MIKE FOGARTY
CHIEF EXECUTIVE OFFICER

MARY FALLIN
GOVERNOR

STATE OF OKLAHOMA

OKLAHOMA HEALTH CARE AUTHORITY

MEDICAL ADVISORY COMMITTEE MEETING
AGENDA
November 16, 2011
1:00 p.m. – Ponca Conference Room
2401 NW 23rd St., Suite 1A
Oklahoma City, OK 73107

I. Welcome, Roll Call, and Public Comment Instructions

II. Approval of minutes of the September 15, 2011 Medical Advisory Committee Meeting

III. MAC Member Comments/Discussion

IV. Financial Report: Gloria Hudson-Hinkle, Director of General Accounting
   A. September Financial Summary
   B. September Financial Detail Report

V. SoonerCare Operations Update: Carolyn Reconnu, Director, Health Management Program
   A. SoonerCare Programs Report
   B. Health Management Program (HMP) Update

VI Dual Eligibles: Sarah Harding and David Ward, Policy, Planning & Integrity

VII. Waiver Development and Reporting: Cara Norris-Ramirez and Kimrey McGinnis, Policy, Planning & Integrity
   A. 1115 SoonerCare Choice waiver renewal
   B. Proposal for limited benefit packages for aspects of BCC program

VIII. Action Items: Traylor Rains, Policy Development Coordinator

OHCA Initiated

11-03 Family Planning Waiver Population to State Plan – OHCA rules for the SoonerPlan Family Planning Program are revised to remove references to the Family Planning Waiver. Section 2303 of the Patient Protection and Affordable Care Act allows individuals receiving Family Planning Waiver services to receive those same services plus additional family planning and family planning related services under the Title XIX State Plan. In addition to a broader service package, the State Plan option allows a more efficient way of making future changes to the SoonerPlan program. If approved, the rule change will allow over 32,000 SoonerPlan members and future members to receive the enhanced package of State Plan

Family Planning services. The rule revision also includes the removal of language relating to family planning centers, clarification of eligibility rules and other minor policy corrections.

Budget Impact – $171,887 state share; $1,246,000 federal share

11-24 Certified Alcohol and Drug Counselors – Rules are revised to reflect that behavioral health therapy services may only be provided by licensed professionals effective July 1, 2013. Currently, Certified Alcohol and Drug Counselors (CADCs) may perform therapy services in accordance with their Licensure Act. Revisions are made to comply with Oklahoma Statues.
Budget Impact – Budget Neutral

11-27 Outpatient Behavioral Health Rules – Agency Behavioral Health rules are revised in order to sufficiently and accurately set forth the substantive and procedural requirements for providing and billing for covered SoonerCare behavioral health services. Provider credentials and coverage guidelines will be transferred from the current Behavioral Health Provider Manual to the Agency's Behavioral Health rules in order to comply with rule promulgation requirements set forth in Oklahoma Administrative Procedures Act (APA). These revisions will not only ensure that the Agency remains in compliance with the APA, but also provides the Agency the necessary legal basis to successfully maintain program integrity. Additionally, Partial Hospitalization Program (PHP) rules are revised in order to provide consistency with the Title XIX State Plan.
Budget Impact – Budget Neutral

Federally Initiated

11-04 "Rosa's Law" Revisions – OHCA rules are revised to change language in policy that references "mental retardation" to "intellectual disabilities". Revisions are necessary to comply with Public Law 111-256 (Rosa's Law) that replaces the term mental retardation with intellectual disability, in federal education, health and labor laws.
Budget Impact –Budget Neutral

11-20 Provider Agreements Clarification– Provider agreement rules are revised to ensure clarity. Revisions are made to reflect language in 42 CFR 455.414; that provider agreements must be renewed at least every five years. Additionally, revisions are made to revise the contact information for the OHCA Provider Contracting Unit.
Budget Impact – Budget Neutral

OKDHS Initiated

11-15 Long-term Care Partnership Program– Oklahoma Health Care Authority long-term care eligibility rules are revised to include a brief description of the Long-term Care Partnership program. The Long-term Care Partnership program (LTCP) allows individuals with qualified LTCP insurance policies the opportunity to protect certain assets in determining eligibility for SoonerCare long term care services.
Budget Impact – Budget Neutral

IX. New Business

X. Adjourn

Next Meeting: Thursday, January 19, 2012.

MEDICAL ADVISORY COMMITTEE MEETING
Draft Meeting Minutes
September 15, 2011

Members attending: Ms. Bellah, Dr. Bourdeau, Ms. Case, Dr. Cavallaro, Dr. Crawford, Mr. Rick Snyder for Craig Jones, Ms. Karen Bradford for Ms. Sherry Davis, Ms. Dempsey for Mr. Goforth, Dr. Grogg (teleconference), Ms. Thayer for Mr. Howard Hendrick, Ms. Holliman-James, Mr. Duehning for Mr. Machtolff, Dr. McNeill, Dr. Post, Dr. Rhynes, Mr. Roye, Dr. Simon, Mr. Steve Buck for Ms. White, Mr. Unruh, Dr. Wells, Dr. Woodward, Dr. Wright

Members absent: Dr. Aulgur, Ms. Bates, Mr. Brose, Dr. Ogle, Dr. Rhoades, Mr. Tallent, Dr. Woodward, Dr. Wright

I. Welcome, Roll Call, and Public Comment Instructions

Dr. Crawford welcomed the committee members and called the meeting to order. Roll call established the presence of a quorum. There were no requests for public comment.

II. Approval of minutes of the May 19, 2011 Medical Advisory Committee Meeting

Ms. Holliman-James made the motion to approve the minutes as presented. Ms. Bellah seconded. Motion carried.

III. MAC Member Comments/Discussion

Dr. Keenan encouraged review of the MAC packets when received.

Ms. Case presented a report on the MAC Workgroup, and a discussion of the terms of service. Membership is statutorily defined at the Federal and State levels. It is the MAC members' responsibility to take the information from the meetings back to their representative organizations. Discussion of rotation of members ensued. In order to rotate members, terms of 1, 2 or 3 years were drawn by members present. Future re-appointment will be for 3 years. Members not present had terms drawn by proxy. The OHCA will send letters to the representative organizations to request they confirm or designate their representative and an alternate for the next term. If a MAC member has missed more than half of the meetings in the previous 12 months, the CEO after soliciting recommendations from the Chair or Vice-Chair may replace the member if it is a mandated seat. If the seat is not mandated, OHCA will contact the appropriate organization to appoint another member and alternate. The OHCA will provide member orientation. Any questions that may come up can be directed to Dr. Keenan.

It is the goal of OHCA to bring any issues that may result in new rules to the MAC for informal discussion.

IV. Financial Report, End of Year: Gloria Hudson-Hinkle, Director of General Accounting

Ms. Hudson-Hinkle reviewed the financial transactions through June 2011. For more detailed information see MAC information packet. There were no questions.

V. Board Retreat Update: Cindy Roberts, Director of Program Integrity and Planning

Dr.. Crawford commented that the Member Task Force was very poignant, they felt very engaged at the Retreat. Other states could emulate. We have a lot of input from different task forces and committees before things finally make it to our Board. A lot of the initiatives actually start in those committees. Dr. Crawford mentioned that the MAC used to have legislative representation, and we could potentially have it again. Ms. Roberts discussed our initiatives done to help keep our per member per month cost down throughout the years, including Care Management functions and ER utilization. The items from the Retreat are on our website.

Ms. Roberts mentioned that Mr. Fogarty did a presentation the previous day that went through the previous expansion and changes in SoonerCare since the beginning of the agency and offered copies for the next MAC meeting.

Dr. McNeill mentioned he went to a site visit to an inner city FQHC clinic in Los Angeles. They were already receiving money and enrolling people who would be eligible in 2014. Dr. McNeill asked if it is available to Oklahoma. Ms. Roberts commented that it is a state option, and Oklahoma has decided to not take that option; State dollars would be required.

Ms Pasternik-Ikard reminded the committee that the current measure on the Fast Facts which indicates we are currently only using about 40% of our capacity is based on the maximum number of members the physicians are currently willing to accept, not on their potential capacity. Recruitment is part of our strategic planning. We have a significant number of pediatric providers which coincides with our larger pediatric population. We do see a need for more primary care providers for adults in the future.

Dr. Post made comment that in some states, chiropractors are allowed to be Medical Home, it's an area they have zero penetration because they cannot apply to participate, and he suggests that chiropractors are considered to help with the influx of people that may be taken on.

Dr. McNeill stated that the biggest problem is the need for specialists, particularly certain ones. Dr. Wells mentioned pediatric dentists, the limited number in the state, and the limited number who take SoonerCare. He doesn't see a way to have a decent level of access to care, without major changes in the Board of Dentistry rules that limit the use of hygienists.

Dr. Rhynes commented on Optometry. Adults need to have access to routine exams and glasses. Dr. Rhynes said if there was access to eye care for adults, it would help recruitment of providers. Medicaid is not going to pay for the exam and glasses. If they have a medical diagnosis they'll pay for the exam, but the patient is responsible for their own glasses (for adults).

Ms. Roberts replied that would be an issue for the benefit package, and we are looking at it for the new population. Currently the adults are not an age group we cover, unless they are in Insure Oklahoma, Aged, Blind, Disabled, or pregnant. Under the new ACA rules, anybody in the income guidelines would be covered. A lot of it comes down to dollars and sense, and whether the federal government will allow or not allow this in the benefit package for the new group of eligibles.

VI. DUR Update: Shellie Keese and Chris Le, OU College of Pharmacy
Ms. Keese and Ms. Le reviewed the handout. There were no questions.

VII. Budget Update: Juarez McCann addressed the MAC and reviewed the handout.
Ms. Case asked if the Dental line adjustment was due to lack of access. Mr. McCann replied no, when we built the budget we projected more of a growth to the program than actually happened.

VIII. SoonerCare Operations Update: Debbie Spaeth, Behavioral Services Director
Ms. Spaeth reviewed the handouts and pointed out there was good growth in the provider network.

IX. Action Items: Traylor Rains, Policy Development Coordinator

<u>OHCA Initiated</u>

11-16 Cost Sharing for Pregnant Women – SoonerCare cost-sharing rules are revised to clarify OHCA's current policy that pregnancy-related services are exempt from cost-sharing requirements.
Budget Impact - Budget Neutral

11-17 Prescription Exemption for DME Repairs – SoonerCare provider rules are amended to exempt durable medical equipment repairs with a cost per item of less than $250.00 from the prescription requirement.
Budget Impact – Budget Neutral

11-18 Supplemental Hospital Offset Payment Program (SHOPP) – OHCA is authorized by 63 Okla. Stat. §§ 3241.1 through 3241.6 to implement the Supplemental Hospital Offset Payment Program (SHOPP). OHCA is required by the SHOPP Act to assess in-state hospitals an assessment fee of 2.5%. Funds derived from the

assessment are used to garner federal matching funds to supplemental Medicaid payment and pay participating hospitals a quarterly access payment.
Budget Impact: The assessment is expected to generate approximately $151 million in state dollars, $30 million of which is allocated to the Medical Payments Cash Management Improvement Act Program Disbursing Fund and used to maintain SoonerCare provider reimbursement rates. After garnering federal matching dollars, $336 million will be available to make supplemental payments to participating hospitals in the state of Oklahoma and approximately $83 million will be available to maintain SoonerCare provider payments.

Rules 11-16, 11-17, 11-18 approved by Dr. McNeill. Dr. Post seconded.

OKDHS Initiated

11-11 ADvantage Waiver Rules - OHCA rules for the ADvantage Waiver are revised to remove Respiratory Therapy as an allowable service within the waiver and remove Hospice when the member is in a nursing facility receiving ADvantage Facility Based Extended Respite. Both services are removed due to lack of utilization. Additionally, rules are revised to remove language allowing for reimbursement to providers of case management transition services when the member fails to transition into the ADvantage waiver program. The revisions are necessary to align OHCA policy with revised operational procedures as approved by the Centers for Medicare and Medicaid Services.
Budget Impact – The Oklahoma Department of Human Services operates the ADvantage waiver and will benefit from the proposed rule change through realization of lower operational costs. An estimated savings of $15,000 annually will be realized through implementation of the rule change.

Ms. Dempsey, representing Mr. Goforth, opposed this item and would like more information. Mr Rains explained that there has been no utilization of this Respiratory Therapy, the $15,000 savings is coming from the transition. Ms. Dempsey said as we're ramping up, even with the ACA, we're re-balancing and it could pose an unnecessary institutionalization of someone. Melinda Jones replied that the reason we took it out of the waiver renewal, was because we had no utilization. Ms. Dempsey said one of those things, especially as the age wave hits and there are more people with asthma and more people with all sorts of conditions therein, it could force them into an institution. Ms. Jones said as a waiver service, they may be getting it under Medicare. The issue was tabled for now, to gather more information and bring back to another meeting.

X. New Business – No new business.

XI. Adjourn – 3:20 p.m.

Pharmacy Update

Pharmacy Help Desk Phone Numbers (405)522-6205 option 4 or (800)522-0114 option 4
Service Hours: Monday – Friday (8:30a – 7:00p); Saturday (9:00a – 5:00p); Sunday (11:00a – 5:00p)
Email: pharmacy@okhca.org OHCA Website: www.okhca.org
PA Criteria: www.okhca.org/providers/rx/pa PA forms: www.okhca.org/rx-forms

November 2, 2011

Electronic Data Interchange: Transition to NCPDP Version D.0

In order to comply with federal requirements, OHCA and SoonerCare providers must utilize the NCPDP version D.0 standard for transmission of pharmacy claims data no later than January 1, 2012.

To minimize disruptions and ensure that appropriate support resources are available for pharmacies on the day of the transition, OHCA would prefer to start using the D.0 standard prior to January 1. We have established a target transition date of December 28, 2011.

Please note that OHCA will not support simultaneous 5.1 / D.0 claims processing, so when the transition occurs, all claims from all providers will need to be submitted using the new D.0 standard. OHCA will contact POS software vendors soon to make arrangements for D.0 testing.

**********NCPDP D.0 READINESS SURVEY**********

In order to assist us in assessing readiness for the D.0 transition, please answer the following questions, and fax this page to (800) 224-4014 or (405) 271-4014.

1. **Pharmacy Name** _____
2. **NPI** _____
3. **Will your POS software vendor be ready to process D.0 claims by December 28, 2011?**
   - ☐ Yes
   - ☐ No
   - ☐ Not Sure
4. **Who is your POS software vendor?**

   Name _____

   Phone _____

   Email _____
5. **Would you like to receive SoonerCare Pharmacy Updates via email? If so, please complete your email address:**

   _____

OKLAHOMA HEALTH CARE AUTHORITY
Summary of Revenues & Expenditures: OHCA
Fiscal Year 2012, For the Three Months Ended September 30, 2011

REVENUES	FY12 Budget YTD	FY12 Actual YTD	Variance	% Over/ (Under)
State Appropriations	$ 308,923,764	$ 308,923,764	$ -	0.0%
Federal Funds	531,992,304	522,375,164	(9,617,139)	(1.8)%
Tobacco Tax Collections	14,377,607	15,547,360	1,169,753	8.1%
Quality of Care Collections	12,937,733	12,815,273	(122,460)	(0.9)%
Prior Year Carryover	45,003,490	45,003,490	-	0.0%
Federal Deferral - Interest	82,350	82,350	-	0.0%
Drug Rebates	46,852,759	51,779,884	4,927,125	10.5%
Medical Refunds	10,087,718	13,776,936	3,689,218	36.6%
Other Revenues	4,173,413	4,197,299	23,886	0.6%
TOTAL REVENUES	**$ 974,431,137**	**$ 974,501,520**	**$ 70,383**	**0.0%**

EXPENDITURES	FY12 Budget YTD	FY12 Actual YTD	Variance	% (Over)/ Under
ADMINISTRATION - OPERATING	**$ 10,940,628**	**$ 9,720,800**	**$ 1,219,828**	**11.1%**
ADMINISTRATION - CONTRACTS	**$ 23,001,295**	**$ 20,510,463**	**$ 2,490,832**	**10.8%**
MEDICAID PROGRAMS				
Managed Care:				
SoonerCare Choice	8,065,735	6,895,329	1,170,406	14.5%
Acute Fee for Service Payments:				
Hospital Services	230,715,137	223,272,201	7,442,936	3.2%
Behavioral Health	75,771,569	82,502,885	(6,731,316)	(8.9)%
Physicians	107,706,085	104,362,704	3,343,380	3.1%
Dentists	38,009,340	37,053,942	955,398	2.5%
Other Practitioners	15,756,401	18,600,889	(2,844,488)	(18.1)%
Home Health Care	5,673,639	5,316,921	356,718	6.3%
Lab & Radiology	12,967,128	13,225,234	(258,106)	(2.0)%
Medical Supplies	11,817,947	11,327,948	489,999	4.1%
Ambulatory Clinics	23,042,689	20,141,020	2,901,669	12.6%
Prescription Drugs	87,794,190	87,403,360	390,831	0.4%
Miscellaneous Medical Payments	7,885,454	8,071,545	(186,091)	(2.4)%
OHCA TFC	-	-	-	0.0%
Other Payments:				
Nursing Facilities	122,663,406	122,263,576	399,830	0.3%
ICF-MR Private	14,304,595	14,181,978	122,617	0.9%
Medicare Buy-In	35,931,193	35,663,593	267,600	0.7%
Transportation	6,989,864	6,849,011	140,853	2.0%
EHR-Incentive Payments	15,905,431	15,905,431	-	0.0%
Part D Phase-In Contribution	18,181,198	18,057,661	123,538	0.7%
Total OHCA Medical Programs	**839,181,000**	**831,095,229**	**8,085,771**	**1.0%**
OHCA Non-Title XIX Medical Payments	89,382	-	89,382	0.0%
TOTAL OHCA	**$ 873,212,305**	**$ 861,326,492**	**$ 11,885,813**	**1.4%**
REVENUES OVER/(UNDER) EXPENDITURES	**$ 101,218,833**	**$ 113,175,028**	**$ 11,956,196**	

OKLAHOMA HEALTH CARE AUTHORITY

Total Medicaid Program Expenditures
by Source of State Funds
Fiscal Year 2012, For the Three Months Ended September 30, 2011

Category of Service	Total	Health Care Authority	Quality of Care Fund	HEEIA	Medicaid Program Fund	BCC Revolving Fund	Other State Agencies
SoonerCare Choice	$ 7,006,950	$ 6,890,068	$ -	$ 111,621	$ -	$ 5,262	$ -
Inpatient Acute Care	168,206,573	150,591,636	121,672	2,959,252	12,578,907	850,756	1,104,351
Outpatient Acute Care	61,729,842	57,776,557	10,401	2,600,612	-	1,342,272	
Behavioral Health - Inpatient	32,369,697	30,455,261	-	-	-	2,658	1,911,777
Behavioral Health - Outpatient	4,761,363	4,751,841	-	-	-	-	9,522
Behavioral Health Facility- Rehab	60,855,502	46,315,868	-	123,403	-	36,230	14,380,001
Behavioral Health - Case Management	-	-	-	-	-	-	
Residential Behavioral Management	3,119,069	-	-	-	-	-	3,119,069
Targeted Case Management	11,999,746	-	-	-	-	-	11,999,746
Therapeutic Foster Care	941,027	941,027	-	-	-	-	-
Physicians	117,555,638	86,639,310	14,525	4,090,557	15,329,967	2,378,902	9,102,377
Dentists	37,074,534	35,080,918	-	20,593	1,954,393	18,631	-
Other Practitioners	18,739,860	18,234,090	111,591	138,971	244,584	10,624	-
Home Health Care	5,316,927	5,305,712	-	6	-	11,209	-
Lab & Radiology	14,048,266	12,842,673	-	823,032	-	382,561	-
Medical Supplies	11,520,034	10,692,495	618,987	192,086	-	16,465	-
Ambulatory Clinics	23,330,867	20,036,553	-	471,189	-	104,467	2,718,658
Personal Care Services	3,097,236	-	-	-	-	-	3,097,236
Nursing Facilities	122,263,576	78,193,112	34,074,241	-	9,987,580	8,644	-
Transportation	6,849,011	6,186,842	643,801	-	16,671	1,697	-
GME/IME/DME	52,521,286	-	-	-	-	-	52,521,286
ICF/MR Private	14,181,978	11,656,582	2,313,174	-	212,222	-	-
ICF/MR Public	14,842,171	-	-	-	-	-	14,842,171
CMS Payments	53,721,254	53,092,016	629,238	-	-	-	-
Prescription Drugs	91,875,336	76,144,481	-	4,471,977	10,754,474	504,405	-
Miscellaneous Medical Payments	8,071,596	7,688,962	-	51	355,875	26,708	-
Home and Community Based Waiver	39,478,016	-	-	-	-	-	39,478,016
Homeward Bound Waiver	21,848,577	-	-	-	-	-	21,848,577
Money Follows the Person	695,827	-	-	-	-	-	695,827
In-Home Support Waiver	6,051,347	-	-	-	-	-	6,051,347
ADvantage Waiver	43,594,264	-	-	-	-	-	43,594,264
Family Planning/Family Planning Waiver	1,673,146	-	-	-	-	-	1,673,146
Premium Assistance*	15,488,606	-	-	15,488,606	-	-	-
EHR Incentive Payments	15,905,431	15,905,431					
Total Medicaid Expenditures	**$ 1,090,734,557**	**$ 735,421,434**	**$ 38,537,630**	**$ 31,491,955**	**$ 51,434,674**	**$ 5,701,491**	**$ 228,147,372**

* Includes $15,405,537.19 paid out of Fund 245

OKLAHOMA HEALTH CARE AUTHORITY

Summary of Revenues & Expenditures:
Other State Agencies
Fiscal Year 2012, For the Three Months Ended September 30, 2011

		FY12
REVENUE		**Actual YTD**
Revenues from Other State Agencies	$	68,456,959
Federal Funds		148,730,361
TOTAL REVENUES	**$**	**217,187,320**

EXPENDITURES	**Actual YTD**
Department of Human Services	
Home and Community Based Waiver	$ 39,478,016
Money Follows the Person	695,827
Homeward Bound Waiver	21,848,577
In-Home Support Waivers	6,051,347
ADvantage Waiver	43,594,264
ICF/MR Public	14,842,171
Personal Care	3,097,236
Residential Behavioral Management	2,212,109
Targeted Case Management	8,625,187
Total Department of Human Services	**140,444,733**
State Employees Physician Payment	
Physician Payments	9,102,377
Total State Employees Physician Payment	**9,102,377**
Education Payments	
Graduate Medical Education	18,150,000
Graduate Medical Education - PMTC	633,152
Indirect Medical Education	29,677,651
Direct Medical Education	4,060,483
Total Education Payments	**52,521,286**
Office of Juvenile Affairs	
Targeted Case Management	567,139
Residential Behavioral Management - Foster Care	15,086
Residential Behavioral Management	891,875
Multi-Systemic Therapy	9,522
Total Office of Juvenile Affairs	**1,483,622**
Department of Mental Health	
Targeted Case Management	-
Hospital	1,911,777
Mental Health Clinics	14,380,001
Total Department of Mental Health	**16,291,779**
State Department of Health	
Children's First	522,694
Sooner Start	529,266
Early Intervention	1,616,666
EPSDT Clinic	385,496
Family Planning	18,369
Family Planning Waiver	1,642,622
Maternity Clinic	40,553
Total Department of Health	**4,755,668**
County Health Departments	
EPSDT Clinic	232,069
Family Planning Waiver	12,155
Total County Health Departments	**244,224**
State Department of Education	**34,509**
Public Schools	**633,551**
Medicare DRG Limit	**-**
Native American Tribal Agreements	**1,531,273**
Department of Corrections	**128,825**
JD McCarty	**975,526**
Total OSA Medicaid Programs	**$ 228,147,372**
OSA Non-Medicaid Programs	**$ 20,106,685**
Accounts Receivable from OSA	**$ 31,066,737**

OKLAHOMA HEALTH CARE AUTHORITY
SUMMARY OF REVENUES & EXPENDITURES:
Fund 230: Nursing Facility Quality of Care Fund
Fiscal Year 2012, For the Three Months Ended September 30, 2011

REVENUES	Total Revenue	State Share
Quality of Care Assessment	$ 12,805,919	$ 12,805,919
Interest Earned	9,354	9,354
TOTAL REVENUES	**$ 12,815,273**	**$ 12,815,273**

EXPENDITURES	FY 12 Total $ YTD	FY 12 State $ YTD	Total State $ Cost
Program Costs			
NF Rate Adjustment	$ 33,130,952	$ 11,615,712	
Eyeglasses and Dentures	72,289	25,344	
Personal Allowance Increase	871,000	305,373	
Coverage for DME and supplies	618,987	217,017	
Coverage of QMB's	258,189	90,521	
Part D Phase-In	629,238	629,238	
ICF/MR Rate Adjustment	1,233,550	432,483	
Acute/MR Adjustments	1,079,624	378,516	
NET - Soonerride	643,801	225,717	
Total Program Costs	**$ 38,537,630**	**$ 13,919,920**	**$ 13,919,920**
Administration			
OHCA Administration Costs	$ 136,287	$ 68,143	
DHS - 10 Regional Ombudsman	-	-	
OSDH-NF Inspectors	-	-	
Mike Fine, CPA	-	-	
Total Administration Costs	**$ 136,287**	**$ 68,143**	**$ 68,143**
Total Quality of Care Fee Costs	**$ 38,673,917**	**$ 13,988,064**	
TOTAL STATE SHARE OF COSTS			**$ 13,988,064**

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

OKLAHOMA HEALTH CARE AUTHORITY

SUMMARY OF REVENUES & EXPENDITURES:

Fund 245: Health Employee and Economy Improvement Act Revolving Fund

Fiscal Year 2012, For the Three Months Ended September 30, 2011

REVENUES	FY 11 Carryover	FY 12 Revenue	Total Revenue
Prior Year Balance	$ 21,470,039	$ -	$ 17,997,318
State Appropriations			
Tobacco Tax Collections	-	12,787,230	12,787,230
Interest Income	-	121,986	121,986
Federal Draws	4,291,223	9,539,233	9,539,233
All Kids Act	(7,464,885)	77,746	77,746
TOTAL REVENUES	$ 18,296,377	$ 22,526,195	$ 40,445,767

EXPENDITURES	FY 11 Expenditures	FY 12 Expenditures	Total $ YTD
Program Costs:			
Employer Sponsored Insurance		$ 15,218,170	$ 15,218,170
College Students		83,068	83,068
All Kids Act		187,367	187,367
Individual Plan			
SoonerCare Choice	$ 108,639	$ 38,089	
Inpatient Hospital	2,946,020	1,032,874	
Outpatient Hospital	2,570,967	901,381	
BH - Inpatient Services	-	-	
BH Facility - Rehabilitation Services	122,478	42,941	
Physicians	4,067,856	1,426,190	
Dentists	16,190	5,676	
Other Practitioners	133,665	46,863	
Home Health	6	2	
Lab and Radiology	811,802	284,618	
Medical Supplies	186,117	65,253	
Ambulatory Clinics	466,650	163,607	
Prescription Drugs	4,409,790	1,546,072	
Miscellaneous Medical	-	-	
Premiums Collected	-	(586,721)	
Total Individual Plan	$ 15,840,180	$ 4,966,846	
College Students-Service Costs	$ 133,061	$ 46,651	
All Kids Act- Service Costs	$ 30,109	$ 10,556	
Total Program Costs	$ 31,491,955	$ 20,512,659	
Administrative Costs			
Salaries	$ 13,534	$ 400,142	$ 413,676
Operating Costs	29,081	23,067	52,148
Health Dept-Postponing	-	-	-
Contract - HP	256,445	496,071	752,516
Total Administrative Costs	$ 299,059	$ 919,280	$ 1,218,340
Total Expenditures			$ 21,730,998
NET CASH BALANCE	$ 17,997,318		$ 18,714,768

OKLAHOMA HEALTH CARE AUTHORITY

SUMMARY OF REVENUES & EXPENDITURES:

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

Fiscal Year 2012, For the Three Months Ended September 30, 2011

REVENUES	FY 12 Revenue	State Share
Tobacco Tax Collections	$ 255,191	$ 255,191
TOTAL REVENUES	**$ 255,191**	**$ 255,191**

EXPENDITURES	FY 12 Total $ YTD	FY 12 State $ YTD	Total State $ Cost
Program Costs			
SoonerCare Choice	$ 5,262	$ 1,291	
Inpatient Hospital	850,756	208,776	
Outpatient Hospital	1,342,272	329,394	
Inpatient Free Standing	2,658	652	
MH Facility Rehab	36,230	8,891	
Case Mangement	0	-	
Nursing Facility	8,644	2,121	
Physicians	2,378,902	583,783	
Dentists	18,631	4,572	
Other Practitioners	10,624	2,607	
Home Health	11,209	2,751	
Lab & Radiology	382,561	93,881	
Medical Supplies	16,465	4,041	
Ambulatory Clinics	104,467	25,636	
Prescription Drugs	504,405	123,781	
Transportation	1,697	416	
Miscellaneous Medical	26,708	6,554	
Total Program Costs	$ 5,701,491	$ 1,399,146	**$ 1,399,146**
TOTAL STATE SHARE OF COSTS			**$ 1,399,146**

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

FINANCIAL REPORT

For the Three Months Ended September 30, 2011
Submitted to the CEO & Board
November 10, 2011

- Revenues for OHCA through September, accounting for receivables, were **$974,501,520** or **(.0%) under** budget.

- Expenditures for OHCA, accounting for encumbrances, were **$861,326,492** or **1.4% under** budget.

- The state dollar budget variance through September is **$11,956,196 positive.**

- The budget variance is primarily attributable to the following (in millions):

Expenditures:		
Medicaid Program Variance		6.3
Administration		1.7
Revenues:		
Taxes and Fees		1.0
Drug Rebate		1.7
Overpayments/Settlements		1.3
Total FY 12 Variance	**$**	**12.0**

ATTACHMENTS

SoonerCare Programs

September 2011 Data for November 2011 Board Meeting

SOONERCARE ENROLLMENT/EXPENDITURES

Delivery System		Monthly Enrollment Average SFY2011	Enrollment September 2011	Total Expenditures September 2011	Average Dollars Per Member Per Month September 2011
SoonerCare Choice Patient-Centered Medical Home		449,392	**446,297**	**$115,376,685**	
	Lower Cost (Children/Parents; Other)		400,883	$77,938,299	$194
	Higher Cost (Aged, Blind or Disabled; TEFRA; BCC)		45,414	$37,438,385	$824
SoonerCare Traditional		239,274	**249,420**	**$219,715,012**	
	Lower Cost (Children/Parents; Other)		142,906	$91,347,082	$639
	Higher Cost (Aged, Blind or Disabled; TEFRA; BCC & HCBS Waiver)		106,514	$128,367,930	$1,205
SoonerPlan		31,082	**39,394**	**$540,946**	$14
Insure Oklahoma		32,181	**32,159**	**$10,186,307**	
	Employer-Sponsored Insurance	19,095	18,194	$5,069,775	$279
	Individual Plan	13,085	13,965	$5,116,533	$366
TOTAL		**751,928**	**767,270**	**$345,818,950**	

The enrollment totals above include all members enrolled during the report month; therefore, some members may not have expenditure data.
Custody expenditures are excluded. Non-member specific expenditures of $23,566,057 are excluded.

Net Enrollee Count Change from Previous Month Total	1,713

New Enrollees	21,290

Opportunities for Living Life (OLL) (subset of data above)

Qualifying Group	Age Group	Enrollment
Aged/Blind/Disabled	*Child*	19,734
Aged/Blind/Disabled	*Adult*	130,261
Other	*Child*	157
Other	*Adult*	20,085
PACE	*Adult*	80
TEFRA	*Child*	397
Living Choice	*Adult*	111
OLL Enrollment		**170,825**

The "Other" category includes DDSD State, PKU, Q1, Q2, Refugee, SLMB, Soon-to-be-Sooners (STBS) and TB members.

Medicare and SoonerCare	Monthly Average SFY2011	Enrolled September 2011
Dual Enrollees	**103,906**	**106,872**

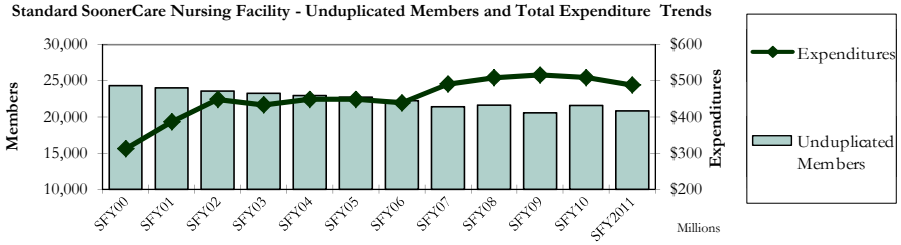
		Monthly Average SFY2011	Enrolled September 2011	PER MEMBER PER MONTH
Long-Term Care Members		**15,733**	**15,786**	**$3,195**
	Child	92	95	
	Adult	15,641	15,691	

SFY2010 Long-Term Care

Statewide LTC Occupancy Rate - 69.8%
SoonerCare funded LTC Bed Days 68.6%

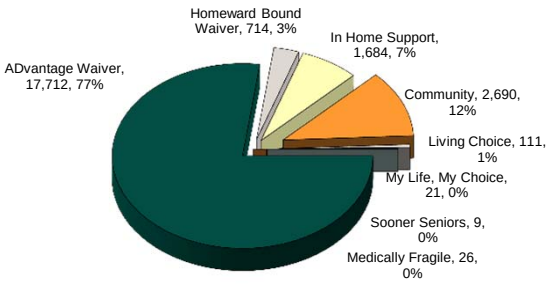
Data as of September 2010

Standard SoonerCare Nursing Facility - Unduplicated Members and Total Expenditure Trends



Data as of Aug. 8, 2011. Figures do not include intermediate care facilities for the mentally retarded (ICF/MR).

Waiver Enrollment Breakdown Percent



ADvantage Waiver - Serves frail elderly individuals age 65 or older and adults age 21 and older with physical disabilities who would otherwise require placement in a nursing facility.
Community - serves individuals 3 years of age and older who have intellectual disabilities and certain persons with related conditions who would otherwise require placement in an intermediate care facility for the mentally retarded/intellectually disabled (ICF/MR).
Homeward Bound Waiver - Designed to serve the needs of individuals with intellectual disabilities or "related conditions" who are also members of the Plaintiff Class in Homeward Bound et al. v. The Hissom Memorial Center, et al, who would otherwise qualify for placement in an ICF/MR.
In Home Support - Serves the needs of individuals 3 years of age and older with intellectual disabilities who would otherwise require placement in an ICF/MR.
Living Choice - Promotes community living for people of all ages who have disabilities or long-term illnesses.
Medically Fragile - This program serves qualifying individuals who meet hospital or skilled nursing facility level of care.
My Life, My Choice - This program is for adults with physical disabilities who transitioned to the community under the Living Choice program.
Sooner Seniors - This program is for adults 65 and older with long term illnesses who transitioned to community-based services in the Living Choice program.

SoonerCare Programs

SOONERCARE CONTRACTED PROVIDER INFORMATION

Provider Counts		Monthly Average SFY2011	Enrolled September 2011
Total Providers		**29,026**	**30,981**
	In-State	20,585	21,585
	Out-of-State	8,442	9,396

Program	% of Capacity Used
SoonerCare Choice	40%
SoonerCare Choice I/T/U	13%
Insure Oklahoma IP	3%

Select Provider Type Counts	*In-State Monthly Average SFY2011**	*In-State Enrolled September 2011***	Total Monthly Average SFY2011	Total Enrolled September 2011
Physician	*6,489*	*6,977*	*11,777*	12,785
Pharmacy	*901*	*866*	*1,230*	1,134
Mental Health Provider	*935*	*861*	*982*	906
Dentist	*798*	*932*	*901*	1,051
Hospital	*187*	*192*	*739*	866
Licensed Behavioral Health Practitioner	*503*	*671*	*524*	703
Extended Care Facility	*392*	*382*	392	382

*The In-State Monthly Averages above were recalculated due to a change in the original methodology.

Total Primary Care Providers	*4,461*	*4,991*	6,467	7,211
Patient-Centered Medical Home	*1,476*	*1,549*	1,502	1,576

Including Physicians, Physician Assistants and Advance Nurse Practitioners.

**Items shaded above represent a 10% or more increase (green) or decrease (red) from the previous fiscal year's average.

ELECTRONIC HEALTH RECORDS (EHR) INCENTIVE STATISTICS

The Electronic Health Records Incentive Program is a federal program that offers major financial support to assist certain providers to adopt (acquire and install), implement (train staff, deploy tools, exchange data), upgrade (expand functionality or interoperability) or meaningfully use certified EHR technology.

	September 2011		Since Inception	
	Number of Payments	Payment Amount	Total Number of Payments	Total Payment Amount
Eligible Professionals	45	$998,750	873	$18,692,917
Eligible Hospitals	4*	$4,929,054	47	$36,781,544
Totals	49	$5,927,804	920	$55,474,461

*Current Eligible Hospitals Paid
CHICKASAW NATION MEDICAL CENTER
HARPER CO COM HSP
PAULS VALLEY GEN HSP
ST ANTHONY HSP

SoonerCare Health Management Program (HMP)

Carolyn Reconnu, RN, BSN, CCM
Manager, Health Management Program

SoonerCare Health Management Program (HMP)

- A formal Disease Management Program, mandated by the Oklahoma Legislature in the Medicaid Reform Act of 2006
  - ✓ Decrease cost for those with chronic conditions
  - ✓ Increase quality of care

- Implemented in February 2008. Began 4th year of program on 2/1/11. Telligen, formerly known as Iowa Foundation for Medical Care (IFMC) is our contractor obtained through competitive bid process

- 2 armed approach consisting of Nurse Case Management and Practice Facilitation

- 5 year plan for independent evaluation by Pacific Health Policy Group. Evaluated thus far through June 30, 2010.

Nurse Case Management

- SoonerCare Choice
  - Age 4-63
  - Selected and stratified using predictive modeling software
  - Holistic approach; managed the whole member with few diagnoses excluded; multiple chronic co-morbidities

- Tier 1 (14 Oklahoma-based nurses)
  - 1,000 very high risk members
  - Face to face nurse care management

- Tier 2 (24 Call Center-based nurses)
  - 4,000 high risk members
  - Telephonic nurse care management

Nurse Case Management

- Assess physical and behavioral health status, related services and needs; socio-economic status; determine education and resource gaps
- Fill need and care gaps; focused education regarding self-management principles, resource availability, service coordination
- Ongoing relationship with member to continually assess status, monitor progress with goals and modify interventions

Nurse Case Management Impact (Utilization)

- Utilization Rates (pre-intervention forecast versus 1 year post-engagement)

Tier 1

- ✓ Inpatient Hospital Days reduced 45%
- ✓ Emergency Department visits reduced 17%

Tier 2

- ✓ Inpatient Hospital Days reduced 37%
- ✓ Emergency Department visits reduced 21%

Nurse Case Management Impact

- Most cost impact seen post-engagement as there is front-loading of cost
- Reducing utilization that typically signifies lack of control of conditions (ER and Inpatient Care)
- Closing care gaps and reducing risk scores

Practice Facilitation

- Onsite technical assistance for the primary care provider to help them build empowered and proactive teams
- Create stable and predictable processes and procedures to foster improved patient care and better outcomes
  - ✓ Implement a registry for population-management and performance measurement
  - ✓ Involve the entire team in quality improvement activities aimed at improving patient care (disease/condition specific and office processes)
  - ✓ Assist with implementation of evidence-based guidelines

Practice Facilitation

- Practice Facilitation provided by Registered Nurses trained in quality improvement
- 8 Practice Facilitators – geographically distributed
- 82 practices, in 35 counties, have received facilitation services since program inception 2/1/08
- Clinics of all size: solo practitioners to academic centers
- Long-term process, customized to fit the needs of the clinic

Practice Facilitation Impact (Quality of Care Analysis)

- Practices served; year end 2009 to year end 2010 findings compared
  - Increased compliance in asthma, coronary artery disease and hypertension measures. Also preventative care measures.

- Based on pre-facilitation/early facilitation period versus most recent quarter of data (2nd Quarter Calendar Year 2011)
  - Increased compliance in asthma, diabetes, congestive heart failure, hypertension, chronic obstructive pulmonary disease measures. Also preventative care and tobacco cessation measures.

Practice Facilitation Impact

- Providers overwhelmingly satisfied (96%) with program and would recommend to peers
- Actual Expenditures reduced from forecasted cost
- $6.5 million saved since program inception

Other PF accomplishments

- Winner of Governor's commendation in Oklahoma Quality Team Day 2011

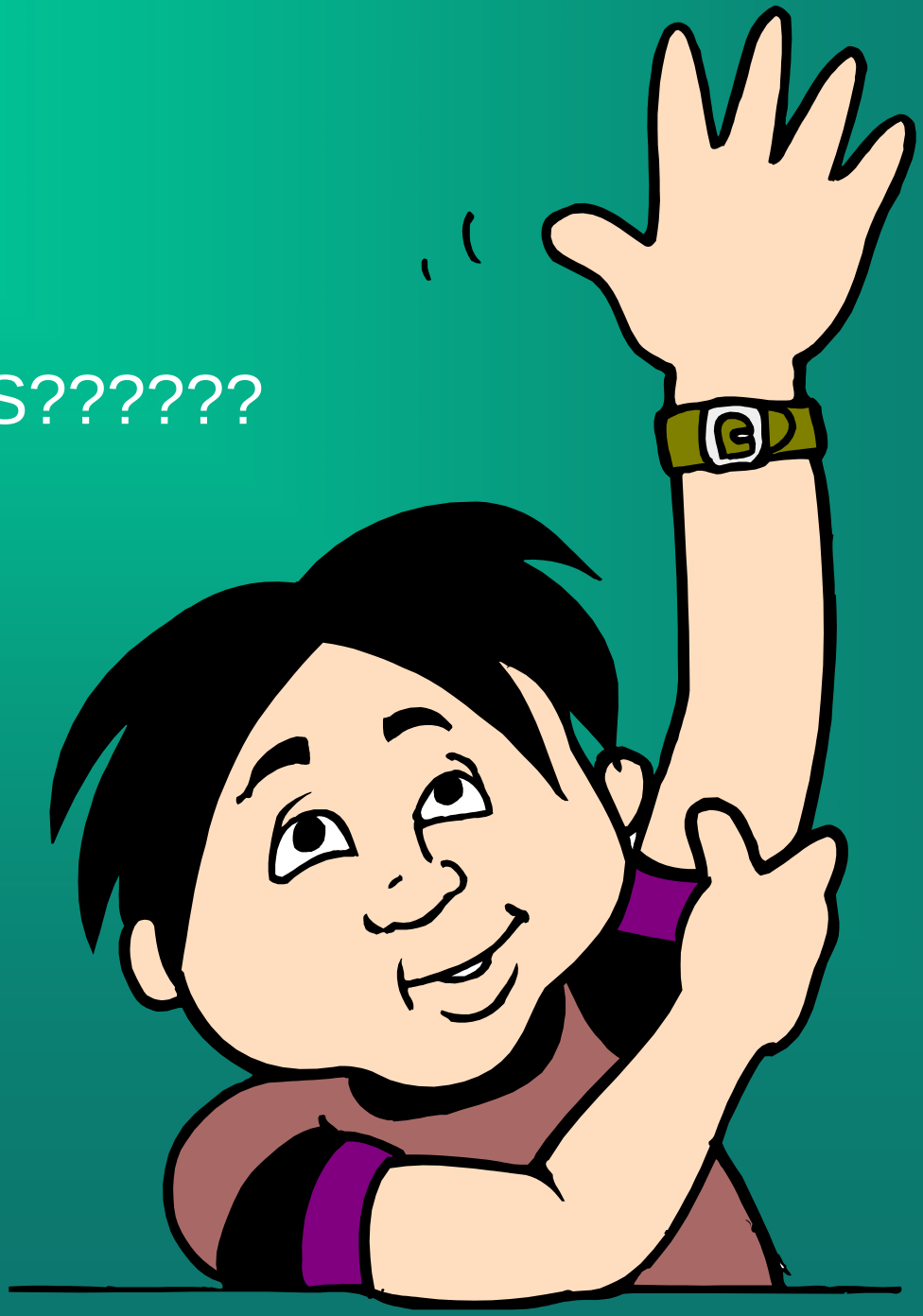
- One of 4 states selected to participate in Reducing Disparities at the Practice Site (RDPS) project
  - Grant funded by Center for Health Care Strategies (CHCS)
  - Process Improvement support to 10 small practices with racially and ethnically disparate populations

- SoonerQuit
  - Grant funded by TSET (Tobacco Settlement Endowment Trust)
  - Child Health unit/ HMP partnership
  - Practice facilitation services to OB practices to promote education regarding the 5 As of tobacco cessation

OHCA Health Management Program Team

- Care Management-MAU-HMP (Marlene Asmussen, Director)
  - Carolyn Reconnu, HMP Manager 522-7630
  - Harvey Reynolds, HMP Program Coordinator 522-7369
  - Casey Dunham, HMP Senior Research Analyst 522-7345
  - Sammie Fraijo, HMP Program Associate 522-7281
  - Cindi Bryan, RN, Exceptional Needs Coord. 522-7826
  - Sherris Harris-Ososanya, Behavioral Health Specialist 522-7740
- Mike Herndon, DO, Medical Director

QUESTIONS??????



