OHCA Medical Advisory Committee

AGENDA

March 10, 2016
1:00 p.m. – 3:30pm

Charles Ed McFall Board Room

I. Welcome, Roll Call, and Public Comment Instructions: **Chairman, Steven Crawford, M.D.**

II. Public Comments (2 minute limit)

III. MAC Member Comments/Discussion

IV. Action Item: Approval of Minutes of the January 21, 2016 Medical Advisory Committee Meeting

V. Financial Report **Gloria Hudson, Director of General Accounting**

VI. SoonerCare Operations Update: **Melody Anthony, Director of Provider/Medical Home Services**

VII. Legislative Verbal Update: **Emily Shipley, Director of Governmental Affairs**

VIII. Proposed Rule Changes: Presentation, Discussion, and Vote: **Demetria Bennett, Policy Development Coordinator**

IX. Action Item: Vote on Proposed Rule Changes: **Chairman, Steven Crawford, M.D.**

- 15-01 – Dental Coverage for Organ Transplant Clearance and Coverage for Emergency Oral Examinations
- 15-07A – General Coverage by Category and Obstetrical Reimbursement
- 15-07B – Obstetrical Reimbursement
- 15-08 - Urine Drug Screening and Testing
- 15-17 – Eyeglasses Cleanup
- 15-18 – Complex Rehabilitation Technology
- 15-21 – Diagnostic Testing Facilities
- 15-24 – Dental Oversight Requirements for Supervision of Anesthetists and General Cleanup of Terms
- 15-28 – Indian Health Services, Tribal and Urban Indian Organization Language Update
- 15-36 – Diabetic Testing Supplies
- 15-38 – Quality of Care Fund Reports
- 15-41 – Third Party Liability
- 15-42 – Audit Procedures
- 15-43 – Appeal Procedures
- 15-48 – Service Quality Review / TPS Employment Relationship with TFC

15-50 – Policy Revision to Amend Policy Regarding Home Property in a Revocable Trust as a Countable Resource
15-52 – Amend Appeal Process to Clarify and Limit the Scope of the ALJ's Jurisdiction
15-53 – Audit Appeals Process
15-54 – Insure Oklahoma Clean Up
15-55 – Programs of the All-Inclusive Care for the Elderly (PACE) Transfer Guidelines
15-56 – Pharmacy Lock-In
15-57 – Long Term Care (LTC) Clean Up
15-58 – DSM Reference Cleanup and Ad Hoc Reviews
15-61 – Appeal Process for contract Terminations
15-62 – Staffing Ratio
15-65 – Behavioral Health Admission Assessment and Evaluations
15-66 – Application Process for Military Personnel

X. Informational Items Only – not actionable: **Melinda Thomason, Health Policy Assistant Director**

1. Access Monitoring Review Plan
2. AMRP Draft Outline

XI. New Business: Chairman, Steven Crawford, M.D

XII. Future Meetings

May 19, 2016 at 1:00 PM

July 21, 2016 at 1:00 PM

September 15, 2016 at 1:00 PM

November 17, 2016 at 1:00 PM

XIII. Adjourn

Next Meeting
Thursday, May 19 , 2016
1:00 p.m. – 3:30pm
Charles Ed McFall Board Room
4345 N Lincoln Blvd
Oklahoma City, OK 73105

MAC Minutes for January 21, 2016

Welcome and Roll Call

Chairman Crawford called the meeting to order at 1:00 PM and asked that the roll call be taken. ***Delegates present were***: Dr. Steve Crawford, Ms. Mary Brinkley, Dr. Joe Catalano, Ms. Wanda Felty, Ms. Terri Fritz, Dr. Melissa Gastorf, Mr. Steve Goforth, Mr. David Rising, Mr. Mark Jones, Ms. Annette Mays, Mr. James Patterson , Ms. Toni Pratt-Reid, Dr. Edd Rhoades, Dr. Jason Rhynes, Ms. Carrie Slatton-Hodges, Mr. Rick Snyder, Mr. Jeff Tallent, and Dr. Rick Walton. ***Alternates present were***: Ms. Sarah Baker, Mr. Victor Clay, Mr. Scott Raybern, and Dr. David Waggoner providing a quorum.

Delegates absent without an alternate were: Dr. David Cavallaro, Dr. Stanley Grogg, Dr. Denae Kirkpatrick, Dr. Kanwal Obhrai, and Dr. Paul Wright.

Introduction of New MAC Members: Dr. Crawford read bios for Dr. Joe Catalano and Mr. David Rising.

Public Comments

Dr. Crawford instructed the public on the rules of making public comments and their time limits for the Medical Advisory Committee and that they would be called in the order that they signed in. There were 55 public comments are they are as follows:

1. Cherie Merkley – Foster/Adoptive parent who spoke of her own experience and felt that the state did not prepare her as a parent to handle a child with behavioral health issue. If they lost access to their therapist it would be detrimental to her child.
2. Josh Kincade – Foster/Adoptive parent who has three children with behavioral health issues and feels that there needs to be freedom to choose to take your child to a private practitioner. He is concerned about the choice of the parent being taken away. To vote “Yes” to this behavioral health rule change then what will be next, medical care? If kids go to agencies then they will be saving the state money because they will not be getting care.
3. Joy Sloan – GCBHS who stated that the state is in crisis, services still preserved for those that need it most, cuts are up with more coming, and most states do not support independent contractors or specialty services.
4. Cindy Lee – Behavioral Project Director for an independent facility (Angels/HALO). Their facility has an 82% rate of clients who do not require any further help upon discharge, two-thirds graduate within 10 weeks, have a 98% success rate and saving the state money. Their funding is 40% paid by Medicaid and 60% from the private sector. They would like to see cuts across the board.
5. Janette Moore – Hope Community Services who is in favor of policy change and states that agencies do have an invested interest in behavioral health. Agencies do have a strong foundation to serve the clients who would be transitioning with this process, nationally trained, trauma focused, certified. They have programs that wrap-around clients (therapy, case management, cell phones, anything that the family may need). They are CARF accredited, DMH certified, strong outcome measurements that show their success. They do not have long waiting lists.
6. Angela Metcalf – SoonerCare Provider in private practice in a small community who feels that changes will not help the budget shortfall. She also states that within 6 months of opening her practice she had to hire several clinicians (without taking from other providers) to fill in the gaps. The 1.2 million dollars that needs to

be eliminated will not be eliminated but only transferred to an agency. If change is passed the private practices will be facing closures.

