem (e.g., ertapenem, meropenem, imipenem/cilastatin), a

cephalosporin (e.g., ceftriaxone, ceftazidime) in combination with metronidazole, or other cost-effective therapeutic equivalent alternative(s) must be provided; and
5. A quantity limit of 56 vials per 14 days will apply.

Xenleta™ (Lefamulin) Approval Criteria:
1. An FDA approved diagnosis of community-acquired bacterial pneumonia (CABP) caused by designated susceptible microorganisms; and
2. Member must be 18 years of age or older; and
3. A patient-specific, clinically significant reason why the member cannot use an appropriate beta-lactam (e.g., ceftriaxone, cefotaxime, ceftaroline, ertapenem, ampicillin/sulbactam) in combination with a macrolide (e.g., azithromycin, clarithromycin) or doxycycline, or other cost-effective therapeutic equivalent alternative(s) must be provided; and
4. Approval quantity will be based on Xenleta™ prescribing information and FDA approved dosing regimen(s).

Recommendation 3: Vote to Prior Authorize Turalio™

The Drug Utilization Review Board recommends the prior authorization of Turalio™ with the following criteria:

Turalio™ (Pexidartinib) Approval Criteria [Soft Tissue Sarcoma – Pigmented Villonodular Synovitis (PVNS)/Tenosynovial Giant Cell Tumor (TGCT) Diagnosis]:
1. Member must not be a candidate for surgery; and
2. Pexidartinib must be used as a single-agent only.

Recommendation 4: Vote to Prior Authorize Elzonris® and Inrebic®

The Drug Utilization Review Board recommends the prior authorization of Elzonris® and Inrebic® with the following criteria:

Elzonris® (Tagraxofusp-erzs) Approval Criteria [Blastic Plasmacytoid Dendritic Cell Neoplasm (BPDCN) Diagnosis]:
1. Diagnosis of BPDCN; and
2. Member must be 2 years of age or older; and
3. Must be used as a single-agent.

Inrebic® (Fedratinib) Approval Criteria [Myelofibrosis Diagnosis]:
1. Diagnosis of myelofibrosis in adult members; and
2. Intermediate-2 or high-risk primary or secondary (post-polycythemia vera or post-essential thrombocythemia).

Recommendation 5: Vote to Prior Authorize Aemcolo™ Motegrity™, Zelnorm™, and Ibsrela®

The Drug Utilization Review Board recommends the prior authorization of Aemcolo™ Motegrity™, Zelnorm™, and Ibsrela® with the following criteria:

Aemcolo™ (Rifamycin) Approval Criteria:

1. An FDA approved diagnosis of travelers' diarrhea; and
2. Member must be 18 years of age or older; and
3. Travelers' diarrhea must be due to non-invasive strains of *Escherichia coli*; and
4. A patient-specific, clinically significant reason why the member cannot use Xifaxan® (rifaximin) oral tablets must be provided; and
5. A quantity limit of 12 tablets per 3 days will apply.

Motegrity™ (Prucalopride) Approval Criteria:

1. An FDA approved diagnosis of chronic idiopathic constipation (CIC) in members 18 years of age or older; and
2. Documentation that constipation-causing therapies for other disease states have been discontinued (excluding opioid pain medications for cancer patients); and
3. Documented and updated colon screening for members older than 50 years of age; and
4. Documentation of hydration attempts and trials of at least 3 different types of products that failed to relieve constipation. Trials must be within the past 90 days. Products may be over-the-counter (OTC) or prescription (does not include fiber or stool softeners); and
    a. One of the 3 trials must be polyethylene glycol 3350 (PEG-3350); and
    b. Members with an oncology-related diagnosis are exempt from the trial requirements; and
5. A patient-specific, clinically significant reason why member cannot use Linzess® (linaclotide), Amitiza® (lubiprostone), or Trulance® (plecanatide) must be provided; and
6. Approval will initially be for 12 weeks of therapy. Further approval may be granted if prescriber documents member is responding well to treatment; and
7. A quantity limit of 30 tablets per 30 days will apply.