Dual Enrollees Fast Facts

September 2011

Dual Enrollees are members who are enrolled in both SoonerCare and Medicare. Dual Enrollees are entitled to Medicare Part A and/or Part B or Part C and qualify for some form of SoonerCare benefit. These members receive SoonerCare Supplemental or SoonerCare Traditional benefits. For more information go to our website at www.okhca.org.

Total Dual Enrollment	Total Enrollment	Percent of Total
106,872	735,111	15%

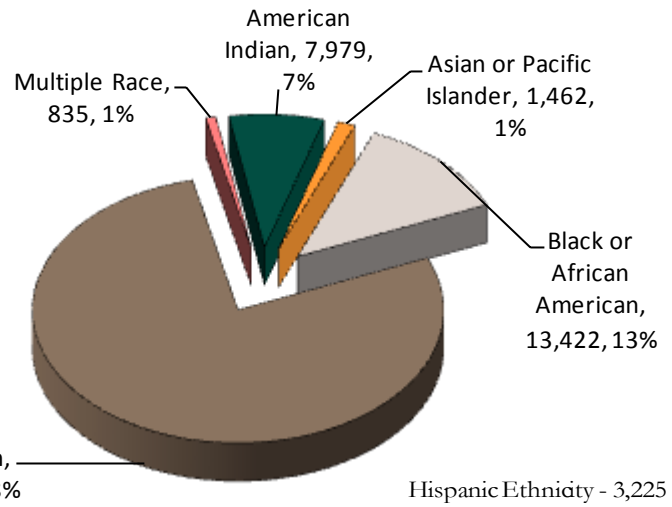
Total Enrollment excludes Insure Oklahoma.

Dual Enrollees with Long-Term Care - 13,458
Dual Enrollees in PACE program - 76
Dual Enrollees in Waiver program - 17,893

Dual Enrollees by Gender and Age			
	Child	Adult	Total
Female	13	67,009	67,022
Male	22	39,828	39,850
Total	35	106,837	106,872

CHILD is defined as an individual age 18 and under.

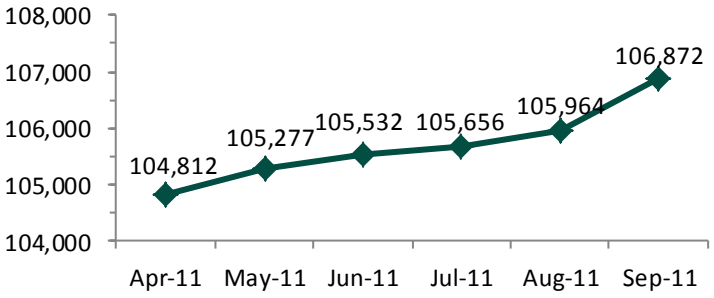
Dual Enrollees by Age



Hispanic Ethnicity - 3,225

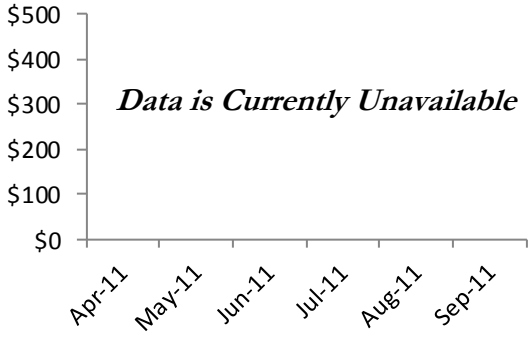
Race is self-reported by members at the time of enrollment. The multiple race members have selected two or more races. Hispanic is an ethnicity not a race. Hispanics can be of any race and are accounted for in a race category above.

Dual Enrollees Enrollment Trend

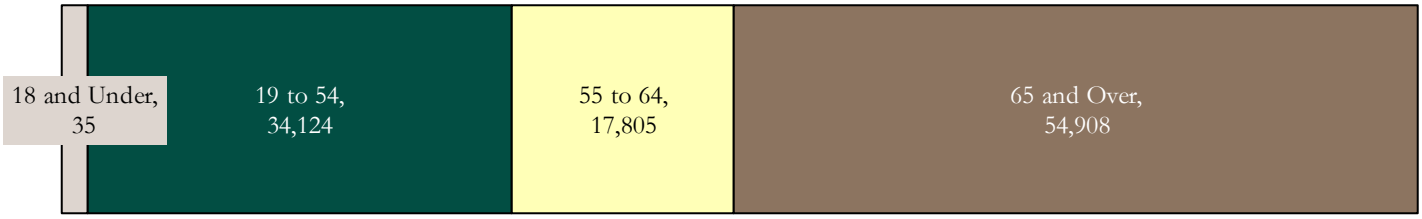


Top 10 Paid Dual Enrollee Services Categorized as:	Members Served (Unduplicated)	Claims Paid	Amount Paid
Data is Currently Unavailable			
All Paid Services in Reporting Month:	Members Served (Unduplicated)	Claims Paid	Amount Paid

Per Member Per Month



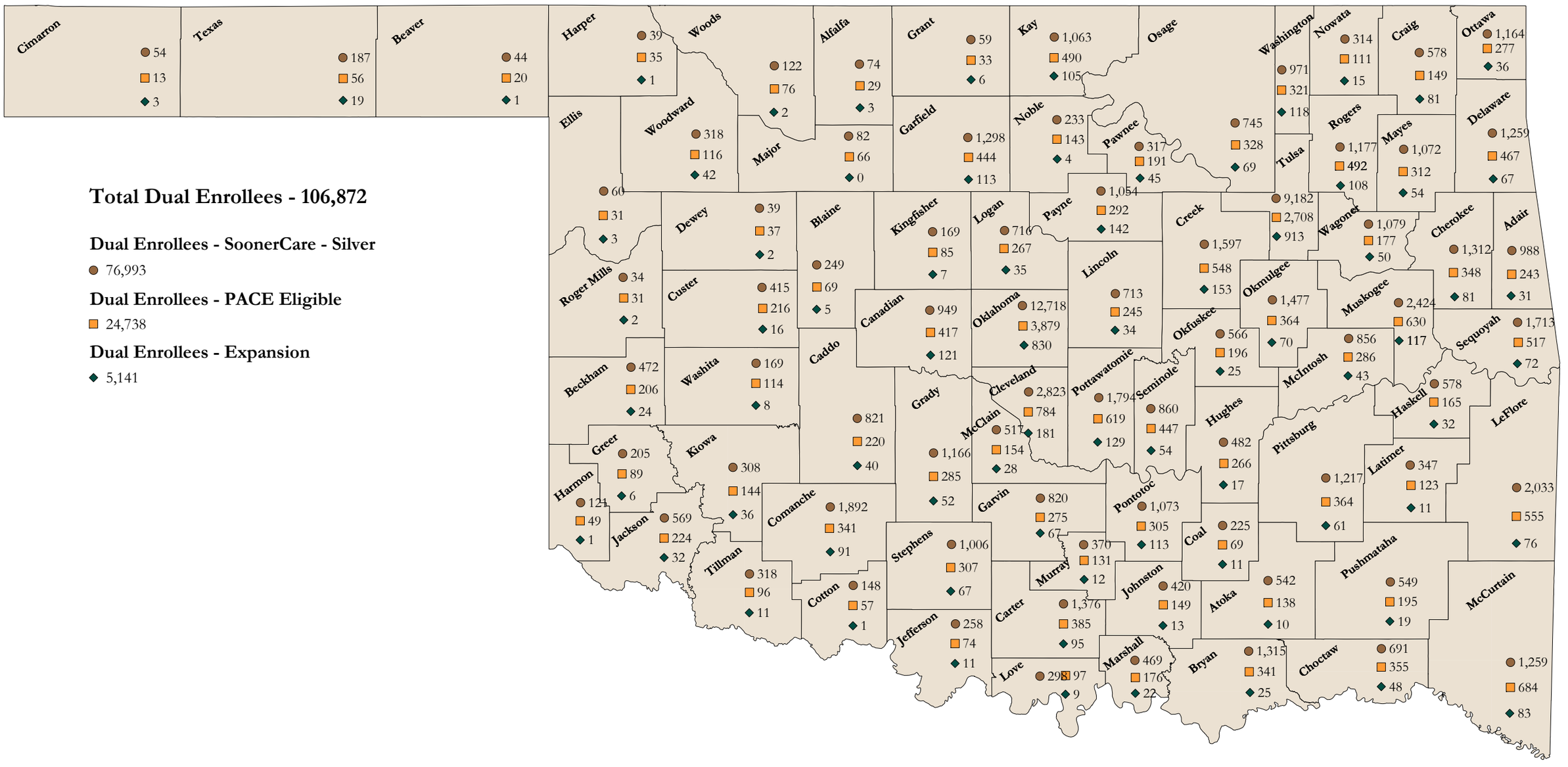
Dual Enrollees by Age



The data is valid as of the report date and is subject to change.

10/13/2011

Dual Enrollees Fast Facts
September 2011



Total Dual Enrollees - 106,872

Dual Enrollees - SoonerCare - Silver
- 76,993

Dual Enrollees - PACE Eligible
- 24,738

Dual Enrollees - Expansion
- 5,141

'Dual Enrollees - PACE Eligible' are Dual Enrollee who are aged 55 or older and in either nursing home level of care or are enrolled in the ADvantage Waiver program, excluding those with assisted living level of care. 'Dual Enrollees - Expansion' are Dual Enrollees enrolled in a waiver program but are not PACE eligible. 'Dual Enrollees - SoonerCare - Silver' are Dual Enrollees who are not PACE eligible or enrolled in a waiver program.

10/13/2011

PROJECT ACTIVITIES and programs

Oklahoma Proposal funded by CMS April 2011

- Key Program Components:
  - Dual Staff hired summer 2011 to develop proposal statewide proposal for services
  - Partnership with OU Tulsa- School of Community Medicine
  - Program of All-Inclusive Care for the Elderly (PACE)

PROJECT PROGRAMS

- SOONERCARE SILVER: Proposed Care Management program for dual eligibles using claims and benefit data
- PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)
- UNIVERSITY OF OKLAHOMA AT TULSA- HIZ/ACCOUNTABLE CARE ORGANIZATION

Project Review

Care coordination within OHCA programs to identify practices for replication

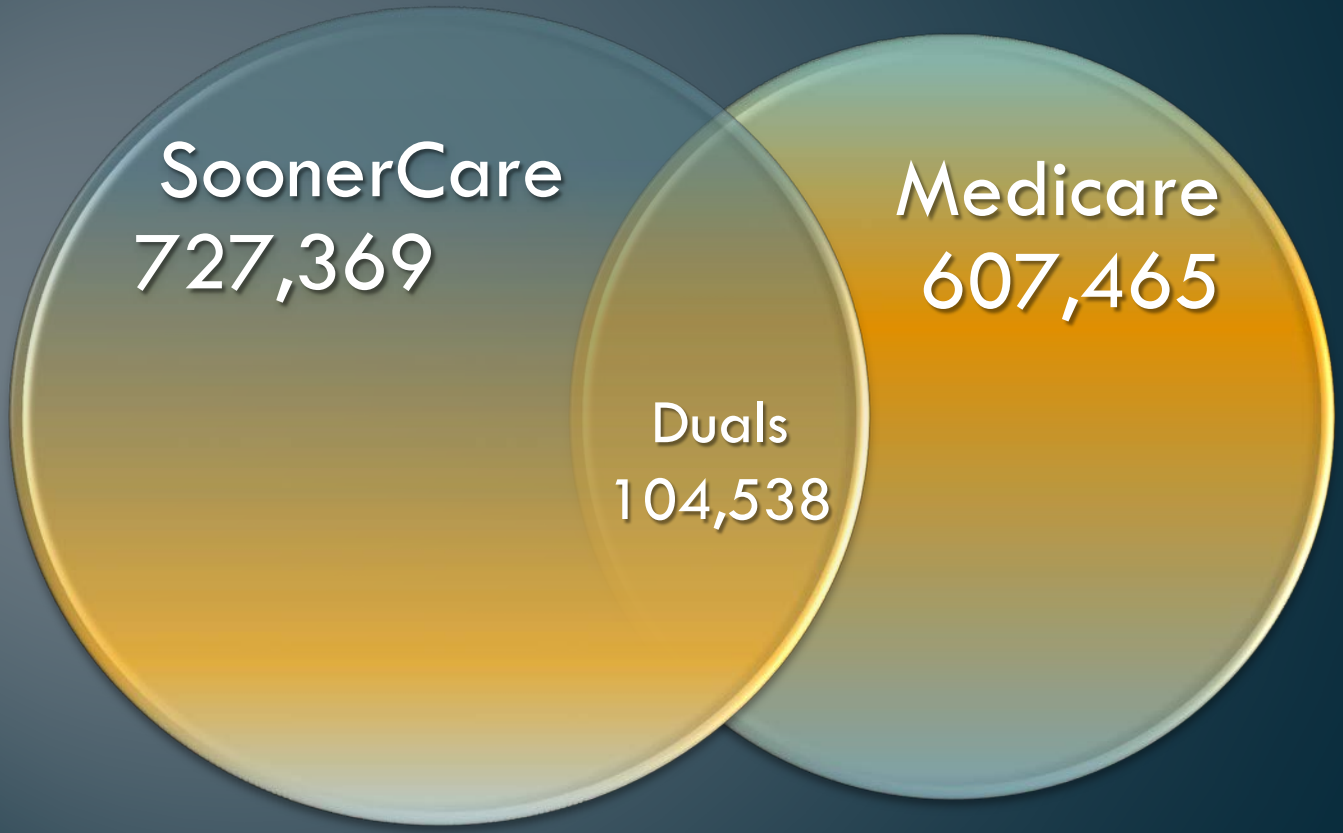
Focusing on ways to Reduce costs:

- Reduce duplications in benefits
- Improve overall quality of care

Workgroup Descriptions

- Coordination of Care and Benefits - Sarah.Harding@okhca.org
- Behavioral Health Services- June.Logan@okhca.org
- Communication: Outreach and Public Information- David.Ward@okhca.org
- Financing Strategies and Quality Medical Outcomes-Marva.Williamson@okhca.org

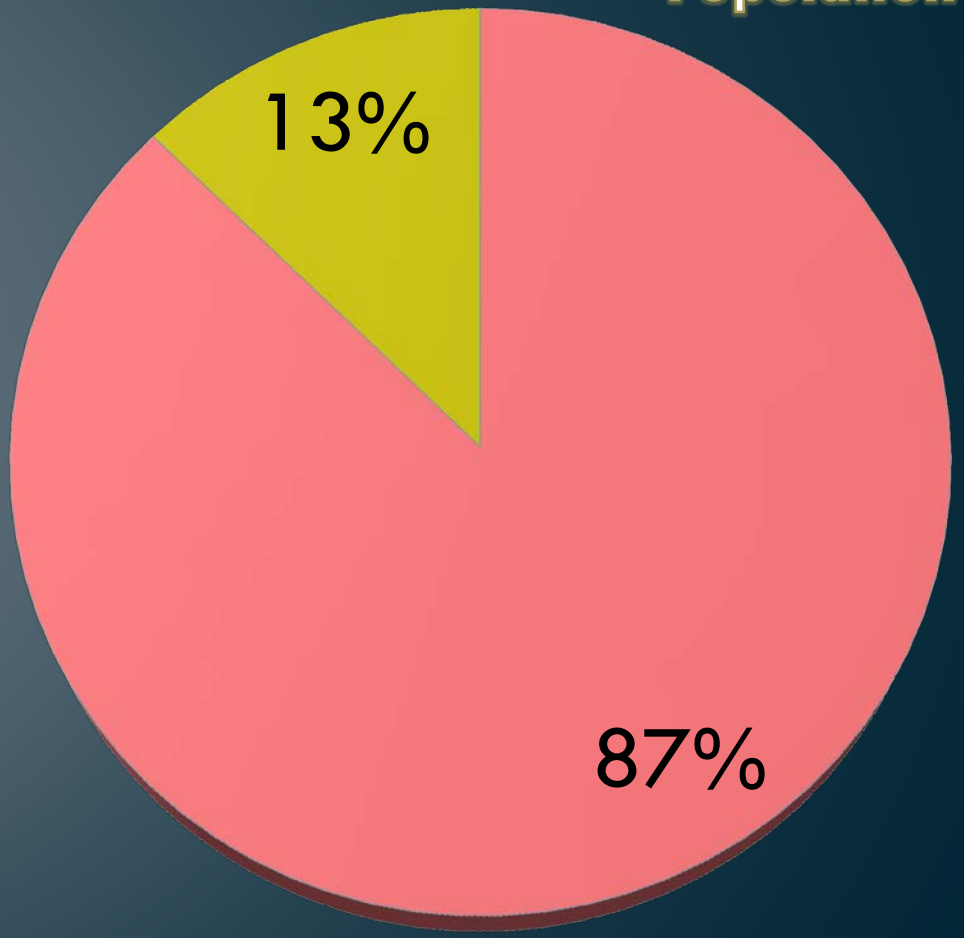
Oklahoma Dual Population



Data as of March 2011

Dual Eligibles Among the SoonerCare Population

- SoonerCare Enrollees
- Dual Eligible Enrollees



Data as of June 2011

Characteristics of the Dual Population

- Higher rate of poor health than those beneficiaries on just Medicare or SoonerCare
  - Weak, Frail
  - Multiple Chronic Conditions
  - Lower Functioning
  - Mental and Behavioral Health Impairments
  - Higher Rate of Being Low-Income

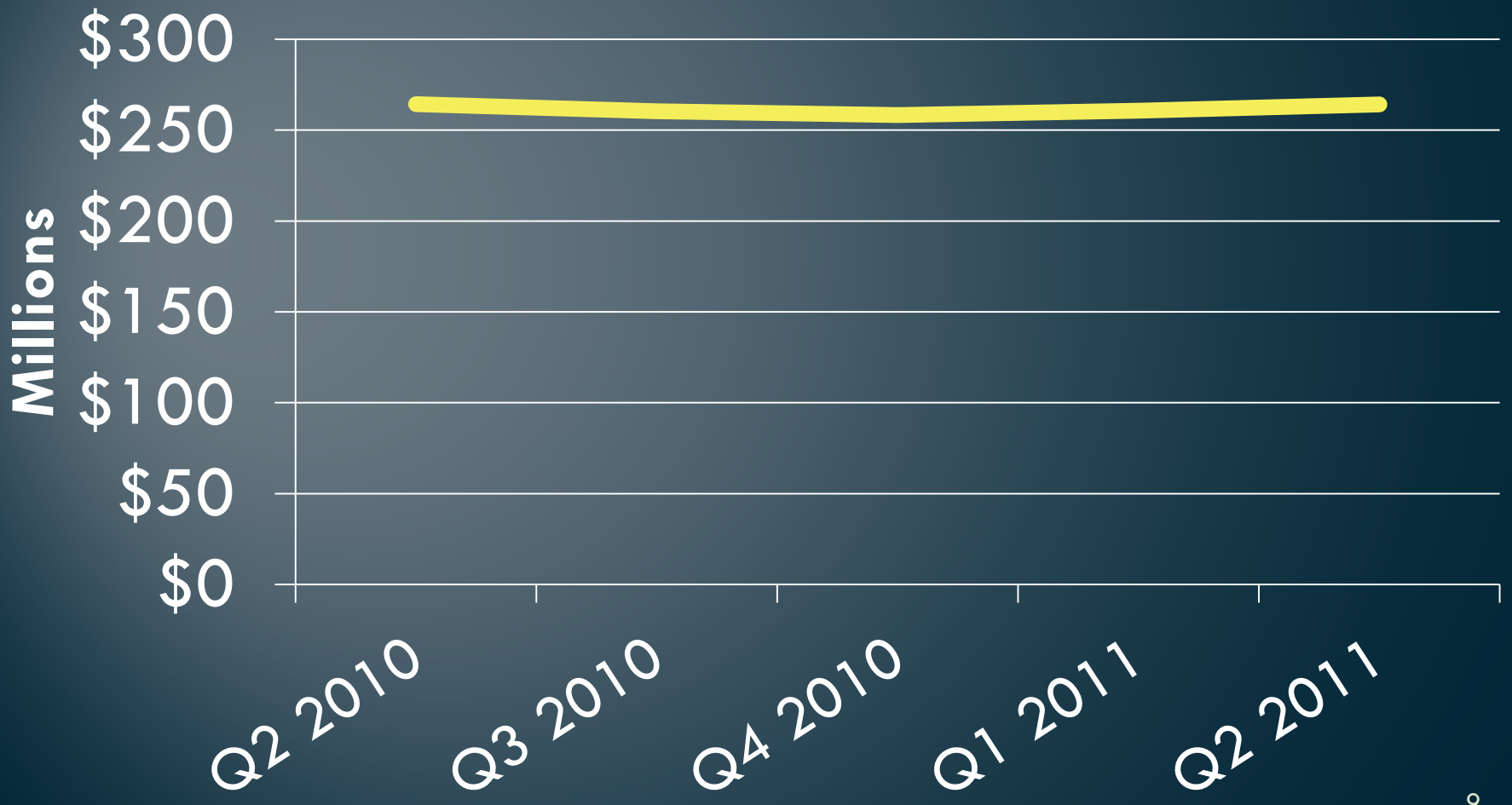
SoonerCare Covered Services

Most Frequently Utilized Services for Duals by Dollar Amount

- Personal Care Services
- Habilitation (waiver)
- Residential Care (waiver)
- Case Management
- Behavioral Health Services

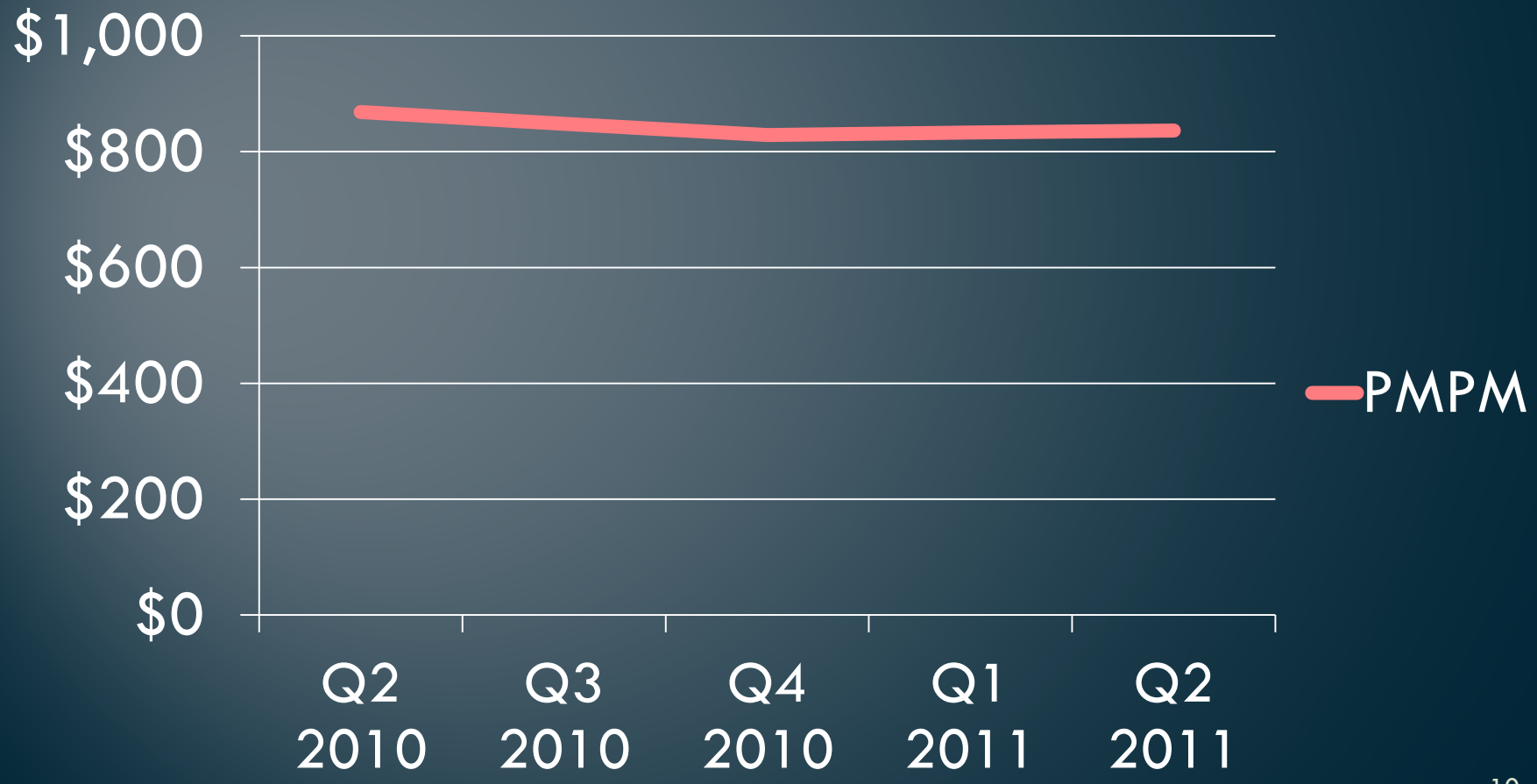
Dual Eligible Reimbursement by Quarter

(2nd Q 2010 – 2nd Q 2011)



Per Member Per Month Cost (monthly average per quarter)

(2nd Q 2010 - 2nd Q 2011)



Medicare Covered Services

- Inpatient Hospital Stays
- Visits to the ER
- Home Health Services
- Outpatient Services
- Part D Prescriptions
- Skilled Nursing Facility (SNF)

Next Stakeholder Meeting

- Brandie.Candelaria@okhca.org
- Wednesday, November 30, 11:30 – 1:30 pm, Metro Tech: 1900 Springlake Drive, Oklahoma City, OK 73111
- (405) 424-8324 in Conference Room I (I as in Indigo)

SoonerCare Choice Renewal

OHCA intends to submit a request for renewal of the SoonerCare Choice/Insure Oklahoma Section 1115(a) Research and Demonstration Waiver to the Centers for Medicare and Medicaid Services (CMS), extending the waiver from January 1, 2013 through December 31, 2015.

The SoonerCare 1115(a) Waiver is currently approved through December 31, 2012. The application to extend the demonstration project is due to CMS December 31, 2011.

OHCA plans to request a renewal of the program in its present form, although amendments will need to be made later for 2014. Only one amendment is requested with the renewal.

Renewal and Amendment Language in the Application:

> Oklahoma is aware that the SoonerCare / Insure Oklahoma waiver will need to be amended in order to bring the program into compliance with provisions of the Patient Protection and Affordable Care Act (PPACA) that take effect January 1, 2014. At this time, the State is requesting renewal of this waiver in its present form, pending instructions from leadership on the direction the State intends to take with regard to health reform. OHCA plans to request appropriate amendments to the waiver after receiving proper guidance. OHCA is also requesting approval to maintain the Health Access Network (HAN) program as a pilot from 2013 to 2015. The State is not at present requesting authorization to implement the HAN program statewide.
>
> The State requests that one amendment be made to the waiver for the extension period; it is specific to the Insure Oklahoma (IO) Individual Plan (IP) program. The State requests that the adult outpatient behavioral health benefit for IO IP be limited to 48 visits per year. This change will match the adult benefit with the children's benefit, which is already limited to 48 outpatient behavioral health visits per year.

Oklahoma Cares Program Change

The objective of the Oklahoma Cares program, which was implemented in January 2005, is to provide eligible women with treatment for breast or cervical cancer and pre-cancerous conditions. Women receiving treatment for these conditions have access to full-scope medical benefits under SoonerCare Choice. Currently, full-scope benefits are also available to women who are completing diagnostic testing following an abnormal finding through fee-for-service. In order to determine if a woman has a qualifying diagnosis to receive full coverage, Oklahoma is seeking to implement a limited diagnostic testing benefit package as an entry-level phase of the Oklahoma Cares program.

Those who qualify for the limited benefit package include women, ages 19 to 65 who receive an abnormal finding result from a CDC screener on their clinical breast exam, mammogram screening or pap smear, and have an income at-or-below 185% FPL or 250% FPL for American Indians.

An abnormal finding is interpreted as:

- A discrete, palpable breast mass (clinical documentation must include a detailed description of when the mass was identified, location, size, shape, tenderness, skin color change);
- Screening mammogram results of BIRAD 0 (only after comparison with prior films and a suspicious clinical exam);
- Screening mammogram results of BIRAD's 3, 4, or 5;
- ASC-H, LISL, HSIL, AGC;
- Cervical Dysplasia (CIN I, II, III).

Women who qualify for the diagnostic testing benefit package have access to the following services:

- Diagnostic Mammogram (not as a primary evaluation)
- Diagnostic Ultrasound (not as a primary evaluation)
- Breast biopsy
- Colposcopy with or without cervical biopsy
- LEEP, Conization
- Pathology
- Breast MRI
- Office Visits

By implementing the diagnostic testing package, women will still be able to receive a definitive diagnosis of their condition; however, full-scope medical coverage will only be available to those women receiving treatment for a cancerous or pre-cancerous condition.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 1. PHYSICIANS

317:30-5-12. Family planning

~~(a) Pregnancy tests are covered.~~
~~(b) Reverse vasectomy is not covered.~~
~~(c) Reversal of sterilization procedures for the purpose of conception are not covered.~~

(a) **Adults.** Payment is made for the following family planning services:

(1) physical examination to determine the general health of the member and most suitable method of contraception;
(2) complete general history of the member and pertinent history of immediate family members;
(3) laboratory services for the determination of pregnancy, detection of certain sexually transmitted infections and detection of cancerous or pre-cancerous conditions of the reproductive anatomy;
(4) education and counseling regarding issues related to reproduction and contraception;
(5) annual supply of chosen contraceptive;
(6) insertion and removal of contraceptive devices;
(7) vasectomy and Tubal Ligation procedures; and
(8) additional visits for members experiencing difficulty with a particular contraceptive method or having concerns related to their reproductive health.

(b) **Children.** Payment is made for children as set forth in this Section for adults. However payment cannot be made for the sterilization of persons under the age of 21.

(c) **SoonerPlan Members.** Non-pregnant women and men ages 19 and older not enrolled in SoonerCare may apply for the SoonerPlan program. Eligible members receive family planning services set forth in this Section as well as family planning related services (vaccinations for the prevention of certain sexually transmitted infections and male exams). SoonerPlan eligibility requirements are found at OAC 317:35-7-48.

(d) **Individuals eligible for Part B of Medicare.** Payment is made utilizing the Medicaid allowable for comparable services. Claims for services which are not covered by Medicare should be filed directly with the Fiscal Agent for payment within the scope of the program.

PART 49. FAMILY PLANNING CENTERS [REVOKED]

317:30-5-465. Eligible providers [REVOKED]

~~In order to be eligible for participation the family planning center must meet the Oklahoma State Health Department Standards and Criteria for Family Planning Centers. The center must declare whether they will bill independently or through a computer billing arrangement with the Oklahoma State Department of Health.~~

317:30-5-466. Coverage by category [REVOKED]

~~Payment is made to family planning centers as set forth in this Section.~~

~~(1)~~ **~~Adults.~~** ~~Payment is made for adults on an encounter basis. Each encounter is all inclusive of the following and payment includes all services provided:~~

~~(A)~~ **~~Initial examination services.~~** ~~Initial examination services that are provided to new family planning patients include:~~

~~(i) Complete physical examination including assessment of height, weight, blood pressure, thyroid, extremities, heart, lungs, breasts, abdomen, pelvic examination, including visualization of the cervix, external genitalia, bimanual exam, and rectal exam as indicated. (Male clients receive examination of genitals and rectum including palpation of the prostate in lieu of pelvic exam given females.)~~

~~(ii) Complete general history of patient and pertinent history of immediate family members. This general history addresses allergies, immunizations, past illnesses, hospitalizations, surgery, review of systems, use of alcohol, tobacco and drugs. Reproductive function history in female patients includes menstrual history, sexual activity, sexually transmitted diseases, contraceptive use, pregnancies, and in utero exposure to DES. Male reproductive general history includes sexual activity, sexually transmitted diseases, fertility, and exposure to DES.~~

~~(iii) Laboratory services to include hematocrit, dip stick urinalysis, pap smear, gonorrhea culture, serologic test for syphilis and rubella screening if indicated.(iv) Education and counseling are offered to provide information regarding reproductive anatomy, range of clinic services, risks benefits and side effects of various methods of contraception, and health promotion/disease prevention topics as needed.~~

~~(v) Provision for an annual supply of chosen contraceptive method to include, but not limited to, injections (administration and medication), oral contraceptive, IUD, diaphragm, foam, condoms or natural family planning.~~

(vi) Treatment of minor gynecological problems, infections, and other conditions.

(vii) Referral to appropriate providers for problems or conditions which are beyond the scope of the clinic to treat.

(B) **Annual examination services.** Annual examination services are provided to continuing patients to include:

(i) Annual update physical examination to include height, weight, blood pressure, extremities, and examination of breasts and pelvic organs. If required, a complete physical examination may be provided as described under the initial visit services above.

(ii) A medical history update is taken to update the general history and includes noting the patient's adaptation to and correct use of contraceptive method, menstrual history, specific warning signs and other side effects related to the contraceptive method. If indicated, a complete general history of the patient will be taken at the annual visit.

(iii) Laboratory services to include pap smear, gonorrhea culture, hematocrit, and serologic test for syphilis.

(iv) Education and counseling regarding specific problems, risks and side effects of the method in use.

(v) Provision for an annual supply of chosen contraceptive method to include, but not limited to, injections (administration and medication), oral contraceptive, IUD, diaphragm, foam, condoms or natural family planning.

(vi) Treatment of minor gynecological problems, infections, and other conditions.

(vii) Referral to appropriate providers for problems or conditions which are beyond the scope of the clinic to treat.

(C) **Encounter visits.**

(i) Encounter visits covers services provided to patients which are not part of the initial/annual examinations. This may include:

(I) A follow-up visit for all new patients to insure they understand and are experiencing no problems with their particular contraceptive method.

(II) A scheduled revisit for a new or continuing patient who may have conditions which places the patient in a high risk category requiring more intensive medical management as outlined in the program medical protocol.

(ii) Encounter visits may also be scheduled at the request of the patient as they are encouraged to return to the clinic at any time they experience difficulty with a particular contraceptive method or have concerns related

to their reproductive health. Pregnancy diagnosis and counseling services are also provided under this category.

(D) **Vasectomy.** For vasectomies, payment will be made as an all-inclusive rate for all services provided in connection with the surgery. Claims must have the Federally mandated consent form properly completed and attached.

(E) **Tubal ligations.** For tubal ligations, payment will be made as an all-inclusive rate for the cost of the surgeon, anesthesiologist, pre and post-operative care and outpatient surgery facility. Claims must have the properly completed Federally mandated consent form attached.

(2) **Children.** Payment is made for children as set forth for adults. However payment cannot be made for the sterilization of persons under the age of 21.

(3) **Individuals eligible for Part B of Medicare.** Payment is made utilizing the Medicaid allowable for comparable services. Claims for services which are not covered by Medicare should be filed directly with the Fiscal Agent for payment within the scope of the program.

317:30-5-467. Coverage limitations [REVOKED]

(a) Sterilizations require proper consent form and are not compensable for patients under 21 years of age.

(b) The following coverage limitations apply to services provided by family planning centers:

(1) Service: Initial Examination; Unit: Completed Examination and Services; Limitation: one initial examination.

(2) Service: Annual; Unit: Completed Examination and Services; Limitation: one annual examination.

(3) Service: Encounter Visit; Unit: Completed Examination and Services; Limitation: one per day.

(4) Service: Vasectomy; Unit: Completed Examination and Services; Limitation: one each (required consent restricted to persons age 21 and over, at time consent form is signed).

(5) Service: Tubal Ligation; Unit: Completed Examination and Services; Limitation: one each (required consent restricted to persons age 21 and over, at time consent form is signed).

PART 75. FEDERALLY QUALIFIED HEALTH CENTERS

317:30-5-664.5. Health Center encounter exclusions and limitations

(a) Service limitations governing the provision of all services apply pursuant to OAC 317:30. Excluded from the definition of reimbursable encounter core services are:

(1) Services provided by an independently CLIA certified and enrolled laboratory.

(2) Radiology services including nuclear medicine and diagnostic ultrasound services.

(3) Venipuncture for lab tests is considered part of the encounter and cannot be billed separately. When a member is seen at the clinic for a lab test only, use the appropriate CPT code. A visit for "lab test only" is not considered a Center encounter.
(4) Durable medical equipment or medical supplies not generally provided during the course of a Center visit such as diabetic supplies. However, gauze, band-aids, or other disposable products used during an office visit are considered as part of the cost of an encounter and cannot be billed separately under SoonerCare.
(5) Supplies and materials that are administered to the member are considered a part of the physician's or other health care practitioner's service.
(6) Drugs or medication treatments provided during a clinic visit are included in the encounter rate. For example, a member has come into the Center with high blood pressure and is treated at the Center with a hypertensive drug or drug samples provided to the Center free of charge are not reimbursable services and are included in the cost of an encounter. Prescriptions are not included in the encounter rate and must be billed through the pharmacy program by a qualified enrolled pharmacy.
(7) Administrative medical examinations and report services;
(8) Emergency services including delivery for pregnant members that are eligible under the Non-Qualified (ineligible) provisions of OAC 317:35-5-25;
(9) ~~Family~~ SoonerPlan family planning services ~~provided to individuals enrolled in the Family Planning Waiver~~;
(10) Optometry and podiatric services other than for dual eligible for Part B of Medicare;
(11) Other services that are not defined in this rule or the State Plan.

(b) In addition, the following limitations and requirements apply to services provided by Health Centers:
(1) Physician services are not covered in a hospital.
(2) Behavioral health case management and psychosocial rehabilitation services are limited to Health Centers enrolled under the provider requirements in OAC 317:30-5-240, and 317:30-5-595 and contracted with OHCA as an outpatient behavioral health agency.

PART 112. PUBLIC HEALTH CLINIC SERVICES

317:30-5-1154. CHD/CCHD services/limitations

CHD/CCHD service limitations are:
(1) Child Guidance services (see OAC 317:30-3-65 through OAC 317:30-3-5-65.11 for specifics regarding program requirements).
(2) Dental services [OAC 317:30-3-65.4(7)].
(3) Early Periodic Screening, Diagnosis, and Treatment services

(including blood lead testing and follow-up services) (see OAC 317:30-3-65 through OAC 30-3-65.11 for specific coverage).
(4) Environmental investigations.
(5) Family Planning ~~services~~ and ~~Family Planning Waiver Services~~ SoonerPlan Family Planning services (see ~~OAC 317:30-5-465 through OAC 317:30-5-467~~ OAC 317:30-5-12 for specific coverage and ~~limitations~~ guidelines).
(6) Immunizations (adult and child).
(7) Blood lead testing (see OAC 317:30-3-65.4 for specific coverage).
(8) Newborn hearing screening.
(9) Newborn metabolic screening.
(10) Maternity services (see OAC 317:30-5-22 for specific coverage).
(11) Public health nursing services.
(12) Tuberculosis case management and directly observed therapy.
(13) Laboratory services.
(14) Targeted case management.

CHAPTER 35. MEDICAL ASSISTANCE FOR ADULTS
SUBCHAPTER 5. ELIGIBILITY AND COUNTABLE INCOME
PART 1. DETERMINATION OF QUALIFYING CATEGORICAL RELATIONSHIPS

317:35-5-2. Categorically related programs

(a) Categorical relationship is established using the same definitions of age, disability and blindness as used by the Social Security Administration (SSA) in determining eligibility for Supplemental Security Income (SSI) or SSA benefits. If the individual is a SSA/SSI recipient in current payment status (including presumptive eligibility), a TANF recipient, or is under age 19, categorical relationship is automatically established. Categorical relationship to pregnancy-related services is established when the determination is made by medical evidence that the individual is or has been pregnant. Pregnancy-related services include all medical services provided within the scope of the program during the prenatal, delivery and postpartum periods. For an individual age 19 or over to be related to AFDC, the individual must have a minor dependent child. Categorical relationship to Refugee services is established in accordance with OAC 317:35-5-25. Categorical relationship for the Breast and Cervical Cancer Treatment program is established in accordance with OAC 317:35-21. Categorical relationship for the SoonerPlan Family Planning ~~Waiver~~ Program is established in accordance with OAC 317:35-5-8. Categorical relationship for pregnancy related benefits covered under Title XXI is established in accordance with OAC 317:35-22. Benefits for pregnancies covered under Title XXI medical services are provided within the scope of the program during the prenatal, delivery and postpartum care when included in the global delivery payment. To be eligible for SoonerCare benefits, an individual

must be related to one of the following:

(1) Aged
(2) Disabled
(3) Blind
(4) Pregnancy
(5) Aid to Families with Dependent Children
(6) Refugee
(7) Breast and Cervical Cancer Treatment program
(8) SoonerPlan Family Planning ~~Waiver~~ Program
(9) Benefits for pregnancies covered under Title XXI.

(b) The Authority may provide SoonerCare to reasonable categories of individuals under age 21 who are not receiving cash assistance under any program but who meet the income requirement of the State's approved AFDC plan.

(1) Individuals eligible for SoonerCare benefits include individuals between the ages of 19 and 21:

(A) for whom a public agency is assuming full or partial financial responsibility who are in custody as reported by the Oklahoma Department of Human Services (OKDHS) and in foster homes, private institutions or public facilities; or
(B) in adoptions subsidized in full or in part by a public agency; or
(C) individuals under age 21 receiving active treatment as inpatients in public psychiatric facilities or programs if inpatient psychiatric services for individuals under age 21 are provided under the State Plan and the individuals are supported in full or in part by a public agency; or

(2) Individuals eligible for SoonerCare benefits include individuals between the ages of 18 and 21 if they are in custody as reported by OKDHS on their 18th birthday and living in an out of home placement.

317:35-5-8. Determining categorical relationship for the SoonerPlan Family Planning ~~Waiver~~ Program

All ~~uninsured~~ non-pregnant women and men ages 19 and older, ~~who have not undergone a sterilization procedure~~, regardless of pregnancy or paternity history, with family income at or below 185% of the federal poverty level and who are otherwise ineligible for SoonerCare ~~benefits~~ are categorically related to the SoonerPlan Family Planning ~~Waiver~~ Program. If eligible for SoonerCare benefits, the individual can choose to enroll only in ~~the Family Planning Waiver Program~~ SoonerPlan with the option of applying for SoonerCare at any time.

SUBCHAPTER 7. MEDICAL SERVICES
PART 5. DETERMINATION OF ELIGIBILITY FOR MEDICAL SERVICES

317:35-7-37. Financial eligibility of individuals categorically

related to AFDC, or pregnancy-related services ~~or Family Planning Waiver Program~~

~~(a)~~ AFDC and/or pregnancy-related services.