7. Carolyn Parks – A Calm Safe Place, Inc. states that if private practices close then every child will need new intake, new treatment plan, new case management services that will be charged to the state and that this would only add to the budget problem. Families who do not have the resources to pay for treatment will fall out in the process.
8. Stephanie Ivey – A Peace Within (private practice in Holdenville) is concerned that agencies can bill for more hours (can bill for 12 hours while private practices can only bill for 8 hrs) and asked how that would be saving the state tax dollars? There are a lot of agencies who will not pick up children under the age of 5 so where do they go? They will be put "under supervision" and told that this will help them. She doesn't think that balancing the budget should mean hurting the child.
9. June Melton – Turning Leaf Counseling (private practice in Holdenville) said that she is using bio-feedback along with alternative herb therapy. These are areas not addressed in agencies but have proven to be popular and very successful with the clients.
10. Karen Coleman – Koinonia Counseling Services, Inc (Private Practice LBHP) said that the first rule of thumb that she was taught is "do no harm to the patient" but these kids are going to be harmed by this proposal. She has served in the agencies but left due to unethical practices. She wants to see the OHCA, DMH, and the State, do what is right and take care of the kids, which is not evident with this proposal.
11. Staci Cochran – LPC - Myriad Counseling Solutions, LLC – She actually goes out to the client rather than having them come in to see her due to the clients not having the resources and if they have to go to an agency, many won't go. Agencies are full with no rooms and it is the kids that are going to suffer.
12. Pat Thompson – Special Ed Teacher/Counselor – located in a rural area where their clients have to travel to Enid to receive services which is 30 minutes away. This would cause hardship on the clients should they have to travel that far to get help.
13. Verna Foust – Red Rock BH – She stated that she believes this is a right decision given that with private practice there are only 11% of the children who are SED (severely and emotionally disabled) but in agencies most of the children are SED. Red Rock is in rural areas, has nationally accredited clinicians, and CARF but another cut would be devastating.
14. Erin DeVoe – Adoptive parent of two boys who went through HALO services and would be hurt by this decision.
15. Kirk Nichalson – LBHP and has worked at two agencies then there was a provider switch in 2010 when LBHP's were allowed to practice independently. He commented that most of the people in private practice are Master level of clinicians and would like to be able to practice in their field. A huge part of this would be taken away because SoonerCare is such a large volume.
16. Richard DeSirey – Director of an Outpatient Agency who is opposed to this based on values and principles. He has been heavily involved with systems of care for 15 years to create communities who are responsive to kids. They are child centered, family driven, culturally competent, collaborative, responsive, and promote access to services. This is designed to help the community mental health system. This would be against children and will not save money due to increased services. This would be a cradle to prison pipeline.
17. John Eikel – Private practice in Blanchard who felt that the focus of the conversation was a little off and needs to be brought back to mental health care increase and not limit it. It can be done by increasing the hours of therapy but to reduce the hours would be better than no therapy. By reducing the hours it would level the playing field and would give both agencies and private practice a chance.

18. Susan Bachmann – Co-owner of a practice of LBHPs who all have prior experience in agencies and believe that they are providing better quality care now in private practice. They had poor access to supervisors in agencies. She believes that there will not be a budget savings but will cause an increase but if there is a savings it would come from reduced care. She gave examples of some of their extreme clients.
19. Kimberly Petty – Private practice and the impact it will have an impact on her practice. She is in a rural area. She has seen over 118 SoonerCare clients over the past year and if this passes they will not be able to get care or the same level of care.
20. Shannon Bengs, RN – She provides care management for people in El Reno. They recently had a case that they were able to contact a therapist for an emergency situation and that therapist was able to reach the individual within one and one half hours where in the past referring to an agency that was not the case. There will be no feedback to the PCP's who see them. It is crucial that they be able to care for people in a timely manner.
21. James Lovett – Private practice who does not believe that it is going to save money or benefit the clients he is seeing now. He states that his practice turns no one away. If you don't have money to pay, he will see you for free where an agency would not be able to do that.
22. Missy Downer – Counselor/Private practice who says that Oklahoma is in a health care crisis. The connection with kids is key and if there is a crisis, she would be there regardless of a way to pay and agencies can't do that.
23. Leslie Keenan – She started a non-profit private practice who service the foster/adoptive community. You can't spring a change like this on children because they have already experienced a high turnover rate with therapists in agencies.
24. Kristen Hale – Partners with Leslie Keenan in private practice in Tulsa who pointed out that the Governor stood up and said that they would help in finding new foster homes but Ms. Hale fails to understand how we can ask new families to invest their time, money, and emotions but will not be supported in terms of therapy services.
25. Nikkie Dunnigan – Owner of The Play Place, a private practice group, in Stillwater. She has always worked with low income families for several years at agencies and was never allowed to provide the care that she wanted to but now she can since she is in private practice. She believes that the real cost will be paid for by the kids.
26. Linda Gray Murphy – OCA (lobbyist) – who voiced its opposition to this rule change and believes that it would have a devastating effect on children under the care of the licensed clinicians. This change would create a monopoly. There are not agencies in every area of the state for people to access.
27. Dr. Randy Rendleman – President of OPA who also owns a mental health clinic and provides testing in the public schools. He feels that agencies can provide care to the kids.
28. Corbin Humble – Counselor/Business degree who has been on staff at agencies and did homebased care and when he went into private practice the things that changed were doing 15 minutes of billing on his own, he did lose any supervision, and had to find own referrals. The agencies trained him but after he knew what to do, the agency provided no benefit.
29. Susan Jordan – Provider in private practice who doesn't see how this isn't a violation of the Federal Mental Health Care Act. She feels that we will be tied up in a lot of litigations. The costs will be an increase to the budget because of transfer fees and paying the agencies will be more than paying private practices.
30. Lea Ann Garcia – Private practice but worked for an agency prior to this. Her entire practice is SoonerCare children and if this passes it will put her out of business. The clients have been through a lot of trauma and

now will be subjected to more. She provides services that she doesn't bill for because she cares about these kids.