Zelnorm™ (Tegaserod) Approval Criteria:

1. An FDA approved diagnosis of irritable bowel syndrome with constipation (IBS-C) in female members 18 to 64 years of age; and
2. Member must be female for authorization of Zelnorm™ (the safety and effectiveness of Zelnorm™ in men with IBS-C have not been established); and
3. Member must not have any of the contraindications for use of Zelnorm™ [i.e., history of myocardial infarction (MI), stroke, transient ischemic attack (TIA), or angina; history of ischemic colitis or other forms of intestinal ischemia; severe renal impairment (estimated glomerular filtration rate {eGFR} <15mL/min/1.73m^2) or end-stage renal disease (ESRD); moderate or severe hepatic impairment (Child-Pugh B or C); history of bowel obstruction, symptomatic gallbladder disease, suspected sphincter of Oddi dysfunction, or abdominal adhesions; hypersensitivity to tegaserod)]; and

4. Documentation that constipation-causing therapies for other disease states have been discontinued (excluding opioid pain medications for cancer patients); and
5. Documented and updated colon screening for members older than 50 years of age; and
6. Documentation of hydration attempts and trials of at least 3 different types of products that failed to relieve constipation. Trials must be within the past 90 days. Products may be over-the-counter (OTC) or prescription (does not include fiber or stool softeners); and

a. One of the 3 trials must be polyethylene glycol 3350 (PEG-3350); and
b. Members with an oncology-related diagnosis are exempt from the trial requirements; and

7. A patient-specific, clinically significant reason why member cannot use Amitiza® (lubiprostone), Linzess® (linaclotide), or Trulance® (plecanatide) must be provided; and
8. Approval will initially be for 6 weeks of therapy. Further approval may be granted if prescriber documents member is responding well to treatment. Zelnorm™ should be discontinued in patients who have not had adequate control of symptoms after 4 to 6 weeks of treatment; and
9. A quantity limit of 60 tablets per 30 days will apply.

Ibsrela® (Tenapanor) Approval Criteria:

1. An FDA approved diagnosis of irritable bowel syndrome with constipation (IBS-C) in members 18 years of age or older; and
2. Documentation that constipation-causing therapies for other disease states have been discontinued (excluding opioid pain medications for cancer patients); and
3. Documented and updated colon screening for members older than 50 years of age; and
4. Documentation of hydration attempts and trials of at least 3 different types of products that failed to relieve constipation. Trials must be within the past 90 days. Products may be over-the-counter (OTC) or prescription (does not include fiber or stool softeners); and
    a. One of the 3 trials must be polyethylene glycol 3350 (PEG-3350); and
    b. Members with an oncology-related diagnosis are exempt from the trial requirements; and
5. A patient-specific, clinically significant reason why member cannot use Amitiza® (lubiprostone), Linzess® (linaclotide), or Trulance® (plecanatide) must be provided; and
6. Approval will initially be for 12 weeks of therapy. Further approval may be granted if prescriber documents member is responding well to treatment; and
7. A quantity limit of 60 tablets per 30 days will apply

Recommendation 6: Vote to Prior Authorize Bevyxxa®

The Drug Utilization Review Board recommends the prior authorization of Bevyxxa® with the following criteria:

Bevyxxa® (Betrixaban) Approval Criteria:

1. An FDA approved indication for the prophylaxis of venous thromboembolism (VTE) in adult patients hospitalized for an acute medical illness who are at risk for thromboembolic complications due to moderate or severe restricted mobility and other risk factors for VTE; and
2. If the member started on the medication in the hospital, number of days of treatment with betrixaban in the hospital must be provided; and
3. Approvals will be for a maximum duration of 42 days (including use accounted for while in hospital); and
4. A quantity limit of 43 capsules per 42 days will apply.

Recommendation 8: Vote to Prior Authorize Avaclyr™

The Drug Utilization Review Board recommends the prior authorization of Avaclyr™ with the following criteria:

Avaclyr™ (Acyclovir 3% Ophthalmic Ointment) Approval Criteria:

1. An FDA approved diagnosis of acute herpetic keratitis (dendritic ulcers) in patients with herpes simplex virus (HSV); and
2. A patient-specific, clinically significant reason why the member cannot use trifluridine 1% ophthalmic solution must be provided; and
3. A patient-specific, clinically significant reason why the member cannot use oral acyclovir, famciclovir, or valacyclovir must be provided.