(1) In determining financial eligibility for an individual related to AFDC or pregnancy-related services, the income of the following persons (if living together or if living apart as long as there has been no break in the family relationship) are considered. These persons include:

(A) the individual;

(B) the spouse of the individual;

(C) the biological or adoptive parent(s) of the individual who is a minor dependent child. Income of the stepparent of the minor dependent child is determined according to OAC 35-10-26(a)(8);

(D) minor dependent children of the individual if the children are being included in the case for Medicaid. If the individual is 19 years or older and not pregnant, at least one minor dependent child must be living in the home and included in the case for the individual to be categorically related to AFDC;

(E) blood related siblings, of the individual who is a minor child, if they are included in the case for Medicaid;

(F) a caretaker relative and spouse (if any) and minor dependent children when the caretaker relative is to be included for coverage.

(2) The family has the option to exclude minor dependent children or blood related siblings see [OAC 317:35-7-37(1)(D) and (E)] and their income from the eligibility process. However, for the adult to be eligible, at least one minor child and his/her income [see OAC 317:35-7-37(a)(4)] must be included in the case. ~~The worker has the responsibility to inform the family of the most advantageous consideration in regard to coverage and income.~~ When determining financial eligibility for an individual related to AFDC or pregnancy-related services, consideration is not given to income of any person who is aged, blind or disabled and is determined to be categorically needy.

(3) An individual categorized as aged, blind, or disabled who is not an SSI recipient has an option to be categorically related to either AFDC or ABD. The individual may be included in the AFDC related benefit group pending determination of eligibility for ABD or SSI if all eligibility requirements are met.

(4) An individual who receives SSI cannot be included in the AFDC related benefit group. When the only dependent child is receiving SSI, the natural or adoptive parent(s) or caretaker relative may be related to AFDC if all other factors of eligibility are met. The benefit group will consist of the adult(s) only. Applicants and ~~recipients~~ members are informed of their responsibility to report to the OKDHS if any member of the benefit group makes application for SSI or becomes eligible

for SSI.

~~(b) **Family Planning Program.** In determining financial eligibility for the FPW program the income of the individual and spouse (if any) is considered. The individual has the option to include or exclude minor dependent children and their income in the eligibility process. The worker has the responsibility to inform the individual of the most advantageous consideration in regard to coverage and income.~~

317:35-7-48. Eligibility for the SoonerPlan Family Planning ~~Waiver~~ Program

(a) ~~Women~~ Non-pregnant women and men ages 19 and above are eligible to receive family planning services if they meet all of the conditions of eligibility in paragraphs (1), (2), (3), and (4) of this Subsection. This is regardless of pregnancy or paternity history and includes women who gain eligibility for SoonerCare family planning services due to a pregnancy, but whose eligibility ends 60 days postpartum.

(1) The countable income is at or below 185% of the federal poverty level. The standard deduction for work related expenses such as income tax payments, Social Security taxes, and transportation to and from work, is $240 per each full-time or part-time employed member of the benefit group. Deductions for work related expenses for self-employed individuals are found at OAC 317:35-10-26(b)(1).

(2) In determining financial eligibility for the SoonerPlan Family Planning program the income of the individual and spouse (if any) is considered. The individual has the option to include or exclude minor dependent children and their income in the eligibility process.

(3) SoonerPlan members with minor dependent children and a parent absent from the home are required to cooperate with the Oklahoma Department of Human Services, Child Support Services Division (OCSS) in the collection of child support payments. Federal regulations provide a waiver of this requirement when cooperation is not in the best interest of the child.

~~(2)~~ (4) Individuals eligible for SoonerCare can choose to enroll only in the SoonerPlan Family Planning ~~Waiver~~ Program with the option of applying for SoonerCare at any time.

~~(3)~~ (5) ~~The individual is uninsured~~. Persons who have Medicare or creditable health insurance coverage are not ~~eligible~~ precluded from applying for the SoonerPlan Family Planning ~~Waiver~~ program. ~~A stand alone policy such as dental, vision or pharmacy is not considered creditable health insurance coverage.~~

~~(4) The individual has not undergone a sterilization procedure.~~

(b) All health insurance is listed on the OKDHS computer system in order for OHCA Third Party Liability Unit to verify insurance coverage. The OHCA is the payer of last resort.

(c) Income for the SoonerPlan Family Planning ~~Waiver~~ Program does

not require verification, unless questionable. If the income is questionable the worker must verify the income.
(d) There is not an asset test for the SoonerPlan Family Planning ~~Waiver~~ Program.

PART 7. CERTIFICATION, REDETERMINATION AND NOTIFICATION

317:35-7-60. Certification for ~~Medical Services~~ SoonerCare

(a) The rules in this Section apply to all categories of eligibles **EXCEPT:**

(1) categorically needy SoonerCare ~~Health Benefit recipients~~ members who are categorically related to AFDC or Pregnancy Related Services, AND

(2) who if eligible, would be enrolled in SoonerCare, or

(3) individuals categorically related to the Family Planning ~~Waiver~~ Program.

(b) An individual determined eligible for ~~Medical Services~~ SoonerCare may be certified for a medical service provided on or after the first day of the third month prior to the month of application if all eligibility criteria are met during the three month period. The certification period is determined beginning with the month the medical service was received or expected to be received or the month of application for categorically needy cases in which a medical service has not been received. The period of certification may cover retroactive or future months. ~~Assignment of the certification period is dependent on the categorical relationship. Form MA-2, Medical Assistance Computation Work Sheet, is used to determine the certification period. The certification period in family cases is assigned for the shortest period of eligibility determined for any individual in the case.~~

(1) **Certification as categorically needy.** A categorically needy individual who is categorically related to ABD is assigned a certification period of 12 months. A categorically needy individual who is determined eligible for a State Supplemental Payment (SSP) is certified effective the month of application. If the individual is also eligible for payment for medical services received during the three months preceding the month of application, the ~~Medicaid~~ SoonerCare benefit is certified for the appropriate months. If the individual is not eligible for SSP, the first month of certification is the month that a medical service was provided or, if no medical service was provided, the month of application.

(A) **Certification of individuals categorically needy and categorically related to ABD.** The certification period for the individual categorically related to ABD can be assigned for up to 12 months. The individual must be determined as categorically needy for each month of the certification

period. The certification period is 12 months unless the individual:

(i) is certified as eligible in a money payment case during the 12 month period;

(ii) is certified for long-term care during the 12 month period;

(iii) becomes ineligible for medical assistance after the initial month;

(iv) becomes ineligible as categorically needy; or

(v) is deceased.

(B) **Certification period.** If any of the situations listed in subparagraph (A) of this paragraph occur after the initial month, the case is closed by the worker.

(i) If income and/or resources change after certification causing the case to exceed the categorically needy maximums, the case is closed.

(ii) A pregnant individual included in an ABD case which closes continues to be eligible for pregnancy related services through the postpartum period.

(2) **Certification of individuals categorically related to ABD and eligible as Qualified Medicare Beneficiaries Plus.** The ~~Medicaid~~ SoonerCare benefit may be certified on the first day of the third month prior to the month of application or later. If the individual receives Medicare and is eligible for SSP, the effective date of certification for the Medicare Part B premium buy-in is the month of certification for SSP. If the individual receives Medicare and is not eligible for SSP, the effective date of certification for the Medicare Part B premium buy-in is the first day of the month following the month in which the eligibility determination is made (regardless of when application was made).

(A) An individual determined eligible for QMBP benefits is assigned a certification period of 12 months. At any time during the certification period that the individual becomes ineligible, the case is closed using regular negative action procedures.

(B) At the end of the certification period a redetermination of QMBP eligibility is required, using the same forms and procedures as for ABD categorically needy individuals.

(3) **Certification of individuals categorically related to ABD and eligible as Qualified Disabled and Working Individual.** The Social Security Administration is responsible for referrals of individuals potentially eligible for QDWI. Eligibility factors verified by the SSA are Medicare Part A eligibility and discontinuation of disability benefits due to excessive earnings. When the OKDHS State Office receives referrals from SSA the county will be notified and is responsible for obtaining an application and establishing other factors of eligibility. If an individual contacts the county office stating he/she has

been advised by SSA that ~~they are~~ he/she is a potential QDWI, the county takes a ~~Medicaid~~ SoonerCare application. ~~If the individual does not have verification of eligibility factors determined by SSA, the county contacts OKDHS, FSSD, State Office, for assistance in verifying those factors. The verification will be obtained by OKDHS State Office and sent to the county office.~~ The effective date of certification for QDWI benefits is based on the date of application and the date all eligibility criteria, including enrollment for Medicare Part A, are met. For example, if an individual applies for benefits in October and is already enrolled in Medicare Part A, eligibility can be effective October 1 (or up to three months prior to October 1, if all eligibility criteria are met during the three month period). However, if in the example, the individual's enrollment for Part A is not effective until November 1, eligibility cannot be effective until that date. Eligibility can never be effective prior to July 1, 1990, the effective date of this provision. These cases will be certified for a period of 12 months. At the end of the 12-month period, eligibility redetermination is required. If the individual becomes ineligible at any time during the certification period, the case is closed. ~~The reason for closure is 69, and the worker completes the Notice to Client form.~~

(4) **Certification of individuals categorically related to ABD and eligible as Specified Low-Income Medicare Beneficiary (SLMB).** The effective date of certification of SLMB benefits may begin on the first day of the third month prior to the month of application or later. A certification can never be earlier than the date of entitlement of Medicare Part A. An individual determined eligible for SLMB benefits is assigned a certification period of 12 months. At any time during the certification period the individual becomes ineligible, the case is closed using standard negative action procedures. At the end of the certification period a redetermination of SLMB eligibility is required. A redetermination of SLMB eligibility must also be done at the same time a dually eligible individual has a redetermination of eligibility for other ~~Medicaid~~ SoonerCare benefits such as long-term care.

(5) **Certification of individuals categorically related to disability and eligible for TB related services.**

(A) An individual determined eligible for TB related services may be certified the first day of the third month prior to the month of application or later, but no earlier than the first day of the month the ~~as long as verification is received of a diagnosis of~~ TB infection is diagnosed.

(B) A certification period of 12 months will be assigned. At any time during the certification period that the individual becomes ineligible, the case is closed using the regular negative action procedures.

(C) At the end of the certification period a new application will be required if additional treatment is needed.

(6) **Certification of individuals categorically related to ABD and eligible as Qualifying Individuals.** The effective date of certification for the QI-1 may begin on the first day of the third month prior to the month of application or later. A certification can never be earlier than the date of entitlement of Medicare Part A. An individual determined eligible for QI benefits is assigned a certification period of 12 months. At any time during the certification period the individual becomes ineligible, the case is closed using standard negative action procedures. At the end of the certification period, a redetermination of QI eligibility is required.

(A) Since the State's allotment to pay Medicare premiums for this group of individuals is limited, the State must limit the number of QIs so that the amount of assistance provided during the year does not exceed the State's allotment for that year.

(B) Persons selected to receive assistance are entitled to receive assistance with their Medicare premiums for the remainder of the federal fiscal year, but not beyond, as long as they continue to qualify. The fact that an individual is selected to receive assistance at any time during the year does not entitle the individual to continued assistance for any succeeding year.

(7) **Certification of individuals Related to Aid to the Disabled for TEFRA.** The certification period for individuals categorically related to the Disabled for TEFRA is 12 months.

317:35-7-60.1. Certification for the SoonerPlan Family Planning ~~Waiver~~ Program.

The effective date of certification for the SoonerPlan Family Planning ~~Waiver~~ Program is the date of application or later. The period of certification may not be for a retroactive period. An individual determined eligible for the SoonerPlan Family Planning ~~Waiver~~ Program is assigned a certification period of 12 months. At any time during the certification period the individual becomes ineligible, the case is closed using standard negative action procedures. At the end of the certification period, a redetermination of eligibility is required.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORTY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 21. OUTPATIENT BEHAVIORAL HEALTH SERVICES

317:30-5-241.2. Psychotherapy

(a) **Individual/Interactive Psychotherapy.**

(1) **Definition.** Individual Psychotherapy is a face-to-face treatment for mental illnesses and behavioral disturbances, in which the clinician, through definitive therapeutic communication, attempts to alleviate the emotional disturbances, reverse or change maladaptive patterns of behavior and encourage growth and development. Insight oriented, behavior modifying and/or supportive psychotherapy refers to the development of insight of affective understanding, the use of behavior modification techniques, the use of supportive interactions, the use of cognitive discussion of reality, or any combination of these items to provide therapeutic change.

(2) **Definition.** Interactive Psychotherapy is individual psychotherapy that involves the use of play therapy equipment, physical aids/devices, language interpreter, or other mechanisms of nonverbal communication to overcome barriers to the therapeutic interaction between the clinician and the member who has not yet developed or who has lost the expressive language communication skills to explain his/her symptoms and response to treatment, requires the use of a mechanical device in order to progress in treatment, or the receptive communication skills to understand the clinician. The service may be used for adults who are hearing impaired and require the use of language interpreter.

(3) **Qualified professionals.** With the exception of a qualified interpreter if needed, only the member and the Licensed Behavioral Health Professional (LBHP) ~~or Certified Alcohol and Drug Counselor (CADC), for substance abuse (SA) only,~~ should be present and the setting must protect and assure confidentiality. Certified Alcohol and Drug Counselors (CADC) are permitted to provide Individual/Interactive Psychotherapy for substance abuse (SA) only through June 30, 2013. Effective July 1, 2013 all Individual/Interactive Psychotherapy must be provided by LBHPs. Ongoing assessment of the member's status and response to treatment as well as psycho-educational intervention are appropriate components of individual

counseling. The counseling must be goal directed, utilizing techniques appropriate to the service plan and the member's developmental and cognitive abilities. Individual/Interactive counseling must be provided by a LBHP ~~or CADC when treatment is for an alcohol or other drug disorder only~~. CADCs are permitted to provide Individual/Interactive counseling for an alcohol or other drug disorders only through June 30, 2013.

(4) **Limitations.** A maximum of 6 units per day per member is compensable.

(b) **Group Psychotherapy.**

(1) **Definition.** Group psychotherapy is a method of treating behavioral disorders using the interaction between the LBHP ~~or the CADC when treating alcohol and other drug disorders only~~, and two or more individuals to promote positive emotional or behavioral change. CADCs are permitted to provide group psychotherapy when treating alcohol and other drug disorders only through June 30, 2013. Effective July 1, 2013, all group psychotherapy must be provided by LBHPs. The focus of the group must be directly related to the goals and objectives in the individual member's current service plan. This service does not include social or daily living skills development as described under Behavioral Health Rehabilitation Services.

(2) **Group sizes.** Group Psychotherapy is limited to a total of eight adult (18 and over) individuals except when the individuals are residents of an ICF/MR where the maximum group size is six. For all children under the age of 18, the total group size is limited to six.

(3) **Multi-family and conjoint family therapy.** Sessions are limited to a maximum of eight families/units. Billing is allowed once per family unit, though units may be divided amongst family members.

(4) **Qualified professionals.** Group psychotherapy will be provided by a LBHP ~~or CADC when treatment is for an alcohol or other drug disorder only~~. CADCs are permitted to provide group psychotherapy when treating alcohol and other drug disorders only through June 30, 2013. Effective July 1, 2013 all group psychotherapy must be provided by LBHPs. Group Psychotherapy must take place in a confidential setting limited to the LBHP or CADC conducting the service, an assistant or co-therapist, if desired, and the group psychotherapy participants.

(5) **Limitations.** A maximum of 12 units per day per member is compensable.

(c) **Family Psychotherapy.**

(1) **Definition.** Family Psychotherapy is a face-to-face psychotherapeutic interaction between a LBHP ~~or CADC~~ and the member's family, guardian, and/or support system. CADCs are permitted to provide family psychotherapy when treating alcohol and other drug disorders only through June 30, 2013. Effective July 1, 2013, all family psychotherapies must be provided by LBHPs. It is typically inclusive of the identified member, but may be performed if indicated without the member's presence. When the member is an adult, his/her permission must be obtained in writing. Family psychotherapy must be provided for the direct benefit of the SoonerCare member to assist him/her in achieving his/her established treatment goals and objectives and it must take place in a confidential setting. This service may include the Evidence Based Practice titled Family Psychoeducation.

(2) **Qualified professionals.** Family Psychotherapy must be provided by a LBHP ~~or CADC when treatment is for an alcohol or other drug disorder only~~. CADCs are permitted to provide family psychotherapy when treating alcohol and other drug disorders only through June 30, 2013. Effective July 1, 2013, all family psychotherapy must be provided by LBHPs.

(3) **Limitations.** A maximum of 12 units per day per member/family unit is compensable.

(d) **Multi-Systemic Therapy (MST).**

(1) **Definition.** MST intensive outpatient program services are limited to children within an Office of Juvenile Affairs (OJA) MST treatment program which provides an intensive, family and community-based treatment targeting specific BH disorders in children with SED who exhibit chronic, aggressive, antisocial, and/or substance abusing behaviors, and are at risk for out of home placement. Case loads are kept low due to the intensity of the services provided.

(2) **Qualified professionals.** Masters level professionals who work with a team that may include bachelor level staff.

(e) **Children/Adolescent Partial Hospitalization Program (PHP).**

(1) **Definition.** Partial hospitalization services are services that (1) Are reasonable and necessary for the diagnosis or active treatment of the member's condition; (2) Are reasonably expected to improve ~~or maintain~~ the member's condition and functional level and to prevent

relapse or hospitalization and (3) ~~Are provided in accordance with services outlined in 42 CFR 410.43.~~ Include the following:

A. Assessment, diagnostic and treatment plan services for mental illness and/or substance abuse disorders provided by LBHPs.

B. Individual/Group/Family (primary purpose is treatment of the member's condition) psychotherapies provided by LBHPs.

C. Substance abuse specific services are provided by LBHPs qualified to provide these services.

D. Drugs and biologicals furnished for therapeutic purposes.

E. Family counseling, the primary purpose of which is treatment of the member's condition.

F. Patient psychosocial rehabilitation training and education services, to the extent the training and educational activities are closely and clearly related to the individual's care and treatment, provided by certified Behavioral Health Rehabilitation Specialists (BHRS).

G. Care Coordination of mental health services provided by certified case managers.

(2) **Qualified professionals.** All services in the PHP are provided by a clinical team, ~~which must be composed of one or more~~ consisting of the following ~~participants~~ professionals: a licensed physician, registered nurse, licensed behavioral health professional (LBHP),advanced practice nurse, psychological clinician, masters or bachelors level health rehabilitation specialist, certified case managers ~~a case manager, or other certified Behavioral Health/Substance Abuse~~ and paraprofessional staff dependent upon the size of the program and the services being provided at the time. ~~Refer to OHCA BH Provider Manual for further requirements.~~ The treatment plan is directed under the supervision of a physician.

(3) **Qualified providers.** Provider agencies for PHP must be accredited by one of the national accrediting bodies; The Joint Commission (TJC), Commission on Accreditation of Rehabilitation Facilities (CARF) or The Council on Accreditation (COA) for partial hospitalization and enrolled in SoonerCare. Staff providing these services are employees or contractors of the enrolled agency.

(4) **Limitations.** Services are limited to children 0-20 only. Services must be offered at a minimum of 3

hours per day, 5 days per week. Therapeutic services are limited to 4 billable hours per day and must be prior authorized. PHP services are all inclusive with the exception of physician services and drugs that cannot be self-administered, those services are separately billable. ~~Refer to OHCA BH Provider Billing Manual for further definition.~~

(5) **Reporting.** Reporting requirements must be followed as outlined in the OHCA BH Provider ~~Billing~~ Manual.

(f) **Children/Adolescent Day Treatment Program.**

(1) **Definition.** Day Treatment Programs are for the stabilization of children and adolescents with severe emotional and/or behavioral disturbances. Treatment is designed for children who have difficulty functioning in mainstream community settings such as classrooms, and who need a higher intensity of services than outpatient counseling provides. Treatment is time limited and includes therapeutically intensive clinical services geared towards reintegration to the home, school, and community.

(2) **Qualified professionals.** All services in Day Treatment are provided by a team, which must be composed of one or more of the following participants: physician, registered nurse, licensed behavioral health professional (LBHP), a case manager, or other certified Behavioral Health/Substance Abuse paraprofessional staff. Refer to OHCA BH Provider ~~Billing~~ Manual for further requirements. Services are directed by an LBHP.

(3) **Qualified providers.** Provider agencies for Day Treatment must be accredited by one of the national accrediting bodies; The Joint Commission (TJC), Commission on Accreditation of Rehabilitation Facilities (CARF) or The Council on Accreditation (COA).

(4) **Limitations.** Services must be offered at a minimum of 4 days per week at least 3 hours per day. Refer to OHCA BH Provider ~~Billing~~ Manual for further requirements.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 6. INPATIENT PSYCHIATRIC HOSPITALS

317:30-5-95.24. ~~Pre-authorization~~ Prior Authorization of inpatient psychiatric services for children

(a) All inpatient psychiatric services for members under 21 years of age must be prior authorized by the OHCA or its designated agent. All inpatient acute and residential psychiatric services will be prior authorized for an approved length of stay. Additional information will be required for a SoonerCare compensable approval on enhanced treatment units or in special population programs. Residential treatment at this level is a longer term treatment that requires a higher staff to member ratio because it is constant, intense, and immediate reinforcement of new behaviors to develop an understanding of the behaviors. The environment of specialized residential treatment centers requires special structure and configuration (e.g., sensory centers for autistic members) and specialized training for the staff in the area of the identified specialty. The physician will see the child at least one time a week. A PRTF will not be considered a specialty treatment program for SoonerCare without prior approval of the OHCA behavioral health unit. A treatment program that has been approved as a specialized treatment program must maintain medical records that document the degree and intensity of the psychiatric care delivered to the children.

(b) Criteria for classification as a specialized PRTF will require a staffing ratio of 1:3 at a minimum during awake hours and 1:6 during time residents are asleep with 24 hour nursing care supervised by a RN for management of behaviors and medical complications. The PRTF will be a secure unit, due to the complexity of needs and safety considerations. Admissions will be restricted to children that meet the medical necessity criteria for RTC and also meet at least two or more of the following:

(1) Have failed at other levels of care or have not been accepted at other levels of care;

(2) Behavioral, emotional, and cognitive problems requiring secure residential treatment that includes 1:1, 1:2, or 1:3 staffing due to the member being a danger to themselves and others, for impairments in socialization problems, communication problems, and restricted, repetitive and stereotyped behaviors. These symptoms are severe and intrusive enough that management and treatment in a less restrictive environment places the child and others in danger but, do not meet acute medical necessity criteria. These symptoms which are exhibited across multiple

environments must include at least two or more of the following:

(A) Marked impairments in the use of multiple nonverbal behaviors such as eye-to-eye gaze, facial expression, body postures, and gestures to regulate social interaction;

(B) Inability to regulate impulse control with frequent displays of aggression or other dangerous behavior toward self and/or others regularly;

(C) Failure to develop peer relationships appropriate to developmental level;

(D) Lack of spontaneously seeking to share enjoyment, interests, or achievements with other people;

(E) Lack of social or emotional reciprocity;

(F) Lack of attachment to caretakers;

(G) Require a higher level of assistance with activities of daily living requiring multiple verbal cues 50 percent of the time to complete tasks;

(H) Delay, or total lack of, the development of spoken language which is not accompanied by an attempt to compensate through alternative modes of communication such as gesture or mime;

(I) Marked impairment in individuals with adequate speech in the ability to initiate or sustain a conversation with others;

(J) Stereotyped and repetitive use of language or idiosyncratic language;

(K) Lack of varied, spontaneous make-believe play or social imitative play appropriate to developmental level;

(L) Encompassing preoccupation with one or more stereotyped and restricted pattern and interest that is abnormal in intensity of focus;

(M) Inflexible adherence to specific, nonfunctional routines or rituals;

(N) Stereotyped and repetitive motor mannerisms (e.g., hand or finger flapping or twisting or complex whole body movements);

(O) Persistent occupation with parts of objects;

(3) Member is medically stable, but has co-morbid medical conditions which require specialized medical care during treatment;

(4) Full scale IQ below 40 (profound mental retardation intellectual disability).

(c) Non-authorized inpatient psychiatric services will not be SoonerCare compensable.

(d) The designated agent will prior authorize all services for an approved length of stay based on the medical necessity

criteria described in ~~in the OHCA Behavioral Health Provider Manual~~ OAC 317:30-5-95.25 through 317:30-5-95.31.
(e) Out of state placements must be approved by the agent designated by the OHCA and subsequently approved by the OHCA, Medical Services Behavioral Health Division. Requests for admission to Psychiatric Residential Treatment Facilities or acute care units will be reviewed for consideration of level of care, availability, suitability, and proximity of suitable services. A prime consideration for placements will be proximity to the family or guardian in order to involve the family or guardian in Active Treatment, including discharge and reintegration planning. Out of state facilities are responsible for insuring appropriate medical care as needed under SoonerCare provisions as part of the per-diem rate. Out of state facilities are responsible for ~~insuring~~ ensuring appropriate medical care as needed under SoonerCare provisions as part of the per-diem rate.
(f) Inpatient psychiatric services in all acute hospitals and psychiatric residential treatment facilities are limited to the approved length of stay. OHCA, or its designated agent, will approve lengths of stay using the current OHCA Behavioral Health medical necessity criteria ~~and following the current OHCA Behavioral Health Provider Manual~~ as described in OAC 317:30-5-95.25 through OAC 317:30-5-95.31. The approved length of stay applies to both hospital and physician services. The Child and Adolescent Level of Care Utilization System ~~(CALOCUS)~~ (CALOCUS®) is a level of care assessment that will be used as a tool to determine the most appropriate level of care treatment for a member by LBHPs in the community.

317:30-5-95.25. Medical necessity criteria for acute psychiatric admissions for children

~~All acute psychiatric admissions for children must meet the medical necessity criteria for acute admission as identified in the OHCA Behavioral Health Provider Manual~~.

Acute psychiatric admissions for children 13 or older must meet the terms and conditions contained in (1), (2), (3), (4) and two of the terms and conditions in (5)(A) to (6)(C) of this subsection. Acute psychiatric admissions for children 12 or younger must meet the terms or conditions contained in (1), (2), (3), (4) and one of (5)(A) to (5)(D), and one of (6)(A) to (6)(C) of this subsection.

(1) An Axis I primary diagnosis from the most recent edition of "The Diagnostic and Statistical Manual of Mental Disorders" (DSM) with the exception of V-codes, adjustment disorders, and substance related disorders, accompanied by a detailed description of the symptoms supporting the diagnosis. In lieu of a qualifying Axis I diagnosis, children 18-21 years of age may have an Axis II diagnosis

of any personality disorder.
(2) Conditions are directly attributable to a psychiatric disorder as the primary need for professional attention (this does not include placement issues, criminal behavior, status offenses). Adjustment or substance related disorder may be a secondary Axis I diagnosis.
(3) It has been determined by the OHCA designated agent that the current disabling symptoms could not have been managed or have not been manageable in a lesser intensive treatment program.
(4) Child must be medically stable.
(5) Within the past 48 hours, the behaviors present an imminent life threatening emergency such as evidenced by:
(A) Specifically described suicide attempts, suicide intent, or serious threat by the patient.
(B) Specifically described patterns of escalating incidents of self-mutilating behaviors.
(C) Specifically described episodes of unprovoked significant physical aggression and patterns of escalating physical aggression in intensity and duration.
(D) Specifically described episodes of incapacitating depression or psychosis that result in an inability to function or care for basic needs.
(6) Requires secure 24-hour nursing/medical supervision as evidenced by:
(A) Stabilization of acute psychiatric symptoms.
(B) Needs extensive treatment under physician direction.
(C) Physiological evidence or expectation of withdrawal symptoms which require 24-hour medical supervision.

317:30-5-95.26. Medical necessity criteria for continued stay - acute psychiatric admission for children

~~All acute psychiatric continued stay authorizations for children must meet the medical necessity criteria for acute admission as identified in the OHCA Behavioral Health Provider Manual~~.

For continued stay acute psychiatric admissions for children must meet all of the conditions set forth in (1) to (4) of this subsection.

(1) An Axis I primary diagnosis from the most recent edition of "The Diagnostic and Statistical Manual of Mental Disorders" (DSM) with the exception of V-Codes, adjustment disorders, and substance abuse related disorders, accompanied by a detailed description of the symptoms supporting the diagnosis. In lieu of a qualifying Axis I diagnosis, children 18-20 years of age may have an Axis II diagnosis of any personality disorder. Adjustment or substance related disorders may be a secondary Axis I

diagnosis.
(2) Patient continues to manifest a severity of illness that requires an acute level of care as defined in the admission criteria and which could not be provided in a less restrictive setting.
(A) Documentation of regression is measured in behavioral terms.
(B) If condition is unchanged, evidence of re-evaluation of treatment objectives and therapeutic interventions.
(3) Conditions are directly attributable to a mental disorder as the primary need for professional attention (this does not include placement issues, criminal behavior, status offenses).
(4) Documented efforts of working with the child's family, legal guardians and/or custodians and other human service agencies toward a tentative discharge date.

317:30-5-95.27. Medical necessity criteria for admission - inpatient chemical dependency detoxification for children

~~All admissions for inpatient chemical dependency detoxification for children must meet the medical necessity criteria for a detoxification admission as identified in the OHCA Behavioral Health Provider Manual.~~

Inpatient chemical dependency detoxification admissions for children must meet the terms and conditions contained in (1), (2), (3), and one of (4)(A) through (D) of this subsection.
(1) Any psychoactive substance dependency disorder described in the most recent edition of "The Diagnostic and Statistical Manual of Mental Disorders" (DSM) with detailed symptoms supporting the diagnosis and need for medical detoxification, except for cannabis, nicotine, or caffeine dependencies.
(2) Conditions are directly attributable to a substance dependency disorder as the primary need for professional attention (this does not include placement issues, criminal behavior, or status offenses).
(3) It has been determined by the OHCA designated agent that the current disabling symptoms could not be managed or have not been manageable in a lesser intensive treatment program.
(4) Requires secure 24-hour nursing/medical supervision as evidenced by:
(A) Need for active and aggressive pharmacological interventions.
(B) Need for stabilization of acute psychiatric symptoms.
(C) Need extensive treatment under physician direction.
(D) Physiological evidence or expectation of withdrawal symptoms which require 24-hour medical supervision.

317:30-5-95.28. Medical necessity criteria for continued stay - inpatient chemical dependency detoxification program for children

Authorization for admission to a chemical dependency detoxification program is limited to up to five days. Exceptions to this limit may be made up to ~~seven to~~ eight days based on a case-by-case review, per medical necessity criteria ~~as identified in the OHCA Behavioral Health Provider Manual~~ as described in OAC 317:30-5-95.27.

317:30-5-95.29. Medical necessity criteria for admission - psychiatric residential treatment for children

~~All psychiatric residential treatment admissions for children must meet the medical necessity criteria for psychiatric residential treatment admission as identified in the OHCA Behavioral Health Provider Manual.~~

Psychiatric Residential Treatment facility admissions for children must meet the terms and conditions in (1) to (4) and one of the (5)(A) through (5)(D), and one of (6)(A) through (6)(C) of this subsection.

(1) An Axis I primary diagnosis form the most recent edition of "The Diagnostic and Statistical Manual of Mental Disorders" (DSM) with the exception of V-codes, adjustment disorders, and substance related disorders, accompanied by detailed symptoms supporting the diagnosis. In lieu of a qualifying Axis I diagnosis, children 18-20 years of age may have an Axis II diagnosis of any personality disorder. Adjustment or substance related disorders may be a secondary Axis I diagnosis.

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

(3) Patient has either received treatment in an acute care setting or it has been determined by the OHCA designated agent that the current disabling symptoms could not or have not been manageable in a less intensive treatment program.

(4) Child must be medically stable.

(5) Patient demonstrates escalating pattern of self injurious or assaultive behaviors as evidenced by:

(A) Suicidal ideation and/or threat.

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

(C) Serious threats or evidence of physical aggression.

(D) Current incapacitating psychosis or depression.

(6) Requires 24-hour observation and treatment as evidenced by:

(A) Intensive behavioral management.

(B) Intensive treatment with the family/guardian and

child in a structured milieu.

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

317:30-5-95.30. Medical necessity criteria for continued stay - psychiatric residential treatment center for children

~~All psychiatric residential treatment continued stay authorizations for children must meet the medical necessity criteria for continued stay for psychiatric residential treatment admission as identified in the OHCA Behavioral Health Provider Manual.~~

For continued stay Psychiatric Residential Treatment Facilities for children, admissions must meet the terms and conditions contained in (1), (2), (5), (6), and either (3) or (4) of this subsection.

(1) An Axis I primary diagnosis from the most recent edition of "The Diagnostic and Statistical Manual of Mental Disorders" (DSM) with the exception of V codes, adjustment disorders, and substance abuse related disorders, accompanied by detailed symptoms supporting the diagnosis. In lieu of a qualifying Axis I diagnosis, children 18-20 years of age may have an Axis II diagnosis of any personality disorder.

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

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

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

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

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

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

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

(A) Documentation of regression is measured in behavioral terms.

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

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

(A) Intensive behavioral management.

(B) Intensive treatment with the family/guardian and child in a structured milieu.
(C) Intensive treatment in preparation for re-entry into community.
(6) Documented efforts of working with child's family, legal guardian and/or custodian and other human service agencies toward a tentative discharge date.

317:30-5-95.31. ~~Pre-authorization~~ Prior Authorization and extension procedures for children

(a) ~~Pre-admission~~ Prior authorization for inpatient psychiatric services for children must be requested from the OHCA or its designated agent. The OHCA or its designated agent will evaluate and render a decision within 24 hours of receiving the request. A prior authorization will be issued by the OHCA or its designated agent, if the member meets medical necessity criteria. For the safety of SoonerCare members, additional approval from OHCA, or its designated agent is required for placement on specialty units or in special population programs or for members with special needs such as very low intellectual functioning.

(b) Extension requests (psychiatric) must be made through OHCA, or its designated agent. All requests are made prior to the expiration of the approved extension ~~following the guidelines in the OHCA Behavioral Health Provider Manual~~. Requests for the continued stay of a child who has been in an acute psychiatric program for a period of 15 days and in a psychiatric residential treatment facility for 3 months will require a review of all treatment documentation completed by the OHCA designated agent to determine the efficiency of treatment.

(c) Providers seeking prior authorization will follow OHCA's, or its designated agent's, prior authorization process guidelines for submitting behavioral health case management requests on behalf of the SoonerCare member.

(d) In the event a member disagrees with the decision by OHCA, or its designated agent, the member receives an evidentiary hearing under OAC 317:2-1-2(a). The member's request for such an appeal must commence within 20 calendar days of the initial decision.

PART 21. OUTPATIENT BEHAVIORAL HEALTH SERVICES

317:30-5-240.2 Provider participation standards

(a) **Accreditation status.** Any agency may participate as an OPBH provider if the agency is qualified to render a covered service and meets the OHCA requirements for provider participation.

(1) Private, Community-based Organizations must be accredited as a provider of outpatient behavioral health services from one of the accrediting bodies and be an incorporated organization governed by a board of directors;
(2) State-operated programs under the direction of ODMHSAS must be accredited by one of the accrediting bodies;
(3) Freestanding Psychiatric Hospitals must be licensed and certified by the State Survey Agency as meeting Medicare psychiatric hospital standards and JCAHO accreditation;
(4) General Medical Surgical Hospitals must be appropriately licensed and certified by the State Survey Agency as meeting Medicare standards, including a JCAHO or AOA accreditation;
(5) Federally Qualified Health Centers/Community Health Centers facilities that qualify under OAC 317:30-5-660;
(6) Indian Health Services/Tribal Clinics/Urban Tribal Clinics facilities that qualify under Federal regulation;
(7) Rural Health Clinics facilities that qualify under OAC 317:30-5-355;
(8) Public Health Clinics and County Health Departments;
(9) Public School Systems.

(b) **Certifications.** In addition to the accreditation in paragraph (a) above, provider specific credentials are required for the following:
(1) Substance Abuse agencies (OAC 450:18-1-1);
(2) ~~Evidenced~~ Evidence Based Best Practices but not limited to:
(A) Assertive Community Treatment (OAC 450:55-1-1);
(B) Multi-Systemic Therapy (Office of Juvenile Affairs); and
(C) Peer Support/Community Recovery Support;
(3) Systems of Care (OAC 340:75-16-46);
(4) Mobile and Facility-based Crisis Intervention (OAC 450:23-1-1);
(5) Case Management (OAC 450:50-1-1);
(6) RBMS in group homes (OAC 377:10-7) or foster care settings (OAC 340:75-8-4);
(7) Day Treatment - CARF, JCAHO, ~~and~~ or COA will be required as of December 31, 2009; and
(8) Partial Hospitalization/Intensive Outpatient CARF, JCAHO, ~~and~~ or COA will be required as of December 31, 2009.

(c) **Provider enrollment and contracting.**
(1) Organizations who have JCAHO, CARF, COA or AOA accreditation will supply the documentation from the accrediting body, along with other information as required for contracting purposes to the OHCA. The contract must include copies of all required state licenses, accreditation and certifications.

(2) If the contract is approved, a separate provider identification number for each outpatient behavioral health service site will be assigned. Each site operated by an outpatient behavioral health facility must have a separate provider contract and site-specific accreditation and/or certification as applicable. A site is defined as an office, clinic, or other business setting where outpatient behavioral health services are routinely performed. When services are rendered at the member's residence, a school, or when provided occasionally at an appropriate community based setting, a site is determined according to where the professional staff perform administrative duties and where the member's chart and other records are kept. Failure to obtain and utilize site specific provider numbers will result in disallowance of services.

(3) Effective 07/01/10, all behavioral health providers are required to have an individual contract with OHCA in order to receive SoonerCare reimbursement. This requirement includes outpatient behavioral health agencies and all individual rendering providers who work within an agency setting. Individual contracting requirements are set forth in ~~the OHCA BH Provider Manual~~ OAC 317:30-3-2 and OAC 317:30-5-280.

(d) **Standards and criteria.** Eligible organizations must meet each of the following:

(1) Have a well-developed plan for rehabilitation services designed to meet the recovery needs of the individuals served.

(2) Have a multi-disciplinary, professional team. This team must include all of the following:

(A) One of the LBHPs;

(B) A BHRS, if individual or group rehabilitative services for behavioral health disorders are provided;

(C) An AODTP, if treatment of alcohol and other drug disorders is provided;

(D) A registered nurse or physician assistant, with a current license to practice in the state in which the services are delivered if Medication Training and Support ~~service~~ Service is provided;

(E) The member for whom the services will be provided, and parent/guardian for those under 18 years of age.

(F) A member treatment advocate if desired and signed off on by the member.

(3) Demonstrate the ability to provide each of the following outpatient behavioral health treatment services as described in OAC 317:30-5-241 et seq., as applicable to their program. Providers must provide proper referral and linkage to providers of needed services if their agency does not have appropriate services.

(A) Assessments and Treatment Plans;
(B) Psychotherapies;
(C) Behavioral Health Rehabilitation services;
(D) Crisis Intervention services;
(E) Support Services; and
(F) Day Treatment/Intensive Outpatient.

(4) Be available 24 hours a day, seven days a week, for Crisis Intervention services.

(5) Provide or have a plan for referral to physician and other behavioral health services necessary for the treatment of the behavioral disorders of the population served.

(6) Comply with all applicable Federal and State Regulations.

(7) Have appropriate written policy and procedures regarding confidentiality and protection of information and records, member grievances, member rights and responsibilities, and admission and discharge criteria, which shall be posted publicly and conspicuously.

(8) Demonstrate the ability to keep appropriate records and documentation of services performed.

(9) Maintain and furnish, upon request, a current report of fire and safety inspections of facilities clear of any deficiencies.

(10) Maintain and furnish, upon request, all required staff credentials including certified transcripts documenting required degrees.

317:30-5-241. Covered Services

(a) Outpatient behavioral health services are covered for adults and children as set forth in this Section ~~and following the requirements as defined in the OHCA BH Provider Manual,~~ unless specified otherwise, and when provided in accordance with a documented individualized service plan, developed to treat the identified behavioral health and/or substance abuse disorder(s).

(b) All services are to be for the goal of improvement of functioning, independence, or well-being of the member. The services and treatment plans are to be recovery focused, trauma and co-occurring specific. The member must be able to actively participate in the treatment. Active participation means that the member must have sufficient cognitive abilities, communication skills, and short-term memory to derive a reasonable benefit from the treatment.

(c) All outpatient BH services will require authorization through OHCA, or its designated agent, following established medical necessity criteria. Providers are required to follow these criteria and guidelines ~~under the OHCA BH Provider Manual~~ as set forth in this Section. OHCA does retain final

administrative review over both prior authorization and review of services as required by 42 CFR 431.10. Authorization and review of services requirement are described as follows:

(1) **General requirement.** All SoonerCare providers who provide outpatient behavioral health services are required to have the services they provide authorized by the OHCA or its designated agent. Services that do not require authorization are as follows:

(A) Crisis Intervention Services;

(B) Adult Facility Based Crisis Stabilization;

(C) One Medication Training and Support Service.

(2) **Authorization process.**

(A) **Definitions.** The following definitions apply to the process of applying for an outpatient behavioral health authorization.

(i) **"Authorization Number"** means the number that is assigned per member and per provider that authorizes payment after services are rendered (ii) **"Correction Request"** means a request to change a prior authorization error made by the OHCA or its designated agent.

(iii) **"Extension Request"** means a request to authorize treatment for a member who has received outpatient treatment in the last six months.

(iv) **"Important notice"** means a notice that informs the provider that information is lacking regarding the approval of any prior authorization request.

(v) **"Initial Request for Treatment"** means a request to authorize treatment for a member that has not received outpatient treatment in the last six months.

(vi) **"Letter of collaboration"** means an agreement between the member and two providers when a member chooses more than one provider during a course of treatment.

(vi) **"Modification of Current Authorization Request"** means a request to modify the current array or amount of services a member is receiving.

(viii) **"Outpatient Request for Authorization"** means the form used to request the OHCA or its designated agent to approve services.

(ix) **"Provider change in demographic information notification"** means a request to change a provider's name, address, phone, and/or fax numbers, or provider identification numbers. Change in demographics will require contractual changes with OHCA. Providers should contact OHCA's Contracts Services Division for more information.

(x) **"Status request"** means a request to ask the OHCA or its designated agent the status of a request.

(B) **Process.** A provider must submit an Initial Request for Treatment, an Extension Request, a Modification of Current Authorization Request, or a Correction Request on a form provided by the OHCA or its designated agent, prior to rendering the initial services or any additional array of services, with the exception of Crisis Intervention Services; Adult Facility Based Crisis Stabilization and one Medication Training and Support Service per month.

(i) These request forms must be fully completed including the following:

(I) pertinent demographic and identifying information;

(II) complete and current CAR or ASI unless another appropriate assessment tool is authorized by the OHCA or its designated agent;

(III) complete multi axial, DSM diagnosis using the most current edition;

(IV) psychiatric and treatment history;

(V) service plan with goals, objectives, treatment duration as requested by the OHCA or its designated agent for clinical review purposes; and

(VI) services requested.

(ii) The OHCA or its designated agent may also require supporting documentation for any data submitted by the provider. The request may be denied if such information is not provided within ten calendar days of notification of the Important Notice.

(iii) Failure to provide a complete request form may result in a delay in the start date of the prior authorization.

(C) **Authorization for services.**

(i) Services are authorized by the OHCA or its designated agent using independent medical judgment to perform the review of prior authorization requests to determine whether the request meets medical necessity criteria. If services are authorized, a treatment course of one to six months will be authorized. The authorization of services is based upon seven levels of care for children and six levels of care for adults. The numerically based levels of care are designed to reflect the member's acuity at each level of care, in ascending order. Additional levels of care are known as Exceptional Case, 0-36

months, ICF/MR, Recovery Maintenance/Relapse Prevention, and RBMS.

(ii) If the provider requests services beyond the initial prior authorization period, additional documentation is required in the Extension Request.