31. Heather Askew – Clinical Social Worker who has worked with the HALO Project. She pointed out that there was not one word to the adverse impact to the client. The only way the math works is if the kids are not seen. She urged the OHCA to table this and come back with better solutions.
32. Henry Kuhlman – Foster parents who are concerned about the termination of the relationship between their child and his therapist and the loss of access to programs such as HALO.
33. Julia Jernigan – Executive Director of the Oklahoma Substance Abuse Services Alliance who states that cuts hurt and if these cuts have to occur then only the members with the highest acuities will be seen. She also hopes that the discourse between the agencies and private practitioners will end for the sake of the member.
34. Julie Bell – LPC who has worked at the Children's Hospital at the OUHSC and she has been told by clients who have contacted agencies that there is a six month waiting list. There are a lot of people who have gone to work for the agencies, get fed up with what they are seeing and having to do, go out on their own and are doing the same thing but for less money. The Oklahoman projected that if we go to just agencies only, the waiting list will become a 2 yr. waiting list.
35. Kelli Marshall - Speech/Language Pathologist at Today's Therapy Solutions but they do provide LBHP services at their place of business. She is concerned of how this will affect the children of the state of Oklahoma. She gave a personal example of needing these counseling services in her own family after her bother passed away and were told by agencies that there would be a wait to counsel her nieces and nephew through grief counseling but the private practice offered them next day service.
36. Jamie Frazier – Independent LCSW in McIntosh County who serves three other counties as well. She wanted to discuss the Federal Mental Health Services Act a little further. When the hours were cut back to 35 hours within a week that went against it because no other agencies were required to cut back to 35 billable hours in a week.
37. Michelle Burke – SoonerCare provider/practitioner in rural NE Oklahoma who is opposed to this rule change. The rural agency providers cannot handle the caseloads that they have let alone take on all of the clients of the private practitioners. Their DMH is telling them that they are limiting their services to the severely mentally ill and those who are actively suicidal. If this is passed this will increase hospitalizations, increase of suicide rates, dropout rates, increase in crime, increase in drug and alcohol abuse, and many others. All of these would lead to increased rates in other areas such as juvenile services, Department of Corrections, the court system, DHS, and the Dept. of Education. She offered alternative budget cuts.
38. Dr. Leah Taylor – She is a little over one year out from working at the OHCA and wanted to plead guilty in being part of the process in helping to open up the Medicaid payment to LBHP who have Master's degrees. She would like to see Medicaid expanded and a moratorium put on tax cuts.
39. Chris Hogue – LMFT who wanted to echo his concern about this being one sided and not a cut across the board.
40. Jennifer Byrd – Foster parents who has used a private therapist who has been a lifeline to their son who has established a relationship with her.
41. Nikki Collins - Private LBHP who states that the majority of their caseloads are children with autism along with other different special needs. She thinks there is a place for both agencies and private practice but the question really is how is this going to affect the most vulnerable children in our state? She thinks that the elimination of LBHPs is short-sighted and will not save as far as the budget is concerned. Why are the agencies advocating to eliminate those in private practice? We are doing the same thing. Why are we

moving towards a monopoly on a human service that will have a negative effect on the rest of society? Is this even ethical?

42. Debra Knight – Parent of a 14 yr. old with Asperger's syndrome who is being seen by a therapist, wanted to know how are we going to transfer all of these clients from their therapist to just a few agencies within such a short amount of time and do so without a lapse in coverage?
43. Dr. Lori Holmquist Day – Pediatric Nurse/Psychologist in private practice who reiterates that in 2010 the private practitioners were allowed to bill Medicaid due to rural area needs. She is already working with physicians to implement a plan to work with individuals with Masters level and clinicians to get better service and not waiting months.
44. Dr. Alecia Hanes – Pediatrician who refers to LPCs and agencies. She had two patients who attempted suicide around Thanksgiving and it was around two months before she could get anybody to see them. Maybe more supervision needs to be done for those who are taking advantage and billing more hours than needed. It is the child who does not get mental health help that ends up suicidal or becoming a criminal when they get older.
45. Darci Otoptuik – Child Placing Agency who recruits families to foster and train them by taking them through the certification process, working with DHS, going through the court system, and going through the counselors. This cut is going to limit access and is actually contrary to what the OHCA mission statement says. The clients still have needs.
46. Todd White – Grandparent who gave an account of his grandchild, who was murdered by a boyfriend of their mother, and the remaining two grandchildren received counseling to deal with that was invaluable. He advocates freedom of choice that allows parents to choose a licensed therapist who is best for them and who share their core values. If this passes, you will be taking away our right to choose who is best to treat our children.
47. Dr. Amy Kesner – has worked for agencies, started her own practice, and is now starting her own agency. She feels like we need to lobby for freedom to practice in a way that they have been trained and taught.
48. Lea May – Instilling Hope, LLC – Licensed Child and Family Counselor who has committed to take SoonerCare clients and has two foster children who have benefited from these services as well. She urged committee to vote no on this policy change.
49. Audra Haney – Child Placing Agency – She is concerned that the proposed changes would limit the services available to the most vulnerable. There is already a recruitment crisis in the state and the cuts would only make it that much more difficult due to lack of support.
50. Valerie Ecton – Adoptive/Foster Parent who gave her experience with the HALO Project and how much it has helped their entire family. She suffered from secondary PTSD just from fostering prior to the help of these counselors and now they are a functioning, healing family.
51. Omar Chatman – LBHP who states that this really gets down to dollars. Counselors with the agencies are being bullied into billing fully allowed billable hours.
52. Fabiana Males – LBHP who does not believe that this policy change will save any money when families have to take their child to do another intake assessment, new treatment plan, and increased service hours. It is the agencies that are the killers of the budget. She also feels that the DMH does not need to have control over the Behavioral Health Medical Budget because it is a conflict of interest and will only choose what would directly benefit them.
53. Carol Mathison – Parent who has had an independent therapist and feels this is very, very important and would be traumatizing if this was taken away.

54. Thomas Martin – Martin Clinic Sleep Center in Pryor, OK who thought he could ask questions concerning sleep apnea but was instructed by Dr. Crawford what the Public Comments at the MAC were and that this had been advocated at another MAC meeting.
55. Susan Kay – She has had a family member in every entity of the system. She is concerned about when OHCA starts cutting all of the children and where they will be put. The caseloads are very high across the board. She quit because she could not justify and did not want to be a part of the extravagant trips to Washington, Oregon, or Chicago and they didn't have to attend the meetings but could go play, go to extravagant dinners/lunches on the taxpayers dollar. She feels like a lot of the money gets wasted.