(d) Unauthorized services will not be SoonerCare compensable, unless designated by OHCA.

317:30-5-241.1. Screening, assessment and service plan

All providers must comply with the requirements as set forth in ~~the OHCA BH Provider Manual~~ this Section.

(1) **Screening.**

(A) **Definition.** Screening is for the purpose of determining whether the member meets basic medical necessity and need for further BH assessment and possible treatment services.

(B) **Qualified professional.** Screenings can be performed by any credentialed staff members as listed under OAC 317:30-5-240.3.

(C) **Target population.** This service is compensable only on behalf of a member who is under a PACT program.

(2) **Assessment.**

(A) **Definition.** Gathering and assessment of historical and current bio-psycho-social information which includes face-to-face contact with the person and/or the person's family or other informants, or group of persons resulting in a written summary report, diagnosis and recommendations. All agencies must assess the medical necessity of each individual to determine the appropriate level of care.

(B) **Qualified professional.** This service is performed by an LBHP. CADCs are permitted to provide Drug and Alcohol assessments through June 30, 2010. Effective July 1, 2010 all assessments must be provided by LBHPs.

(C) **Time requirements.** The minimum face-to-face time spent in assessment session(s) with the member and others as identified previously in paragraph (1) of this subsection for a low complexity Behavioral Health Assessment by a Non-Physician is one and one half hours. For a moderate complexity, it is two hours or more.

(D) **Target population and limitations.** This service is compensable on behalf of a member who is seeking services for the first time from the contracted agency. This service is not compensable if the member has previously received or is currently receiving services from the agency, unless there has been a gap in service of more than six months and it has been more than one year since the previous assessment.

(E) **Documentation requirements.** The assessment must include all elements and tools required by the OHCA. In the case of children under the age of 18, it is performed with the direct, active face-to-face participation of the parent or guardian. The child's level of participation is based on age, developmental and clinical appropriateness. The assessment must include a DSM multi-axial diagnosis completed for all five axes from the most recent DSM edition. The assessment must contain but is not limited to the following:

(i) Date, to include month, day and year of the assessment session(s);

(ii) Source of information;

(iii) Member's first name, middle initial and last name;

(iv) Gender;

(v) Birth Date

(vi) Home address;

(vii) Telephone number;

(viii) Referral source;

(ix) Reason for referral;

(x) Person to be notified in case of emergency;

(xi) Presenting reason for seeking services;

(xii) Start and stop time for each unit billed;

(xiii) Signature of parent of guardian participating in face-to-face assessment. Signature required for members over the age of 14;

(xiv) Bio-Psychosocial information which must include:

(I) Identification of the member's strengths, needs, abilities and preferences;

(II) History of the presenting problem;

(III) Previous psychiatric treatment history, include treatment for psychiatric; substance abuse; drug and alcohol addiction; and other addictions;

(IV) Health history and current biomedical conditions and complications;

(V) Alcohol, Drug, and/or other addictions history;

(VI) Trauma, abuse, neglect, violence, and/or sexual assault history of self and/or others, include Department of Human Services involvement;

(VII) Family and social history, include MH, SA, Addictions, Trauma/Abuse/Neglect;

(VIII) Educational attainment, difficulties and history;

(IX) Cultural and religious orientation;

(X) Vocational, occupational and military history;
(XI) Sexual history, including HIV, AIDS, and STD at-risk behaviors;
(XII) Marital or significant other relationship history;
(XIII) Recreation and leisure history;
(XIV) Legal or criminal record, including the identification of key contacts, (i.e. attorneys, probation officers, etc.);
(XV) Present living arrangements;
(XVI) Economic resources;
(XVII) Current support system including peer and other recovery supports.

(xv) Mental status and Level of Functioning information, including questions regarding:
(I) Physical presentation, such as general appearance, motor activity, attention and alertness, etc.;
(II) Affective process, such as mood, affect, manner and attitude, etc.;
(III) Cognitive process, such as intellectual ability, social-adaptive behavior, thought processes, thought content, and memory, etc; and
(IV) Full Five Axes DSM diagnosis.

(xvi) Pharmaceutical information to include the following for both current and past medications;
(I) Name of medication;
(II) Strength and dosage of medication;
(III) Length of time on the medication; and
(IV) Benefit(s) and side effects of medication.

(xvii) LBHP's interpretation of findings and diagnosis;

(xviii) Signature and credentials of LBHP who performed the face-to-face behavioral assessment;

(xix) Client Data Core Elements reported into designated OHCA representative.

A Service Plan Development, Low Complexity is required every 6 months and must include an update to the bio-psychosocial assessment and re-evaluation of diagnosis.

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

(A) **Definition.** The Behavioral Health Service Plan is developed based on information obtained in the assessment and includes the evaluation of all pertinent information by the practitioners and the member. It includes a discharge plan. It is a process whereby an individualized rehabilitation plan is developed that addresses the member’s strengths, functional assets, weaknesses or liabilities, treatment goals, objectives

and methodologies that are specific and time limited, and defines the services to be performed by the practitioners and others who comprise the treatment team. BH Service Plan Development is performed with the direct active participation of the member and a member support person or advocate if requested by the member. In the case of children under the age of 18, it is performed with the participation of the parent or guardian and the child as age and developmentally appropriate, and must address school and educational concerns and assisting the family in caring for the child in the least restrictive level of care. For adults, it is focused on recovery and achieving maximum community interaction and involvement including goals for employment, independent living, volunteer work, or training.

(B) **Qualified professional.** This service is performed by an LBHP.

(C) **Time requirements.** Service Plan updates must be conducted face-to-face and are required every six months during active treatment. Updates can be conducted whenever it is clinically needed as determined by the ~~provider~~ LBHP and member.

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

(i) member strengths, needs, abilities, and preferences(SNAP);

(ii) identified presenting challenges, problems, needs and diagnosis;

(iii) specific goals for the member;

(iv) objectives that are specific, attainable, realistic, and time-limited;

(v) each type of service and estimated frequency to be received;

(vi) the practitioner(s) name and credentials that will be providing and responsible for each service;

(vii) any needed referrals for service;

(viii) specific discharge criteria;

(ix) description of the member's involvement in, and responses to, the treatment plan, and his/her signature and date;

(x) service plans are not valid until all signatures are present (signatures are required from the member (if 14 or over), the parent/guardian (if younger than 18 or otherwise applicable), and the primary LBHP; and

(xi) all changes in service plan must be documented in a service plan update (low complexity) or within

the service plan until time for the update (low complexity).

(xii) Updates to goals, objectives, service provider, services, and service frequency, must be documented within the service plan until the six month review/update is due.

(xiii) Service plan updates must address the following:

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

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

(III) a statement documenting a review of the current service plan and an explanation if no changes are to be made to the service plan;

(IV) change in goals and/or objectives (including target dates) based upon member's progress or identification of new need, challenges and problems;

(V) change in frequency and/or type of services provided;

(VI) change in practitioner(s) who will be responsible for providing services on the plan;

(VII) change in discharge criteria;

(VIII) description of the member's involvement in, and responses to, the treatment plan, and his/her signature and date; and

(IX) service plans are not valid until all signatures are present. The required signatures are: from the member (if 14 or over), theparent/guardian (if younger than 18 or otherwise applicable), and the primary LBHP.

(E) **Service limitations:**

(i) Behavioral Health Service Plan Development, Moderate complexity (i.e., pre-admission procedure code group) are limited to 1 per member, per provider, unless more than a year has passed between services, then another one can be requested and may be authorized by OHCA or its designated agent.

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

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

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

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

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

(i) date;

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

(iii) signature of the provider;

(iv) credentials of provider;

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

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

(vii) progress made toward goals and objectives

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

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

(D) Service Limitations. Any testing authorization request for a child younger than three must meet 0-3 medical necessity criteria. Evaluation and testing is clinically appropriate and allowable when an accurate diagnosis and determination of treatment needs is needed. Eight hours/units of testing per patient over the age of two, per provider is allowed with authorization every 12 months. In circumstances where it is determined that further testing is medically necessary, additional hours/units may be prior authorized by the OHCA or designated agent based upon medical necessity and consultation review. In circumstances where there is a clinical need for specialty testing, then more hours/units of testing can

be authorized. Testing units must be billed on the date the actual testing, interpretation, scoring, and reporting are performed. A maximum of 12 hours of therapy and testing, per day per rendering provider are allowed. A child who is being treated in an acute inpatient setting can receive separate psychological services by a physician or psychologist as the inpatient per diem is for "non-physician" services only. A child receiving Residential level treatment in either an therapeutic foster care home, or group home may not receive additional individual, group or family counseling or psychological testing unless allowed through prior authorization by the OHCA or its designated agent. Psychologists employed in State and Federal Agencies, who are not permitted to engage in private practice, cannot be reimbursed for services as an individually contracted provider. For assessment conducted in a school setting the Oklahoma State Department of Education requires that a licensed supervisor sign the assessment. Individuals who qualify for Part B of Medicare: Payment is made utilizing the SoonerCare allowable for comparable services. Payment is made to physicians, LBHPs or psychologists with a license to practice in the state where the services is performed or to practitioners who have completed education requirements and are under current board approved supervision to become licensed.

317:30-5-241.2. Psychotherapy

(a) **Individual/Interactive Psychotherapy.**

(1) **Definition.** Individual Psychotherapy is a face-to-face treatment for mental illnesses and behavioral disturbances, in which the clinician, through definitive therapeutic communication, attempts to alleviate the emotional disturbances, reverse or change maladaptive patterns of behavior and encourage growth and development. Insight oriented, behavior modifying and/or supportive psychotherapy refers to the development of insight of affective understanding, the use of behavior modification techniques, the use of supportive interactions, the use of cognitive discussion of reality, or any combination of these items to provide therapeutic change.

(2) **Definition.** Interactive Psychotherapy is individual psychotherapy that involves the use of play therapy equipment, physical aids/devices, language interpreter, or other mechanisms of nonverbal communication to overcome barriers to the therapeutic interaction between the clinician and the member who has not yet developed or who has lost the expressive language communication skills to

explain his/her symptoms and response to treatment, requires the use of a mechanical device in order to progress in treatment, or the receptive communication skills to understand the clinician. The service may be used for adults who are hearing impaired and require the use of language interpreter.

(3) **Qualified professionals.** With the exception of a qualified interpreter if needed, only the member and the Licensed Behavioral Health Professional (LBHP) or Certified Alcohol and Drug Counselor (CADC), for substance abuse (SA) only, should be present and the setting must protect and assure confidentiality. Ongoing assessment of the member's status and response to treatment as well as psycho-educational intervention are appropriate components of individual counseling. The counseling must be goal directed, utilizing techniques appropriate to the service plan and the member's developmental and cognitive abilities. Individual/Interactive counseling must be provided by a LBHP or CADC when treatment is for an alcohol or other drug disorder only.

(4) **Limitations.** A maximum of 6 units per day per member is compensable.

(b) **Group Psychotherapy.**

(1) **Definition.** Group psychotherapy is a method of treating behavioral disorders using the interaction between the LBHP or the CADC when treating alcohol and other drug disorders only, and two or more individuals to promote positive emotional or behavioral change. The focus of the group must be directly related to the goals and objectives in the individual member's current service plan. This service does not include social or daily living skills development as described under Behavioral Health Rehabilitation Services.

(2) **Group sizes.** Group Psychotherapy is limited to a total of eight adult (18 and over) individuals except when the individuals are residents of an ICF/MR where the maximum group size is six. For all children under the age of 18, the total group size is limited to six.

(3) **Multi-family and conjoint family therapy.** Sessions are limited to a maximum of eight families/units. Billing is allowed once per family unit, though units may be divided amongst family members.

(4) **Qualified professionals.** Group psychotherapy will be provided by a LBHP or CADC when treatment is for an alcohol or other drug disorder only. Group Psychotherapy must take place in a confidential setting limited to the LBHP or CADC conducting the service, an assistant or co-therapist, if desired, and the group psychotherapy participants.

(5) **Limitations.** A maximum of 12 units per day per member is compensable.

(c) **Family Psychotherapy.**

(1) **Definition.** Family Psychotherapy is a face-to-face psychotherapeutic interaction between a LBHP or CADC and the member's family, guardian, and/or support system. It is typically inclusive of the identified member, but may be performed if indicated without the member's presence. When the member is an adult, his/her permission must be obtained in writing. Family psychotherapy must be provided for the direct benefit of the SoonerCare member to assist him/her in achieving his/her established treatment goals and objectives and it must take place in a confidential setting. This service may include the Evidence Based Practice titled Family Psychoeducation.

(2) **Qualified professionals.** Family Psychotherapy must be provided by a LBHP or CADC when treatment is for an alcohol or other drug disorder only.

(3) **Limitations.** A maximum of 12 units per day per member/family unit is compensable. The provider may not bill any time associated with note taking and/or medical record upkeep. The provider may only bill the time spent in direct face-to-face contact. Provider must comply with documentation requirements listed in OAC 317:30-5-248.

(d) **Multi-Systemic Therapy (MST).**

(1) **Definition.** MST intensive outpatient program services are limited to children within an Office of Juvenile Affairs (OJA) MST treatment program which provides an intensive, family and community-based treatment targeting specific BH disorders in children with SED who exhibit chronic, aggressive, antisocial, and/or substance abusing behaviors, and are at risk for out of home placement. Case loads are kept low due to the intensity of the services provided.

(2) **Qualified professionals.** Masters level professionals who work with a team that may include bachelor level staff.

(3) **Documentation requirements.** Providers must comply with documentation requirements in 317:30-5-248.

(4) **Service limitations.** Partial billing is not allowed, when only one service is provided in a day, providers should not bill for services performed for less than 8 minutes.

(e) **Children/Adolescent Partial Hospitalization Program (PHP).**

(1) **Definition.** Partial hospitalization services are services that (1) Are reasonable and necessary for the diagnosis or active treatment of the member's condition; (2) Are reasonably expected to improve ~~or maintain~~ the member's condition and functional level and to prevent

relapse or hospitalization and (3) ~~Are provided in accordance with services outlined in 42 CFR 410.43.~~ Include the following:

(A) Assessment, diagnostic and treatment plan services for mental illness and/or substance abuse disorders provided by LBHPs.

(B) Individual/Group/Family (primary purpose is treatment of the member's condition) psychotherapies provided by LBHPs.

(C) Substance abuse specific services are provided by LBHPs qualified to provide these services.

(D) Drugs and biologicals furnished for therapeutic purposes.

(E) Family counseling, the primary purpose of which is treatment of the member's condition.

(F) Patient psychosocial rehabilitation training and education services to the extent the training and educational activities are closely and clearly related to the member's care and treatment, provided by a Behavioral Health Rehabilitation Specialist (BHRS) who meets the professional requirements listed in 317:30-5-240.3(c).

(G) Care Coordination of behavioral health services provided by certified case managers.

(2) **Qualified professionals.** All services in the PHP are provided by a clinical team, ~~which must be composed~~ consisting of ~~one or more of~~ the following ~~participants~~ professionals: a licensed physician, registered nurse, licensed behavioral health professional (LBHP), advanced practice nurse, psychological clinician, masters or bachelors level behavioral health rehabilitation specialist, ~~a~~ certified case manager, ~~or other certified Behavioral Health/Substance Abuse paraprofessional staff.~~ and paraprofessional staff dependent upon size of program and the services being provided at the time. ~~Refer to OHCA BH Provider Manual for further requirements.~~ The treatment plan is directed under the supervision of a physician.

(3) **Qualified providers.** Provider agencies for PHP must be accredited by one of the national accrediting bodies; The Joint Commission (TJC), Commission on Accreditation of Rehabilitation Facilities (CARF) or The Council on Accreditation (COA) for partial hospitalization and enrolled in SoonerCare. Staff providing these services are employees or contractors of the enrolled agency.

(4) **Limitations.** Services are limited to children 0-20 only. Services must be offered at a minimum of 3 hours per day, 5 days per week. Therapeutic services are limited to 4 billable hours per day and must be prior authorized. PHP services are all inclusive with the exception of physician

services and drugs that cannot be self-administered, those services are separately billable. ~~Refer to OHCA BH Provider Billing Manual for further definition.~~ Group size is limited to a maximum of 8 individuals as clinically appropriate given diagnostic and developmental functioning. Occupational, Physical and Speech therapy will be provided by the Independent School District (ISD).

~~(5) **Reporting.** Reporting requirements must be followed as outlined in the OHCA BH Provider Billing Manual~~

(5) **Service requirements.**

(A) Therapeutic Services are to include the following:

(i) Psychiatrist/physician face-to-face visit 2 times per month;

(ii) Crisis management services available 24 hours a day, 7 days a week;

(B) Psychotherapies to be provided a minimum of four (4) hours per week and include the following:

(i) Individual therapy – a minimum of 1 session per week;(ii) Family therapy – a minimum of 1 session per week; and

(iii) Group therapy – a minimum of 2 sessions per week;

(C) Interchangeable therapies which include the following:

(i) Case Management (face-to-face);(ii) BHRS/ alcohol and other drug abuse education;

(iii) Medication Training and Support; and

(iv) Expressive therapy.

(6) **Documentation requirements.** – Documentation needs to specify active involvement of the member's family, caretakers, or significant others involved in the individual's treatment. A nursing health assessment must be completed within 24 hours of admission. A physical examination and medical history must be coordinated with the Primary Care Physician. Service plan updates are required every three (3) months or more frequently based on clinical need. Records must be documented according to Section OAC 317:30-5-248.

(7) **Staffing requirements.** Staffing requirements must consist of the following:

(A) RN trained and competent in the delivery of behavioral health services as evidenced by education and/or experience that is available onsite during program hours to provide necessary nursing care and/or psychiatric nursing care (1 RN at a minimum can be backed up by an LPN but an RN must always be onsite). Nursing staff administers medications, follows up with families on medication compliance, and restraint assessments.

(B) Medical director must be a licensed psychiatrist.

(C) A psychiatrist/physician must be available 24 hours a day, 7 days a week.

(f) **Children/Adolescent Day Treatment Program.**

(1) **Definition.** Day Treatment Programs are for the stabilization of children and adolescents with severe emotional and/or behavioral disturbances. Treatment is designed for children who have difficulty functioning in mainstream community settings such as classrooms, and who need a higher intensity of services than outpatient counseling provides. Treatment is time limited and includes therapeutically intensive clinical services geared towards reintegration to the home, school, and community.

(2) **Qualified professionals.** All services in Day Treatment are provided by a team, which must be composed of one or more of the following participants: physician, registered nurse, licensed behavioral health professional (LBHP), a case manager, or other certified Behavioral Health/Substance Abuse paraprofessional staff. ~~Refer to OHCA BH Provider Billing Manual for further requirements.~~ Services are directed by an LBHP.

(3) **Qualified providers.** Provider agencies for Day Treatment must be accredited by one of the national accrediting bodies; The Joint Commission (TJC), Commission on Accreditation of Rehabilitation Facilities (CARF) or The Council on Accreditation (COA).

(4) **Limitations.** Services must be offered at a minimum of 4 days per week at least 3 hours per day. ~~Refer to OHCA BH Provider Billing Manual for further requirements.~~ Group size is limited to a maximum of 8 individuals as clinically appropriate given diagnostic and developmental functioning.

(5) **Service requirements.** On-call crisis intervention services must be available 24 hours a day, 7 days a week (When members served have psychiatric needs, psychiatric services are available which include the availability of a psychiatrist 24 hours a day, 7 days a week. A psychiatrist can be available either on site or on call but must be available at all times). Day treatment program will provide assessment and diagnostic services and/or medication monitoring, when necessary.

(A) Treatment activities are to include the following every week:

(i) Family therapy at least one hour per week (additional hours of FT may be substituted for other day treatment services;

(ii) Group therapy at least two hours per week; and

(iii) Individual therapy at least one hour per week.

(B) Additional services are to include at least one of the following services per day:

(i) Medication training and support (nursing) once monthly if on medications;

(ii) BHRS to include alcohol and other drug education if clinically necessary and appropriate

(iii) Case management as needed and part of weekly hours for member;

(iv) Occupational therapy as needed and part of weekly hours for member; and

(v) Expressive therapy as needed and part of weekly hours for the member.

(6) **Documentation requirements.** Service plans are required every three (3) months.

317:30-5-241.3. Behavioral Health Rehabilitation (BHR) services

(a) **Definition.** BHR are behavioral health rehabilitation services which are necessary to improve the member's ability to function in the community. They are performed to improve the skills and abilities of members to live interdependently in the community, improve self-care and social skills, and promote lifestyle change and recovery practices. This service may include the Evidence Based Practice of Illness, Management, and Recovery.

(1) **Clinical restrictions.** This service is generally performed with only the members and the BHRS, but may include a member and the member's family/support system group that focuses on the member's diagnosis, management, and recovery based curriculum.

(2) **Qualified providers.** A BHRS, CADC, or LBHP may perform BHR, following a treatment curriculum approved by a LBHP. Staff must be appropriately trained in a recognized behavioral/management intervention program such as MANDT or CAPE or trauma informed methodology.

(3) **Group sizes.** The minimum staffing ratio is fourteen members for each BHRS, CADC, or LBHP for adults and eight to one for children under the age of eighteen.

(4) **Limitations.**

(A) **Transportation.** Travel time to and from BHR treatment is not compensable. Group psychosocial rehabilitation services do not qualify for the OHCA transportation program, but they will arrange for transportation for those who require specialized transportation equipment. A member who at the time of service is not able to cognitively benefit from the treatment due to active hallucinations, substance use, or other impairments is not suitable for this service.

(B) **Time.** Breaks, lunchtime and times when the member is unable or unwilling to participate are not compensable and must be deducted from the overall billed time.

(C) **Location.** In order to develop and improve the member's community and interpersonal functioning and self care abilities, rehabilitation may take place in settings away from the outpatient behavioral health agency site. When this occurs, the BHRS, CADC, or LBHP must be present and interacting, teaching, or supporting the defined learning objectives of the member for the entire claimed time.

(D) **Billing.** Residents of ICF/MR facilities and children receiving RBMS in a group home or therapeutic foster home are not eligible for this service, unless prior approved by OHCA or its designated agent.

(i) **Group.** The maximum is 24 units per day for adults and 16 units per day for children.

(ii) **Individual.** The maximum is six units per day. Children under an ODMHSAS Systems of Care program may be prior authorized additional units as part of an intensive transition period.

(E) **Documentation requirements.** Progress notes for intensive outpatient mental health, substance abuse or integrated programs may be in the form of daily summary or weekly summary notes and must include the following:

(i) Curriculum sessions attended each day and/or dates attending during the week;

(ii) Start and stop times for each day attended and the physical location in which the service was rendered;

(iii) Specific goal(s) and objectives addressed during the week;

(iv) Type of Skills Training provided each day and/or during the week including the specific curriculum used with member;

(v) Member satisfaction with staff intervention(s);

(vi) Progress, or barrier to, made towards goals, objectives;

(vii) New goal(s) or objective(s) identified;

(viii) Signature of the lead BHRS; and

(ix) Credentials of the lead BHRS.

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

(1) **Definition.** Medication Training and Support is a documented review and educational session by a registered nurse, or physician assistant focusing on a member's response to medication and compliance with the medication regimen. The review must include an assessment of medication compliance and medication side effects. Vital

signs must be taken including pulse, blood pressure and respiration and documented within the medical or clinical record. A physician is not required to be present, but must be available for consult. Medication Training and Support is designed to maintain the member on the appropriate level of the least intrusive medications, encourage normalization and prevent hospitalization.

(2) **Limitations.**

(A) Medication Training and Support may not be billed for SoonerCare members who reside in ICF/MR facilities.

(B) One unit is allowed per month per patient without prior authorization.

(C) Medication Training & Support is not allowed to be billed on the same day as pharmacological management.

(3) **Qualified professionals.** Must be provided by a licensed registered nurse, or a physician assistant as a direct service under the supervision of a physician.

(4) **Documentation requirements** - Medication Training and Support documented review must focus on:

(A) a member's response to medication;

(B) compliance with the medication regimen;

(C) medication benefits and side effects;

(D) vital signs, which include pulse, blood pressure and respiration; and

(E) documented within the progress notes/medication record.

317:30-5-241.4 Crisis Intervention

(a) **Onsite and Mobile Crisis Intervention Services (CIS).**

(1) **Definition.** Crisis Intervention Services are face- to-face services for the purpose of responding to acute behavioral or emotional dysfunction as evidenced by psychotic, suicidal, homicidal severe psychiatric distress, and/or danger of AOD relapse. The crisis situation including the symptoms exhibited and the resulting intervention or recommendations must be clearly documented.

(2) **Limitations.** Crisis Intervention Services are not compensable for SoonerCare members who reside in ICF/MR facilities, or who receive RBMS in a group home or Therapeutic Foster Home. CIS is also not compensable for members who experience acute behavioral or emotional dysfunction while in attendance for other behavioral health services, unless there is a documented attempt of placement in a higher level of care. The maximum is eight units per month; established mobile crisis response teams can bill a maximum of sixteen units per month, and 40 units each 12 months per member. Prior authorization is not required.

(3) **Qualified professionals.** Services must be provided by a LBHP.

(b) **Facility Based Crisis Stabilization (FBCS).** FBCS services are 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.

(1) **Qualified professionals.** FBCS services are provided under the supervision of a physician aided by a licensed nurse, and also include LBHPs for the provision of group and individual treatments. A physician must be available. This service is limited to providers who contract with or are operated by the ODMHSAS to provide this service within the overall behavioral health service delivery system.

(2) **Limitations.** The unit of service is per hour. Providers of this service must meet the requirements delineated in the OAC 450:23. Children's facility based stabilization (0-18 years of age) requires prior authorization. Documentation of records must comply with OAC 317:30-5-248.

317:30-5-241.5 Support services

(a) **Program of Assertive Community Treatment (PACT) Services.**

(1) **Definition.** PACT is provided by an interdisciplinary team that ensures service availability 24 hours a day, seven days a week and is prepared to carry out a full range of treatment functions wherever and whenever needed. An individual is referred to the PACT team service when it has been determined that his/her needs are so pervasive and/or unpredictable that it is unlikely that they can be met effectively by other combinations of available community services, or in circumstances where other levels of outpatient care have not been successful to sustain stability in the community.

(2) **Target population.** Individuals 18 years of age or older with serious and persistent mental illness and co-occurring disorders. PACT services are those services delivered within an assertive community-based approach to provide treatment, rehabilitation, and essential behavioral health supports on a continuous basis to individuals 18 years of age or older with serious mental illness with a self-contained multi-disciplinary team. The team must use an integrated service approach to merge essential clinical and rehabilitative functions and staff expertise. This level of service is to be provided only for persons most clearly in need of intensive ongoing services.

(3) **Qualified professionals.** Providers of PACT services are specific teams within an established organization and must be operated by or contracted with and certified by the

ODMHSAS in accordance with 43A O.S. 319 and OAC 450:55. The team leader must be an LBHP.

(4) **Limitations.** A maximum of 105 hours per member per year in the aggregate. All PACT compensable SoonerCare services are required to be face-to-face. SoonerCare members who are enrolled in this service may not receive other outpatient behavioral health services except for FBCS and CM.

(5) **Service requirements.** PACT services must include the following:

(A) PACT assessments (initial and comprehensive);

(i) **Initial assessment** – is the initial evaluation of the member based upon available information, including self-reports, reports of family members and other significant parties, and written summaries from other agencies, including police, court, and outpatient and inpatient facilities, where applicable, culminating in a comprehensive initial assessment. Member assessment information for admitted members shall be completed on the day of admission to the PACT. The start and stop times for this service should be recorded in the chart.

(ii) Comprehensive assessment – is the organized process of gathering and analyzing current and past information with each member and the family and/or support system and other significant people to evaluate: 1) mental and functional status; 2) effectiveness of past treatment; 3) current treatment, rehabilitation and support needs to achieve individual goals and support recovery; and 4) the range of individual strengths (e.g., knowledge gained from dealing with adversity or personal/professional roles, talents, personal traits) that can act as resources to the member and his/her recovery planning team in pursuing goals. Providers must bill only the face-to-face service time with the member. Non-face to face time is not compensable. The start and stop times for this service should be recorded in the chart.

(B) Behavioral health service plan (moderate and low complexity);

(i) Service plan development by a non-physician (treatment planning and review) – is a process by which the information obtained in the comprehensive assessment, course of treatment, the member, and/or treatment team meetings is evaluated and used to develop a service plan that has individualized goals,

objectives, activities and services that will enable a member to improve. The initial assessment serves as a guide until the comprehensive assessment is completed. It is to focus on recovery and must include a discharge plan. It is performed with the direct active participation by the member. SoonerCare compensation for this service includes only the face to face time with the member. The start and stop times for this service should be recorded in the chart.

(C) Treatment team meetings (team conferences with the member present is a billable service);

(i) Treatment team meetings (team conferences). This service is conducted by the treatment team, which includes the member and all involved practitioners. For a complete description of this service, see OAC 450:55-5-6 Treatment Team Meetings. This service can be billed to SoonerCare only when the member is present and participating in the treatment team meeting. The conference starts at the beginning of the review of an individual member and ends at the conclusion of the review. Time related to record keeping and report generation is not reported. The start and stop should be recorded in the member's chart. The participating psychiatrist/physician should bill the appropriate CPT code; and the agency is allowed to bill one treatment team meeting per member as medically necessary.

(D) Individual and family psychotherapy;

(E) Individual rehabilitation;

(F) Recovery support services;

(G) Group rehabilitation;

(H) Group psychotherapy;

(I) Crisis Intervention;

(J) Medication training and support services;

(K) Blood draws and /or other lab sample collection services performed by the nurse.

(b) **Behavioral Health Aide Services.**

(1) **Definition.** Behavioral Health Aides provide behavior management and redirection and behavioral and life skills remedial training. The behavioral health aide also provides monitoring and observation of the child's emotional/behavioral status and responses, providing interventions, support and redirection when needed. Training is generally focused on behavioral, interpersonal, communication, self help, safety and daily living skills.

(2) **Target population.** This service is limited to children with serious emotional disturbance who are in an ODMHSAS contracted systems of care community based treatment

program, or are under OKDHS or OJA custody residing within a RBMS level of care, who need intervention and support in their living environment to achieve or maintain stable successful treatment outcomes.

(3) **Qualified professionals.** Behavioral Health Aides must be trained/credentialed through ODMHSAS.

(4) **Limitations.** The Behavioral Health Aide cannot bill for more than one individual during the same time period.

(5) Documentation requirements. Providers must follow requirements listed in OAC 317:30-5-248.

(c) **Family Support and Training.**

(1) **Definition.** This service provides the training and support necessary to ensure engagement and active participation of the family in the treatment planning process and with the ongoing implementation and reinforcement of skills learned throughout the treatment process. Child Training is provided to family members to increase their ability to provide a safe and supportive environment in the home and community for the child. Parent Support ensures the engagement and active participation of the family in the treatment planning process and guides families toward taking a proactive role in their child's treatment. Parent Training is assisting the family with the acquisition of the skills and knowledge necessary to facilitate an awareness of their child's needs and the development and enhancement of the family's specific problem-solving skills, coping mechanisms, and strategies for the child's symptom/behavior management.

(2) **Target population.** Family Support and Training is designed to benefit the SoonerCare eligible child experiencing a serious emotional disturbance who is in an ODMHSAS contracted systems of care community based treatment program, are diagnosed with a pervasive developmental disorder, or are under OKDHS or OJA custody, are residing within a RBMS level of care or are at risk for out of home placement, and who without these services would require psychiatric hospitalization.

(3) **Qualified professionals.** Family Support Providers (FSP) must be trained/credentialed through ODMHSAS.

(4) **Limitations.** The FSP cannot bill for more than one individual during the same time period.

(5) **Documentation requirements.** Providers must comply with requirements listed in OAC 317:30-5-248.

(d) **Community Recovery Support (CRS).**

(1) **Definition.** CRS (or Peer Recovery Support) services are an EBP model of care which consists of a qualified recovery support specialist provider (RSS) who assists individuals with their recovery from behavioral health

disorders. Recovery Support is a service delivery role in the ODMHSAS public and contracted provider system throughout the behavioral health care system where the provider understands what creates recovery and how to support environments conducive of recovery. The role is not interchangeable with traditional staff members who usually work from the perspective of their training and/or their status as a licensed behavioral health provider; rather, this provider works from the perspective of their experimental expertise and specialized credential training. They lend unique insight into mental illness and what makes recovery possible because they are in recovery.

(2) **Target population.** Adults 18 and over with SMI and/or AOD disorder(s).

(3) **Qualified professionals.** Recovery Support Specialists (RSS) must be trained/credentialed through ODMHSAS.

(4) **Limitations.** The RSS cannot bill for more than one individual during the same time period. This service can be an individual or group service. Groups have no restriction on size.

(5) **Documentation requirements.** Providers must comply with requirements listed in OAC 317:30-5-248.

(6) **Service requirements.**

(A) CRS/RSS staff utilizing their knowledge, skills and abilities will:

(i) teach and mentor the value of every individual's recovery experience;

(ii) model effective coping techniques and self-help strategies;

(iii) assist members in articulating personal goals for recovery; and

(iv) assist members in determining the objectives needed to reach his/her recovery goals.

(B) CRS/RSS staff utilizing ongoing training must:

(i) proactively engage members and possess communication skills/ability to transfer new concepts, ideas, and insight to others;

(ii) facilitate peer support groups;

(iii)assist in setting up and sustaining self-help (mutual support) groups;

(iv) support members in using a Wellness Recovery Action Plan (WRAP);

(v) assist in creating a crisis plan/Psychiatric Advanced Directive;

(vi) utilize and teach problem solving techniques with members;

(vii) teach members how to identify and combat negative self-talk and fears;

(viii) support the vocational choices of members and assist him/her in overcoming job-related anxiety;
(ix) assist in building social skills in the community that will enhance quality of life. Support the development of natural support systems;
(x) assist other staff in identifying program and service environments that are conducive to recovery; and
(xi) attend treatment team and program development meetings to ensure the presence of the member's voice and to promote the use of self-directed recovery tools.

PART 25. PSYCHOLOGISTS

317:30-5-276. Coverage by category

(a) **Outpatient Behavioral Health Services.** Outpatient behavioral health services are covered for children as set forth in this Section ~~and following the requirements as defined in the OHCA BH Provider Manual~~, unless specified otherwise, and when provided in accordance with a documented individualized service plan medical record, developed to treat the identified behavioral health and/or substance abuse disorder(s).

(1) All services are to be for the goal of improvement of functioning, independence, or wellbeing of the member. The services and treatment plans are to be recovery focused, trauma and co-occurring specific. The member must be able to actively participate in the treatment. Active participation means that the member must have sufficient cognitive abilities, communication skills, and short-term memory to derive a reasonable benefit from the treatment.

(2) All outpatient BH services will require authorization through OHCA, or its designated agent, following established medical necessity criteria. Providers are required to follow these criteria and guidelines under OAC 317:30-5-241 and the OHCA BH Provider Manual. OHCA does retain final administrative review over both prior authorization and review of services as required by 42 CFR 431.10.

(3) Unauthorized services will not be SoonerCare compensable, unless designated by OHCA.

(b) **Adults.** There is no coverage for adults for services by a psychologist.

(c) **Children.** Coverage for children includes the following services (all services, except Initial or Level of Care Assessment, health and behavior codes and/or Crisis

Intervention services, require authorization by OHCA, or its designated agent):

(1) Bio-Psycho-Social Assessments. Psychiatric Diagnostic Interview Examination (PDIE) initial assessment or Level of Care Assessment. The interview and assessment is defined as a face-to-face interaction with the member. Psychiatric diagnostic interview examination includes a history, mental status, and a disposition, and may include communication with family or other sources, ordering and medical interpretation of laboratory or other medical diagnostic studies. Only one PDIE is allowable per provider per member. If there has been a break in service over a six month period, then an additional unit of PDIE can be prior authorized by OHCA, or their designated agent.

(2) Individual and/or Interactive psychotherapy in an outpatient setting including an office, clinic, or other confidential setting. The services may be performed at the residence of the member if it is demonstrated that it is clinically beneficial, or if the member is unable to go to a clinic or office. Individual psychotherapy is defined as a one to one treatment using a widely accepted modality or treatment framework suited to the individual's age, developmental abilities and diagnosis. It may include specialized techniques such as biofeedback or hypnosis.

(3) Family Psychotherapy is performed in an outpatient setting limited to an office, clinic, or other confidential setting. Family therapy is a face-to-face interaction between a therapist and the patient/family to facilitate emotional, psychological or behavioral changes and promote communication and understanding. Family therapy must be provided for the benefit of a SoonerCare eligible child as a specifically identified component of an individual treatment plan.

(4) Group and/or Interactive Group psychotherapy in an outpatient setting must be performed in the psychologist's office, clinic, or other confidential setting. Group therapy is a face to face interaction between a therapist and two or more unrelated patients (though there may be siblings in the same group, just not siblings only) to facilitate emotional, psychological, or behavioral changes. All group therapy records must indicate group size. Maximum total group size is six patients for children four years of age up to the age of 18. Groups 18-20 year olds can include eight individuals. Group therapy must be provided for the benefit of a SoonerCare eligible child four years of age or older as a specifically identified component of an individual treatment plan. Multi-family group therapy size is limited to eight family units.

(5) Assessment/Evaluation and testing is provided by a psychological technician of a psychologist or a LBHP utilizing tests selected from currently accepted assessment test batteries. For assessments conducted in a school setting, the Oklahoma State Department of Education requires that a licensed supervisor sign the assessment. Eight hours/units of testing per patient (over the age of two), per provider is allowed with authorization every 12 months. In circumstances where it is determined that further testing is medically necessary, and or needed for specialty testing, additional hours/units may be prior authorized by the OHCA or designated agent based upon medical necessity and consultation review. Test results must be reflected in the service plan or medical record. The service must clearly document the need for the testing and what the testing is expected to achieve. Any testing performed for a child under three must be prior authorized. Testing units must be billed on the date the testing, interpretation, scoring, and/or reporting was performed and supported by documentation.

(6) Health and Behavior codes B behavioral health services are available only to chronically and severely medically ill children.

(7) Crisis intervention services for the purpose of stabilization and hospital diversion as clinically appropriate.

(8) Payment for therapy services provided by a psychologist to any one member is limited to eight sessions/units per month. All units/sessions, except the Initial or Level of Care Assessments or Crisis Intervention must be authorized by the OHCA or its designated agent. A maximum of 12 sessions/units of therapy and testing services per day per provider are allowed. Case Management services are considered an integral component of the behavioral health services listed above.

(9) A child who is being treated in an acute psychiatric inpatient setting can receive separate Psychological services as the inpatient per diem is for "non-physician" services only.

(10) A child receiving Residential Behavioral Management in a foster home, also known as therapeutic foster care, or a child receiving Residential Behavioral Management in a group home, also known as therapeutic group home, may not receive individual, group or family counseling or psychological testing without prior authorization by the OHCA or its designated agent.

(d) **Home and Community Based Waiver Services for the ~~Mentally Retarded~~ Intellectually Disabled.** All providers participating in the Home and Community Based Waiver Services for the

~~mentally retarded~~ intellectually disabled program must have a separate contract with this Authority to provide services under this program. All services are specified in the individual's plan of care.

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

317:30-5-281. Coverage by Category

(a) **Outpatient Behavioral Health Services.** Outpatient behavioral health services are covered for children as set forth in this Section ~~and following the requirements as defined in the OHCA BH Provider Manual~~, unless specified otherwise, and when provided in accordance with a documented individualized service plan and/or medical record, developed to treat the identified behavioral health and/or substance abuse disorder(s).

(1) All services are to be for the goal of improvement of functioning, independence, or wellbeing of the member. The services and treatment plans are to be recovery focused, trauma and co-occurring specific. The member must be able to actively participate in the treatment. Active participation means that the member must have sufficient cognitive abilities, communication skills, and short-term memory to derive a reasonable benefit from the treatment.

(2) All outpatient BH services will require authorization through OHCA, or its designated agent, following established medical necessity criteria. Providers are required to follow these criteria and guidelines under the OHCA BH Provider Manual. OHCA does retain final administrative review over both prior authorization and review of services as required by 42 CFR 431.10.

(3) Unauthorized services will not be SoonerCare compensable, unless designated by OHCA.

(b) **Adults.** There is no coverage for adults for services by a LBHP.

(c) **Children.** Coverage for children includes the following services (all services, except for the Initial or Level of Care Assessments or Crisis Intervention, require authorization by OHCA or its designated agent, providers listed in 317:30-5-280(a)(1),(a)(3)and (a)(4) are exempt from authorization):

(1) Bio-Psycho-Social and Level of Care Assessments.

(A) The interview and assessment is defined as a face-to-face interaction with the member. Assessment includes a history, mental status, full bio-psycho-social evaluation, a disposition, communications with family or other sources, review of laboratory or other pertinent medical information, and medical/clinical consultations as necessary.

(B) Assessments for Children's Level of Care determination of medical necessity must follow a specified assessment process through OHCA or their designated agent. Only one assessment is allowable per provider per member. If there has been a break in service over a six month period, or the assessment is conducted for the purpose of determining a child's need for inpatient psychiatric admission, then an additional unit can be authorized by OHCA, or their designated agent.

(2) Individual and/or Interactive psychotherapy in an outpatient setting including an office, clinic, or other confidential setting. The services may be performed at the residence of the member if it is demonstrated that it is clinically beneficial, or if the member is unable to go to a clinic or office. Individual psychotherapy is defined as a one to one treatment using a widely accepted modality or treatment framework suited to the individual's age, developmental abilities and diagnosis. It may include specialized techniques such as biofeedback or hypnosis.

(3) Family Psychotherapy is performed in an outpatient setting limited to an office, clinic, or other confidential setting. Family therapy is a face-to-face interaction between a therapist and the patient/family to facilitate emotional, psychological or behavioral changes and promote communication and understanding. Family therapy must be provided for the benefit of the member as a specifically identified component of an individual treatment plan.

(4) Group and/or Interactive Group psychotherapy in an outpatient setting must be performed in an office, clinic, or other confidential setting. Group therapy is a face-to-face interaction between a therapist and two or more unrelated patients (though there may be siblings in the same group, just not siblings only) to facilitate emotional, psychological, or behavioral changes. All group therapy records must indicate group size. Maximum total group size is six for ages four up to 18. Groups 18-20 year olds can include eight individuals. Group therapy must be provided for the benefit of the member as a specifically identified component of an individual treatment plan. Multi-family group therapy size is limited to eight family units.

(5) Assessment/Evaluation and testing is provided by a psychologist, certified psychometrist, psychological technician of a psychologist or a LBHP utilizing tests selected from currently accepted assessment test batteries. For assessments conducted in a school setting, the Oklahoma State Department of Education requires that a licensed supervisor sign the assessment. Eight hours/units of

testing per patient (over the age of two), per provider is allowed with authorization every 12 months. In circumstances where it is determined that further testing is medically necessary and/or needed for specialty testing, additional hours/units may be prior authorized by the OHCA or designated agent based upon medical necessity and consultation review. Test results must be reflected in the service plan or medical record. The service plan must clearly document the need for the testing and what the testing is expected to achieve. Any testing performed for a child under three must be prior authorized. Testing units must be billed on the date the testing, interpretation, scoring, and/or reporting was performed and supported by documentation.

(6) Crisis intervention services for the purpose of stabilization and hospitalization diversion as clinically appropriate.

(7) Payment for therapy services provided by a LBHP to any one member is limited to eight sessions/units per month. All units/sessions, except Assessment and Crisis Intervention must be authorized by the OHCA or their designated agent. A maximum of 12 sessions/units of therapy and testing services per day per provider are allowed. Case Management services are considered an integral component of the behavioral health services listed above.

(8) A child receiving Residential Behavioral Management in a foster home, also known as therapeutic foster care, or a child receiving Residential Behavioral Management in a group home, also known as therapeutic group home, may not receive individual, group or family counseling or testing without authorization by the OHCA or their designated agent.

(d) **Home and Community Based Waiver Services for the ~~Mentally Retarded~~ Intellectually Disabled**. All providers participating in the Home and Community Based Waiver Services for the ~~mentally retarded~~ intellectually disabled program must have a separate contract with this Authority to provide services under this program. All services are specified in the individual's plan of care.