MAC Member Comments/Discussion

Dr. Crawford asked if any MAC member would like to make a comment and Dr. Walton stated that he wanted to have a discussion on this policy change but will wait until the rule is presented. Mary Brinkley thanked everyone for being in the meeting and stated that we have to be proactive. She encouraged everyone to take their concerns to the capital, to the elected officials who make these decisions. She encouraged everyone to go to Senior Day at the Capital on February 21st. The theme is going to be about the Oklahoma Standard in caring for our seniors. We, as Oklahomans, have to find a workable solution. The agencies have been told to make these cuts but we need to be very creative and sensitive on how these cuts are made. Dr. Melissa Gastorf, as a family medicine doctor, voiced her concern about the cuts because when she tries to find counselors for her patients it is very difficult. She is afraid that the kids will not get the services when they need them. She states that the cost savings of no treatments would eventually cost more down the road when these individuals become more acute.

BREAK

Dr. Crawford gave everyone a 10 minute break upon request.

Member Comments Approval of Minutes

Approval of the November 19, 2015 Minutes: Dr. Crawford asked that a motion for approval of the minutes of November 19, 2015 be made. Mr. Jeff Tallent moved to accept the minutes and Ms. Terri Fritz seconded the motion. The vote to accept was unanimous.

Financial Update

Gloria Hudson, Director of General Accounting, reported on the state's fiscal year 2016 financial transactions through the month of November 2015. She reports that the total for FY 2016 variance is a positive $15.9 million dollars. On December 21, 2015 the Office of Management and Enterprise Services (OMES) determined that revenue services were insufficient to make full revenue allocations to state agencies for the FY 2016. The revenue failure required OMES to reduce agency allocations by 3%. This resulted in a loss to OHCA of 27.4 million state dollars. On January 7, 2016, as required by OMES, OHCA filed the revision for FY 2016 budget reflecting this reduction. We balanced the budget for the remainder of this year by using the $15.9 million from our current year carryover and the anticipated $10.7 million in state savings from the 3.0% rate reduction which were implemented beginning January 1, 2016.

SoonerCare Operations Update

Nancy Nesser, Pharmacy Director, reported on the November 2015 data on SoonerCare Operations. There was a slight decrease in total SoonerCare enrollment for November across the board. Ms. Nesser then reported on the

In-State Contracted Provider numbers with it being over 34,000 which is a change of over 200. The chart highlights Pharmacy, Optometrists, Extended Care Facility, and Hospitals which are relatively stable. The second chart breaks out Physicians, Mental Health Providers, PCMH, and Dentists and those are all stable or trending upwards. The third chart is a look at our Opioid Analgesics for adults (ages 19-65) during calendar year 2015 which shows our spending there is relatively flat, there are members, claims, and reimbursements along with the averages. The reason this was put in was to discuss the new Pain Management Program which Dr. Herndon is going to explain.

1. Pain Management Program – Dr. Mike Herndon along with Jaclyn Mullen have developed a Provider Toolkit to help equip the Providers with the tools and knowledge to treat chronic pain. He presented a slide presentation over the program and talked about the Provider Toolkit that contains Treatment protocols, Oklahoma Opioid Prescribing Guidelines, Office visit forms, Patient handouts, Monitoring recommendations, and additional resources. Our goal over the next 3 years is to get into 100-120 practices with 2 practice facilitators who will train them using the toolkit along with 2 substance abuse licensed counselors which is built into the program. This launched last week and are currently in one practice already.

2. Comprehensive Diabetes Care – Sarah Walker, Clinical Data Analyst, who followed up on the neuropathy quality measure question from the last MAC meeting in November. The question was asked as to what was included in the numerator when we calculated that measure so that just has numbers that 18 – 75 years old who have diabetes who have had either neuropathy screening tests or evidence of neuropathy. The SPARCS say evidence of neuropathy are treatment for neuropathy and ACD/ARD therapy, evidence of chronic kidney disease, evidence of SRG or kidney transplant, or a visit with a neurologist.

3. Agency reorganization – Dr. Sylvia Lopez informed the members of the MAC that there have been some changes to the Executive Staff. Effective January 1, 2016 Dr. Garth Splinter is now the Deputy CEO of the Agency and Ms. Becky Pasternik-Ikard is our new State Medicaid Director.

Legislative Update

Emily Shipley, Director of Governmental Affairs, stated that the legislative session begins February 1, 2016 as well as the Governor's state of the State address where she will lay out the budget plan for this next year. Today is actually the deadline for the bills to be filed. She will be giving an update at the next MAC meeting as to the status of the bills that affect the Agency.

Health Policy-Proposed Rule Changes

A) Item #16-01 (per request) - Reimbursement for Licensed Behavioral Health Professionals in Independent Practice. Traylor Rains-Sims, Oklahoma Department of Mental Health & Substance Abuse Services, presented the rule summary. DMHSAS was notified in December 2015 that there was a 9.1 million dollar shortfall and had to address this by January 2016. In order to address the cuts they looked at the administrative side of things first and did take 8 million out of ODMHSAS's administrative costs before they looked at the Medicaid cuts. He states that they are looking at making another 10% cut next year as well. They will strive to make sure that the most severe will get continued care. They are looking not only at the

SED but also prevention level. He expressed his thanks to the individuals who came to advocate for their clients and it is the desire of the ODMHSAS to expand mental health services but they don't have the funds to do that. After reading the summary, Jeff Tallent reiterated that they looked at several options and there were no good options and they chose the least worst option and with that he moved that the committee accept the recommendations. Dr. Crawford informed the audience that Mr. Tallent represents persons with mental illness as a member of the MAC. The motion was seconded by Edd Rhoades. Dr. Crawford asked for questions from the members of the MAC. There was lengthy discussion over cost comparisons, level of severity of clients, transitioning costs, obtaining hard facts, and legality of proposal between Mr. Traylor Rains-Sims and the MAC members. Dr. Crawford introduced Terri White, Commissioner for the Oklahoma Department of Mental Health, who stated that if we don't make these cuts now then the more acute will cost more later and this is the least harmful choice. If this proposal does not pass then they will be back with a worse choice. The DMHSAS is trying to make sure that those needing services receive it. We have to preserve the system. The proposal change offers a 2.2 million dollar savings but in reality will probably only be 1 million. Dr. Joe Catalano called the question and Jeff Tallent seconded. The roll call vote was taken and quickly tallied and verbally reported to be 10 in favor and 10 opposed. (See table below)