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

PART 67. BEHAVIORAL HEALTH CASE MANAGEMENT SERVICES

317:30-5-596. Coverage by category

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

(1) Payment is made for services rendered to SoonerCare ~~member's~~ members as follows:

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

(i) Behavioral health case management services are provided to assist eligible individuals in gaining access to needed medical, social, educational and other services essential to meeting basic human needs. The behavioral health case manager provides assessment of case management needs, development of a case management care plan, referral, linkage, monitoring and advocacy on behalf of the member to gain access to appropriate community resources. The behavioral health case manager must monitor the progress in gaining access to services and continued appropriate utilization of necessary community resources. Behavioral case management is designed to promote recovery, maintain community tenure, and to assist individuals in accessing services for themselves following the case management guidelines established by ODMHSAS. In order to be compensable, the service must be performed utilizing the Strengths Based model of case management. This model of case management assists individuals in identifying and securing the range of resources, both environmental and personal, needed to live in a normally interdependent way in the community. The focus for the helping process is on strengths, interests, abilities, knowledge and capacities of each person, not on their diagnosis, weakness or deficits. The relationship between the service member and the behavioral health case manager is characterized by mutuality, collaboration, and partnership. Assistive activities are designed to occur primarily in the community, but may take place in the behavioral health case manager's office, if more appropriate. The community based behavioral health case management agency will coordinate with the member and family (if

applicable) by phone or face-to-face, to identify immediate needs for return to home/community no more than 72 hours after notification that the member/family requests case management services. For member's discharging from a higher level of care than outpatient, the higher level of care facility is responsible for scheduling an appointment with a case management agency for transition and post discharge services. The case manager will make contact with the member and family (if applicable) for transition from the higher level of care than outpatient back to the community, within 72 hours of discharge, and then conduct a follow-up appointment/contact within seven days. The case manager will provide linkage/referral to physicians/medication services, counseling services, rehabilitation and/or support services as described in the case management service plan. Case Managers may also provide crisis diversion (unanticipated, unscheduled situation requiring supportive assistance, face-to-face or telephone, to resolve immediate problems before they become overwhelming and severely impair the individual's ability to function or maintain in the community) to assist member(s) from progression to a higher level of care. During the follow-up phase of these referrals or links, the behavioral health case manager will provide aggressive outreach if appointments or contacts are missed within two business days of the missed appointments. Community/home based case management to assess the needs for services will be scheduled as reflected in the case management service plan, but not less than one time per month. The member/parent/guardian has the right to refuse behavioral health case management and cannot be restricted from other services because of a refusal of behavioral health case management services.

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

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

(iv) The individual plan of care must include general goals and objectives pertinent to the overall

recovery of the ~~member~~ member's (and ~~family's~~ family, if applicable) needs. Progress notes must relate to the individual plan of care and describe the specific activities to be performed. The individual plan of care must be developed with participation by, as well as, reviewed and signed by the member, the parent or guardian (if the member is under 18), the behavioral health case manager, and a Licensed Behavioral Health Professional as defined in OAC 317:30-5-240(d).

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

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

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

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

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

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

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

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

(VIII) Transitioning from institutions to the community. Individuals (except individuals ages 22 to 64 who reside in an institution for mental diseases (IMD) or individuals who are inmates of public institutions) may be considered to be transitioning to the community during the last 60 consecutive days of a covered, long-term, institutional stay that is 180 consecutive days

or longer in duration. For a covered, short term, institutional stay of less than 180 consecutive days, individuals may be considered to be transitioning to the community during the last 14 days before discharge. These time requirements are to distinguish case management services that are not within the scope of the institution's discharge planning activities from case management required for transitioning individuals with complex, chronic, medical needs to the community.

(B) Levels of Case Management

(i) Basic Case Management/Resource Coordination. Resource coordination services are targeted to adults with serious and persistent mental illness and children and adolescents with mental illness or serious emotional disturbance, and their families, who need assistance in accessing, coordination, and monitoring of resources and services. Services are provided to assess an ~~individuals~~ individual's strengths and meet needs in order to achieve stability in the community. Standard managers have with caseloads of 30 – 35 members.

(ii) Intensive Case Management (ICM)/Wraparound Facilitation Case Management (WFCM).

Intensive Case Management is targeted to adults with serious and persistent mental illness (including ~~member's~~ members in PACT programs) and Wraparound Facilitation Case Management is targeted to children with serious mental illness and emotional disorders (including ~~member's~~ members in a System of Care Network) who are deemed high risk and in need of more intensive CM services. It is designed to ensure access to community agencies, services, and people whose functions are to provide the support, training and assistance required for a stable, safe, and healthy community life, and decreased need for higher levels of care. To produce a high fidelity wraparound process, a facilitator can facilitate between 8 and 10 families. To ensure that these intense needs are met, case manager caseloads are limited ~~to 25~~ between 10-15 caseloads. The ICM shall be a Certified Behavioral Health Case Manager, have a minimum of 2 years Behavioral Health Case Management experience, crisis diversion experience, must have attended the ODMHSAS 6 hours ICM training, and 24 hour availability is required

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

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

(ii) Managing finances; or

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

(iv) Delivering bus tickets, food stamps, money, etc.; or

(v) Counseling, rehabilitative services, psychiatric assessment, or discharge planning; or

(vi) Filling out forms, applications, etc., on behalf of the member when the member is not present; or

(vii) Filling out SoonerCare forms, applications, etc.;

(viii) Mentoring or tutoring;

(ix) Provision of behavioral health case management services to the same family by two separate behavioral health case management agencies ; ~~or~~

(x) Non face-to-face time spent preparing the assessment document and the service plan paperwork~~.~~;

(xi) monitoring financial goals;

(xii) services to nursing home residents;

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

(xix) services to members residing in ICF/MR facilities.

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

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

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

(iii) Residents of ICF/MR and nursing facilities unless transitioning into the community;

(iv) Members receiving services under a Home and Community Based services (HCBS) waiver program.

(E) Case management services provided to Medicare eligible members should be filed directly with the fiscal agent.

(F) **Documentation requirements.** The service plan must include general goals and objectives pertinent to the overall recovery needs of the member. Progress notes

must relate to the service plan and describe the specific activities performed. Behavioral health case management service plan development is compensable time if the time is spent communicating with the participation by, as well as, reviewed and signed by the member, the behavioral health case manager, and a licensed behavioral health professional as defined at OAC 317:30-5-240.3(a). All behavioral health case management services rendered must be reflected by documentation in the records. In addition to a complete behavioral health case management service, plan documentation of each session must include but is not limited to:

(i) date;
(ii) person(s) to whom services are rendered;
(iii) start and stop times for each service;
(iv) original signature or the service provider (original signatures for faxed items must be added to the clinical file within 30 days);
(v) credentials of the service provider ;
(vi) specific service plan needs, goals and/or objectives addressed;
(vii) specific activities performed by the behavioral health case manager on behalf of the child related to advocacy, linkage, referral, or monitoring used to address needs, goals and/or objectives;
(viii) progress and barriers made towards goals, and/or objectives;
(ix) member (family when applicable) response to the service;
(x) any new service plan needs, goals, and/or objectives identified during the service; and
(xi) member satisfaction with staff intervention.

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

317:30-5-596.1. Prior authorization

(a) Prior authorization of behavioral health case management services is mandatory. The provider must request prior authorization from the OHCA, or its designated agent. In order for the services to be prior authorized, member information requested must be submitted. Member information includes but is not limited to the following.

(1) Complete multi-axial DSM diagnosis with supportive documentation and mental status examination summary;
(2) Treatment history;
(3) Current psycho social information;
(4) Psychiatric history; and
(5) Fully developed case management service plan, with goals, objectives, and time frames for services.

(b) SoonerCare members who are eligible for services will be considered for prior authorization after receipt of complete and appropriate information submitted by the provider in accordance with the guidelines for behavioral health case management services developed by OHCA or its designated agent. Based on diagnosis, functional assessment, history and other SoonerCare services being received, the SoonerCare member may be approved to receive case management services. SoonerCare members who reside in nursing facilities, residential behavior management services, group or foster homes, or ICF/MR's may not receive SoonerCare compensable case management services unless transitioning from a higher level of care than outpatient. A SoonerCare member may be approved for a time frame of one to twelve months. The OHCA, or its designated agent will review the initial request in accordance with the guidelines for prior authorization ~~in the Outpatient Behavioral Health Service Provider Manual~~. An initial request for case management services requires the provider to submit specific documentation to OHCA, or its designated agent. A fully developed individual plan of service is not required at the time of initial request. The provider will be given a time frame to develop the individual plan of service while working with the child and his/her family and corresponding units of service will be approved prior to the completion of the service plan. Prior authorization requests will be reviewed by licensed behavioral health professionals as defined at OAC 317:30-5-240.

PART 83. RESIDENTIAL BEHAVIOR MANAGEMENT SERVICES IN FOSTER CARE SETTINGS

317:30-5-741. Coverage by category

(a) **Adults.** Outpatient Behavioral Health Services in Therapeutic Foster settings are not covered for adults.

(b) **Children.** Outpatient behavioral health services are authorized in therapeutic foster care settings for certain children and youth by the designated agent of the Oklahoma Health Care Authority. The children and youth authorized for services in this setting have special psychological, social and emotional needs, requiring more intensive, therapeutic care than can be found in the traditional foster care setting. The designated children and youth must continually meet

medical necessity criteria to be eligible for coverage in this setting. The medical necessity criteria are continually met for initial requests for services and all subsequent requests for services/ extensions. Medical necessity criteria is delineated ~~in the OHCA Behavioral Health Provider Manual.~~ as follows:

(1) An Axis I primary diagnosis from the most recent edition of "The Diagnostic and Statistical Manual of Mental Disorders" (DSM), with the exception of V codes and adjustment disorders, with a detailed description of the symptoms supporting the diagnosis. Children with a provisional diagnosis may be admitted for a maximum of 30 days. An assessment must be completed by a Licensed Behavioral Health Professional (LBHP) as defined in OAC 317:30-5-240.3(a) within the 30 day period resulting in an Axis I primary diagnosis form the most recent edition of "the Diagnostic and Statistical Manual of Mental Disorders"(DSM) primary diagnosis with the exception of V codes and adjustments disorders, with a detailed description of the symptoms supporting the diagnosis to continue RBMS in a foster care setting.

(2) Conditions are directly attributed to a mental illness/serious emotional disturbance as the primary need for professional attention.

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

(4) Evidence that the child's presenting emotional and/or behavioral problems prohibit full integration in a family/home setting without the availability of 24 hour crisis response/behavior management and intensive clinical interventions from professional staff, preventing the child from living in a traditional family home.

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

(6) The legal guardian/parent of the child (OKDHS/OJA if custody child) agrees to actively participate in the child's treatment needs and planning. (a) Prior authorization of behavioral health case management services is mandatory. The provider must request prior authorization from the OHCA, or its designated agent. In order for the services to be prior authorized, member information requested must be submitted. Member information includes but is not limited to the following.

(1) Complete multi-axial DSM diagnosis with supportive documentation and mental status examination summary;

(2) Treatment history;

(3) Current psycho social information;

(4) Psychiatric history; and
(5) Fully developed case management service plan, with goals, objectives, and time frames for services.

(b) SoonerCare members who are eligible for services will be considered for prior authorization after receipt of complete and appropriate information submitted by the provider in accordance with the guidelines for behavioral health case management services developed by OHCA or its designated agent. Based on diagnosis, functional assessment, history and other SoonerCare services being received, the SoonerCare member may be approved to receive case management services. SoonerCare members who reside in nursing facilities, residential behavior management services, group or foster homes, or ICF/MR's may not receive SoonerCare compensable case management services unless transitioning from a higher level of care than outpatient. A SoonerCare member may be approved for a time frame of one to twelve months. The OHCA, or its designated agent will review the initial request in accordance with the guidelines for prior authorization ~~in the Outpatient Behavioral Health Service Provider Manual~~. An initial request for case management services requires the provider to submit specific documentation to OHCA, or its designated agent. A fully developed individual plan of service is not required at the time of initial request. The provider will be given a time frame to develop the individual plan of service while working with the child and his/her family and corresponding units of service will be approved prior to the completion of the service plan. Prior authorization requests will be reviewed by licensed behavioral health professionals as defined at OAC 317:30-5-240.

PART 83. RESIDENTIAL BEHAVIOR MANAGEMENT SERVICES IN FOSTER CARE SETTINGS

317:30-5-741. Coverage by category

(a) **Adults.** Outpatient Behavioral Health Services in Therapeutic Foster settings are not covered for adults.

(b) **Children.** Outpatient behavioral health services are authorized in therapeutic foster care settings for certain children and youth by the designated agent of the Oklahoma Health Care Authority. The children and youth authorized for services in this setting have special psychological, social and emotional needs, requiring more intensive, therapeutic care than can be found in the traditional foster care setting. The designated children and youth must continually meet medical necessity criteria to be eligible for coverage in this setting. The medical necessity criteria are continually met for initial requests for services and all subsequent requests for services/ extensions. Medical necessity criteria is

delineated ~~in the OHCA Behavioral Health Provider Manual.~~ as follows:

(1) An Axis I primary diagnosis from the most recent edition of "The Diagnostic and Statistical Manual of Mental Disorders" (DSM), with the exception of V codes and adjustment disorders, with a detailed description of the symptoms supporting the diagnosis. Children with a provisional diagnosis may be admitted for a maximum of 30 days. An assessment must be completed by a Licensed Behavioral Health Professional (LBHP) as defined in OAC 317:30-5-240.3(a) within the 30 day period resulting in an Axis I primary diagnosis form the most recent edition of "the Diagnostic and Statistical Manual of Mental Disorders"(DSM) primary diagnosis with the exception of V codes and adjustments disorders, with a detailed description of the symptoms supporting the diagnosis to continue RBMS in a foster care setting.

(2) Conditions are directly attributed to a mental illness/serious emotional disturbance as the primary need for professional attention.

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

(4) Evidence that the child's presenting emotional and/or behavioral problems prohibit full integration in a family/home setting without the availability of 24 hour crisis response/behavior management and intensive clinical interventions from professional staff, preventing the child from living in a traditional family home.

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

(6) The legal guardian/parent of the child (OKDHS/OJA if custody child) agrees to actively participate in the child's treatment needs and planning.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 3. GENERAL PROVIDER POLICIES
PART 3. GENERAL MEDICAL PROGRAM INFORMATION

317:30-3-40. Home and Community-Based Services Waivers for persons with intellectual disabilities ~~(mental retardation)~~ or certain persons with related conditions

(a) **Introduction to HCBS Waivers for ~~Persons~~ persons with intellectual disabilities.** The Medicaid Home and Community-Based Services (HCBS) Waiver programs are authorized in accordance with Section 1915(c) of the Social Security Act.

(1) Oklahoma Department of Human Services Developmental Disabilities Services Division (DDSD) operates HCBS Waiver programs for persons with ~~(mental retardation)~~ intellectual disabilities and certain persons with related conditions. Oklahoma Health Care Authority (OHCA), as the State's single Medicaid agency, retains and exercises administrative authority over all HCBS Waiver programs.

(2) Each waiver allows for the provision of specific SoonerCare-compensable services that assist members to reside in the community and avoid institutionalization.

(3) Waiver services:

(A) complement and supplement services available to members through the Medicaid State Plan or other federal, state, or local public programs, as well as informal supports provided by families and communities;

(B) can only be provided to persons who are Medicaid eligible, outside of a nursing facility, hospital, or institution; and

(C) are not intended to replace other services and supports available to members.

(4) Any waiver service must be:

(A) appropriate to the member's needs; and

(B) included in the member's Individual Plan (IP).

(i) The IP:

(I) is developed annually by the member's Personal Support Team, per OAC 340:100-5-52; and

(II) contains detailed descriptions of services provided, documentation of amount and frequency of services, and types of providers to provide services.

(ii) Services are authorized in accordance with OAC 340:100-3-33 and 340:100-3-33.1.

(5) DDSD furnishes case management, targeted case management, and services to members as a Medicaid State Plan

service under Section 1915(g)(1) of the Social Security Act in accordance with OAC 317:30-5-1010 through 317:30-5-1012.

(b) **Eligible providers.** All providers must have entered into contractual agreements with OHCA to provide HCBS for persons with ~~mental retardation~~ an intellectual disability or related conditions.

(c) **Coverage.** All services must be included in the member's IP. Arrangements for services must be made with the member's case

317:30-3-42. Services in a Nursing Facility (NF)

Nursing facility services are those services furnished pursuant to a physician's orders which require the skills of technical or professional personnel, e.g., registered nurses, licensed practical nurses, physical therapists, occupational therapists, speech pathologists or audiologists. This care is provided by nursing facilities licensed under State law to provide, on a regular basis, health related care and services to individuals who do not require hospitalization but whose physical or mental condition requires care and services above the level of room and board which can be made available to them only through a nursing facility.

(1) To be eligible for nursing facility services the individual must:

(A) Require a treatment plan involving the planning and administration of services which require skills of licensed technical or professional personnel that are provided directly or under the supervision of such personnel and are prescribed by the physician;

(B) Have a physical impairment or combination of physical and mental impairments;

(C) Require professional nursing supervision (medication, hygiene and dietary assistance);

(D) Lack the ability to care for self or communicate needs to others; and

(E) Require medical care and treatment in a nursing facility to minimize physical health regression and deterioration. A physician’s order and results from a standardized assessment which evaluates type and degree of disability and need for treatment must support the individual’s need for NF level of care. Only standardized assessments approved by the OHCA and administered in accordance with Medicaid approved procedures shall be used to make the NF level of care determination.

(2) If the individual experiences mental illness or ~~mental retardation~~ an intellectual disability or a related

condition, payment cannot be made for services in a nursing facility unless the individual has been assessed through the Preadmission Screening and Resident Review (PASRR) process and the appropriate MR or MI authority has determined that nursing facility services are required. If it is determined that the patient also requires specialized services, the state must provide or arrange for the provision of such services. These determinations must be made prior to the patient's admission to the nursing facility.

(3) Payment cannot be made for an individual who is actively psychotic or capable of imminent harm to self or others (i.e., suicidal or homicidal).

(4) Payment is made to licensed nursing facilities that have agreements with the Authority.

317:30-3-57. General SoonerCare coverage - categorically needy

The following are general SoonerCare coverage guidelines for the categorically needy:

(1) Inpatient hospital services other than those provided in an institution for mental diseases.

(A) Adult coverage for inpatient hospital stays as described at OAC 317:30-5-41.

(B) Coverage for members under 21 years of age is not limited. All admissions must be medically necessary. All psychiatric admissions require prior authorization for an approved length of stay.

(2) Emergency department services.

(3) Dialysis in an outpatient hospital or free standing dialysis facility.

(4) Outpatient therapeutic radiology or chemotherapy for proven malignancies or opportunistic infections.

(5) Outpatient surgical services - facility payment for selected outpatient surgical procedures to hospitals which have a contract with OHCA.

(6) Outpatient Mental Health Services for medical and remedial care including services provided on an outpatient basis by certified hospital based facilities that are also qualified mental health clinics.

(7) Rural health clinic services and other ambulatory services furnished by rural health clinic.

(8) Optometrists' services - only as listed in Subchapter 5, Part 45, Optometrist specific rules of this Chapter.

(9) Maternity Clinic Services.

(10) Outpatient diagnostic x-rays and lab services. Other outpatient services provided to adults, not specifically addressed, are covered only when prior authorized by the agency's Medical Authorization Unit.

(11) Medically necessary screening mammography. Additional follow-up mammograms are covered when medically necessary.
(12) Nursing facility services (other than services in an institution for tuberculosis or mental diseases).
(13) Early and Periodic Screening, Diagnosis and Treatment Services (EPSDT) are available for members under 21 years of age to provide access to regularly scheduled examinations and evaluations of the general physical and mental health, growth, development, and nutritional status of infants, children, and youth. Federal regulations also require that diagnosis and treatment be provided for conditions identified during a screening whether or not they are covered under the State Plan, as long as federal funds are available for these services. These services must be necessary to ameliorate or correct defects and physical or mental illnesses or conditions and require prior authorization. EPSDT/OHCA Child Health services are outlined in OAC 317:30-3-65.2 through 317:30-3-65.4.

(A) Child health screening examinations for eligible children by a medical or osteopathic physician, physician assistant, or advanced practice nurse practitioner.
(B) Diagnostic x-rays, lab, and/or injections when prescribed by a provider.
(C) Immunizations.
(D) Outpatient care.
(E) Dental services as outlined in OAC 317:30-3-65.8.
(F) Optometrists' services. The EPSDT periodicity schedule provides for at least one visual screening and glasses each 12 months. In addition, payment is made for glasses for children with congenital aphakia or following cataract removal. Interperiodic screenings and glasses at intervals outside the periodicity schedule for optometrists are allowed when a visual condition is suspected.
(G) Hearing services as outlined in OAC 317:30-3-65.9.
(H) Prescribed drugs.
(I) Outpatient Psychological services as outlined in OAC 317:30-5-275 through OAC 317:30-5-278.
(J) Inpatient Psychotherapy services and psychological testing as outlined in OAC 317:30-5-95 through OAC 317:30-5-97.
(K) Transportation. Provided when necessary in connection with examination or treatment when not otherwise available.
(L) Inpatient hospital services.
(M) Medical supplies, equipment, appliances and prosthetic devices beyond the normal scope of SoonerCare.

(N) EPSDT services furnished in a qualified child health center.

(14) Family planning services and supplies for members of child-bearing age, including counseling, insertion of intrauterine device, implantation of subdermal contraceptive device, and sterilization for members 21 years of age and older who are legally competent, not institutionalized and have signed the "Consent Form" at least 30 days prior to procedure. Reversal of sterilization procedures for the purposes of conception is not covered. Reversal of sterilization procedures are covered when medically indicated and substantiating documentation is attached to the claim.

(15) Physicians' services whether furnished in the office, the member's home, a hospital, a nursing facility, ICF/MR, or elsewhere. For adults, payment is made for compensable hospital days described at OAC 317:30-5-41. Office visits for adults are limited to four per month except when in connection with conditions as specified in OAC 317:30-5-9(b).

(16) Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law. See applicable provider section for limitations to covered services for:

(A) Podiatrists' services
(B) Optometrists' services
(C) Psychologists' services
(D) Certified Registered Nurse Anesthetists
(E) Certified Nurse Midwives
(F) Advanced Practice Nurses
(G) Anesthesiologist Assistants

(17) Free-standing ambulatory surgery centers.

(18) Prescribed drugs not to exceed a total of six prescriptions with a limit of two brand name prescriptions per month. Exceptions to the six prescription limit are:

(A) unlimited medically necessary monthly prescriptions for:

(i) members under the age of 21 years; and

(ii) residents of Nursing Facilities or Intermediate Care Facilities for the Mentally Retarded.

(B) seven medically necessary generic prescriptions per month in addition to the six covered under the State Plan are allowed for adults receiving services under the 1915(c) Home and Community Based Services Waivers. These additional medically necessary prescriptions beyond the

two brand name or thirteen total prescriptions are covered with prior authorization.

(19) Rental and/or purchase of durable medical equipment.

(20) Adaptive equipment, when prior authorized, for members residing in private ICF/MR's.

(21) Dental services for members residing in private ICF/MR's in accordance with the scope of dental services for members under age 21.

(22) Prosthetic devices limited to catheters and catheter accessories, colostomy and urostomy bags and accessories, tracheostomy accessories, nerve stimulators, hyperalimentation and accessories, home dialysis equipment and supplies, external breast prostheses and support accessories, oxygen/oxygen concentrator equipment and supplies, respirator or ventilator equipment and supplies, and those devices inserted during the course of a surgical procedure.

(23) Standard medical supplies.

(24) Eyeglasses under EPSDT for members under age 21. Payment is also made for glasses for children with congenital aphakia or following cataract removal.

(25) Blood and blood fractions for members when administered on an outpatient basis.

(26) Inpatient services for members age 65 or older in institutions for mental diseases, limited to those members whose Medicare, Part A benefits are exhausted for this particular service and/or those members who are not eligible for Medicare services.

(27) Nursing facility services, limited to members preauthorized and approved by OHCA for such care.

(28) Inpatient psychiatric facility admissions for members under 21 are limited to an approved length of stay effective July 1, 1992, with provision for requests for extensions.

(29) Transportation and subsistence (room and board) to and from providers of medical services to meet member's needs (ambulance or bus, etc.), to obtain medical treatment.

(30) Extended services for pregnant women including all pregnancy-related and postpartum services to continue to be provided, as though the women were pregnant, for 60 days after the pregnancy ends, beginning on the last date of pregnancy.

(31) Nursing facility services for members under 21 years of age.

(32) Personal care in a member's home, prescribed in accordance with a plan of treatment and rendered by a qualified person under supervision of a R.N.

(33) Part A deductible and Part B Medicare Coinsurance and/or deductible.
(34) Home and Community Based Waiver Services for the ~~mentally retarded~~ intellectually disabled.
(35) Home health services limited to 36 visits per year and standard supplies for 1 month in a 12-month period. The visits are limited to any combination of Registered Nurse and nurse aide visits, not to exceed 36 per year.
(36) Medically necessary solid organ and bone marrow/stem cell transplantation services for children and adults are covered services based upon the conditions listed in (A)-(D) of this paragraph:

(A) Transplant procedures, except kidney and cornea, must be prior authorized to be compensable.

(B) To be prior authorized all procedures are reviewed based on appropriate medical criteria.

(C) To be compensable under the SoonerCare program, all transplants must be performed at a facility which meets the requirements contained in Section 1138 of the Social Security Act.

(D) Finally, procedures considered experimental or investigational are not covered.

(37) Home and community-based waiver services for ~~mentally retarded~~ intellectually disabled members who were determined to be inappropriately placed in a NF (Alternative Disposition Plan - ADP).
(38) Case Management services for the chronically and/or severely mentally ill.
(39) Emergency medical services including emergency labor and delivery for illegal or ineligible aliens.
(40) Services delivered in Federally Qualified Health Centers. Payment is made on an encounter basis.
(41) Early Intervention services for children ages 0-3.
(42) Residential Behavior Management in therapeutic foster care setting.
(43) Birthing center services.
(44) Case management services through the Oklahoma Department of Mental Health and Substance Abuse Services.
(45) Home and Community-Based Waiver services for aged or physically disabled members.
(46) Outpatient ambulatory services for members infected with tuberculosis.
(47) Smoking and Tobacco Use Cessation Counseling for children and adults.
(48) Services delivered to American Indians/Alaskan Natives in I/T/Us. Payment is made on an encounter basis.

(49) OHCA contracts with designated agents to provide disease state management for individuals diagnosed with certain chronic conditions. Disease state management treatments are based on protocols developed using evidence-based guidelines.

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 6. INPATIENT PSYCHIATRIC HOSPITALS

317:30-5-96.2. Payments definitions

The following words and terms, when used in Sections OAC 317:30-5-96.3 through 317:30-5-96.7, shall have the following meaning, unless the context clearly indicates otherwise:

"Allowable costs" means costs necessary for the efficient delivery of member care.

"Ancillary Services" means the services for which charges are customarily made in addition to routine services. Ancillary services include, but are not limited to, physical therapy, speech therapy, laboratory, radiology and prescription drugs.

"Border Status" means a placement in a state that does not border Oklahoma but agrees to the same terms and conditions of instate or border facilities.

"Developmentally disabled child" means a child with deficits in adaptive behavior originating during the developmental period. This condition may exist concurrently with a significantly subaverage general intellectual functioning.

"Eating Disorders Programs" means acute or intensive residential behavioral, psychiatric and medical services provided in a discreet unit to individuals experiencing an eating disorder.

"Professional services" means services of a physician, psychologist or dentist legally authorized to practice medicine and/or surgery by the state in which the function is performed.

"Psychiatric Residential Treatment Facility (PRTF)" means a non-hospital with an agreement to provide inpatient psychiatric services to individuals under the age of 21.

"Routine Services" means services that are considered routine in the freestanding PRTF setting. Routine services include, but are not limited to:

(A) room and board;
(B) treatment program components;
(C) psychiatric treatment;
(D) professional consultation;
(E) medical management;
(F) crisis intervention;

(G) transportation;
(H) rehabilitative services;
(I) case management;
(J) interpreter services (if applicable);
(K) routine health care for individuals in good physical health; and
(L) laboratory services for a substance abuse/detoxification program.

"Specialty treatment program/specialty unit" means acute or intensive residential behavioral, psychiatric and medical services that provide care to a population with a special need or issues such as developmentally disabled, ~~mentally retarded~~ intellectually disabled, autistic/Asperger's, eating disorders, sexual offenders, or reactive attachment disorders. These members require a higher level of care and staffing ratio than a standard PRTF and typically have multiple problems.

"Treatment Program Components" means therapies, activities of daily living and rehabilitative services furnished by physician/psychologist or other licensed mental health professionals.

"Usual and customary charges" refers to the uniform charges listed in a provider's established charge schedule which is in effect and applied consistently to most members and recognized for program reimbursement. To be considered "customary" for reimbursement, a provider's charges for like services must be imposed on most members regardless of the type of member treated or the party responsible for payment of such services.

PART 9. LONG TERM CARE FACILITIES

317:30-5-122. Levels of care

(a) This rule sets forth the criteria used to determine whether an individual who is seeking SoonerCare payment for long term care services needs services at the level of Skilled Nursing Facility, or Intermediate Care Facility for People with Mental Retardation (ICF/MR). The criteria set forth in this Section must be used when determining level of care for individuals seeking SoonerCare coverage of either facility-based institutional long term care services or Home and Community Based Services (HCBS) Waivers.

(b) The level of care provided by a long term care facility or through a HCBS Waiver is based on the nature of the person's needs and the care, services, and treatment required from appropriately qualified personnel. The level of care review is a determination of an individual's physical, mental and

social/emotional status to determine the appropriate level of care required. In addition to level of care requirements, other applicable eligibility criteria must be met.

(1) **Skilled Nursing facility.** When total payments from all other payers are less than the Medicaid rate, payment is made for the Part A coinsurance for Medicare covered skilled nursing facility care for dually eligible, categorically needy individuals.

(2) **Nursing Facility.** Care provided by a nursing facility to patients who require professional nursing supervision and a maximum amount of nonprofessional nursing care due to physical conditions or a combination of physical and mental conditions.

(3) **Intermediate Care Facility for the Mentally Retarded.** Care for persons with ~~mental retardation~~ intellectual disabilities or related conditions to provide health and/or habilitative services in a protected residential setting. To qualify for ICF/MR level of care, persons must have substantial functional limitations in three or more of the following areas of major life activity:

(A) Self-care. The individual requires assistance, training or supervision to eat, dress, groom, bathe, or use the toilet.

(B) Understanding and use of language. The individual lacks functional communication skills, requires the use of assistive devices to communicate, does not demonstrate an understanding of request or is unable to follow two-step instructions.

(C) Learning. The individual has a valid diagnosis of intellectual disability ~~(mental retardation)~~ as defined in the Diagnostic and Statistical Manual of Mental Disorders.

(D) Mobility. The individual requires the use of assistive devices to be mobile and cannot physically self-evacuate from a building during an emergency without assistive device.

(E) Self-direction. The individual is 7 years old or older and significantly at risk in making age appropriate decisions or an adult who is unable to provide informed consent for medical care, personal safety or for legal, financial, habilitative or residential issues and/or has been declared legally incompetent. The individual is a danger to himself or others without supervision.

(F) Capacity for independent living. The individual who is 7 years old or older and is unable to locate and use a telephone, cross the street safely or understand that it is unsafe to accept rides, food or money from strangers or

an adult who lacks basic skills in the areas of shopping, preparing food, housekeeping or paying bills.

PART 39. SKILLED NURSING SERVICES

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

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

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

(A) direct nursing care;

(B) assessment and documentation of health changes;

(C) documentation of significant observations;

(D) maintenance of nursing plans of care;

(E) medication administration;

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

(G) preventive and health care procedures; and

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

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

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

(1) Individual providers must be currently licensed in Oklahoma as a:

(A) registered nurse; or

(B) licensed practical nurse.

(2) Agency providers must:

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

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

PART 41. FAMILY SUPPORT SERVICES

317:30-5-410. Home and Community-Based Services Waivers for persons with ~~mental retardation~~ an intellectual disability or certain persons with related conditions

(a) The Oklahoma Health Care Authority (OHCA) administers Home and Community-Based Services (HCBS) Waivers for persons with ~~mental retardation~~ an intellectual disability and certain persons with related conditions that are operated by the Oklahoma Department of Human Services (OKDHS) Developmental Disabilities Services Division (DDSD). Each waiver allows payment for family support services as defined in the waiver approved by the Centers for Medicare and Medicaid Services (CMS). Waiver services:

(1) when utilized with services normally covered by SoonerCare, other generic services, and natural supports provide for health and developmental needs of members who otherwise would not be able to live in a home or community setting;

(2) are provided with the goal of promoting independence through strengthening the member's capacity for self-care and self-sufficiency;

(3) are centered on the needs and preferences of the member and support the integration of the member within his/her community; and

(4) do not include room and board. The costs associated with room and board must be met by the member.

(b) The DDSD case manager develops the Individual Plan (IP) and Plan of Care (Plan) per OAC 340:100-5-53. The IP contains descriptions of the services provided, documentation of the amount, frequency and duration of the services, and types of service providers.

(1) Services:

(A) are authorized per OAC 340:100-3-33 and 100-3-33.1.

(B) provided prior to the development of the IP or not included in the IP are not compensable. The Plan may not be backdated;

(C) may be provided on an emergency basis when approved by the area manager or designee. The plan must be revised to reflect the additional services; and

(D) are provided by qualified provider entities contracted with the OHCA.

(2) Members have freedom of choice of providers and in the selection of HCBS or institutional services.

PART 43. AGENCY COMPANION, SPECIALIZED FOSTER CARE, DAILY LIVING SUPPORTS, GROUP HOMES, AND COMMUNITY TRANSITION SERVICES

317:30-5-420. Home and Community-Based Services Waivers for persons with ~~mental retardation~~ an intellectual disability or certain persons with related conditions

The Oklahoma Health Care Authority (OHCA) administers Home and Community-Based Services (HCBS) Waivers for persons with ~~mental retardation~~ an intellectual disability and certain persons with related conditions that are operated by the Oklahoma Department of Human Services Developmental Disabilities Services Division (DDSD). The Community Waiver and Homeward Bound Waiver allow payment for residential supports as defined in the waiver approved by the Centers for Medicare and Medicaid Services (CMS).

317:30-5-423. Coverage limitations

(a) Coverage limitations for residential supports for members with ~~mental retardation~~ an intellectual disability are:

(1) Description: agency companion services (ACS); Unit: one day; Limitation: 366 units per year;

(2) Description: specialized foster care (SFC); Unit: one day; Limitation: 366 units per year;

(3) Description: daily living supports (DLS); Unit: one day; Limitation: 366 units per year; and

(4) Description: group home services; Unit: one day; Limitation: 366 units per year.

(b) Members may not receive ACS, SFC, DLS and group home services at the same time.

(c) Community transition services (CTS) are limited to $2,400 per eligible member.

(1) CTS is limited to one transition over the member's lifetime. If the member's situation changes after receipt of CTS and hospitalization or readmission to an intermediate care facility for the mentally retarded (ICF/MR) is necessary, CTS is not authorized upon transition back into the community.

(2) Members moving into a group home, SFC, or ACS arrangement in the companion's home are not eligible to receive CTS.

PART 51. HABILITATION SERVICES

317:30-5-480. Home and Community-Based Services for persons with ~~mental retardation~~ an intellectual disability or certain persons with related conditions

The Oklahoma Health Care Authority (OHCA) administers Home and Community-Based Services (HCBS) Waivers for persons with

~~mental retardation~~ intellectual disabilities or certain persons with related conditions that are operated by the Oklahoma Department of Human Services Developmental Disabilities Services Division (DDSD). Each waiver allows Medicaid compensable services provided to persons who are:

(1) medically and financially eligible; and

(2) not covered through the OHCA's SoonerCare program.

PART 53. SPECIALIZED FOSTER CARE

317:30-5-495. Home and Community-Based Services Waivers for persons with ~~mental retardation~~ an intellectual disability or certain persons with related conditions

(a) **Introduction to waiver services.** The Oklahoma Health Care Authority (OHCA) administers Home and Community-Based Services (HCBS) Waivers for persons with ~~mental retardation~~ an intellectual disability or certain persons with related conditions that are operated by Oklahoma Department of Human Services (OKDHS) Developmental Disabilities Services Division (DDSD). The Community Waiver and Homeward Bound Waiver allow payment for specialized foster care (SFC), also known as specialized family care, as defined in the waiver approved by Centers for Medicare and Medicaid Services.

(b) **Eligible providers.** All SFC providers must:

(1) enter into contractual agreements with the OHCA to provide HCBS for persons with ~~mental retardation~~ an intellectual disability or certain persons with related conditions;

(2) have an approved home profile per OAC 317:40-5-40;

(3) complete training per OAC 340:100-3-38;

(4) have the ability to implement the member's Individual Plan (IP); and

(5) be emotionally and financially stable, in good health, and of reputable character.

PART 55. RESPITE CARE

317:30-5-515. Home and Community-Based Services Waivers for persons with ~~mental retardation~~ an intellectual disability or certain persons with related conditions

The Oklahoma Health Care Authority administers Home and Community-Based Services (HCBS) Waivers for persons with ~~mental retardation~~ an intellectual disability or certain persons with related conditions that are operated by the Oklahoma Department of Human Services Developmental Disabilities Services Division. Each waiver allows payment for respite care as defined in the

waiver approved by the Centers for Medicare and Medicaid Services.

PART 59. HOMEMAKER SERVICES

317:30-5-535. Home and Community-Based Services Waiver for persons with ~~mental retardation~~ an intellectual disability or certain persons with related conditions

(a) **Introduction to waiver services.** The Oklahoma Health Care Authority (OHCA) administers Home and Community-Based Services (HCBS) Waivers for persons with ~~mental retardation~~ an intellectual disability or certain persons with related conditions that are operated by the Oklahoma Department of Human Services Developmental Disabilities Services Division. Each waiver allows payment for homemaker or homemaker respite services as defined in the waiver approved by the Centers for Medicare and Medicaid Services.

(b) **Eligible providers.** All homemaker services providers must enter into contractual agreements with the OHCA to provide HCBS for persons with ~~mental retardation~~ an intellectual disability or related conditions.

PART 79. DENTISTS

317:30-5-696. Coverage by category

Payment is made for dental services as set forth in this Section.

(1) **Adults.**

(A) Dental coverage for adults is limited to:

(i) emergency extractions;

(ii) Smoking and Tobacco Use Cessation Counseling; and

(iii) medical and surgical services performed by a dentist, to the extent such services may be performed under State law either by a doctor of dental surgery or dental medicine, when those services would be covered if performed by a physician.

(B) Payment is made for dental care for adults residing in private Intermediate Care Facilities for the Mentally Retarded (ICF/MR) and who have been approved for ICF/MR level of care, similar to the scope of services available to individuals under age 21.

(C) Pregnant women are covered under a limited dental benefit plan (Refer to (a)(4)of this Section).

(2) **Home and community based waiver services (HCBWS) for the ~~mentally retarded~~ intellectually disabled.** All providers participating in the HCBWS must have a separate contract with the OHCA to provide services under the HCBWS. Dental services are defined in each waiver and must be prior authorized.

(3) **Children.** The OHCA Dental Program provides the basic medically necessary treatment. The services listed below are compensable for members under 21 years of age without prior authorization. ALL OTHER DENTAL SERVICES MUST BE PRIOR AUTHORIZED. Anesthesia services are covered for children in the same manner as adults. All providers performing preventive services must be available to perform needed restorative services for those members receiving any evaluation and preventive services.

(A) **Comprehensive oral evaluation.** This procedure is performed for any member not seen by any dentist for more than 12 months.

(B) **Periodic oral evaluation.** This procedure may be provided for a member of record if she or he has not been seen for more than six months.

(C) **Emergency examination/limited oral evaluation.** This procedure is not compensable within two months of a periodic oral examination or if the member is involved in active treatment unless trauma or acute infection is the presenting complaint.

(D) **Radiographs (x-rays).** To be SoonerCare compensable, x-rays must be of diagnostic quality and medically necessary. A clinical examination must precede any radiographs, and chart documentation must include member history, prior radiographs, caries risk assessment and both dental and general health needs of the member. The referring dentist is responsible for providing properly identified x-rays of acceptable quality with a referral, if that provider chooses to expose and submit for reimbursement prior to referral. Panoramic films are allowable once in a three year period and must be of diagnostic quality. Panoramic films are only compensable when chart documentation clearly indicates the test is being performed to rule out or evaluate non-caries related pathology. Prior authorization and a detailed medical need narrative are required for additional panoramic films taken within three years of the original set.

(E) **Dental sealants.** Tooth numbers 2, 3, 14, 15, 18, 19, 30 and 31 must be caries free on the

interproximal and occlusal surfaces to be eligible for this service. This service is available through 18 years of age and is compensable only once per lifetime. Replacement of sealants is not a covered service under the SoonerCare program.

(F) **Dental prophylaxis.** This procedure is provided once every 184 days including topical application of fluoride.

(G) **Composite restorations.**

(i) This procedure is compensable for primary incisors as follows:

(I) tooth numbers O and P to age 4 years;

(II) tooth numbers E and F to age 6 years;

(III) tooth numbers N and Q to 5 years; and

(IV) tooth numbers D and G to 6 years.

(ii) The procedure is also allowed for use in all vital and successfully treated non-vital permanent anterior teeth.

(iii) Class I and II composite restorations are allowed in posterior teeth; however, the OHCA has certain restrictions for the use of this restorative material. (See OAC 317:30-5-699).

(H) **Amalgam.** Amalgam restorations are allowed in:

(i) posterior primary teeth when:

(I) 50 percent or more root structure is remaining;

(II) the teeth have no mobility; or

(III) the procedure is provided more than 12 months prior to normal exfoliation.

(ii) any permanent tooth, determined as medically necessary by the treating dentist.

(I) **Stainless steel crowns.** The use of stainless steel crowns is allowed as follows:

(i) Stainless steel crowns are allowed if:

(I) the child is five years of age or under;

(II) 70 percent or more of the root structure remains; or

(III) the procedure is provided more than 12 months prior to normal exfoliation.

(ii) Stainless steel crowns are treatment of choice for:

(I) primary teeth with pulpotomies or pulpectomies, if the above conditions exist;

(II) primary teeth where three surfaces of extensive decay exist; or

(III) primary teeth where cuspal occlusion is lost due to decay or accident.

(iii) Stainless steel crowns are the treatment of choice on posterior permanent teeth that have completed endodontic therapy, if more than three surfaces of extensive decay exist or where cuspal occlusion are lost due to decay prior to age 16 years.

(iv) Preoperative periapical x-rays must be available for review, if requested.

(v) Placement of a stainless steel crown includes all related follow up service for a period of two years. No other prosthetic procedure on that tooth is compensable during that period of time. A stainless steel crown is not a temporizing treatment to be used while a permanent crown is being fabricated.

(J) **Pulpotomies and pulpectomies.**

(i) Therapeutic pulpotomies are allowable for molars and teeth numbers listed below. Pre and post operative periapical x-rays must be available for review, if requested.

(I) Primary molars having at least 70 percent or more of their root structure remaining or more than 12 months prior to normal exfoliation;

(II) Tooth numbers O and P before age 5 years;

(III) Tooth numbers E and F before 6 years;

(IV) Tooth numbers N and Q before 5 years; and

(V) Tooth numbers D and G before 5 years.

(ii) Pulpectomies are allowed for primary teeth if exfoliation of the teeth is not expected to occur for at least one year or if 70 percent or more of root structure is remaining.

(K) **Anterior root canals.** Payment is made for the services provided in accordance with the following:

(i) This procedure is done for permanent teeth when there are no other missing anterior teeth in the same arch requiring replacement.

(ii) Acceptable ADA filling materials must be used.

(iii) Preauthorization is required if the member's treatment plan involves more than four anterior root canals.