OHCA Medical Advisory Committee

Voting Summary for MAC Members related to Proposed Rule Change item 16-01 (1/21/16)				
MAC Delegate	Alternate	Yes	No	Not present during vote
Crawford, Steve		X		
Goforth, Steve		X		
Bierig, Teresa	***Baker, Sarah***		X	
Brinkley, Mary			X	
Catalano, Joe			X	
Cavallaro, David				
Felty, Wanda			X	
Fritz, Terrie			X	
Gallaway, Samantha	***Raybern, Scott***	X		
Gastorf, Melissa			X	
Grogg, Stanley				
Jones, Mark		X		
Kirkpatrick, Danae				
Mays, Annette			X	
Moran, Liz	***Clay, Victor***		X	
Obhrai, Kanwal				
Patterson, James		X		
Post, Daniel	***Waggoner, David***			X
Pratt-Reid, Antonia			X	
Rhodes, Edd		X		
Rhynes, Jason				X
Rising, David			X	
Slatton-Hodges, Carrie		X		
Snyder, Rick		X		
Tallent, Jeff		X		
Walton, Rick		X		
Wright, Paul				
	Total:	10	10	2

Those highlighted were absent

*** Those in blue were present via phone but could not participate due to technical difficulties***

Those italicized in red were present and voted

Member was present at the start of the meeting but left before the vote was taken

B) **Item #15-02:** After the reading of the summary, Dr. Joe Catalano moved for acceptance; Ms. Annette Mays seconded the motion and it passed unanimously.

C) **Item #15-13:** After the reading of the summary, Dr. Joe Catalano moved for acceptance; Dr. Edd Rhoades seconded the motion and it passed unanimously.

D) **Item #15-15:** After the reading of the summary and a brief request for clarification, Ms. Terri Fritz moved for acceptance; Dr. Joe Catalano seconded the motion and it passed unanimously.

E) **Item #15-22:** After the reading of the summary, Dr. Joe Catalano moved for acceptance; Ms. Terri Fritz seconded the motion and it passed unanimously.

F) **Item #15-27A:** After the reading of the summary, Dr. Joe Catalano moved for acceptance; Ms. Annette Mays seconded the motion and it passed unanimously.

G) **Item #15-27B:** After the reading of the summary, Dr. Rick Walton moved for acceptance; Ms. Annette Mays seconded the motion and it passed unanimously.

H) **Item #15-29:** After the reading of the summary, Dr. Rick Walton moved for acceptance; Dr. Joe Catalano seconded the motion and it passed unanimously.

I) **Item #15-30:** After the reading of the summary and a request by Dr. Rick Walton for clarification, Dr. Joe Catalano moved for acceptance; Mr. Jim Patterson seconded the motion and it passed unanimously.

J) **Item #15-32:** After the reading of the summary, Dr. Joe Catalano moved for acceptance; Mr. Steve Goforth seconded the motion and it passed unanimously.

K) **Item #15-40:** After the reading of the summary, a question concerning the holding of beds was asked by Dr. Joe Catalano and Dr. Crawford offered explanation, Mr. Jeff Tallent moved for acceptance; Dr. Melissa Gastorf seconded the motion and it passed unanimously.

New Business / Member Comments

There was no new business or member comments.

Adjournment

Dr. Crawford thanked everyone for coming and encouraged them to contact legislators. The meeting was adjourned by acclamation. Dr. Crawford announced that the next MAC meeting will be March 10, 2016.

AGENDA

FINANCIAL REPORT

For the Six Months Ended December 31, 2015
Submitted to the CEO & Board

- Revenues for OHCA through December, accounting for receivables, were **$2,020,933,626** or **.1% over** budget.
- Expenditures for OHCA, accounting for encumbrances, were **$1,966,690,271 or .6% under** budget.
- The state dollar budget variance through December is a **positive $8,749,503.**
- The budget variance is primarily attributable to the following (in millions):

Expenditures:		
Medicaid Program Variance		2.0
Administration		2.6
Revenues:		
Drug Rebate		2.3
Taxes and Fees		2.1
Overpayments/Settlements		(.3)
Total FY 16 Variance	**$**	**8.7**

ATTACHMENTS

Summary of Revenue and Expenditures: OHCA	1
Medicaid Program Expenditures by Source of Funds	2
Other State Agencies Medicaid Payments	3
Fund 205: Supplemental Hospital Offset Payment Program Fund	4
Fund 230: Quality of Care Fund Summary	5
Fund 245: Health Employee and Economy Act Revolving Fund	6
Fund 250: Belle Maxine Hilliard Breast and Cervical Cancer Treatment Revolving Fund	7

AGENDA

OKLAHOMA HEALTH CARE AUTHORITY
Summary of Revenues & Expenditures: OHCA
SFY 2016, For the Six Month Period Ending December 31, 2015

REVENUES	FY16 Budget YTD	FY16 Actual YTD	Variance	% Over/ (Under)
State Appropriations	$ 474,001,888	$ 474,001,888	$ -	0.0%
Federal Funds	1,159,237,308	1,153,223,779	(6,013,530)	(0.5)%
Tobacco Tax Collections	23,130,082	25,216,168	2,086,086	9.0%
Quality of Care Collections	38,529,345	38,033,383	(495,962)	(1.3)%
Prior Year Carryover	67,016,727	67,016,727	-	0.0%
Federal Deferral - Interest	152,737	152,737	-	0.0%
Drug Rebates	130,133,583	135,910,903	5,777,320	4.4%
Medical Refunds	18,521,273	17,843,043	(678,230)	(3.7)%
Supplemental Hospital Offset Payment Program	100,738,627	100,738,627	-	0.0%
Other Revenues	8,405,916	8,796,371	390,455	4.6%
TOTAL REVENUES	**$ 2,019,867,486**	**$ 2,020,933,626**	**$ 1,066,140**	**0.1%**

EXPENDITURES	FY16 Budget YTD	FY16 Actual YTD	Variance	% (Over)/ Under
ADMINISTRATION - OPERATING	**$ 27,168,720**	**$ 25,035,397**	**$ 2,133,323**	**7.9%**
ADMINISTRATION - CONTRACTS	**$ 48,455,129**	**$ 44,773,474**	**$ 3,681,655**	**7.6%**
MEDICAID PROGRAMS				
Managed Care:				
SoonerCare Choice	19,864,236	19,471,886	392,350	2.0%
Acute Fee for Service Payments:				
Hospital Services	458,215,345	457,629,154	586,191	0.1%
Behavioral Health	9,923,461	10,123,479	(200,018)	(2.0)%
Physicians	236,448,769	236,266,295	182,474	0.1%
Dentists	67,555,165	67,436,093	119,072	0.2%
Other Practitioners	22,583,470	22,501,514	81,956	0.4%
Home Health Care	9,983,190	9,983,190	-	0.0%
Lab & Radiology	31,870,392	31,493,850	376,542	1.2%
Medical Supplies	23,198,602	23,133,799	64,802	0.3%
Ambulatory/Clinics	64,344,509	65,238,212	(893,703)	(1.4)%
Prescription Drugs	261,063,430	261,063,430	-	0.0%
OHCA Therapeutic Foster Care	401,248	283,851	117,397	29.3%
Other Payments:				
Nursing Facilities	288,239,103	288,239,103	-	0.0%
Intermediate Care Facilities for Individuals with Intellectual Disabilities Private	30,415,250	30,415,250	-	0.0%
Medicare Buy-In	67,817,524	67,817,524	-	0.0%
Transportation	32,764,964	32,764,964	-	0.0%
Money Follows the Person-OHCA	357,438	227,711	129,727	0.0%
Electonic Health Records-Incentive Payments	3,743,987	3,743,987	-	0.0%
Part D Phase-In Contribution	40,180,721	40,179,000	1,721	0.0%
Supplemental Hospital Offset Payment Program	226,781,184	226,781,184	-	0.0%
Telligen	2,988,640	2,087,924	900,716	30.1%
Total OHCA Medical Programs	**1,898,740,627**	**1,896,881,400**	**1,859,227**	**0.1%**
OHCA Non-Title XIX Medical Payments	9,158	-	9,158	0.0%
TOTAL OHCA	**$ 1,974,373,634**	**$ 1,966,690,271**	**$ 7,683,363**	**0.4%**
REVENUES OVER/(UNDER) EXPENDITURES	**$ 45,493,852**	**$ 54,243,355**	**$ 8,749,503**	

AGENDA

OKLAHOMA HEALTH CARE AUTHORITY
Total Medicaid Program Expenditures
by Source of State Funds
SFY 2016, For the Six Month Period Ending December 31, 2015

Category of Service	Total	Health Care Authority		Quality of Care Fund	HEEIA	SHOPP Fund	BCC Revolving Fund	Other State Agencies
SoonerCare Choice	$ 19,539,659	$ 19,465,466	$ 19,471,886	$ -	$ 67,773	$ -	$ 6,419	$ -
Inpatient Acute Care	565,485,309	313,825,078	482,811,124	243,343	1,997,384	167,684,823	1,057,880	80,676,801
Outpatient Acute Care	189,691,715	140,739,973	187,794,765	20,802	1,896,950	45,291,912	1,742,078	
Behavioral Health - Inpatient	24,206,307	6,100,931	19,115,396	-	131,388	13,014,465	-	4,959,523
Behavioral Health - Psychiatrist	4,812,532	4,022,548	4,812,532	-	-	789,984	-	-
Behavioral Health - Outpatient	14,347,111	-	-	-	-	-	-	14,347,111
Behaviorial Health-Health Home	10,547,359	-		-	-	-	-	10,547,359
Behavioral Health Facility- Rehab	129,176,359	-	-	-	-	-	40,488	129,176,359
Behavioral Health - Case Management	9,226,035	-	-	-	-	-	-	9,226,035
Behavioral Health - PRTF	41,961,704	-	-	-	-	-	-	41,961,704
Residential Behavioral Management	10,058,388	-	-	-	-	-	-	10,058,388
Targeted Case Management	32,475,090	-	-	-	-	-	-	32,475,090
Therapeutic Foster Care	283,851	283,851	283,851	-	-	-	-	-
Physicians	266,627,027	233,449,293	236,266,295	29,050	929,369	-	2,787,952	29,431,362
Dentists	67,441,593	67,429,238	67,436,093	-	5,500	-	6,855	-
Mid Level Practitioners	1,292,182	1,284,474	1,284,808	-	7,374	-	334	-
Other Practitioners	21,258,736	20,990,642	21,216,706	223,182	42,030	-	2,882	-
Home Health Care	9,985,561	9,978,537	9,983,190	-	2,371	-	4,652	-
Lab & Radiology	32,163,582	31,284,788	31,493,850	-	669,732	-	209,062	-
Medical Supplies	23,265,166	21,759,094	23,133,799	1,355,766	131,366	-	18,939	-
Clinic Services	65,835,537	61,564,760	61,647,075	-	312,440	-	82,315	3,876,022
Ambulatory Surgery Centers	3,652,708	3,583,079	3,591,137	-	61,571	-	8,059	-
Personal Care Services	6,468,314	-		-	-	-	-	6,468,314
Nursing Facilities	288,239,103	181,780,346	288,239,103	106,435,281	-	-	23,476	-
Transportation	32,668,772	31,346,339	32,668,772	1,321,481	-	-	952	-
GME/IME/DME	61,536,864	-		-	-	-	-	61,536,864
ICF/IID Private	30,415,250	24,850,887	30,415,250	5,564,363	-	-	-	-
ICF/IID Public	18,329,923	-	-	-	-	-	-	18,329,923
CMS Payments	107,996,524	107,635,500	107,996,524	361,024	-	-	-	
Prescription Drugs	266,635,170	260,215,617	261,063,430	-	5,571,739	-	847,813	-
Miscellaneous Medical Payments	96,191	95,974	96,191	-	-	-	217	-
Home and Community Based Waiver	100,393,962	-	-	-	-	-	-	100,393,962
Homeward Bound Waiver	44,226,663	-	-	-	-	-	-	44,226,663
Money Follows the Person	3,128,516	227,711	227,711	-	-	-	-	2,900,805
In-Home Support Waiver	13,122,964	-	-	-	-	-	-	13,122,964
ADvantage Waiver	90,942,756	-	-	-	-	-	-	90,942,756
Family Planning/Family Planning Waiver	2,977,630	-	-	-	-	-	-	2,977,630
Premium Assistance*	22,667,418	-	-	-	22,667,418	-	-	-
Telligen	2,087,924	2,087,924	2,087,924	-	-	-	-	-
Electronic Health Records Incentive Payments	3,743,987	3,743,987	3,743,987	-	-	-	-	-
Total Medicaid Expenditures	**$ 2,639,011,441**	**$ 1,547,746,038**	**$ 1,896,881,400**	**$ 115,554,293**	**$ 34,494,406**	**$ 226,781,184**	**$ 6,840,373**	**$ 707,635,635**