(iv) Teeth with less than 50 percent of clinical crown should not be treatment-planned for root canal therapy.

(v) Pre and post operative periapical x-rays must be available for review.

(vi) Pulpotomy may be performed for the relief of pain while waiting for the decision from the OHCA.

(vii) Providers are responsible for any follow-up treatment required due to a failed root canal therapy for 24 month post completion.

(viii) Endodontic treated teeth should be restored to limited occlusal function and all contours should be replaced. These teeth are not automatically approved for any type of crown.

(ix) If there are three or more missing teeth in the arch that requires replacement, root therapy will not be allowed.

(L) **Space maintainers.** Certain limitations apply with regard to this procedure. Providers are responsible for recementation of any maintainer placed by them for six months post insertion.

(i) **Band and loop type space maintenance.** This procedure must be provided in accordance with the following guidelines:

(I) This procedure is compensable for all primary molars where permanent successor is missing or where succedaneous tooth is more than 5mm below the crest of the alveolar ridge or where the successor tooth would not normally erupt in the next 12 months.

(II) First primary molars are not allowed space maintenance if the second primary and first permanent molars are present and in cuspal interlocking occlusion regardless of the presence or absence of normal relationship.

(III) If there are missing teeth bilaterally in the same arch, under the above guidelines, bilateral space maintainer is the treatment of choice.

(IV) The teeth numbers shown on the claim should be those of the missing teeth.

(V) Post operative bitewing x-rays must be available for review.

(VI) Bilateral band and loop space maintainer is allowed if member does not have eruption of the four mandibular anterior teeth in position or if sedation case that presents limitations to fabricate other space maintenance appliances.

(ii) **Lingual arch bar.** Payment is made for the services provided in accordance with the following:

(I) Lingual arch bar is used when permanent incisors are erupted and multiple missing teeth exist in the same arch.

(II) The requirements are the same as for band and loop space maintainer.

(III) Multiple missing upper anterior primary incisors may be replaced with the appliance to age ~~6.0~~ 6 years to prevent abnormal swallowing habits.

(IV) Pre and post operative x-rays must be available.

(iii) **Interim partial dentures.** This service is for anterior permanent tooth replacement or if the member is missing three or more posterior teeth to age 16 years.

(M) **Analgesia.** Analgesia services are reimbursable in accordance with the following:

(i) **Inhalation of nitrous oxide.** Use of nitrous oxide is compensable for four occurrences per year and is not separately reimbursable, if provided on the same date by the same provider as IV sedation, non-intravenous conscious sedation or general anesthesia. The need for this service must be documented in the member's record. This procedure is not covered when it is the dentist's usual practice to offer it to all patients.

(ii) **Non-intravenous conscious sedation.** Non-intravenous conscious sedation is not separately reimbursable, if provided on the same date by the same provider as analgesia, anxiolysis, inhalation of nitrous oxide, IV sedation or general anesthesia. Non-intravenous conscious sedation is reimbursable when determined to be medically necessary for documented handicapped members, uncontrollable members or justifiable

medical or dental conditions. The report must detail the member's condition. No services are reimbursable when provided primarily for the convenience of the member and /or the dentist, it must be medically necessary.

(N) **Pulp caps.** Indirect and direct pulp cap must be ADA accepted materials, not a cavity liner. Indirect and direct pulp cap codes require specific narrative support addressing materials used, intent and reasons for use. Application of chemicals used for dentinal hypersensitivity is not allowed as indirect pulp cap. Utilization of these codes is verified by post payment review.

(O) **Sedative restorations.** Sedative restorations include removal of decay, if present, and direct or indirect pulp cap, if needed. These services are reimbursable for the same tooth on the same date of service. Permanent restoration of the tooth is allowed after 30 days unless the tooth becomes symptomatic and requires pain relieving treatment.

(P) **History and physical.** Payment is made for services for the purpose of admitting a patient to a hospital for dental treatment.

(Q) **Local anesthesia.** This procedure is included in the fee for all services.

(R) **Smoking and Tobacco Use Cessation Counseling.** Smoking and Tobacco Use Cessation Counseling is covered when performed utilizing the five intervention steps of asking the member to describe his/her smoking, advising the member to quit, assessing the willingness of the member to quit, assisting with referrals and plans to quit, and arranging for follow-up. Up to eight sessions are covered per year per individual who has documented tobacco use. It is a covered service when provided by physicians, physician assistants, nurse practitioners, nurse midwives, and Oklahoma State Health Department and FQHC nursing staff in addition to other appropriate services rendered. Chart documentation must include a separate note, separate signature, and the member specific information addressed in the five steps and the time spent by the practitioner performing the counseling. Anything under three minutes is considered part of a routine visit.

(4) **Pregnant Women.** Dental coverage for this special population is provided regardless of age.

(A) Proof of pregnancy is required (Refer to OAC 317:35-5-6).
(B) Coverage is limited to a time period beginning at the diagnosis of pregnancy and ending upon 60 days post partum.
(C) In addition to dental services for adults, other services available include:
(i) Comprehensive oral evaluation must be performed and recorded for each new member, or established member not seen for more than 24 months;
(ii) Periodic oral evaluation as defined in OAC 317:30-5-696(3)(B);
(iii) Emergency examinations/limited oral evaluation. This procedure is not allowed within two months of an oral examination by the same provider for the same member, or if the member is under active treatment;
(iv) Radiographs as defined in OAC 317:30-5-696(3)(D);
(v) Dental prophylaxis as defined in OAC 317:30-5-696(3)(F);
(vi) Composite restorations:
(I) Any permanent tooth that has an opened lesion that is a food trap will be deemed medically necessary for this program and will be allowed for all anterior teeth.
(II) Class I posterior composite resin restorations are allowed in posterior teeth that qualify;
(vii) Amalgam. Any permanent tooth that has an opened lesion that is a food trap will be deemed as medically necessary and will be allowed; and
(viii) Analgesia. Analgesia services are reimbursable in accordance with OAC 317:30-5-696(iii)(M)
(D) Services requiring prior authorization (Refer to OAC 317:30-5-698).
(E) Periodontal scaling and root planing. Required that 50% or more of six point measurements be ~~4~~ 5 millimeters or greater. This procedure is designed for the removal of cementum and dentin that is rough, and/or permeated by calculus or contaminated with toxins and microorganism and requires anesthesia and some soft tissue removal.

(5) **Individuals eligible for Part B of Medicare.**

(A) Payment is made based on the member's coinsurance and deductibles.
(B) Services which have been denied by Medicare as non-compensable should be filed directly with the OHCA with a copy of the Medicare EOB indicating the reason for denial.

317:30-5-698. Services requiring prior authorization

(a) Providers must have prior authorization for certain specified services before delivery of that service, unless the service is provided on an emergency basis (See OAC 317:30-5-695(d)(2). Requests for dental services requiring prior authorization must be accompanied by sufficient documentation. X-rays, six point periodontal charting and comprehensive treatment plans are required. Study models and narratives may be requested by OHCA or representatives of OHCA. If the quality of the supporting material is such that a determination of authorization cannot be made, the material is returned to the provider. Any new documentation must be provided at the provider's expense. Submitted documentation used to base a decision will not be returned.

(b) Requests for prior authorization are filed on the currently approved ADA form. OHCA notifies the provider on the determination of prior authorization using OHCA Prior Authorization Request Decision form. Prior authorized services must be billed exactly as they appear on the prior authorization. Payment is not made for any services provided prior to receiving authorization except for the relief of pain.

(c) Prosthodontic services provided to members who have become ineligible mid-treatment are covered if the member was eligible for SoonerCare on the date the final impressions were made.

(d) Listed below are examples of services requiring prior authorization for members under 21 and eligible ICF/MR residents. Minimum required records to be submitted with each request are right and left mounted bitewing x-rays and periapical films of tooth/teeth involved or the edentulous areas if not visible in the bitewings. X-rays must be submitted with x-ray film mounts and each film or print must be of good readable quality. X-rays must be identified by left and right sides with the date, member name, member ID, provider name, and provider ID. All x-rays, regardless of the media, must be placed together in the same envelope with a completed comprehensive treatment plan and a completed current ADA form requesting all treatments requiring prior authorization. The film, digital media or printout must be of sufficient quality to clearly demonstrate for the reviewer, the pathology which is the basis for the authorization request. If radiographs are not

taken, provider must include in narrative sufficient information to confirm diagnosis and treatment plan.

(1) **Endodontics.** Pulpotomy may be performed for the relief of pain while waiting for the decision from the OHCA on request for endodontics. A permanent restoration is not billable to the OHCA when performing pulpotomy or pulpal debridement on a permanent tooth.

(A) **Anterior root canals.** This procedure is for members who have a treatment plan requiring more than four anterior and/or posterior root canals. Payment is made for services provided in accordance with the following:

(i) Permanent teeth numbered 6, 7, 8, 9, 10, 11, 22, 23, 24, 25, 26 and 27 are eligible for therapy if there are no other missing teeth in the same arch requiring replacement, unless numbers 6 , 11 , 22, or 27 are abutments for prosthesis.

(ii) Accepted ADA materials must be used.

(iii) Pre and post operative periapical x-rays must be available for review.

(iv) Providers are responsible for any follow-up treatment required by a failed endodontically treated tooth within 24 months post completion.

(v) A tooth will not be approved if it appears there is not adequate natural tooth structure remaining to establish good tooth/restorative margins or if crown to root ratio is poor.

(vi) An endodontic procedure may not be approved if the tooth requires a post and core to retain a crown.

(vii) If there are three or more missing teeth in the arch that requires replacement, root therapy will not be authorized.

(B) **Posterior endodontics.** The guidelines for this procedure are as follows:

(i) The provider documents that the member has improved oral hygiene and flossing ability in this member's records.

(ii) Teeth that would require pre-fabricated post and cores to retain a restoration due to lack of natural tooth structure should not be treatment planned for root canal therapy.

(iii) Pre and post operative periapical x-rays must be available for review.

(iv) Providers are responsible for any follow-up treatment required by a failed endodontically treated tooth within 24 months post completion.

(v) A tooth will not be approved if it appears there is not adequate natural tooth structure remaining to

establish good tooth/restorative margins or if there is a poor crown to root ratio or weakened root furcation area. Approval of second molars is contingent upon proof of medical necessity.

(vi) Only ADA accepted materials are acceptable under the OHCA policy.

(vii) Posterior endodontic procedure is limited to a maximum of five teeth. A request may not be approved if the tooth requires a post and core in order to present adequate structure to retain a crown.

(viii) Endodontics will not be considered if:

(I) there are missing teeth in the same arch requiring replacement;

(II) an opposing tooth has super erupted;

(III) loss of tooth space is one third or greater;

(IV) opposing second molars are involved unless prior authorized; or

(V) the member has multiple teeth failing due to previous inadequate root canal therapy or follow-up.

(ix) Endodontically treated teeth must be restored to limited occlusal function and all contours must be replaced. Core build-up code is only available for use if other restorative codes are not sufficient. These teeth will not be approved for a crown if it appears the apex is not adequately sealed.

(x) a failing root canal is determined not medically necessary for re-treatment.

(2) **Cast metal crowns or ceramic-based crowns.** These procedures are compensable for restoration of natural teeth for members who are 16 years of age or older and adults residing in private Intermediate Care Facilities for the Mentally Retarded(ICF/MR) and who have been approved for (ICF/MR) level of care. Certain criteria and limitations apply.

(A) The following conditions must exist for approval of this procedure.

(i) The tooth must be fractured or decayed to such an extent to prevent proper cuspal or incisal function.

(ii) The clinical crown is destroyed by the above elements by one-half or more.

(iii) Endodontically treated teeth must have three or more surfaces restored or lost due to carious activity to be considered.

(B) The conditions listed in (A)(i) through (A)(iii) of this paragraph should be clearly visible on the submitted x-rays when a request is made for any type of crown.

(C) Routine build-up(s) for authorized crowns are included in the fee for the crown.

(D) A crown will not be approved if adequate tooth structure does not remain to establish cleanable margins, poor crown to root ratio, or the tooth appears to retain insufficient amounts of natural tooth structure. Cast dowel cores are not allowed.

(E) Preformed post(s) and core build-up(s) are not routinely provided with crowns for endodontically treated teeth.

(F) Ceramic-metal based crowns will be considered only for tooth numbers 4 through 13 and 21 through 28.

(G) Porcelain/Ceramic substrate crowns are allowed on maxillary and mandibular incisors only.

(H) Full cast metal crowns are treatment for all posterior teeth,

(I) Provider is responsible for replacement or repair of all cast crowns if due to failure caused by poor laboratory processes or procedure by provider for 48 months post insertion.

(3) **Cast frame partial dentures.** This appliance is the treatment of choice for replacement of three or more missing permanent teeth in the same arch for members 16 through 20 years of age. Provider must indicate tooth number to be replaced and teeth to be clasped.

(4) **Acrylic partial.** This appliance is the treatment of choice for replacement of missing anterior permanent teeth or three or more missing teeth in the same arch for members 12 through 16 years of age and adults residing in private Intermediate Care Facilities for the Mentally Retarded (ICF/MR) and who have been approved for ICF/MR level of care. Provider must indicate tooth numbers to be replaced and teeth to be clasped. This appliance includes all necessary clasps and rests.

(5) **Occlusal guard.** Narrative of clinical findings must be sent with prior authorization request.

(6) **Fixed cast non-precious metal or porcelain/metal bridges.** Only members 17 through 20 years of age where the bite relationship precludes the use of removable partial dentures are considered. Members must have excellent oral hygiene documented in the requesting provider's records. Provider is responsible for any needed follow up for a period of five years post insertion.

(7) **Periodontal scaling and root planing.** This procedure requires that 50% or more of the six point measurements be five millimeters or greater and must involve two or more teeth per quadrant for consideration. This procedure is

allowed on members 12 to 20 years of age and requires anesthesia and some soft tissue removal. The procedure is not allowed in conjunction with any other periodontal surgery. Allowance may be made for submission of required authorization data post treatment if the member has a medical or emotional problem that requires sedation.

(8) **Additional prophylaxis.** The OHCA recognizes that certain physical conditions require more than two prophylaxes. The following conditions may qualify a member for one additional prophylaxis per year:

(A) dilantin hyperplasia;

(B) cerebral palsy;

(C) ~~mental retardation~~ intellectual disabilities;

(D) juvenile periodontitis.

PART 85. ADVANTAGE PROGRAM WAIVER SERVICES

317:30-5-760. ADvantage program

The ADvantage Program is a Medicaid Home and Community Based Services (HCBS) Waiver used to finance noninstitutional long-term care services through Oklahoma's Medicaid program for elderly and disabled individuals. To receive ADvantage Program services, individuals must meet the nursing facility (NF) level of care (LOC) criteria, be age 65 years or older, or age 21 or older if physically disabled and not developmentally disabled, or if developmentally disabled and between the ages of 21 and 65, not have ~~mental retardation~~ an intellectual disability or a cognitive impairment related to the developmental disability. ADvantage Program recipients must be Medicaid eligible. The number of recipients of ADvantage services is limited.

PART 101. TARGETED CASE MANAGEMENT SERVICES FOR PERSONS WITH ~~MENTAL RETARDATION~~ AN INTELLECTUAL DISABILITY AND/OR RELATED CONDITIONS

317:30-5-1011. Coverage by category

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

(1) **Adults.** Payment is made for services to persons with ~~mental retardation~~ an intellectual disability and/or related conditions as follows:

(A) The target group for Developmental Disabilities Services Division Targeted Case Management (DDSDTCM) services are Medicaid eligible individuals:

(i) served by the Home and Community Based Waivers operated by the Department of Human

Services/Developmental Disabilities Services Division (DHS/DDSD); or

(ii) residing in institutions who:

(I) have requested Home and Community Based Waiver services operated by DHS/DDSD, and

(II) receive targeted case management services during a transition period not to exceed 180 consecutive days immediately prior to entering the Waiver; or

(iii) who are being assessed for admission to the Home and Community Based Waiver operated by DHS/DDSD.

(B) Targeted case management services may be provided when the client, the client's family as appropriate, the client's legal representative and case manager have worked together to achieve a plan.

(2) **Children.** Services for children are the same as for adults.

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

317:30-5-1076. Coverage by category

Payment is made for Nutritional Services as set forth in this section.

(1) **Adults.** Payment is made for six hours of medically necessary nutritional counseling per year by a licensed registered dietician. All services must be prescribed by a physician, physician assistant, advanced practice nurse, or nurse midwife and be face to face encounters between a licensed registered dietitian and the member. Services must be expressly for diagnosing, treating or preventing, or minimizing the effects of illness. Nutritional services for the treatment of obesity is not covered unless there is documentation that the obesity is a contributing factor in another illness.

(2) **Children.** Payment is made for medically necessary nutritional counseling as described above for adults. Nutritional services for the treatment of obesity may be covered for children as part of the EPSDT benefit. Additional services which are deemed medically necessary and allowable under federal regulations may be covered by the EPSDT benefit found at 317:30-3-65 and 317:30-3-65.11.

(3) **Home and Community Based Waiver Services for the ~~Mentally Retarded~~ Intellectually Disabled.** All providers participating in the Home and Community Based Waiver Services for the ~~Mentally Retarded~~ intellectually disabled program must have a separate contract with OHCA to provide

Nutrition Services under this program. All services are specified in the individual's plan of care.

(4) **Individuals eligible for Part B of Medicare.** Payment is made utilizing the Medicaid allowable for comparable services. Services which are not covered under Medicare should be billed directly to OHCA.

(5) **Obstetrical patients.** Payment is made for a maximum of six hours of medically necessary nutritional counseling per year by a licensed registered dietitian for members at risk for or those who have been recently diagnosed with gestational diabetes. The initial consultation may be in a group setting for a maximum of two hours of class time. Thereafter, four hours of nutritional counseling by a licensed registered dietitian may be provided to the individual if deemed medically necessary, which may include a post-partum visit, typically done at 6 weeks after delivery. All services must be prescribed by a physician, physician assistant, advanced practice nurse or a nurse midwife and be face-to-face between a licensed registered dietitian and the member(s). Services must be solely for the prevention, diagnosis, or treatment of gestational diabetes.

PART 113. LIVING CHOICE PROGRAM

317:30-5-1201. Benefits for members with ~~mental retardation~~ an intellectual disability

(a) Living Choice program participants with ~~mental retardation~~ an intellectual disability may receive a range of necessary medical and home and community based services for one year after moving from the institution. The one year period begins the day the member occupies a qualified residence in the community. Once this transition period is complete, the member receives services through the Community waiver.

(b) Services must be billed using the appropriate HCPCS or CPT codes and must be medically necessary.

(c) All services must be necessary for the individual to live in the community, require prior authorization, and must be documented in the individual transition plan. The number of units of services the member is eligible to receive is limited to the amounts approved in the transition plan. The transition plan may be amended as the member's needs change.

(d) Services that may be provided to members with ~~mental retardation~~ intellectual disabilities are listed in paragraphs (1) through (28) of this subsection:

(1) assistive technology;

(2) adult day health care;

(3) architectural modifications;
(4) audiology evaluation and treatment;
(5) community transition;
(6) daily living support;
(7) dental services;
(8) family counseling;
(9) family training;
(10) group home;
(11) respite care;
(12) homemaker services;
(13) habilitation training services;
(14) home health care;
(15) intensive personal support;
(16) extended duty nursing;
(17) skilled nursing;
(18) nutrition services;
(19) therapy services including physical, occupational, and speech;
(20) psychiatry services;
(21) psychological services;
(22) agency companion services;
(23) non-emergency transportation;
(24) pre-vocational services;
(25) supported employment services;
(26) specialized foster care;
(27) specialized medical equipment and supplies; and
(28) SoonerCare compensable medical services.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 35. MEDICAL ASSISTANCE FOR ADULTS AND CHILDREN-ELIGIBILITY
SUBCHAPTER 5. ELIGIBILITY AND COUNTABLE INCOME
PART 5. COUNTABLE INCOME AND RESOURCES

317:35-5-42. Determination of countable income for individuals categorically related to aged, blind and disabled

(a) **General.** The term income is defined as that gross gain or gross recurrent benefit which is derived from labor, business, property, retirement and other benefits, and many other forms which can be counted on as currently available for use on a regular basis. When an individual's income is reduced due to recoupment of an overpayment or garnishment, the gross amount before the recoupment or garnishment is counted as income.

(1) If it appears the applicant or SoonerCare member is eligible for any type of income (excluding SSI) or resources, he/she must be notified in writing by the Agency of his/her potential eligibility. The notice must contain

the information that failure to file for and take all appropriate steps to obtain such benefit within 30 days from the date of the notice will result in a determination of ineligibility.

(2) If a husband and wife are living in their own home, the couple's total income and/or resource is divided equally between the two cases. If they both enter a nursing facility, their income and resources are considered separately.

(3) If only one spouse in a couple is eligible and the couple ceases to live together, only the income and resources of the ineligible spouse that are actually contributed to the eligible spouse beginning with the month after the month which they ceased to live together are considered.

(4) In calculating monthly income, cents are included in the computation until the monthly amount of each individual's source of income has been established. When the monthly amount of each income source has been established, cents are rounded to the nearest dollar (1 - 49 cents is rounded down, and 50 - 99 cents is rounded up). For example, an individual's weekly earnings of $99.90 are multiplied by 4.3 and the cents rounded to the nearest dollar ($99.90 x 4.3 = $429.57 rounds to $430). See rounding procedures in OAC 340:65-3-4 when using BENDEX to verify OASDI benefits.

(b) **Income disregards.** In determining need, the following are not considered as income:

(1) The coupon allotment under the Food Stamp Act of 1977;

(2) Any payment received under Title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970;

(3) Educational grants (excluding work study), scholarships, etc., that are contingent upon the student regularly attending school. The student's classification (graduate or undergraduate) is not a factor;

(4) Loans (regardless of use) if a bona fide debt or obligation to pay can be established. Criteria to establish a loan as bona fide includes:

(A) An acknowledgment of obligation to repay or evidence that the loan was from an individual or financial institution in the loan business. If the loan agreement is not written, an OKDHS Form 08AD103E, Loan Verification, should be completed by the borrower attesting that the loan is bona fide and signed by the lender verifying the date and amount of loan. When copies of written agreements or OKDHS Form 08AD103E are not available, detailed case documentation must include

information that the loan is bona fide and how the debt amount and date of receipt was verified.

(B) If the loan was from a person(s) not in the loan business, the borrower's acknowledgment of obligation to repay (with or without interest) and the lender's verification of the loan are required to indicate that the loan is bona fide.

(C) Proceeds of a loan secured by an exempt asset are not an asset;

(5) One-third of child support payments received on behalf of the disabled minor child;

(6) Indian payments (including judgment funds or funds held in trust) distributed by the Secretary of the Interior (BIA) or distributed by the tribe subject to approval by the Secretary of the Interior. Also, any interest or investment income accrued on such funds while held in trust or any purchases made with judgment funds, trust funds, interest or investment income accrued on such funds. Any income from mineral leases, from tribal business investments, etc. However, any interest or income derived from the principal or produced by purchases made with funds after distribution is considered as any other income;

(7) Special allowance for school expenses made available upon petition (in writing) for funds held in trust for the student;

(8) Title III benefits from State and Community Programs on Aging;

(9) Payment for supportive services or reimbursement of out-of-pocket expenses made to individual volunteers serving as foster grandparents, senior health aides, or senior companions, and to persons serving in the Service Corps of Retired Executives (SCORE) and Active Corps of Executives (ACE);

(10) Payments to volunteers under the Domestic Volunteer Services Act of 1973 (VISTA), unless the gross amount of VISTA payments equals or exceeds the state or federal minimum wage, whichever is greater;

(11) The value of supplemental food assistance received under the Child Nutrition Act or the special food service program for children under the national School Lunch Act;

(12) Any portion of payments made under the Alaska Native Claims Settlement Act to an Alaska Native which are exempt from taxation under the Settlement Act;

(13) Reimbursements from an employer for out-of-pocket expenditures and allowances for travel or training to the extent the funds are used for expenses directly related to

such travel or training and uniform allowance if the uniform is uniquely identified with company names or logo;
(14) Assistance or services from the Vocational Rehabilitation program such as transportation expenses to a rehabilitation center, extra clothing, lunches, grooming needed for a training program and any other such complementary payments;
(15) Experimental Housing Allowance Program (EHAP) payments made under Annual Contributions Contracts entered into prior to January 1, 1975, under Section 23 of the U.S. Housing Act of 1937, as amended;
(16) Payments made by a public or private non-profit child care agency for a child placed in foster care or subsidized adoption;
(17) Governmental rental or housing subsidies by governmental agencies, e.g., HUD (received in-kind or in cash) for rent, mortgage payments or utilities;
(18) LIHEAP payments for energy assistance and payments for emergency situations under Emergency Assistance to Needy Families with Children;
(19) Payments made from the Agent Orange Settlement Fund or any other fund established pursuant to the settlement in the In Re Agent Orange product liability litigation, M.D.L. No. 381 (E.D.N.Y.);
(20) Payments made from the Radiation Exposure Compensation Trust Fund as compensation for injuries or deaths resulting from the exposure to radiation from nuclear testing and uranium mining;
(21) Federal major disaster and emergency assistance provided under the Disaster Relief Act of 1974, and comparable disaster assistance provided by States, local governments and disaster assistance organizations;
(22) Income of a sponsor to the sponsored eligible alien;
(23) Income that is set aside under an approved Plan for Achieving Self-Support for Blind or Disabled People (PASS). The Social Security Administration approves the plan, the amount of income excluded and the period of time approved. A plan can be approved for an initial period of 18 months. The plan may be extended for an additional 18 months if needed, and an additional 12 months (total 48 months) when the objective involves a lengthy educational or training program;
(24) Payments made to individuals because of their status as victims of Nazi persecution (PL 103-286);
(25) Payments received under the Civil Liberties Act of 1988. These payments are to be made to individuals of

Japanese ancestry who were detained in internment camps during World War II;

(26) Payments received as a result of participation in a class action lawsuit entitled "Factor VIII or IX Concentrate Blood Products Litigation". These payments are made to hemophilia patients who are infected with HIV. However, if the payments are placed in an interest-bearing account, or some other investment medium that produces income, the income generated by the account may be countable as income to the individual;

(27) Payments made to certain Vietnam veterans' children with spina bifida (PL 104-204);

(28) Payments made to certain Korea service veterans' children with spina bifida (PL 108-183);

(29) Payments made to the children of women Vietnam veterans who suffer from certain birth defects (PL 106-419);

(30) Additional payments of regular unemployment compensation in the amount of $25 per week ending June 30, 2010, and any amount of emergency unemployment compensation paid through May 31, 2010, as authorized under the American Recovery and Reinvestment Tax Act of 2009; and

(31) Wages paid by the Census Bureau for temporary employment related to Census activities.

(c) **Determination of income.** The member is responsible for reporting information regarding all sources of available income. This information is verified and used by the worker in determining eligibility.

(1) Gross income is listed for purposes of determining eligibility. It may be derived from many sources, and some items may be automatically disregarded by the computer when so provided by state or federal law.

(2) If a member is determined to be categorically needy and is also an SSI recipient, any change in countable income (see OAC 317:35-5-42(d)(3) to determine countable income) will not affect receipt of SoonerCare and amount of State Supplemental Payment (SSP) as long as the amount does not cause SSI ineligibility. Income which will be considered by SSI in the retrospective cycle is documented in the case with computer update at the time that SSI makes the change (in order not to penalize the member twice). If the SSI change is not timely, the worker updates the computer using the appropriate date as if it had been timely. If the receipt of the income causes SSI ineligibility, the income is considered immediately with proper action taken to reduce or close the SoonerCare benefit and SSP case. Any SSI overpayment caused by SSA not making timely changes will result in recovery by SSI in the future. When the worker

becomes aware of income changes which will affect SSI eligibility or payment amount, the information is to be shared with the SSA office.

(3) Some of the more common income sources to be considered in determining eligibility are as follows:

(A) **Retirement and disability benefits.** These include but are not limited to OASDI, VA, Railroad Retirement, SSI, and unemployment benefits. Federal and State benefits are considered for the month they are intended when determining eligibility.

(i) Verifying and documenting the receipt of the benefit and the current benefit amount are achieved by:

(I) seeing the member's award letter or warrant;

(II) obtaining a signed statement from the individual who cashed the warrant; or

(III) by using BENDEX and SDX.

(ii) Determination of OASDI benefits to be considered (disregarding COLA's) for former State Supplemental recipients who are reapplying for medical benefits under the Pickle Amendment must be computed according to OKDHS Form 08AX011E.

(iii) The Veterans Administration allows their recipients the opportunity to request a reimbursement for medical expenses not covered by SoonerCare. If a recipient is eligible for the readjustment payment, it is paid in a lump sum for the entire past year. This reimbursement is disregarded as income and a resource in the month it is received; however, any amount retained in the month following receipt is considered a resource.

(iv) Government financial assistance in the form of VA Aid and Attendance or Champus payments is considered as follows:

(I) **Nursing facility care.** VA Aid and Attendance or Champus payment whether paid directly to the member or to the facility, are considered as third party resources and do not affect the income eligibility or the vendor payment of the member.

(II) **Own home care.** The actual amount of VA Aid and Attendance payment paid for an attendant in the home is disregarded as income. In all instances, the amount of VA Aid and Attendance is shown on the computer form.

(v) Veterans or their surviving spouse who receive a VA pension may have their pension reduced to $90 by the VA if the veteran does not have dependents, is

SoonerCare eligible, and is residing in a nursing facility that is approved under SoonerCare. Section 8003 of Public Law 101-508 allows these veterans' pensions to be reduced to $90 per month. None of the $90 may be used in computing any vendor payment or spenddown. In these instances, the nursing home resident is entitled to the $90 reduced VA pension as well as the regular nursing facility maintenance standard. Any vendor payment or spenddown will be computed by using other income minus the monthly nursing facility maintenance standard minus any applicable medical deduction(s). Veterans or their surviving spouse who meet these conditions will have their VA benefits reduced the month following the month of admission to a SoonerCare approved nursing facility.

(B) **SSI benefits.** SSI benefits may be continued up to three months for a recipient who enters a public medical or psychiatric institution, a SoonerCare approved hospital, extended care facility, intermediate care facility for the mentally retarded or nursing facility. To be eligible for the continuation of benefits, the SSI recipient must have a physician's certification that the institutionalization is not expected to exceed three months and there must be a need to maintain and provide expenses for the home. These continued payments are intended for the use of the recipient and do not affect the vendor payment.

(C) **Lump sum payments.**

(i) Any income received in a lump sum (with the exception of SSI lump sum) covering a period of more than one month, whether received on a recurring or nonrecurring basis, is considered as income in the month it is received. Any amount from any lump sum source, including SSI (with the exception of dedicated bank accounts for disabled/blind children under age 18), retained on the first day of the next month is considered as a resource. Such lump sum payments may include, but are not limited to, accumulation of wages, retroactive OASDI, VA benefits, Workers' Compensation, bonus lease payments and annual rentals from land and/or minerals.

(ii) Lump sum payments used to establish dedicated bank accounts by representative payees in order to receive and maintain retroactive SSI benefits for disabled/blind children under age 18 are excluded as income. The interest income generated from dedicated

bank accounts is also excluded. The dedicated bank account consisting of the retroactive SSI lump sum payment and accumulated interest is excluded as a resource in both the month received and any subsequent months.

(iii) A life insurance death benefit received by an individual while living is considered as income in the month received and as a resource in the following months to the extent it is available.

(iv) Changing a resource from one form to another, such as converting personal property to cash, is not considered a lump sum payment.

(D) **Income from capital resources and rental property.** Income from capital resources can be derived from rental of a house, rental from land (cash or crop rent), leasing of minerals, life estate, homestead rights or interest.

(i) If royalty income is received monthly but in irregular amounts, an average based on the previous six months' royalty income is computed and used to determine income eligibility. Exception: At any time that the county becomes aware of and can establish a trend showing a dramatic increase or decrease in royalty income, the previous two month's royalty income is averaged to compute countable monthly income.

(ii) Rental income may be treated as earned income when the individual participates in the management of a trade or business or invests his/her own labor in producing the income. The individual's federal income tax return will verify whether or not the income is from self-employment. Otherwise, income received from rent property is treated as unearned income.

(iii) When property rental is handled by a leasing agent who collects the rent and deducts a management fee, only the rent actually received by the member is considered as income.

(E) **Earned income/self-employment.** The term "earned income" includes income in cash earned by an individual through the receipt of wages, salary, commission or profit from activities in which he/she is engaged as a self-employed individual or as an employee. See subparagraph (G) of this paragraph for earnings received in fluctuating amounts. "Earned Income" is also defined to include in-kind benefits received by an employee from an employer in lieu of wages or in conjunction with wages. Such benefits received in-kind are considered as earned income only when the employee/employer

relationship has been established. The cash value of the in-kind benefits must be verified by the employer. Income from self-employment also includes in-kind benefits for a work activity or service for which the self-employed person ordinarily receives payment in his/her business enterprise. An exchange of labor or services; e.g., barter, is considered as an in-kind benefit. Medical insurance secured through the employer, whether purchased or as a benefit, is not considered in-kind but is recorded on the case computer input document for coordination with SoonerCare benefits.

(i) Work study received by an individual who is attending school is considered as earned income with appropriate earned income disregards applied.

(ii) Money from the sale of whole blood or blood plasma is considered as self-employment income subject to necessary business expense and appropriate earned income disregards.

(iii) Self-employment income is determined as follows:

(I) Generally, the federal or state income tax form for the most recent year is used for calculating the self-employment income to project income on a monthly basis for the certification period. The gross income amount as well as the allowable deductions are the same as can be claimed under the Internal Revenue code for tax purposes.

(II) Self-employment income which represents a household's annual support is prorated over a 12-month period, even if the income is received in a short period of time. For example, self-employment income received by crop farmers is averaged over a 12-month period if the income represents the farmer's annual support.

(III) If the household's self-employment enterprise has been in existence for less than a year, the income from that self-employment enterprise is averaged over the period of time the business has been in operation to establish the monthly income amount.

(IV) If a tax return is not available because one has not been filed due to recent establishment of the self-employment enterprise, a profit and loss statement must be seen to establish the monthly income amount.

(V) The purchase price and/or payment(s) on the principal of loans for capital assets, equipment, machinery, and other durable goods is not

considered as a cost of producing self-employed income. Also not considered are net losses from previous periods, depreciation of capital assets, equipment, machinery, and other durable goods; and federal, state and local income taxes, FICA, money set aside for retirement purposes, and other work related personal expenses, such as meals and necessary transportation (these expenses are accounted for by the work related expense deduction given in OAC 340:10-3-33(1)).

(iv) Countable self-employment income is determined by deducting allowable business expenses to determine the adjusted gross income. The earned income deductions are then applied to establish countable earned income.

(F) **Inconsequential or irregular income.** Inconsequential or irregular receipt of income in the amount of $10 or less per month or $30 or less per quarter is disregarded. The disregard is applied per individual for each type of inconsequential or irregular income. To determine whether the income is inconsequential or irregular, the gross amount of earned income and the gross minus business expense of self-employed income are considered.

(G) **Monthly income received in fluctuating amounts.** Income which is received monthly but in irregular amounts is averaged using two month's income, if possible, to determine income eligibility. Less than two month's income may be used when circumstances (e.g., new employment, unpaid sick leave, etc.) would indicate that previous income amounts would not be appropriate to use in determining future income amounts. Income received more often than monthly is converted to monthly amounts as follows:

(i) **Daily.** Income received on a daily basis is converted to a weekly amount then multiplied by 4.3.

(ii) **Weekly.** Income received weekly is multiplied by 4.3.

(iii) **Twice a month.** Income received twice a month is multiplied by 2.

(iv) **Biweekly.** Income received every two weeks is multiplied by 2.15.

(H) **Non-negotiable notes and mortgages.** Installment payments received on a note, mortgage, etc., are considered as monthly income.

(I) **Income from the Job Training and Partnership Act (JTPA).** Unearned income received by an adult, such as a needs based payment, cash assistance, compensation in lieu of wages, allowances, etc., from a program funded by

JTPA is considered as any other unearned income. JTPA earned income received as wages is considered as any other earned income.

(J) **Other income.** Any other monies or payments which are available for current living expenses must be considered.

(d) **Computation of income.**

(1) **Earned income.** The general income exclusion of $20 per month is allowed on the combined earned income of the eligible individual and eligible or ineligible spouse. See paragraph (6) of this subsection if there are ineligible minor children. After the $20 exclusion, deduct $65 and one-half of the remaining combined earned income.

(2) **Unearned income.** The total gross amount of unearned income of the eligible individual and eligible or ineligible spouse is considered. See paragraph (6) of this subsection if there are ineligible minor children.

(3) **Countable income.** The countable income is the sum of the earned income after exclusions and the total gross unearned income.

(4) **Deeming computation for disabled or blind minor child(ren).** An automated calculation is available for computing the income amount to be deemed from parent(s) and the spouse of the parent to eligible disabled or blind minor child(ren) by use of transaction CID. The ineligible minor child in the computation regarding allocation for ineligible child(ren) is defined as: a dependent child under age 18.

(A) A ~~mentally retarded~~ intellectually disabled child living in the home who is ineligible for SSP due to the deeming process may be approved for SoonerCare under the Home and Community Based Services Waiver (HCBS) Program as outlined in OAC 317:35-9-5.

(B) For TEFRA, the income of child's parent(s) is not deemed to him/her.

(5) **Premature infants.** Premature infants (i.e., 37 weeks or less) whose birth weight is less than 1200 grams (approximately 2 pounds 10 ounces) will be considered disabled by SSA even if no other medical impairment(s) exist. In this event, the parents' income is not deemed to the child until the month following the month in which the child leaves the hospital and begins living with his/her parents.

(6) **Procedures for deducting ineligible minor child allocation.** When an eligible individual has an ineligible spouse and ineligible minor children (not receiving TANF), the computation is as follows:

(A) Each ineligible child's allocation (OKDHS Form 08AX001E, Schedule VII. C.) minus each child's gross

countable income is deducted from the ineligible spouse's income. Deeming of income is not done from child to parent.

(B) The deduction in subparagraph (A) of this paragraph is prior to deduction of the general income exclusion and work expense.

(C) After computations in subparagraphs (A) and (B) of this paragraph, the remaining amount is the ineligible spouse's countable income considered available to the eligible spouse.

(7) **Special exclusions for blind individuals.** Any blind individual who is employed may deduct the general income exclusion and the work exclusion from the gross amount of earned income. After the application of these exclusions, one-half of the remaining income is excluded. The actual work expense is then deducted from the remaining half to arrive at the amount of countable income. If this blind individual has a spouse who is also eligible due to blindness and both are working, the amount of ordinary and necessary expenses attributable to the earning of income for each of the blind individuals may be deducted. Expenses are deductible as paid but may not exceed the amount of earned income. To be deductible, an expense need not relate directly to the blindness of the individual, it need only be an ordinary and necessary work expense of the blind individual. Such expenses fall into three broad categories:

(A) transportation to and from work;

(B) job performance; and

(C) job improvement.

SUBCHAPTER 9. ICF/MR, HCBW/MR, AND INDIVIDUALS AGE 65 OR OLDER IN MENTAL HEALTH HOSPITALS
PART 1. SERVICES

317:35-9-1. Overview of long-term medical care services; relationship to QMB, SLMB, and other Medicaid services eligibility, and spenddown calculation

(a) **Long Term Medical Care Services.** Long-term medical care for the categorically needy includes care in a nursing facility (refer to OAC 317:35-19), public and private intermediate care facility for the mentally retarded (refer to this subchapter), persons age 65 years or older in mental health hospitals (refer to this subchapter), Home and Community Based Waiver Services for the ~~Mentally Retarded~~ Intellectually Disabled (refer to this subchapter), and Home and Community Based Waiver Services for frail elderly and a targeted group of adults with physical disabilities age 21 and over who have not been determined to

have a developmental disability, ~~mental retardation~~ an intellectual disability or a related condition (refer to OAC 317:35-17). Personal Care provides services in the own home for categorically needy individuals (refer to OAC 317:35-15). Any time an individual is certified as eligible for Medicaid coverage of long-term care, the individual is also eligible for other Medicaid services. Another application or additional spenddown computation is not required. Spenddown is applied to the first long-term care claim filed. Any time an aged, blind or disabled individual is determined eligible for long-term care, a separate determination must be made to see if eligibility conditions as a Qualified Medicare Beneficiary (QMB) or Specified Low-Income Medicare Beneficiary (SLMB) are met. Another application for QMB or SLMB benefits is not required. Any spenddown computed for long-term care is not applicable to QMB or SLMB coverage.

(b) **Medicaid recovery.** The State of Oklahoma operates a Medicaid Recovery program to recover for services identified in OAC 317:35-9-15. Recovery can be accomplished in two ways: liens against real property or claims made against estates.

317:35-9-5. Home and Community - Based Services (HCBS) Waivers for persons with intellectual disabilities ~~(mental retardation)~~ or certain persons with related conditions

(a) Home and Community Based Services (HCBS) Waivers for persons with intellectual disabilities ~~(mental retardation)~~ or certain persons with related conditions are operated by the Oklahoma Department of Human Services (OKDHS) Developmental Disabilities Services Division (DDSD) per OAC 317:40-1-1. Oklahoma's Medicaid agency, the Oklahoma Health Care Authority (OHCA), provides oversight of Waiver operation. HCBS Waivers allow the OHCA to offer certain home and community based services to categorically needy members who, without such services, would be eligible for care in an Intermediate Care Facility for persons with Mental Retardation (ICF/MR).

(b) Members receiving HCBS Waiver services per OAC 317:40-1-1 are subject to HCBS Waiver service conditions (1)-(11) of this subsection. The rules in this subsection shall not be construed as a limitation of the rights of class members set forth in the Second Amended Permanent Injunction in Homeward Bound vs. The Hissom Memorial Center.

(1) HCBS Waiver services are subject to annual appropriations by the Oklahoma Legislature.

(2) DDSD must limit the utilization of the HCBS Waiver services based on:

(A) the federally-approved member capacity for the individual HCBS Waivers; and

(B) the cost effectiveness of the individual HCBS Waivers as determined according to federal requirements; and

(3) DDSD must limit enrollment when utilization of services under the HCBS Waiver programs is projected to exceed the spending authority.

(4) Members receiving Waiver services must have full access to State plan services for which they are eligible including Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services when children participate in a Waiver.

(5) A member's room and board expenses may not be paid through a Waiver. Room and board expenses must be met from member resources or through other sources.

(6) A member must require at least one Waiver service per month or monthly case management monitoring in order to function in the community.

(7) Waiver services required by a member must be documented in advance of service delivery in a written plan of care.

(8) Members exercise freedom of choice by choosing Waiver services instead of institutional services.

(9) Members have the right to freely select from among any willing and qualified provider of Waiver services.

(10) The average costs of providing Waiver and non-Waiver SoonerCare services must be no more costly than the average costs of furnishing institutional (and other SoonerCare state plan) services to persons who require the same level of care.

(11) Members approved for services provided in a specific Waiver must be afforded access to all necessary services offered in the specific Waiver if the member requires the service.

PART 3. APPLICATION PROCEDURES

317:35-9-25. Application for ICF/MR, ~~HCBW/MR~~ HCBW/ID, and persons aged 65 or over in mental health hospitals.

(a) **Application procedures for long-term medical care.** An application for these types of services consists of the Medical Assistance Application. The Medical Assistance Application is signed by the patient, parent, spouse, guardian or someone else acting on the patient's behalf.

(1) All conditions of eligibility must be verified and documented in the case record. When current information already available in the local office establishes eligibility, such information may be used by recording source and date of information. If the applicant also wishes to apply for a State Supplemental Payment, either the applicant or his/her guardian must sign the application form.

(2) At the request of an individual in an ICF/MR or receiving Home and Community Based Waiver Services for the ~~Mentally Retarded~~ Intellectually Disabled or the community spouse, if application for Medicaid is not being made, an assessment of the resources available to each spouse is made by use of DHS Form MA-11, Assessment of Assets. Documentation of resources must be provided by the individual and/or spouse. This assessment reflects all countable resources of the couple (owned individually or as a couple) and establishes the spousal share to be protected when subsequent determination of Medicaid eligibility is made. A copy of Form MA-11 is provided to each spouse for planning in regard to future eligibility. A copy is retained in the county office in case of subsequent application.

(3) If assessment by Form MA-11 was not done at the time of entry into the ICF/MR or ~~HCBW/MR~~ HCBW/ID services, assessment by use of Form MA-11 must be done at the time of application for Medicaid. The spousal share of resources is determined in either instance for the month of entry into the ICF/MR or ~~HCBW/MR~~ HCBW/ID services. If the individual applies for Medicaid at the time of entry into the ICF/MR or ~~HCBW/MR~~ HCBW/ID services, Form MA-11 is not appropriate. However, the spousal share must be determined using the resource information provided on the Medicaid application form and computed using DHS Form MA-12, Title XIX Worksheet.

(b) **Date of application.** When application is made in the county office the date of application is the date the applicant or someone acting on his/her behalf signs the application form. When the application is initiated outside the county office, the date of application is the date the application is stamped into the county office. When a request for Medicaid is first made by an oral request, and the application form is signed later, the date of the oral request is entered in "red" above the date the form is signed. The date of the oral request is the date of application.

PART 5. DETERMINATION OF MEDICAL ELIGIBILITY FOR ICF/MR, HCBW/MR, AND INDIVIDUALS AGE 65 OR OLDER IN MENTAL HEALTH HOSPITALS

317:35-9-45. Determination of medical eligibility for care in a private Intermediate Care Facility for Persons with Mental Retardation

(a) **Pre-approval of medical eligibility.** Pre-approval of medical eligibility for private ICF/MR care is based on level of care requirements per OAC 317:30-5-122. Pre-approval is not

necessary for individuals with a severe or profound intellectual disability ~~(mental retardation)~~. Pre-approval is made by Oklahoma Health Care Authority (OHCA) Level of Care Evaluation Unit (LOCEU) analysts.

(b) **Application for ICF/MR services.** Within 30 calendar days after services begin, the facility must submit:

(1) the original of the ICF/MR Level of Care Assessment form (LTC-300) to LOCEU. Required attachments include:

(A) Current (within 90 days of requested approval date) medical information signed by a physician.

(B) A current (within 12 months of requested approval date) psychological evaluation by a licensed Psychologist or State staff supervised by a licensed Psychologist. The evaluation must include intelligence testing that yields a full-scale intelligence quotient, a full-scale functional or adaptive assessment, as well as the age of onset.

(C) A copy of the pertinent section of the Individual Plan or other appropriate documentation relative to the ICF/MR admission and the need for ICF/MR level of care.

(D) A statement that the member is not an imminent threat of harm to self or others (i.e., suicidal or homicidal).

(2) If pre-approval was determined by LOCEU and the above information is received, medical approval will be entered on an electronic medical case list known as MEDATS. Pre-approval is not needed for individuals with a severe or profound intellectual disability ~~(mental retardation)~~.

(c) **Categorical relationship.** Categorical relationship must be established for determination of eligibility for long-term medical care. If categorical relationship has not already been established, the proper forms and medical information are submitted to LOCEU. (Refer to OAC 317:35-5-4). In such instances LOCEU will render a decision on categorical relationship using the same definition as used by the with SSA. A follow-up is required by the OKDHS social worker with the SSA to be sure that their disability decision agrees with the decision of LOCEU.

(d) **Medical eligibility for ICF/MR services.**

(1) Individuals must require active treatment per 42 CFR 483.440.

(2) Individuals must have a diagnosis of intellectual disability ~~(mental retardation)~~ or a related condition based on level of care requirements per OAC 317:30-5-122 and results of a current comprehensive psychological evaluation by a licensed Psychologist or State staff supervised by a licensed Psychologist.

(A) Per the Diagnostic and Statistical Manual of Mental Disorders, intellectual disability ~~(mental retardation)~~ is a condition characterized by a significantly sub-average general intellectual functioning existing concurrently with deficits in adaptive behavior and originating before 18 years of age.

(B) Per 42 CFR 435.1010, persons with related conditions means individuals who have a severe, chronic disability that meets the following conditions:

(i) It is attributable to cerebral palsy or epilepsy; or

(ii) it is attributable to any other condition, other than mental illness, found to be closely related to intellectual disability ~~(mental retardation)~~ because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of persons with intellectual disability ~~(mental retardation)~~ and requires treatment or services similar to those required for these persons.

(iii) It is manifested before the person reaches age 22.

(iv) It is likely to continue indefinitely.

(v) It results in substantial functional limitations in three or more areas of major life activity per OAC 317:30-5-122.

(C) Conditions closely related to intellectual disability ~~(mental retardation)~~ include, but are not limited to the following:

(i) autism or autistic disorder, childhood disintegrative disorder, Rett syndrome and pervasive developmental disorder, not otherwise specified (only if "typical autism");

(ii)severe brain injury (acquired brain injury, traumatic brain injury, stroke, anoxia, meningitis);

(iii) fetal alcohol syndrome;

(iv) chromosomal disorders (Down syndrome, fragile x syndrome, Prader-Willi syndrome);and

(v) other genetic disorders (Williams syndrome, spina bifida, phenylketonuria).

(D) The following diagnoses do not qualify as conditions related to intellectual disability.~~(mental retardation)~~ Nevertheless, a person with any of these conditions is not disqualified if there is a simultaneous occurrence of a qualifying condition:

(i) learning disability;

(ii) behavior or conduct disorders;

(iii) substance abuse;

(iv) hearing impairment or vision impairment;
(v) mental illness that includes psychotic disorders, adjustment disorders, reactive attachment disorders, impulse control disorders, and paraphilias;
(vi) borderline intellectual functioning, developmental disability that does not result in an intellectual impairment, developmental delay or "at risk" designations;
(vii) physical problems (such as multiple sclerosis, muscular dystrophy, spinal cord injuries and amputations);
(viii) medical health problems (such as cancer, acquired immune deficiency syndrome and terminal illnesses);
(ix) milder autism spectrum disorders (such as Asperger's disorder and pervasive developmental disorder not otherwise specified if not "atypical autism");
(x) neurological problems not associated with intellectual deficits (such as Tourette's syndrome, fetal alcohol effects and non-verbal learning disability);or
(xi) mild traumatic brain injury (such as minimal brain injury and post-concussion syndrome).

317:35-9-48.1 Determining ICF/MR institutional level of care for TEFRA children

In order to determine level of care for TEFRA children:

(1) The child must be age 18 years or younger and expected to meet the following criteria for at least 30 days.

(A) Applicants under age three must:

(i) have a diagnosis of a developmental disability; and

(ii) have been evaluated by the SoonerStart Early Intervention Program and found to have severe dysfunctional deficiencies with findings of at least two standard deviations in at least two developmental areas.

(B) Applicants age three years and older must:

(i) have a diagnosis of ~~mental retardation~~ an intellectual disability or a developmental disability; and

(ii) have received a psychological evaluation by a licensed psychologist or school psychologist certified by the Oklahoma Department of Education (ODE) within the last 12 months. The evaluation must include intelligence testing that yields a full-scale

intelligence quotient, and a full-scale functional or adaptive assessment that yields a composite functional age. Eligibility for TEFRA ICF/MR level of institutional care requires an IQ of 75 or less, and a full-scale functional assessment (Vineland or Battelle) indicating a functional age composite that does not exceed 50% of the child's chronological age. In no case shall eligibility be granted for a functional age greater than eight years.

(2) Psychological evaluations required for children who are approved for TEFRA under ICF/MR level of care. Children under age six will be required to undergo a full psychological evaluation, including both intelligence testing and adaptive/functional assessment, by a licensed psychologist or school psychologist certified by the ODE, at age three and again at age six to ascertain continued eligibility for TEFRA under the ICF/MR level of institutional care. The psychological evaluation must be completed and submitted to the LOCEU no later than 90 days following the child's third and sixth birthday.

317:35-9-49. Determination of medical eligibility for Home and Community Based Waiver Services for the ~~Mentally Retarded~~ Intellectually Disabled

Determinations of medical eligibility for Home and Community Based Waiver Services for the ~~Mentally Retarded (HCBW/MR)~~ Intellectually Disabled (HCBW/ID) is made through referral to the DHS DDSD case manager.

(1) **Referral.** If the county receives an application, Form K-13 is forwarded to the DDSD case manager, who is responsible for securing a ~~HCBW/MR~~ HCBW/ID medical determination and a disability decision, if needed.

(2) **Initial request.** If the initial request is through DDSD, Form K-13 is forwarded to the county for completing the application process.

(3) **Plan of care packet.** The DDSD case manager submits the necessary information to LOCEU for medical determination and a disability decision if needed.

(4) **County notification.** LOCEU notifies the county and DDSD case manager of determination by updating the MEDATS file.

(5) **Procedures for an individual returning home.** If referral is from a public ICF/MR for an individual returning to the home, the DDSD case manager forwards to the worker the medical eligibility determination for ~~HCBW/MR~~ HCBW/ID along with the latest application form and redetermination of eligibility form used to determine eligibility for institutional care. A new application will not be required.

A case number will be assigned retaining the application date, certification date and redetermination of eligibility date.

(6) **Determination of continued eligibility for ~~HCBW/MR~~** HCBW/ID. The case manager is responsible for assuring that the individual's needs are re-evaluated and that recertification is established annually. Determination of continued medical eligibility is not necessary unless there is a significant change in the client=s condition. The DDSD cases manager will notify LOCEU if this is the case.

PART 11. PAYMENT, BILLING, AND OTHER ADMINISTRATIVE PROCEDURES

317:35-9-97. Payment for Home and Community Based Waiver services for the ~~Mentally Retarded (HCBW/MR)~~ Intellectually Disabled (HCBW/ID)

Payment is made to ~~HCBW/MR~~ HCBW/ID providers who have been certified as eligible to provide such services by the DHS Developmental Disabilities Services Division (DDSD). Certification is made after the provider has completed required training or meets the State licensing requirements for that medical discipline. Each provider must enter into a contract to provide ~~HCBW/MR~~ HCBW/ID services. Payment is made on a procedure-based reimbursement methodology for each service. All services must be preauthorized before payment can be made.

SUBCHAPTER 10. OTHER ELIGIBILITY FACTORS FOR FAMILIES WITH CHILDREN AND PREGNANT WOMEN

PART 5. INCOME

317:35-10-38. Temporary absence from the home.

An individual who is temporarily absent from the home for the purpose of receiving training or education for employment, certain medical services, etc., may be considered part of the benefit group.

(1) Individuals temporarily absent from the home, receiving training or education for employment are considered part of the benefit group during the period of time the training or educational activities are taking place.

(2) Children temporarily absent from the home to attend boarding school are considered part of the benefit group during the school term.

(3) Individuals temporarily absent from the home because of entrance into a private facility for counseling, rehabilitation, behavioral problems or special training, etc., are considered part of the benefit group. If care is projected for a period exceeding 90 days, the absence is not considered temporary. At any time an absence is determined

as not temporary or no longer temporary, the needs of the individual cannot be included in the benefit group.

(4) Individuals temporarily absent from the home for medical services, other than institutionalization for treatment of mental illness, ~~mental retardation~~ intellectual disability, or tuberculosis, are considered part of the benefit group for up to six months. Six-month extensions may be allowed when the worker's verification indicates the individual may return to the home within the next six months.

SUBCHAPTER 15. PERSONAL CARE SERVICES

317:35-15-1. Overview of long-term medical care services; relationship to QMB, SLMB and other SoonerCare service eligibility and spenddown calculation

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

SUBCHAPTER 17. ADVANTAGE WAIVER SERVICES

317:35-17-1. Overview of long-term medical care services; relationship to QMBP, SLMB, and other Medicaid services eligibility

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

(1) care in a nursing facility (refer to OAC 317:35-19);

(2) care in a public or private intermediate care facility for the mentally retarded (refer to OAC 317:35-9);

(3) care of persons age 65 years or older in mental health hospitals (refer to OAC 317:35-9);
(4) Home and Community Based Services Waivers for the ~~Mentally Retarded~~ Intellectually Disabled (refer to OAC 317:35-9);
(5) Personal Care services (refer to OAC 317:35-15); and
(6) the Home and Community Based Services Waiver for frail elderly, a targeted group of adults with physical disabilities age 21 and over who do not have ~~mental retardation~~ an intellectual disability or a cognitive impairment (ADvantage Waiver).

(b) Any time an individual is certified as eligible for SoonerCare coverage of long-term care, the individual is also eligible for other SoonerCare services. ADvantage Waiver members do not have a copayment for ADvantage services except for prescription drugs. For members residing in an ADvantage Assisted Living Center, any income beyond 150% of the federal benefit rate is available to defray the cost of the Assisted Living services received. The member is responsible for payment to the Assisted Living Services Center provider for days of service from the first day of each month in which services have been received until the vendor pay obligation is met. Any time an aged, blind or disabled individual is determined eligible for long-term care, a separate eligibility determination must be made for Qualified Medicare Beneficiary Plus (QMBP) or Specified Low-Income Medicare Beneficiary (SLMB) benefits. An ADvantage program member may reside in a licensed assisted living facility only if the assisted living center is a certified ADvantage Assisted Living Services provider from whom the member is receiving ADvantage Assisted Living services.

317:35-17-2. Level of care medical eligibility determination

The OKDHS area nurse, or nurse designee, determines medical eligibility for ADvantage program services based on the Long Term Care (LTC) nurse's Uniform Comprehensive Assessment Tool (UCAT) III assessment and the determination that the client has unmet care needs that require ADvantage or NF services to assure client health and safety. ADvantage services are initiated to support the informal care that is being provided in the client's home, or, that based on the UCAT, can be expected to be provided in the client's home upon discharge of the client from a NF or hospital. These services are not intended to take the place of regular care provided by family members and/or by significant others. When there is an

informal (not paid) system of care available in the home, ADvantage service provision will supplement the system within the limitations of ADvantage Program policy.

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

(A) **"ADL"** means the activities of daily living. Activities of daily living are activities that reflect the client's ability to perform self-care tasks essential for sustaining health and safety such as:

(i) bathing,
(ii) eating,
(iii) dressing,
(iv) grooming,
(v) transferring (includes getting in and out of a tub, bed to chair, etc.),
(vi) mobility,
(vii) toileting, and
(viii) bowel/bladder control.

(B) **"ADLs score in high risk range"** means the client's total weighted UCAT ADL score is 10 or more which indicates the client needs some help with 5 ADLs or that the client cannot do 3 ADLs at all plus the client needs some help with 1 other ADL.

(C) **"ADLs score at the high end of the moderate risk range"** means client's total weighted UCAT ADL score is 8 or 9 which indicates the client needs help with 4 ADLs or the client cannot do 3 ADLs at all.

(D) **"CHC"** means Comprehensive Home Care.

(E) **"Client Support high risk"** means client's UCAT Client Support score is 25 which indicates in the UCAT assessor's clinical judgment, excluding from consideration existing Ryan White CARE Act, Indian Health Service, Medicaid NF, ADvantage and/or State Plan Personal Care services, very little or no support is available from informal and formal sources and the client requires additional care that is not available through Medicare, Veterans Administration, or other Federal entitlement programs.

(F) **"Client Support moderate risk"** means client's UCAT Client Support score is 15 which indicates in the UCAT assessor's clinical judgment, excluding from consideration existing Ryan White CARE Act, Indian Health Service, Medicaid NF, ADvantage and/or State Plan Personal Care services, support from informal and formal sources is available, but overall, it is inadequate, changing, fragile or otherwise problematic and the client

requires additional care that is not available through Medicare, Veterans Administration, or other federal entitlement programs.

(G) **"Cognitive Impairment"** means that the person, as determined by the clinical judgment of the LTC Nurse or the AA, does not have the capability to think, reason, remember or learn required for self-care, communicating needs, directing care givers and/or using appropriate judgment for maintenance of their own health or safety. The clinical judgment of cognitive impairment is based on MSQ performance in combination with a more general evaluation of cognitive function from interaction with the person during the UCAT assessment.

(H) **"Developmental Disability"** means a severe, chronic disability of an individual that:

(i) is attributable to a mental or physical impairment or combination of mental and physical impairments;

(ii) is manifested before the individual attains age 22;

(iii) is likely to continue indefinitely;

(iv) results in substantial functional limitations in three or more of the following areas of major life activity:

(I) self-care;

(II) receptive and expressive language;

(III) learning;

(IV) mobility;

(V) self-direction;

(VI) capacity for independent living; and

(VII) economic self-sufficiency; and

(v) reflects the individual’s need for a combination and sequence of special, interdisciplinary, or generic services, supports, or other assistance that is of lifelong or extended duration and is individually planned and coordinated.

(I) **"Environment high risk"** means client's UCAT Environment score is 25 which indicates in the UCAT assessor's clinical judgment, the physical environment is strongly negative or hazardous.

(J) **"Environment moderate risk"** means client's UCAT Environment score is 15 which indicates in the UCAT assessor's clinical judgment, many aspects of the physical environment are substandard or hazardous.

(K) **"Health Assessment high risk"** means client's UCAT health assessment score is 25 which indicates in the UCAT assessor's clinical judgment, the client has one or more chronic health conditions, whose symptoms are rapidly

deteriorating, uncontrolled, or not well controlled and requiring a high frequency or intensity of medical care/oversight to bring under control and whose functional capacity is so limited as to require full time assistance or care performed daily, by, or under the supervision of professional personnel and has multiple unmet needs for services available only through the ADvantage program or a Nursing Facility (NF) and requires NF placement immediately if these needs cannot be met by other means.

(L) **"Health Assessment low risk"** means client's health assessment score is 5 which indicates, in the UCAT assessor's clinical judgment, the client has one or more chronic, stable, health conditions, whose symptoms are controlled or nearly controlled, which benefit from available, or usually available, medical treatment or corrective measures, and may have an unmet need for a service available only through the ADvantage program or a Nursing Facility (NF) but is not likely to enter a NF if these needs are not met.

(M) **"Health Assessment moderate risk"** means client's UCAT Health Assessment score is 15 which indicates in the UCAT assessor's clinical judgment, the client has one or more chronic changing health conditions, whose symptoms are fragile or worsening and require medical care/oversight, to bring under control or to maintain in a stable, controlled state and has multiple unmet needs for services available only through the ADvantage program or a Nursing Facility (NF) and is likely to enter a NF if these needs are not met.

(N) **"IADL"** means the instrumental activities of daily living.

(O) **"IADLs score in high risk range"** means client's total weighted UCAT IADL score is 12 or more which indicates the client needs some help with 6 IADLs or cannot do 4 IADLs at all.

(P) **"Instrumental activities of daily living"** means those activities that reflect the client's ability to perform household chores and tasks within the community essential for sustaining health and safety such as:

(i) shopping,
(ii) cooking,
(iii) cleaning,
(iv) managing money,
(v) using a telephone,
(vi) doing laundry,
(vii) taking medication, and

(viii) accessing transportation.

(Q) ~~**"Mental Retardation"**~~ **"Intellectual Disability"** means that the person has, as determined by a PASRR level II evaluation, substantial limitations in functional ability due to significantly sub-average intellectual functioning related to an event occurring before the age of 18.

(R) **"MSQ"** means the mental status questionnaire.

(S) **"MSQ score in high risk range"** means the client's total weighted UCAT MSQ score is 12 or more which indicates a severe orientation-memory-concentration impairment, or a severe memory impairment.

(T) **"MSQ score at the high end of the moderate risk range"** means the client's total weighted UCAT MSQ score is (10) or (11) which indicates an orientation-memory-concentration impairment, or a significant memory impairment.

(U) **"Nutrition high risk"** means a total weighted UCAT Nutrition score is 12 or more which indicates the client has significant eating difficulties combined with poor appetite, weight loss, and/or special diet requirements.

(V) **"Progressive degenerative disease process that responds to treatment"** means a process such as, but not limited to, Multiple Sclerosis (MS), Parkinson's Disease, Human Immunodeficiency Virus (HIV), or Acquired Immunodeficiency Syndrome (AIDS), that, untreated, systematically impairs normal body function which leads to acute illness and/or disability but that reacts positively to a medically prescribed treatment intervention (usually medication) which arrests or significantly delays the destructive action of the process.

(W) **"Social Resources high risk"** means a total weighted UCAT Social Resources score is 15 or more, which indicates the client lives alone, combined with none or very few social contacts and no supports in times of need.

(2) **Minimum UCAT criteria.** The minimum UCAT criteria for NF level of care criteria are:

(A) The UCAT documents need for assistance to sustain health and safety as demonstrated by:

(i) either the ADLs or MSQ score is in the high risk range; or

(ii) any combination of two or more of the following:

(I) ADLs score is at the high end of moderate risk range; or,

(II) MSQ score is at the high end of moderate risk range; or,

(III) IADLs score is in the high risk range; or,
(IV) Nutrition score is in the high risk range; or,
(V) Health Assessment is in the moderate risk range, and, in addition;

(B) The UCAT documents absence of support or adequate environment to meet the needs to sustain health and safety as demonstrated by:

(i) Client Support is moderate risk; or,
(ii) Environment is high risk; or,
(iii) Environment is moderate risk and Social Resources is in the high risk range; or, regardless of whether criteria under (A) of need and (B) of absence of support are met;

(C) The UCAT documents that:

(i) the client has a clinically documented progressive degenerative disease process that will produce health deterioration to an extent that the person will meet OAC 317:35-17-2(2)(A) criteria if untreated; and
(ii) the client previously has required Hospital or NF level of care services for treatment related to the condition; and
(iii) a medically prescribed treatment regimen exists that will significantly arrest or delay the disease process; and
(iv) only by means of ADvantage Program eligibility will the individual have access to the required treatment regimen to arrest or delay the disease process.

(3) **NF Level of Care Services.** To be eligible for NF level of care services, meeting the minimum UCAT criteria demonstrates the individual must:

(A) require a treatment plan involving the planning and administration of services that require the skills of licensed or otherwise certified technical or professional personnel, and are provided directly or under the supervision of such personnel;
(B) have a physical impairment or combination of physical, mental and/or functional impairments;
(C) require professional nursing supervision (medication, hygiene and/or dietary assistance);
(D) lack the ability to adequately and appropriately care for self or communicate needs to others;
(E) require medical care and treatment in order to minimize physical health regression or deterioration;
(F) require care that is not available through family and friends, Medicare, Veterans Administration, or other

federal entitlement program with the exception of Indian Health Services; and

(G) require care that cannot be met through Medicaid State Plan Services, including Personal Care, if financially eligible.

317:35-17-3. ADvantage program services

(a) The ADvantage program is a Medicaid Home and Community Based Waiver used to finance non-institutional long-term care services for elderly and a targeted group of physically disabled adults when there is a reasonable expectation that within a 30 day period, the person's health, due to disease process or disability, would, without appropriate services, deteriorate and require nursing facility care to arrest the deterioration. ADvantage program members must be SoonerCare eligible and must not reside in an institution, room and board, licensed residential care facility, or licensed assisted living facility, unless the facility is an ADvantage Assisted Living Center. The number of individuals who may receive ADvantage services is limited.

(1) To receive ADvantage services, individuals must meet one of the following categories:

(A) be age 65 years or older, or

(B) be age 21 or older if physically disabled and not developmentally disabled or if the person has a clinically documented, progressive degenerative disease process that responds to treatment and previously has required hospital or nursing facility (NF) level of care services for treatment related to the condition and requires ADvantage services to maintain the treatment regimen to prevent health deterioration, or

(C) if developmentally disabled and between the ages of 21 and 65, not have ~~mental retardation~~ an intellectual disability or a cognitive impairment related to the developmental disability.

(2) In addition, the individual must meet the following criteria:

(A) require nursing facility level of care [see OAC 317:35-17-2];

(B) meet service eligibility criteria [see OAC 317:35-17-3(d)]; and

(C) meet program eligibility criteria [see OAC 317:35-17-3(e)].

(b) Home and Community Based Waiver Services are outside the scope of Medicaid State Plan services. The Medicaid waiver allows the OHCA to offer certain Home and Community Based services to an annually capped number of persons who are

categorically needy (refer to OKDHS form 08AX001E (Appendix C-1), Schedule VIII. B. 1.) and without such services would be institutionalized. The estimated cost of providing an individual's care outside the nursing facility cannot exceed the annual cost of caring for that individual in a nursing facility. When determining the ADvantage service plan cost cap for an individual, the comparable SoonerCare cost to serve that individual in a nursing facility is estimated. If the individual has Acquired Immune Deficiency Syndrome (AIDS) or if the individual requires ventilator care, the appropriate SoonerCare enhanced nursing facility rate to serve the individual is used to estimate the ADvantage cost cap.

(c) Services provided through the ADvantage waiver are:

(1) case management;
(2) respite;
(3) adult day health care;
(4) environmental modifications;
(5) specialized medical equipment and supplies;
(6) physical therapy/occupational therapy/respiratory therapy/speech therapy or consultation;
(7) advanced supportive/restorative assistance;
(8) skilled nursing;
(9) home delivered meals;
(10) hospice care;
(11) medically necessary prescription drugs within the limits of the waiver;
(12) personal care (state plan) or ADvantage personal care;
(13) Personal Emergency Response System (PERS);
(14) Consumer-Directed Personal Assistance Services and Supports (CD-PASS);
(15) Institution Transition Services;
(16) assisted living; and
(17) SoonerCare medical services for individuals age 21 and over within the scope of the State Plan.

(d) The OKDHS area nurse or nurse designee makes a determination of service eligibility prior to evaluating the UCAT assessment for nursing facility level of care. The following criteria are used to make the service eligibility determination:

(1) an open ADvantage Program waiver slot, as authorized by the waiver document approved by the Centers for Medicare and Medicaid Services (CMS), is available to assure federal participation in payment for services to the individual. If the OKDHS/ASD determines all ADvantage waiver slots are filled, the individual cannot be certified on the OKDHS computer system as eligible for ADvantage services and the individual's name is placed on a waiting list for entry as

an open slot becomes available. ADvantage waiver slots and corresponding waiting lists, if necessary, are maintained for persons that have a developmental disability and those that do not have a developmental disability.

(2) the individual is in the ADvantage targeted service group. The target group is an individual who is frail and 65 years of age or older or age 21 or older with a physical disability and who does not have ~~mental retardation~~ an intellectual disability or a cognitive impairment.

(3) the individual does not pose a physical threat to self or others as supported by professional documentation.

(4) members of the household or persons who routinely visit the household, as supported by professional documentation, do not pose a threat of harm or injury to the individual or other household visitors.

(e) The OKDHS/ASD determines ADvantage program eligibility through the service plan approval process. The following criteria are used to make the ADvantage program eligibility determination that an individual is not eligible:

(1) if the individual's needs as identified by UCAT and other professional assessments cannot be met through ADvantage program services, Medicaid State Plan services and other formal or informal services. The State, as part of the waiver program approval authorization, assures CMS that each waiver individual's health, safety, or welfare can be maintained in their home. If a member's identified needs cannot be met through provision of ADvantage program or Medicaid State Plan
services and other formal or informal services are not in place or immediately available to meet those needs, the individual's health, safety or welfare in their home cannot be assured.

(2) if the individual poses a physical threat to self or others as supported by professional documentation.

(3) if other members of the household or persons who routinely visit the household who, as supported by professional documentation, pose a threat of harm or injury to the individual or other household visitors.

(4) if the individual's needs are being met, or do not require ADvantage services to be met, or if the individual would not require institutionalization if needs are not met.

(5) if, after the service and care plan is developed, the risk to individual's health and safety is not acceptable to the individual, or to the interdisciplinary service plan team, or to the OKDHS/ASD.

(f) The case manager provides the OKDHS/ASD with professional documentation to support the recommendation for redetermination

of program eligibility. The service providers continue providing services according to the service plan as provider safety permits until the individual is removed from the ADvantage program. As a part of the procedures requesting redetermination of program eligibility, the OKDHS/ASD will provide technical assistance to the Provider for transitioning the individual to other services.
(g) Individuals determined ineligible for ADvantage program services are notified in writing by OKDHS of the determination and of their right to appeal the decision.

SUBCHAPTER 19. NURSING FACILITY SERVICES

317:35-19-3. Services in a Nursing Facility (NF)

(a) Nursing facility services are those services furnished pursuant to a physician's orders which require the skills of technical or professional personnel, e.g., registered nurses, licensed practical nurses, physical therapists, occupational therapists, speech pathologists or audiologists. The care is provided by nursing facilities licensed under state law to provide, on a regular basis, health related care and services to individuals who do not require hospitalization but whose physical or mental condition requires care and services above the level of room and board which can be made available to them only through a nursing facility. To be eligible for nursing facility services, the UCAT demonstrates the individual must:

(1) require a treatment plan involving the planning and administration of services which require skills of licensed technical or professional personnel that are provided directly or under the supervision of such personnel and are prescribed by the physician;

(2) have a physical impairment or combination of physical and mental impairments;

(3) require professional nursing supervision (medication, hygiene and dietary assistance);

(4) lack the ability to care for self or communicate needs to others; and

(5) require medical care and treatment in a nursing facility to minimize physical health regression and deterioration. A physician’s order and results from a standardized assessment which evaluates type and degree of disability and need for treatment must support the individual’s need for NF level of care. Only standardized assessments approved by the OHCA and administered in accordance with Medicaid approved procedures shall be used to make the NF level of care determination.

(b) If the individual experiences mental illness or ~~mental retardation~~ an intellectual disability or a related condition, payment cannot be made for services in a nursing facility unless the individual has been assessed through the PASRR process and the appropriate MR or MI authority has determined that nursing facility services are required. If it is determined that the client also requires specialized services, the state must provide or arrange for the provision of such services. These determinations must be made prior to the patient's admission to the nursing facility. Payment cannot be made for an individual who is in imminent danger of harm to self or others.
(c) Payment is made to licensed nursing facilities that have agreements with the OHCA.
(d) Nursing facility clients are eligible for ADvantage waiver services and must be informed by the LTC nurse of the ADvantage waiver and given the option to apply for ADvantage services.

317:35-19-8. Pre-admission screening and resident review
(a) Federal Regulations govern the State's responsibility for Preadmission Screening and Resident Review (PASRR) of individuals with mental illness and ~~mental retardation~~ intellectual disabilities. PASRR applies to the screening or reviewing of all individuals for mental illness or ~~mental retardation~~ intellectual disability or related conditions who apply to or reside in Medicaid certified nursing facilities regardless of the source of payment for the nursing facility services and regardless of the individual's or resident's known diagnoses. The NF must independently evaluate the Level I PASRR Screen regardless of who completes the form and determine whether or not to admit an individual to the facility. If an individual is admitted to the NF inappropriately, the NF is subject to recoupment of Medicaid funds and penalties imposed by CMS. Federal financial participation (FFP) may not be paid until results of any needed PASRR Level II evaluations are received. PASRR is a requirement for nursing facilities with dually certified (both Medicare and Medicaid) beds. There are no PASRR requirements for Medicare skilled beds that are not dually certified, nor is PASRR required for individuals seeking residency in an intermediate care facility for the mentally retarded (ICF/MR).
(b) For Medicaid applicants, medical and financial eligibility determinations are also required.

317:35-19-9. PASRR screening process
(a) **Level I screen for PASRR.**

(1) OHCA Form LTC-300R, Nursing Facility Level of Care Assessment, must be completed by an authorized NF official or designee. An authorized NF official or designee must consist of one of the following:

(A) The nursing facility administrator or co-administrator;

(B) A licensed nurse, social service director, or social worker from the nursing facility; or

(C) A licensed nurse, social service director, or social worker from the hospital.

(2) Prior to admission, the authorized NF official must evaluate the properly completed OHCA Form LTC-300R and the Minimum Data Set (MDS), if available, as well as all other readily available medical and social information, to determine if there currently exists any indication of mental illness (MI), ~~mental retardation (MR)~~ intellectual disability (ID), or other related condition, or if such condition existed in the applicant's past history. Form LTC-300R constitutes the Level I PASRR Screen and is utilized in determining whether or not a Level II is necessary prior to allowing the patient to be admitted.

(3) The nursing facility is responsible for determining from the evaluation whether or not the patient can be admitted to the facility. A "yes" response to any question from Form LTC-300R, Section E, will require the nursing facility to contact the Level of Care Evaluation Unit (LOCEU) for a consultation to determine if a Level II assessment is needed. The NF is also responsible for consulting with the LOCEU regarding any ~~MI/MR~~ MI/ID /related condition information that becomes known either from completion of the MDS or throughout the resident's stay. The original Form LTC-300R must be submitted to the LOCEU by mail within 10 days of the resident's admission. SoonerCare payment may not be made for a resident whose LTC-300R requirements have not been satisfied in a timely manner.

(4) Upon receipt and review of the PASRR eligibility information packet, the LOCEU may, in coordination with the Oklahoma Department of Human Services (OKHDS) area nurse, re-evaluate whether a Level II PASRR assessment may be required. If a Level II assessment is not required, as determined by the LOCEU, the area nurse, or nurse designee, documents this and continues with the process of determining medical eligibility. If a Level II is required, a medical decision is not made until the area nurse is notified of the outcome of the Level II assessment. The results of the Level II assessment are considered in the medical eligibility decision. The area nurse, or nurse designee,

makes the medical eligibility decision within ten working days of receipt of the medical information when a Level II assessment is not required. If a Level II assessment is required, the area nurse makes the decision within five working days if appropriate.

(b) **Pre-admission Level II assessment for PASRR.** The authorized official is responsible for consulting with the OHCA LOCEU in determining whether a Level II assessment is necessary. The decision for Level II assessment is made by the LOCEU.

(1) Any one of the following three circumstances will allow a patient to enter the nursing facility without being subjected to a Level II PASRR assessment:

(A) The patient has no current indication of mental illness or ~~mental retardation~~ an intellectual disability or other related condition and there is no history of such condition in the patient's past;

(B) The patient does not have a diagnosis of ~~mental retardation~~ an intellectual disability or related condition; or

(C) The patient has indications of mental illness or ~~mental retardation~~ an intellectual disability or other related condition, but is not a danger to self and/or others, and is being released from an acute care hospital as part of a medically prescribed period of recovery (Exempted Hospital Discharge). If an individual is admitted to an NF based on Exempted Hospital Discharge, it is the responsibility of the NF to ensure that the individual is either discharged by the 30th day or that a Level II has been requested and is in process. Exempted Hospital Discharge is allowed only if all of the following three conditions are met:

(i) The individual must be admitted to the NF directly from a hospital after receiving acute inpatient care at the hospital (not including psychiatric facilities);

(ii) The individual must require NF services for the condition for which he/she received care in the hospital; and

(iii) The attending physician must certify before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. The nursing facility will be required to furnish documentation to the OHCA upon request.

(2) If the patient has current indications of mental illness or ~~mental retardation~~ an intellectual disability or other

related condition, or if there is a history of such condition in the patient's past, the patient cannot be admitted to the nursing facility until the LOCEU is contacted to determine if a Level II PASRR assessment must be performed. Results of any Level II PASRR assessment ordered must indicate that nursing facility care is appropriate prior to allowing the patient to be admitted.

(3) The OHCA Level of Care Evaluation Unit authorizes Advance Group Determinations for the MI and MR Authorities in the categories listed in the following categories listed in (A) through (C) of this paragraph. Preliminary screening by the LOCEU should indicate eligibility for nursing facility level of care prior to consideration of the provisional admission.

(A) **Provisional admission in cases of delirium.** Any person with mental illness, ~~mental retardation~~ an intellectual disability or related condition who is not a danger to self and/or others, may be admitted to a Medicaid certified NF if the individual is experiencing a condition that precludes screening, i.e., effects of anesthesia, medication, unfamiliar environment, severity of illness, or electrolyte imbalance.

(i) A Level II evaluation is completed immediately after the delirium clears. LOCEU must be provided with written documentation by a physician that supports the individual's condition which allows provisional admission as defined in (i) of this subparagraph.

(ii) Payment for NF services will not be made after the provisional admission ending date. If an individual is determined to need a longer stay, the individual must receive a Level II evaluation before continuation of the stay may be permitted and payment made for days beyond the ending date.

(B) **Provisional admission in emergency situations.** Any person with a mental illness, ~~mental retardation~~ an intellectual disability or related condition, who is not a danger to self and/or others, may be admitted to a Medicaid certified nursing facility for a period not to exceed seven days pending further assessment in emergency situations requiring protective services. The request for Level II evaluation must be made immediately upon admission to the NF if a longer stay is anticipated. LOCEU must be provided with written documentation from Adult Protective Services or the nursing facility which supports the individual's emergency admission. Payment

for NF services will not be made beyond the emergency admission ending date.

(C) **Respite care admission.** Any person with mental illness, ~~mental retardation~~ an intellectual disability or related condition, who is not a danger to self and/or others, may be admitted to a Medicaid certified nursing facility to provide respite to in-home caregivers to whom the individual is expected to return following the brief NF stay. Respite care may be granted up to 15 consecutive days per stay, not to exceed 30 days per calendar year.

(i) In rare instances, such as illness of the caregiver, an exception may be granted to allow 30 consecutive days of respite care. However, in no instance can respite care exceed 30 days per calendar year.

(ii) Respite care must be approved by LOCEU staff prior to the individual's admission to the NF. The NF provides the LOCEU with written documentation concerning circumstances surrounding the need for respite care, the date the individual wishes to be admitted to the facility, and the date the individual is expected to return to the caregiver. Payment for NF services will not be made after the respite care ending date.

(c) **PASRR Level II resident review.** The resident review is used primarily as a follow-up to the pre-admission assessment.

(1) The nursing facility's routine resident assessment will identify those individuals previously undiagnosed as ~~MR~~ intellectually disabled or MI. A new condition of ~~MR~~ intellectual disabilities or MI must be referred to LOCEU by the NF for determination of the need for the Level II. The facility's failure to refer such individuals for a Level II assessment may result in recoupment of funds and/or penalties from CMS.

(2) A Level II resident review may be conducted the following year for each resident of a nursing facility who was found to experience a serious mental illness with no primary diagnosis of dementia on his or her pre-admission Level II to determine whether, because of the resident's physical and mental condition, the resident requires specialized services.

(3) A Level II resident review may be conducted for each resident of a nursing facility who has mental illness or ~~mental retardation~~ an intellectual disability or other related condition when there is a significant change in the resident's mental condition. If such a change should occur

in a resident's condition, it is the responsibility of the nursing facility to have a consultation with the LOCEU concerning the need to conduct a resident review.

(4) Individuals who were determined to have a serious mental illness (as defined by CMS) on their last PASRR Level II evaluation will receive a resident review at least within one year of the previous evaluation.

(d) **Results of pre-admission Level II assessment and Resident Review.** Through contractual arrangements between the Oklahoma Health Care Authority and the Mental Illness/Mental Retardation Authorities/Community Mental Health Centers, individualized assessments are conducted and findings presented in written evaluative reports. The reports recommend if nursing facility services are needed, if specialized services or less than specialized services are needed, and if the individual meets the federal PASRR definition of mental illness or ~~mental retardation~~ intellectual disability or related conditions. Evaluative reports are delivered to the OHCA's LOCEU within federal regulatory and state contractual timelines to allow the LOCEU to process formal, written notification to patient, guardian, NF and significant others.

(e) **Evaluation of pre-admission Level II or Resident Review assessment to determine Medicaid medical eligibility for long term care.** The determination of medical eligibility for care in a nursing facility is made by the area nurse (or nurse designee) unless the individual has ~~mental retardation~~ an intellectual disability or related condition or a serious mental illness (as defined by CMS). The procedures for obtaining and submitting information required for a decision are outlined in this subsection. When an active long term care patient enters the facility and nursing care is being requested:

(1) The pre-admission screening process must be performed and must allow the patient to be admitted.

(2) The facility will notify the local county office by the OKDHS Form 08MA083E, Notification Regarding Patient in a Nursing Facility, Intermediate Care Facility for the Mentally Retarded or Hospice and Form 08MA084E, Management of Recipient's Funds, of the member’s admission.

(3) The local county office will send the NF the OKDHS Form 08MA038E, Notice Regarding Financial Eligibility, indicating actions that are needed or have been taken regarding the member.

SUBCHAPTER 23. LIVING CHOICE PROGRAM

317:35-23-2. Eligibility criteria

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

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

(2) He/she must reside in an institution (nursing facility or public ICF/MR) for at least 90 consecutive days prior to the proposed transition date. If any portion of the 90 days includes time in a skilled nursing facility, those days cannot be counted toward the 90 day requirement, if the member received Medicare post-hospital extended care rehabilitative services.

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

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

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

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

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

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

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

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

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 40. DEVELOPMENTAL DISABILITIES SERVICES
SUBCHAPTER 1. GENERAL PROVISIONS

317:40-1-1. Home and Community-Based Services (HCBS) Waivers for persons with intellectual disabilities ~~(mental retardation)~~ or certain persons with related conditions

(a) **Applicability.** The rules in this Section apply to services funded through Medicaid HCBS Waivers per OAC 317:35-9-5 and as defined in Section 1915(c) of the Social Security Act. The specific waivers are the In-Home Supports Waiver (IHSW) for

Adults, the In-Home Supports Waiver (IHSW) for Children, the Community Waiver, and the Homeward Bound Waiver.

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

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

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

(3) choosing between services provided through a HCBS Waiver and institutional care.

(c) **Waiver Eligibility.** To be eligible for Waiver services, an applicant must meet the criteria established in paragraph (1) of this Subsection and the criteria for one of the Waivers established in Subparagraph (A), (B), or (C) of this Subsection.

(1) Services provided through a HCBS Waiver are available to Oklahoma residents meeting SoonerCare eligibility requirements established by law, regulatory authority, and policy within funding available through State or Federal resources. To be eligible for and receive services funded through any of the Waivers listed in subsection (a) of this Section, a person must meet conditions per OAC 317:35-9-5. The individual must be determined financially eligible for SoonerCare per OAC 317:35-9-68. The SoonerCare eligible individual may not simultaneously be enrolled in any other Medicaid Waiver program or receiving services in an institution including a hospital, rehabilitation facility, mental health facility, nursing facility, residential care facility as described in Section 1-819 of Title 63 of Oklahoma Statutes, or Intermediate Care facility for persons with mental retardation (ICF/MR). The individual may not be receiving DDSD state-funded services such as the Family Support Assistance Payment, Respite Voucher Program, sheltered workshop services, community integrated employment services, or assisted living without waiver supports per OAC 340:100-5-22.2. The individual must also meet other Waiver-specific eligibility criteria.

(A) **In-Home Supports Waivers.** To be eligible for services funded through the In-Home Supports Waiver (IHSW), a person must:

(i) meet all criteria given in subsection (c) of this Section; and

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

(iii) be determined to have a disability, and a diagnosis of intellectual disability ~~(mental retardation)~~ as defined in the Diagnostic and Statistical Manual of Mental Disorders by the OHCA Level of Care Evaluation Unit (LOCEU);

(iv) be three years of age or older;

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

(vi) reside in:

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

(II) his or her own home;

(III) an OKDHS Children and Family Services Division (CFSD) foster home; or

(IV) a CFSD group home; and

(vii) have critical support needs that can be met through a combination of non-paid, non-Waiver, and SoonerCare resources available to the individual, and with HCBS Waiver resources that are within the annual per capita Waiver limit agreed between the State of Oklahoma and the Centers for Medicare and Medicaid Services (CMS).

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

(i) meet all criteria given in subsection (c) of this Section;

(ii) be determined to have a disability and a diagnosis of intellectual disability ~~(mental retardation)~~ by the SSA; or

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

(iv) be determined to have a disability and a diagnosis of intellectual disability ~~(mental retardation)~~ as defined in the Diagnostic and Statistical Manual of Mental Disorders or the OHCA/LOCEU; and

(v) be three years of age or older; and

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

(vii) have critical support needs that can be met by the Community Waiver and cannot be met by IHSW services or other service alternatives, as determined by the DDSD Division Director or designee.