* Includes $22,513,118 paid out of Fund 245

AGENDA

OKLAHOMA HEALTH CARE AUTHORITY
Summary of Revenues & Expenditures:
Other State Agencies
SFY 2016, For the Six Month Period Ending December 31, 2015

REVENUE		FY16 Actual YTD
Revenues from Other State Agencies	$	294,805,092
Federal Funds		436,734,345
TOTAL REVENUES	**$**	**731,539,437**

EXPENDITURES		Actual YTD
Department of Human Services		
Home and Community Based Waiver	$	100,393,962
Money Follows the Person		2,900,805
Homeward Bound Waiver		44,226,663
In-Home Support Waivers		13,122,964
ADvantage Waiver		90,942,756
Intermediate Care Facilities for Individuals with Intellectual Disabilities Public		18,329,923
Personal Care		6,468,314
Residential Behavioral Management		7,997,038
Targeted Case Management		26,877,861
Total Department of Human Services		**311,260,286**
State Employees Physician Payment		
Physician Payments		29,431,362
Total State Employees Physician Payment		**29,431,362**
Education Payments		
Graduate Medical Education		24,915,759
Graduate Medical Education - Physicians Manpower Training Commission		2,436,996
Indirect Medical Education		32,248,316
Direct Medical Education		1,935,793
Total Education Payments		**61,536,864**
Office of Juvenile Affairs		
Targeted Case Management		1,606,496
Residential Behavioral Management		2,061,350
Total Office of Juvenile Affairs		**3,667,845**
Department of Mental Health		
Case Management		9,226,035
Inpatient Psychiatric Free-standing		4,959,523
Outpatient		14,347,111
Health Homes		10,547,359
Psychiatric Residential Treatment Facility		41,961,704
Rehabilitation Centers		129,176,359
Total Department of Mental Health		**210,218,092**
State Department of Health		
Children's First		895,686
Sooner Start		1,395,611
Early Intervention		2,525,364
Early and Periodic Screening, Diagnosis, and Treatment Clinic		1,163,223
Family Planning		68,555
Family Planning Waiver		2,895,219
Maternity Clinic		6,803
Total Department of Health		**8,950,461**
County Health Departments		
EPSDT Clinic		390,913
Family Planning Waiver		13,856
Total County Health Departments		**404,769**
State Department of Education		**114,265**
Public Schools		**455,418**
Medicare DRG Limit		**74,500,000**
Native American Tribal Agreements		**919,472**
Department of Corrections		**735,918**
JD McCarty		**5,440,883**
Total OSA Medicaid Programs	**$**	**707,635,635**
OSA Non-Medicaid Programs	**$**	**36,143,570**
Accounts Receivable from OSA	**$**	**12,239,767**

AGENDA

OKLAHOMA HEALTH CARE AUTHORITY
SUMMARY OF REVENUES & EXPENDITURES:
Fund 205: Supplemental Hospital Offset Payment Program Fund
SFY 2016, For the Six Month Period Ending December 31, 2015

REVENUES	FY 16 Revenue
SHOPP Assessment Fee	$ 100,460,830
Federal Draws	139,785,611
Interest	69,705
Penalties	208,092
State Appropriations	(15,100,000)
TOTAL REVENUES	**$ 225,424,237**

EXPENDITURES	Quarter	Quarter	FY 16 Expenditures
Program Costs:	7/1/15 - 9/30/15	10/1/15 - 12/31/15	
Hospital - Inpatient Care	83,225,354	84,459,469	$ 167,684,823
Hospital -Outpatient Care	22,465,442	22,826,470	45,291,912
Psychiatric Facilities-Inpatient	6,265,547	6,748,918	13,014,465
Rehabilitation Facilities-Inpatient	392,213	397,771	789,984
Total OHCA Program Costs	112,348,555	114,432,629	$ 226,781,185
Total Expenditures			**$ 226,781,185**

CASH BALANCE	$ (1,356,947)

*** Expenditures and Federal Revenue processed through Fund 340

AGENDA

OKLAHOMA HEALTH CARE AUTHORITY
SUMMARY OF REVENUES & EXPENDITURES:
Fund 230: Nursing Facility Quality of Care Fund
SFY 2016, For the Six Month Period Ending December 31, 2015

REVENUES	Total Revenue	State Share
Quality of Care Assessment	$ 38,012,639	$ 38,012,639
Interest Earned	20,744	20,744
TOTAL REVENUES	**$ 38,033,383**	**$ 38,033,383**

EXPENDITURES	FY 16 Total $ YTD	FY 16 State $ YTD	Total State $ Cost
Program Costs			
Nursing Facility Rate Adjustment	$ 104,618,386	$ 40,131,613	
Eyeglasses and Dentures	138,534	53,142	
Personal Allowance Increase	1,678,360	643,819	
Coverage for Durable Medical Equipment and Supplies	1,355,766	520,072	
Coverage of Qualified Medicare Beneficiary	516,378	198,083	
Part D Phase-In	361,024	138,489	
ICF/IID Rate Adjustment	2,631,179	1,009,320	
Acute Services ICF/IID	2,933,184	1,125,169	
Non-emergency Transportation - Soonerride	1,321,481	506,920	
Total Program Costs	**$ 115,554,293**	**$ 44,326,627**	**$ 44,326,627**
Administration			
OHCA Administration Costs	$ 262,245	$ 131,123	
DHS-Ombudsmen	-	-	
OSDH-Nursing Facility Inspectors	-	-	
Mike Fine, CPA	-	-	
Total Administration Costs	**$ 262,245**	**$ 131,123**	**$ 131,123**
Total Quality of Care Fee Costs	**$ 115,816,538**	**$ 44,457,749**	
TOTAL STATE SHARE OF COSTS			**$ 44,457,749**

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.