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

(i) be certified by the United States District Court for the Northern District of Oklahoma as a member of the plaintiff class in *Homeward Bound et al. v. The Hissom Memorial Center*, Case No. 85-C-437-E;

(ii) meet all criteria for HCBS Waiver services given in subsection (c) of this Section; and

(iii) be determined to have a disability and a diagnosis of intellectual disability ~~(mental retardation)~~ by SSA; or

(iv) have an intellectual disability ~~(mental retardation)~~ as defined in the Diagnostic and Statistical Manual o Mental Disorders or a related condition per OAC 317:35-9-45 by DDSD and to be covered under the State's alternative disposition plan adopted under Section 1919(e)(7)(E) of the Social Security Act; or

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

(vi) meet the ICF/MR Institutional Level of Care requirements per OAC 317:30-5-122 by the OHCA/LOCEU.

(2) The person desiring services through any of the Waivers listed in subsection (a) of this Section participates in diagnostic evaluations and provides information necessary to determine HCBS Waiver services eligibility, including:

(A) a psychological evaluation, by a licensed Psychologist or State staff supervised by a licensed Psychologist, current within 12 months of requested approval date, that includes:

(i) a full scale functional and/or adaptive assessment; and

(ii) a statement of age of onset of the disability; and

(iii) intelligence testing that yields a full scale intelligence quotient.

(B) a social service summary, current within 12 months of requested approval date, that includes a developmental history; and

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

(D) a completed ICF/MR Level of Care Assessment form (LTC-300); and

(E) proof of disability according to SSA guidelines. If a disability determination had not been made by SSA, the OHCA/LOCEU may make a disability determination using the same guidelines as SSA.

(3) The OHCA reviews the diagnostic reports listed in paragraph (2) of this subsection and makes a determination of eligibility for DDSD HCBS Waivers.

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

(5) A determination of need for ICF/MR Institutional Level of Care does not limit the opportunities of the person receiving services to participate in community services. Individuals are assured of the opportunity to exercise informed choice in the selection of services.

(d) **Request list.** When State DDSD resources are unavailable for new persons to be added to services funded through a HCBS Waiver, persons are placed on a statewide Request for Waiver Services List.

(1) The Request for Waiver Services List is maintained in chronological order based on the date of receipt of a written request for services.

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

(3) An individual is removed from the Request for Waiver Services List if the individual:

(A) is found to be ineligible for services;

(B) cannot be located by OKDHS;

(C) does not provide required information to OKDHS;

(D) is not a resident of the state of Oklahoma at the time of requested Waiver approval date; or

(E) declines an offer of Waiver services

(e) **Applications.** When resources are sufficient for initiation of HCBS Waiver services, DDSD ensures action regarding a

request for services occurs within 45 days. If action is not taken within the required 45 days, the applicant may seek resolution as described in OAC 340:2-5.

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

(2) If requested information is not provided within 60 days, the applicant is notified that the request has been denied, and the individual is removed from the Request for Waiver Services List.

(f) **Admission protocol.** Initiation of services funded through a HCBS Waiver occurs in chronological order from the Request for Waiver Services List in accordance with subsection (d) of this Section based on the date of DDSD receipt of a completed request for services, as a result of the informed choice of the person requesting services or his or her legal guardian, and upon determination of eligibility, in accordance with subsection (c) of this Section. Exceptions to the chronological requirement may be made when:

(1) an emergency situation exists in which the health or safety of the person needing services, or of others, is endangered, and there is no other resolution to the emergency. An emergency exists when:

(A) the person is unable to care for himself or herself and:

(i) the person's caretaker, as defined in Section 10-103 of Title 43A of the Oklahoma Statutes:

(I) is hospitalized;

(II) has moved into a nursing facility;

(III) is permanently incapacitated; or

(IV) has died; and

(ii) there is no caretaker to provide needed care to the individual; or

(iii) an eligible person is living at a homeless shelter or on the street;

(B) the OKDHS finds that the person needs protective services due to experiencing ongoing physical, sexual, or emotional abuse or neglect in his or her present living situation, resulting in serious jeopardy to the person's health or safety;

(C) the behavior or condition of the person needing services is such that others in the home are at risk of being seriously harmed by the person. For example, the person is routinely physically assaultive to the caretaker or others living in the home and sufficient supervision cannot be provided to ensure the safety of those in the home or community; or

(D) the person's medical, psychiatric, or behavioral challenges are such that the person is seriously injuring or harming himself or herself, or is in imminent danger of doing so.

(2) the Legislature has appropriated special funds with which to serve a specific group or a specific class of individuals under the provisions of a HCBS Waiver;

(3) Waiver services are required for people who transition to the community from a public or ICF/MR who are children in the State's custody receiving services from OKDHS. Under some circumstances Waiver services related to accessibility may be authorized in advance of transition, but may not be billed until the day the member leaves the ICF/MR and enters the Waiver;

(4) individuals subject to the provisions of Public Law 100-203 residing in nursing facilities for at least 30 continuous months prior to January 1, 1989,and who are determined by Preadmission Screening and Resident Review (PASRR) evaluation conducted pursuant to the provisions of 42 CFR 483.100 et seq to have intellectual disability ~~(mental retardation)~~ or a related condition, who are covered under the State's alternative disposition plan adopted under Section 1919(e)(7)(E) of the Social Security Act, choose to receive services funded through the Community or Homeward Bound Waiver.

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

(1) When a member receiving services funded through the IHSW for children becomes 18 years of age, services through the IHSW for adults become effective.

(2) Change to services funded through the Community Waiver from services funded through the IHSW occurs only when:

(A) a member has critical support needs that cannot be met by IHSW services, non-Waiver services, or other resources as determined by the DDSD Director or designee; and

(B) funding is available per OAC 317:35-9-5..

(3) Change to services funded through the IHSW from services funded through the Community Waiver may only occur when a member's history of annual service utilization has been within the per capita allowance of the IHSW.

(4) When a member served through the Community Waiver has support needs that can be met within the per capita Waiver allowance of the applicable IHSW and through a combination

of non-Waiver resources, the individual may choose to receive services through the IHSW.

(h) **Continued eligibility for HCBS Waiver services.** Eligibility for members receiving services provided through the HCBS Waiver is re-determined by the OHCA/LOCEU when a determination of disability has not been made by the Social Security Administration. The OHCA/LOCEU determines categorical relationship to the SoonerCare disabled category according to Social Security Administration guidelines. OHCA/LOCEU also approves level of care per OAC 317:30-5-122 and confirms a diagnosis of intellectual disability ~~(mental retardation)~~ as defined in the Diagnostic and Statistical Manual of Mental Disorders. DDSD may require a new diagnostic evaluation in accordance with paragraph (c)(2) of this subsection and re-determination of eligibility at any time when a significant change of condition, disability, or psychological status determined under paragraph (c)(2) of this Section has been noted.

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

(1) when a member or the member's legal guardian chooses to no longer receive Waiver services;

(2) when a member is incarcerated;

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

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

(5) when a member is determined by the OHCA/LOCEU to no longer be eligible;

(6) when a member moves out of state, or the custodial parent or guardian of a member who is a minor moves out of state;

(7) when a member is admitted to a nursing facility, ICF/MR, residential care facility, hospital, rehabilitation facility, or mental health facility for more than 30 consecutive days;

(8) when the guardian of a member who is a minor or adjudicated adult fails to cooperate during the annual review process as described in OAC 340:100-5-50 through 340:100-5-58;

(9) when the guardian of a member who is a minor or adjudicated adult fails to cooperate in the implementation of OKDHS policy or service delivery in a manner that places the health or welfare of the member at risk, after efforts to remedy the situation through Adult Protective Services or Child Protective Services have not been effective;

(10) when the member is determined to no longer be SoonerCare eligible; or

(11) when there is sufficient evidence that the member or his/her legal representative has engaged in fraud or misrepresentation, failed to use resources as agreed on in the Individual Plan, or knowingly misused public funds associated with these services;

(12) when the member or his/her legal representative either cannot be located, has not responded to, or has not allowed case management to complete plan development or monitoring activities as required by policy and the member or his/her legal representative:

(A) does not respond to the notice of intent to terminate; or

(B) the response prohibits case management (the case manager) from being able to complete plan development or monitoring activities as required by policy;

(13) when the member or his/her legal representative fails to cooperate with the case manager to implement a Fair Hearing decision;

(14) when it is determined that services provided through a HCBS Waiver are no longer necessary to meet the member's needs and professional documentation provides assurance that the member's health, safety, and welfare can be maintained without Waiver supports;

(15) when the member or his/her legal representative fails to cooperate with service delivery;

(16) when a family member, authorized representative, other individual in the member's household or persons who routinely visit, pose a threat of harm or injury to provider staff or official representatives of OKDHS; or

(17) when a member no longer receives a minimum of one Waiver service per month and DDSD is unable to monitor member on a monthly basis.

(j) **Reinstatement of services.** Waiver services are reinstated when:

(1) the situation resulting in case closure of a Hissom class member is resolved;

(2) a member is incarcerated for 90 days or less;

(3) a member is admitted to a nursing facility, ICF/MR, residential care facility, hospital, rehabilitation facility, or mental health facility for 90 days or less; or

(4) a member's SoonerCare eligibility is re-established within 90 days of the date of SoonerCare ineligibility.

SUBCHAPTER 5. MEMEBER SERVICES
PART 11. OTHER COMMUNITY RESIDENTIAL SUPPORTS

317:40-5-152. Group home services for persons with ~~mental retardation~~ an intellectual disability or certain persons with related conditions

(a) **General Information.** Group homes provide a congregate living arrangement offering up to 24-hour per day supervision, supportive assistance, and training in daily living skills to persons who are eligible 18 years of age or older. Upon approval of the Oklahoma Department of Human Services (OKDHS) Developmental Disabilities Services Division (DDSD) director or designee, persons younger than 18 may be served.

(1) Group homes ensure members reside and participate in the community. Services are provided in homes located in close proximity to generic community services and activities.

(2) Group homes must be licensed by DDSD in accordance with Section 1430.1 et seq. of Title 10 of the Oklahoma Statutes.

(3) Residents of group homes receive no other form of residential supports.

(4) Habilitation training specialist (HTS) services or homemaker services for residents of group homes may be approved only by the DDSD director or designee to resolve a temporary emergency when no other resolution exists.

(b) **Minimum provider qualifications.** Approved providers must have a current contract with the Oklahoma Health Care Authority (OHCA) to provide DDSD Home and Community-Based Services (HCBS) Waiver for persons with ~~mental retardation~~ an intellectual disability or related conditions.

(1) Group home providers must have a completed and approved application to provide DDSD group home services.

(2) Group home staff must:

(A) complete the OKDHS DDSD-sanctioned training curriculum per OAC 340:100-3-38; and

(B) fulfill requirements for pre-employment screening per OAC 340:100-3-39.

(c) **Description of services.**

(1) Group home services:

(A) meet all applicable requirements of OAC 340:100; and

(B) are provided in accordance with each member's Individual Plan (IP) developed per OAC 340:100-5-50 through 340:100-5-58.

(i) Health care services are secured for each member per OAC 340:100-5-26.

(ii) Members are offered recreational and leisure activities maximizing the use of generic programs and resources, including individual and group activities.

(2) Group home providers:

(A) follow protective intervention practices per OAC 340:100-5-57 and 340:100-5-58;

(B) in addition to the documentation required per OAC 340:100-3-40, must maintain:

(i) staff time sheets that document the hours each staff was present and on duty in the group home; and

(ii) documentation of each member's presence or absence on the daily attendance form provided by DDSD; and

(C) ensure program coordination staff (PCS) meet staff qualifications and supervise, guide, and oversee all aspects of group home services per OAC 340:100-5-22.6 and 340:100-6, as applicable.

(d) **Coverage limitations.** Group home services are provided up to 366 days per year.

(e) **Types of group home services.** There are three types of group home services provided through HCBS Waivers.

(1) **Traditional group homes.** Traditional group homes serve no more than 12 members per OAC 340:100-6.

(2) **Community living homes.** Community living homes serve no more than 12 members.

(A) Members who receive community living home services have:

(i) needs that cannot be met in a less structured setting; and

(ii) a diagnosis of a severe or profound ~~mental retardation~~ intellectual disability requiring frequent assistance in the performance of activities necessary for daily living or continual supervision to ensure the member's health and safety; or

(iii) complex needs requiring frequent:

(I) assistance in the performance of activities necessary for daily living, such as frequent assistance of staff for positioning, bathing, or other necessary movement; or

(II) supervision and training in appropriate social and interactive skills in order to remain included in the community.

(B) Services offered in a community living home include:

(i) 24-hour awake supervision when a member's IP indicates it is necessary; and

(ii) program supervision and oversight including hands-on assistance in performing activities of daily living, transferring, positioning, skill-building, and training.

(3) **Alternative group homes.** Alternative group homes serve no more than four members who have evidence of behavioral or

emotional challenges in addition to ~~mental retardation~~ an intellectual disability and require extensive supervision and assistance in order to remain in the community.

(A) Members who receive alternative group home services must meet criteria per in OAC 340:100-5-22.6.

(B) A determination must be made by the DDSD Community Services Unit that alternative group home services are appropriate.

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

317:40-7-4. Services provided through Waiver Employment Services

(a) Employment Services are offered under the Medicaid Home and Community-Based Waiver for persons with ~~mental retardation~~ intellectual disabilities at rates prescribed by the Oklahoma Health Care Authority.

(b) Types of Waiver Employment Services offered include:

(1) Vocational Habilitation Training Specialist (VHTS), Supplemental Support;

(2) Employment Training Specialist (ETS);

(3) Center-Based Services;

(4) Community-Based Services;

(5) Enhanced Community-Based Services;

(6) Job Coaching;

(7) Enhanced Job Coaching; and

(8) Stabilization Services.

(c) State-funded services described in OAC 340:100-17-30 may supplement Employment Services funded through the Community Waiver.

CHAPTER 50. HOME AND COMMUNITY BASED SERVICES WAIVERS
SUBCHAPTER 1. MEDICALLY FRAGILE WAIVER SERVICES

317:50-1-2. Definitions

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

(1) **"ADL"** means the activities of daily living. Activities of daily living are activities that reflect the member's ability to perform self-care tasks essential for sustaining health and safety such as:

(A) bathing,

(B) eating,

(C) dressing,

(D) grooming,

(E) transferring (includes getting in and out of a tub, bed to chair, etc.),
(F) mobility,
(G) toileting, and
(H) bowel/bladder control.

(2) **"Cognitive Impairment"** means that the person, as determined by the clinical judgment of the LTC Nurse or the AA, does not have the capability to think, reason, remember or learn required for self-care, communicating needs, directing care givers and/or using appropriate judgment for maintenance of their own health or safety. The clinical judgment of cognitive impairment is based on MSQ performance in combination with a more general evaluation of cognitive function from interaction with the person during the UCAT assessment.

(3) **"Developmental Disability"** means a severe, chronic disability of an individual that:
(A) is attributable to a mental or physical impairment or combination of mental and physical impairments;
(B) is manifested before the individual attains age 22;
(C) is likely to continue indefinitely;
(D) results in substantial functional limitations in three or more of the following areas of major life activity:
(i) self-care;
(ii) receptive and expressive language;
(iii) learning;
(iv) mobility;
(v) self-direction;
(vi) capacity for independent living; and
(vii) economic self-sufficiency; and
(E) reflects the individual=s need for a combination and sequence of special, interdisciplinary, or generic services, supports, or other assistance that is of lifelong or extended duration and is individually planned and coordinated.

(4) **"IADL"** means the instrumental activities of daily living.

(5) **"Instrumental activities of daily living"** means those activities that reflect the member's ability to perform household chores and tasks within the community essential for sustaining health and safety such as:
(A) shopping,
(B) cooking,
(C) cleaning,
(D) managing money,
(E) using a telephone,

(F) doing laundry,
(G) taking medication, and
(H) accessing transportation.

(6) **" Level of Care Service**s." To be eligible for level of care services, meeting the minimum UCAT criteria established for SNF or hospital level of care demonstrates the individual must:

(A) require a treatment plan involving the planning and administration of services that require the skills of licensed or otherwise certified technical or professional personnel, and are provided directly or under the supervision of such personnel;

(B) have a physical impairment or combination of physical, mental and/or functional impairments;

(C) require professional nursing supervision (medication, hygiene and/or dietary assistance);

(D) lack the ability to adequately and appropriately care for self or communicate needs to others;

(E) require medical care and treatment in order to minimize physical health regression or deterioration;

(F) require care that is not available through family and friends, Medicare, Veterans Administration, or other federal entitlement program with the exception of Indian Health Services; and

(G) require care that cannot be met through Medicaid State Plan Services, including Personal Care, if financially eligible.

(7) ~~**"Mental Retardation"**~~ "Intellectual Disability" means that the person has, as determined by a PASRR level II evaluation, substantial limitations in functional ability due to significantly sub-average intellectual functioning related to an event occurring before the age of 18.

(8) **"MSQ"** means the mental status questionnaire.

(9) **"Progressive degenerative disease process that responds to treatment"** means a process such as, but not limited to, Multiple Sclerosis (MS), Parkinson's Disease, Human Immunodeficiency Virus (HIV), or Acquired Immunodeficiency Syndrome (AIDS), that, untreated, systematically impairs normal body function which leads to acute illness and/or disability but that reacts positively to a medically prescribed treatment intervention (usually medication) which arrests or significantly delays the destructive action of the process.

317:50-1-3. Medically Fragile Program overview

(a) The Medically Fragile Waiver program is a Medicaid Home and Community Based Services Waiver used to finance non-

institutional long-term care services for a targeted group of physically disabled adults when there is a reasonable expectation that the person's health, due to disease process or disability, would, without appropriate services, deteriorate and require skilled nursing facility or hospital level of care to arrest the deterioration. Medically Fragile Waiver program members must be SoonerCare eligible and must not reside in an institution, room and board licensed residential care facility, or licensed assisted living facility. The number of members who may receive Medically Fragile Waiver services is limited.

(1) To receive Medically Fragile Waiver services, individuals must meet the following criteria:

(A) be 19 years of age or older;

(B) have a chronic medical condition which results in prolonged dependency on medical care for which daily skilled intervention is necessary and is characterized by one or more of the following:

(i) a life threatening condition characterized by reasonably frequent periods of acute exacerbation which requires frequent medical supervision and/or physician consultation and which, in the absence of such supervision or consultation, would require hospitalization;

(ii) require frequent time consuming administration of specialized treatments which are medically necessary;

(iii) be dependent on medical technology such that without the technology, a reasonable level of health could not be maintained.

(2) In addition, the individual must meet the following criteria:

(A) meet service eligibility criteria [see OAC 317:50-1-3(d)]; and

(B) meet program eligibility criteria [see OAC 317:50-1-3(e)].

(b) Home and Community Based Waiver Services are outside the scope of state plan Medicaid services. The Medicaid waiver allows the OHCA to offer certain Home and Community Based services to an annually capped number of persons who are categorically needy (refer to OKDHS form 08AX001E, Schedule VIII. B. 1) and without such services would be institutionalized.

(c) Services provided through the Medically Fragile Waiver are:

(1) case management;

(2) respite;

(3) adult day health care;

(4) environmental modifications;

(5) specialized medical equipment and supplies;

(6) physical therapy, occupational therapy, respiratory therapy, speech therapy or consultation;
(7) advanced supportive/restorative assistance;
(8) skilled nursing;
(9) home delivered meals;
(10) hospice care;
(11) medically necessary prescription drugs within the limits of the waiver;
(12) personal care (state plan), Medically Fragile Waiver personal care;
(13) Personal Emergency Response System (PERS);
(14) Self Direction; and
(15) SoonerCare medical services within the scope of the State Plan.

(d) A service eligibility determination is made using the following criteria:

(1) an open Medically Fragile Waiver Program waiver slot, as authorized by the waiver document approved by the Centers for Medicare and Medicaid Services (CMS), is available to assure federal participation in payment for services to the member. If it is determined that all Medically Fragile Waiver slots are filled, the member cannot be certified as eligible for Medically Fragile Waiver services and the member's name is placed on a waiting list for entry as an open slot becomes available. Medically Fragile Waiver slots and corresponding waiting lists, if necessary, are maintained.

(2) the member is in the Medically Fragile Waiver targeted service group. The target group is an individual who is age 19 or older with a physical disability and may also have ~~mental retardation~~ an intellectual disability or a cognitive impairment.

(3) the individual does not pose a physical threat to self or others as supported by professional documentation.

(4) members of the household or persons who routinely visit the household, as supported by professional documentation, do not pose a threat of harm or injury to the individual or other household visitors.

(e) The Medically Fragile Waiver program eligibility determination is made through the service plan approval process. The following criteria are used to make the determination that an individual is not eligible:

(1) if the individual's needs as identified by UCAT and other professional assessments cannot be met through Medically Fragile Waiver program services, SoonerCare State Plan services and other formal or informal services. The State, as part of the waiver program approval authorization,

assures CMS that each waiver member's health, safety, or welfare can be maintained in their home. If an individual's identified needs cannot be met through provision of Medically Fragile Waiver program or SoonerCare State Plan services and other formal or informal services are not in place or immediately available to meet those needs, the individual's health, safety or welfare in their home cannot be assured.

(2) if the individual poses a physical threat to self or others as supported by professional documentation.

(3) if other members of the household or persons who routinely visit the household who, as supported by professional documentation, pose a threat of harm or injury to the individual or other household visitors.

(4) if the individual's needs are being met, or do not require Medically Fragile Waiver services to be met, or if the individual would not require institutionalization if needs are not met.

(5) if, after the service and care plan is developed, the risk to individual health and safety is not acceptable to the individual, or to the interdisciplinary service plan team, or to the OHCA.

(f) Professional documentation is provided to support the recommendation for redetermination of program eligibility. The service providers continue providing services according to the service plan as provider safety permits until the member is removed from the Medically Fragile Waiver program. As a part of the procedures requesting redetermination of program eligibility, the OHCA will provide technical assistance to the Provider for transitioning the member to other services.

(g) Individuals determined ineligible for Medically Fragile Waiver program services are notified in writing of the determination and of their right to appeal the decision.

SUBCHAPTER 3. MY LIFE, MY CHOICE

317:50-3-2. Definitions

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

"ADL" means the activities of daily living. Activities of daily living are activities that reflect the member's ability to perform self-care tasks essential for sustaining health and safety such as:

(A) bathing,

(B) eating,

(C) dressing,

(D) grooming,
(E) transferring (includes getting in and out of a tub, bed to chair, etc.),
(F) mobility,
(G) toileting, and
(H) bowel/bladder control.

"ADLs score in high risk range" means the member's total weighted UCAT ADL score is 10 or more which indicates the member needs some help with 5 ADLs or that the member cannot do 3 ADLs at all plus the member needs some help with 1 other ADL.

"ADLs score at the high end of the moderate risk range" means member's total weighted UCAT ADL score is 8 or 9 which indicates the member needs help with 4 ADLs or the member cannot do 3 ADLs at all.

"Cognitive Impairment" means that the person, as determined by the clinical judgment of the LTC Nurse does not have the capability to think, reason, remember or learn required for self-care, communicating needs, directing care givers and/or using appropriate judgment for maintenance of their own health or safety. The clinical judgment of cognitive impairment is based on MSQ performance in combination with a more general evaluation of cognitive function from interaction with the person during the UCAT assessment.

"Developmental Disability" means a severe, chronic disability of an individual that:

(A) is attributable to a mental or physical impairment or combination of mental and physical impairments;
(B) is manifested before the individual attains age 22;
(C) is likely to continue indefinitely;
(D) results in substantial functional limitations in three or more of the following areas of major life activity:
(E) self-care;
(F) receptive and expressive language;
(G) learning;
(H) mobility;
(I) self-direction;
(J) capacity for independent living;
(K) economic self-sufficiency; and
(L) reflects the individual=s need for a combination and sequence of special, interdisciplinary, or generic services, supports, or other assistance that is of lifelong or extended duration and is individually planned and coordinated.

"Environment high risk" means member's UCAT Environment score is 25 which indicates in the UCAT assessor's clinical

judgment, the physical environment is strongly negative or hazardous.

"Environment moderate risk" means member's UCAT Environment score is 15 which indicates in the UCAT assessor's clinical judgment, many aspects of the physical environment are substandard or hazardous.

"Health Assessment high risk" means member's UCAT health assessment score is 25 which indicates in the UCAT assessor's clinical judgment, the member has one or more chronic health conditions, whose symptoms are rapidly deteriorating, uncontrolled, or not well controlled and requiring a high frequency or intensity of medical care/oversight to bring under control and whose functional capacity is so limited as to require full time assistance or care performed daily, by, or under the supervision of professional personnel and has multiple unmet needs for services available only through the My Life, My Choice program or a Nursing Facility (NF) and requires NF placement immediately if these needs cannot be met by other means.

"Health Assessment low risk" means member's health assessment score is 5 which indicates, in the UCAT assessor's clinical judgment, the member has one or more chronic, stable, health conditions, whose symptoms are controlled or nearly controlled, which benefit from available, or usually available, medical treatment or corrective measures, and may have an unmet need for a service available only through the My Life, My Choice program or a Nursing Facility (NF) but is not likely to enter a NF if these needs are not met.

"Health Assessment moderate risk" means member's UCAT Health Assessment score is 15 which indicates in the UCAT assessor's clinical judgment, the member has one or more chronic changing health conditions, whose symptoms are fragile or worsening and require medical care/oversight, to bring under control or to maintain in a stable, controlled state and has multiple unmet needs for services available only through the My Life, My Choice program or a Nursing Facility (NF) and is likely to enter a NF if these needs are not met.

"IADL" means the instrumental activities of daily living.

"IADLs score in high risk range" means member's total weighted UCAT IADL score is 12 or more which indicates the member needs some help with 6 IADLs or cannot do 4 IADLs at all.

"Instrumental activities of daily living" means those activities that reflect the member's ability to perform

household chores and tasks within the community essential for sustaining health and safety such as:

(A) shopping,
(B) cooking,
(C) cleaning,
(D) managing money,
(E) using a telephone,
(F) doing laundry,
(G) taking medication, and
(H) accessing transportation.

"Member Support high risk" means member's UCAT Member Support score is 25 which indicates in the UCAT assessor's clinical judgment, excluding from consideration existing Ryan White CARE Act, Indian Health Service, Medicaid NF, My Life, My Choice and/or State Plan Personal Care services, very little or no support is available from informal and formal sources and the member requires additional care that is not available through Medicare, Veterans Administration, or other Federal entitlement programs.

"Member Support moderate risk" means member's UCAT Member Support score is 15 which indicates in the UCAT assessor's clinical judgment, excluding from consideration existing Ryan White CARE Act, Indian Health Service, Medicaid NF, My Life, My Choice and/or State Plan Personal Care services, support from informal and formal sources is available, but overall, it is inadequate, changing, fragile or otherwise problematic and the member requires additional care that is not available through Medicare, Veterans Administration, or other federal entitlement programs.

~~**"Mental Retardation"**~~ **"Intellectual Disability"** means that the person has, as determined by a PASRR level II evaluation, substantial limitations in functional ability due to significantly sub-average intellectual functioning related to an event occurring before the age of 18.

"MSQ" means the mental status questionnaire.

"MSQ score in high risk range" means the member's total weighted UCAT MSQ score is 12 or more which indicates a severe orientation-memory-concentration impairment, or a severe memory impairment.

"MSQ score at the high end of the moderate risk range" means the member's total weighted UCAT MSQ score is (10) or (11) which indicates an orientation-memory-concentration impairment, or a significant memory impairment.

"Nutrition high risk" means a total weighted UCAT Nutrition score is 12 or more which indicates the member has significant eating difficulties combined with poor appetite, weight loss, and/or special diet requirements.

"Progressive degenerative disease process that responds to treatment" means a process such as, but not limited to, Multiple Sclerosis (MS), Parkinson's Disease, Human Immunodeficiency Virus (HIV), or Acquired Immunodeficiency Syndrome (AIDS), that, untreated, systematically impairs normal body function which leads to acute illness and/or disability but that reacts positively to a medically prescribed treatment intervention (usually medication) which arrests or significantly delays the destructive action of the process.

"Social Resources high risk" means a total weighted UCAT Social Resources score is 15 or more, which indicates the member lives alone, combined with

in this subchapter, shall have the following meaning, unless the context clearly indicates otherwise:

"ADL" means the activities of daily living. Activities of daily living are activities that reflect the member's ability to perform self-care tasks essential for sustaining health and safety such as:

(A) bathing,

(B) eating,

(C) dressing,

(D) grooming,

(E) transferring (includes getting in and out of a tub, bed to chair, etc.), none or very few social contacts and no supports in times of need.

SUBCHAPTER 5. SOONER SENIORS

317:50-5-2. Definitions

The following words and terms when used

(F) mobility,

(G) toileting, and

(H) bowel/bladder control.

"ADLs score in high risk range" means the member's total weighted UCAT ADL score is 10 or more which indicates the member needs some help with 5 ADLs or that the member cannot do 3 ADLs at all plus the member needs some help with 1 other ADL.

"ADLs score at the high end of the moderate risk range" means member's total weighted UCAT ADL score is 8 or 9 which indicates the member needs help with 4 ADLs or the member cannot do 3 ADLs at all.

"Cognitive Impairment" means that the person, as determined by the clinical judgment of the LTC Nurse does not have the capability to think, reason, remember or learn required for self-care, communicating needs, directing care givers and/or

using appropriate judgment for maintenance of their own health or safety. The clinical judgment of cognitive impairment is based on MSQ performance in combination with a more general evaluation of cognitive function from interaction with the person during the UCAT assessment.

"Environment high risk" means member's UCAT Environment score is 25 which indicates in the UCAT assessor's clinical judgment, the physical environment is strongly negative or hazardous.

"Environment moderate risk" means member's UCAT Environment score is 15 which indicates in the UCAT assessor's clinical judgment, many aspects of the physical environment are substandard or hazardous.

"Health Assessment high risk" means member's UCAT health assessment score is 25 which indicates in the UCAT assessor's clinical judgment, the member has one or more chronic health conditions, whose symptoms are rapidly deteriorating, uncontrolled, or not well controlled and requiring a high frequency or intensity of medical care/oversight to bring under control and whose functional capacity is so limited as to require full time assistance or care performed daily, by, or under the supervision of professional personnel and has multiple unmet needs for services available only through the Sooner Seniors program or a Nursing Facility (NF) and requires NF placement immediately if these needs cannot be met by other means.

"Health Assessment low risk" means member's health assessment score is 5 which indicates, in the UCAT assessor's clinical judgment, the member has one or more chronic, stable, health conditions, whose symptoms are controlled or nearly controlled, which benefit from available, or usually available, medical treatment or corrective measures, and may have an unmet need for a service available only through the Sooner Seniors program or a Nursing Facility (NF) but is not likely to enter a NF if these needs are not met.

"Health Assessment moderate risk" means member's UCAT Health Assessment score is 15 which indicates in the UCAT assessor's clinical judgment, the member has one or more chronic changing health conditions, whose symptoms are fragile or worsening and require medical care/oversight, to bring under control or to maintain in a stable, controlled state and has multiple unmet needs for services available only through the Sooner Seniors program or a Nursing Facility (NF) and is likely to enter a NF if these needs are not met.

"IADL" means the instrumental activities of daily living.

"IADLs score in high risk range" means member's total weighted UCAT IADL score is 12 or more which indicates the member needs some help with 6 IADLs or cannot do 4 IADLs at all.

"Instrumental activities of daily living" means those activities that reflect the member's ability to perform household chores and tasks within the community essential for sustaining health and safety such as:

(A) shopping,
(B) cooking,
(C) cleaning,
(D) managing money,
(E) using a telephone,
(F) doing laundry,
(G) taking medication, and
(H) accessing transportation.

"Member Support high risk" means member's UCAT Member Support score is 25 which indicates in the UCAT assessor's clinical judgment, excluding from consideration existing Ryan White CARE Act, Indian Health Service, Medicaid NF, Sooner Seniors and/or State Plan Personal Care services, very little or no support is available from informal and formal sources and the member requires additional care that is not available through Medicare, Veterans Administration, or other Federal entitlement programs.

"Member Support moderate risk" means member's UCAT Member Support score is 15 which indicates in the UCAT assessor's clinical judgment, excluding from consideration existing Ryan White CARE Act, Indian Health Service, Medicaid NF, Sooner Seniors and/or State Plan Personal Care services, support from informal and formal sources is available, but overall, it is inadequate, changing, fragile or otherwise problematic and the member requires additional care that is not available through Medicare, Veterans Administration, or other federal entitlement programs.

~~**"Mental Retardation"**~~ **"Intellectual Disability"** means that the person has, as determined by a PASRR level II evaluation, substantial limitations in functional ability due to significantly sub-average intellectual functioning related to an event occurring before the age of 18.

"MSQ" means the mental status questionnaire.

"MSQ score in high risk range" means the member's total weighted UCAT MSQ score is 12 or more which indicates a severe orientation-memory-concentration impairment, or a severe memory impairment.

"MSQ score at the high end of the moderate risk range" means the member's total weighted UCAT MSQ score is (10) or (11)

which indicates an orientation-memory-concentration impairment, or a significant memory impairment.

"Nutrition high risk" means a total weighted UCAT Nutrition score is 12 or more which indicates the member has significant eating difficulties combined with poor appetite, weight loss, and/or special diet requirements.

"Progressive degenerative disease process that responds to treatment" means a process such as, but not limited to, Multiple Sclerosis (MS), Parkinson's Disease, Human Immunodeficiency Virus (HIV), or Acquired Immunodeficiency Syndrome (AIDS), that, untreated, systematically impairs normal body function which leads to acute illness and/or disability but that reacts positively to a medically prescribed treatment intervention (usually medication) which arrests or significantly delays the destructive action of the process.

"Social Resources high risk" means a total weighted UCAT Social Resources score is 15 or more, which indicates the member lives alone, combined with none or very few social contacts and no supports in times of need.

CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 3. GENERAL PROVIDER POLICIES
PART 1. GENERAL SCOPE AND ADMINISTRATION

317:30-3-2. Provider agreements

In order to be eligible for payment, providers must have on file with OHCA, an approved Provider Agreement. Through this agreement, the provider certifies all information submitted on claims is accurate and complete, assures that the State Agency's requirements are met and assures compliance with all applicable Federal and State regulations. These agreements are renewed ~~annually~~ at least every 5 years with each provider.

(1) The provider further assures compliance with Section 1352, Title 31 of the U.S. Code and implemented at 45 CFR Part 93 which provides that if payments pursuant to services provided under Medicaid are expected to exceed $100,000.00, the provider certifies federal funds have not been used nor will they be used to influence the making or continuation of the agreement to provide services under Medicaid. Upon request, the Authority will furnish a standard form to the provider for the purpose of reporting any non-federal funds used for influencing agreements.

(2) The provider assures in accordance with 31 ~~USCA~~ USC 6101, Executive Order 12549, that they are not presently or have not in the last three years been debarred, suspended, proposed for debarment or declared ineligible by any Federal department or agency.

(3) For information regarding ~~annual~~ Provider Agreements or for problems related to a current agreement, contact the Oklahoma Health Care Authority, Provider Enrollment, ~~P.O. Box 18299, Oklahoma City, Oklahoma 73154-0299, or call 1-800-871-9347 for out-of-state or 405-525-1092 from within the state.~~ P.O. Box 54015, Oklahoma City, Oklahoma 73154, or call 1-800-522-0114 option 5 toll free or 405-522-6205 for the Oklahoma City area.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 35. MEDICAL ASSISTANCE FOR ADULTS AND CHILDREN-ELIGIBILITY
SUBCHAPTER 5. ELIGIBILITY AND COUNTABLE INCOME
PART 5. COUNTABLE INCOME AND RESOURCES

317:35-5-41.8. Eligibility regarding long-term care services

(a) **Home Property.** In determining eligibility for long-term care services for applications filed on or after January 1, 2006, home property is excluded from resources unless the individual's equity interest in his or her home exceeds $500,000.

(1) Long-term care services include nursing facility services and other long-term care services. For purposes of this Section, other long-term care services include services detailed in (A) through (B) of this paragraph.

(A) A level of care in any institution equivalent to nursing facility services; and

(B) Home and community-based services furnished under a waiver.

(2) An individual whose equity interest exceeds $500,000 is not eligible for long-term care services unless one of the following circumstances applies:

(A) The individual has a spouse who is lawfully residing in the individual's home;

(B) The individual has a child under the age of twenty-one who is lawfully residing in the individual's home;

(C) The individual has a child of any age who is blind or permanently and totally disabled who is lawfully residing in the individual's home; or

(D) The denial would result in undue hardship. Undue hardship exists when denial of SoonerCare long-term care services based on an individual's home equity exceeding $500,000 would deprive the individual of medical care such that the individual's health or life would be endangered; or of food, clothing, shelter, or other necessities of life.

(3) Absence from home due to nursing facility care does not affect the home exclusion as long as the individual intends to return home within 12 months from the time he/she entered the facility. The OKDHS Form 08MA010E, Acknowledgment of Temporary Absence/Home Property Policy, is completed at the time of application for nursing facility care when the applicant has home property. After explanation of temporary absence, the member, guardian or responsible person indicates whether there is or is not intent to return to the home and signs the form.

(A) If at the time of application the applicant states he/she does not have plans to return to the home, the home property is considered a countable resource. For members in nursing facilities, a lien may be filed in accordance with OAC

317:35-9-15 and OAC 317:35-19-4 on any real property owned by the member when it has been determined, after notice and opportunity for a hearing, that the member cannot reasonably be expected to be discharged and return home. However, a lien is not filed on the home property of the member while any of the persons described in OAC 317:35-9-15(b)(1) and OAC 317:35-19-4(b)(1) are lawfully residing in the home:

(B) If the individual intends to return home, he/she is advised that:

(i) the 12 months of home exemption begins effective with the date of entry into the nursing home regardless of when application is made for SoonerCare benefits, and

(ii) after 12 months of nursing care, it is assumed there is no reasonable expectation the member will be discharged from the facility and return home and a lien may be filed against real property owned by the member for the cost of medical services received.

(C) "Intent" in regard to absence from the home is defined as a clear statement of plans in addition to other evidence and/or corroborative statements of others.

(D) At the end of the 12-month period the home property becomes a countable resource unless medical evidence is provided to support the feasibility of the member to return to the home within a reasonable period of time (90 days). This 90-day period is allowed only if sufficient medical evidence is presented with an actual date for return to the home.

(E) A member who leaves the nursing facility must remain in the home at least three months for the home exemption to apply if he/she has to re-enter the facility.

(F) However, if the spouse, minor child(ren) under 18, or relative who is aged, blind or disabled or a recipient of TANF resides in the home during the individual's absence, the home continues to be exempt as a resource so long as the spouse or relative lives there (regardless of whether the absence is temporary).

(G) For purpose of this reference a relative is defined as: son, daughter, grandson, granddaughter, stepson, stepdaughter, in-laws, mother, father, stepmother, stepfather, half-sister, half-brother, niece, nephew, grandmother, grandfather, aunt, uncle, sister, brother, stepbrother, or stepsister.

(H) Once a lien has been filed against the property of an NF resident, the property is no longer considered as a countable resource.

(b) **Promissory notes, loans, or mortgages.** The rules regarding the treatment of funds used to purchase a promissory note, loan, or mortgage on or after February 8, 2006, are found in (1) through (2) of this subsection.

(1) Funds used to purchase a promissory note, loan, or mortgage

on or after February 8, 2006, are treated as assets transferred for less than fair market value in the amount of the outstanding balance due on the note, loan, or mortgage as of the date of the individual's application for medical assistance unless the note, loan, or mortgage meets all of the conditions in paragraphs (A) through (C) of this paragraph.

(A) The note, loan, or mortgage has a repayment term that is actuarially sound (as determined in accordance with actuarial publications of the Office of the Chief Actuary of the United States Social Security Administration).

(B) The note, loan, or mortgage provides for payments to be made in equal amounts during the term of the loan, with no deferral and no balloon payments made.

(C) The note, loan, or mortgage prohibits the cancellation of the balance upon the death of the lender.

(2) Funds used to purchase a promissory note, loan, or mortgage for less than its fair market value are treated as assets transferred for less than fair market value regardless of whether:

(A) The note, loan, or mortgage was purchased before February 8, 2006; or

(B) The note, loan, or mortgage was purchased on or after February 8, 2006, and the conditions described in paragraph (1) of this subsection were met.

(c) **Annuities.** Treatment of annuities purchased on or after February 8, 2006.

(1) The entire amount used to purchase an annuity on or after February 8, 2006, is treated as assets transferred for less than fair market value unless the annuity meets one of the conditions described in (A) through (C) of this paragraph.

(A) The annuity is an annuity described in subsection (b) or (q) of Section 408 of the United States Internal Revenue Code of 1986.

(B) The annuity is purchased with proceeds from:

(i) An account or trust described in subsection (a), (c), or (p) of Section 408 of the United States Internal Revenue Code of 1986;

(ii) A simplified employee pension as defined in Section 408(k) of the United States Internal Revenue Code of 1986;

(iii) A Roth IRA described in Section 408A of the United States Internal Revenue Code of 1986.

(C) The annuity:

(i) is irrevocable and nonassignable;

(ii) is actuarially sound as determined in accordance with actuarial publications of the Office of the Chief Actuary of the United States Social Security Administration; and

(iii) provides for payments in equal amounts during the term of the annuity, with no deferral and no balloon payments made.

(2) In addition, the entire amount used to purchase an annuity

on or after February 8, 2006, is treated as a transfer of assets unless the Oklahoma Health Care Authority is named as the remainder beneficiary either:

(A) in the first position for at least the total amount of medical assistance paid on behalf of the institutionalized individual; or

(B) in the second position after the community spouse, child under 21 years of age, or disabled child and in the first position if the spouse or a representative of the child disposes of any of the remainder for less than fair market value.

(d) **Life Estates.** This subsection pertains to the purchase of a life estate in another individual's home.

(1) The entire amount used to purchase a life estate in another individual's home on or after February 8, 2006, is treated as assets transferred for less than fair market value, unless the purchaser resides in the home for at least one year after the date of the purchase.

(2) Funds used to purchase a life estate in another individual's home for less than its fair market value are treated as assets transferred for less than fair market value regardless of whether:

(A) The life estate was purchased before February 8, 2006; or

(B) The life estate was purchased on or after February, 8, 2006, and the purchaser resided in the home for one year after the date of purchase.

(e) **Oklahoma Long-Term Care Partnership (LTCP) Program.** This subsection pertains to individuals with Oklahoma Long-Term Care Partnership policies. The Oklahoma Insurance Department approves long-term care insurance policies as Long-term Care Partnership Program policies. The face page of the policy document will indicate if the insurance qualifies as a Long Term Care Partnership Program policy.

(1) Benefits from the LTCP policy must be exhausted before the individual can be eligible for long term care under the SoonerCare program.

(2) Assets in an amount equal to the amount paid out under the LTCP policy can be protected for the insured individual once the LTCP policy benefits are exhausted. Protected assets are disregarded when determining eligibility for the SoonerCare program per 317:35-5-41.9(26). A record of the amount paid on behalf of the policy holder is available through the OHCA or insurance company holding the LTCP policy.

(A) At the time of application for SoonerCare the individual must determine the asset(s) to be protected. The protected asset(s) cannot be changed. If the value of the protected asset(s) decreases, the individual does not have the option to select additional assets to bring the total up to the protected amount.

(B) If the protected asset(s) are income-producing, the income earned while on SoonerCare is counted in accordance with 317:35-5-42.
(C) The individual can choose to transfer the protected asset without incurring a transfer of assets penalty.
(D) When determining resource eligibility for a couple when one of them enters the nursing home or applies for a HCBS waiver, the LTCP protected asset(s) are disregarded in determining the total amount of the couple's resources.

MIKE FOGARTY
CHIEF EXECUTIVE OFFICER

BRAD HENRY
GOVERNOR

STATE OF OKLAHOMA

OKLAHOMA HEALTH CARE AUTHORITY

2012 MAC DATES

January 19, 2012
March 7, 2012*
May 17, 2012
July 19, 2012
September 20, 2012
November 14, 2012**

*** Changed to Wednesday, March 7th, due to OHCA Board Meeting.**

**** Changed to Wednesday, November 14th, due to OHCA Board meeting on the 15th.**