AGENDA

OKLAHOMA HEALTH CARE AUTHORITY
SUMMARY OF REVENUES & EXPENDITURES:
Fund 245: Health Employee and Economy Improvement Act Revolving Fund
SFY 2016, For the Six Month Period Ending December 31, 2015

REVENUES	FY 15 Carryover	FY 16 Revenue	Total Revenue
Prior Year Balance	$ 27,746,235	$ -	$ 1,498,834
State Appropriations	(25,000,000)	-	-
Tobacco Tax Collections	-	20,740,186	20,740,186
Interest Income	-	109,610	109,610
Federal Draws	235,637	14,880,181	14,880,181
TOTAL REVENUES	**$ 2,981,872**	**$ 35,729,976**	**$ 37,228,811**

EXPENDITURES		FY 15 Expenditures	FY 16 Expenditures	Total $ YTD
Program Costs:				
	Employer Sponsored Insurance		$ 22,513,118	$ 22,513,118
	College Students		154,300	59,190
Individual Plan				
	SoonerCare Choice		$ 64,815	$ 24,863
	Inpatient Hospital		1,983,502	760,872
	Outpatient Hospital		1,870,131	717,382
	BH - Inpatient Services-DRG		128,164	49,164
	BH -Psychiatrist		-	-
	Physicians		907,269	348,029
	Dentists		4,516	1,732
	Mid Level Practitioner		7,275	2,791
	Other Practitioners		41,494	15,917
	Home Health		2,371	909
	Lab and Radiology		657,311	252,144
	Medical Supplies		125,654	48,201
	Clinic Services		308,351	118,284
	Ambulatory Surgery Center		61,571	23,619
	Prescription Drugs		5,498,113	2,109,076
	Miscellaneous Medical		-	-
	Premiums Collected		-	(219,075)
Total Individual Plan			**$ 11,660,538**	**$ 4,253,907**
	College Students-Service Costs		**$ 166,450**	**$ 63,850**
Total OHCA Program Costs			**$ 34,494,406**	**$ 26,890,065**
Administrative Costs				
	Salaries	$ 73,467	$ 1,071,261	$ 1,144,728
	Operating Costs	60,069	449,565	509,633
	Health Dept-Postponing	-	-	-
	Contract - HP	1,349,503	4,827,177	6,176,679
Total Administrative Costs		**$ 1,483,038**	**$ 6,348,003**	**$ 7,831,041**
Total Expenditures				**$ 34,721,106**
NET CASH BALANCE		**$ 1,498,834**		**$ 2,507,705**

AGENDA

OKLAHOMA HEALTH CARE AUTHORITY

SUMMARY OF REVENUES & EXPENDITURES:

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

SFY 2016, For the Six Month Period Ending December 31, 2015

REVENUES	FY 16 Revenue	State Share
Tobacco Tax Collections	$ 413,789	$ 413,789
TOTAL REVENUES	**$ 413,789**	**$ 413,789**

EXPENDITURES	FY 16 Total $ YTD	FY 16 State $ YTD	Total State $ Cost
Program Costs			
SoonerCare Choice	$ 6,419	$ 985	
Inpatient Hospital	1,057,880	162,385	
Outpatient Hospital	1,742,078	267,409	
Inpatient Services-DRG	-	-	
Psychiatrist	-	-	
TFC-OHCA	-	-	
Nursing Facility	3,113	478	
Physicians	2,787,952	427,951	
Dentists	6,855	1,052	
Mid-level Practitioner	334	51	
Other Practitioners	2,882	442	
Home Health	4,652	714	
Lab & Radiology	209,062	32,091	
Medical Supplies	18,939	2,907	
Clinic Services	82,315	12,635	
Ambulatory Surgery Center	8,059	1,237	
Prescription Drugs	847,813	130,139	
Transportation	21,316	3,272	
Miscellaneous Medical	217	33	
Total OHCA Program Costs	**$ 6,799,885**	**$ 1,043,782**	
OSA DMHSAS Rehab	$ 40,488	$ 10,685	
Total Medicaid Program Costs	**$ 6,840,373**	**$ 1,054,467**	
TOTAL STATE SHARE OF COSTS			**$ 1,054,467**

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.

AGENDA

SoonerCare Operations Update

OHCA Board Meeting
February 11, 2016
(December 2015 Data)

SOONERCARE ENROLLMENT/EXPENDITURES

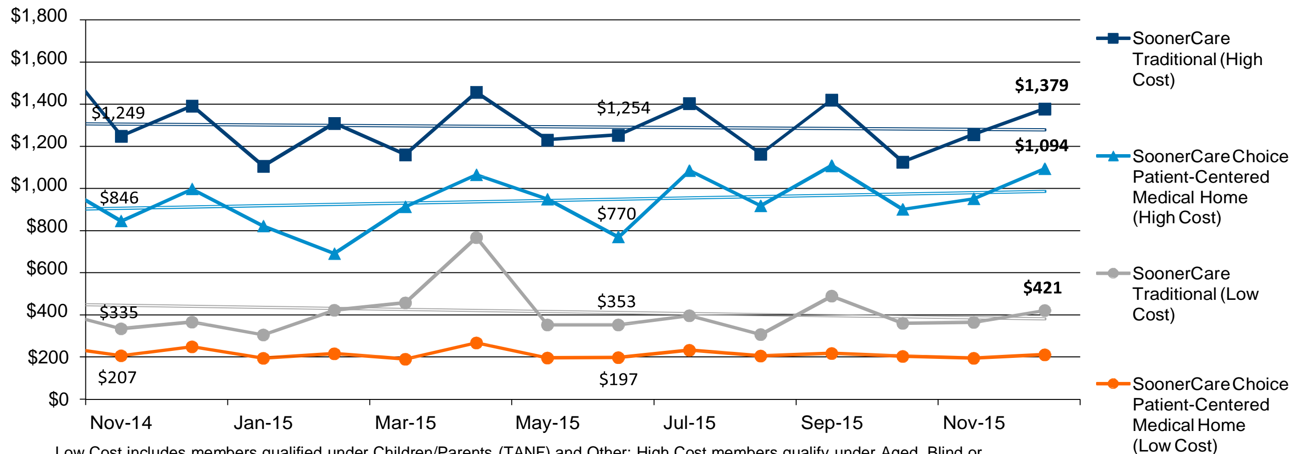
Delivery System			Enrollment December 2015	Children December 2015	Adults December 2015	Enrollment Change	Total Expenditures December	PMPM December 2015	December 2015 Trend PMPM
SoonerCare Choice Patient-Centered Medical Home			**528,202**	**435,237**	**92,965**	**-3,470**	**$150,844,265**		
	Lower Cost	*(Children/Parents; Other)*	484,242	421,339	62,903	-3,567	$102,770,193	$212	$205
	Higher Cost	*(Aged, Blind or Disabled; TEFRA; BCC)*	43,960	13,898	30,062	97	$48,074,073	$1,094	$1,026
SoonerCare Traditional			**235,442**	**89,294**	**146,148**	**-2,467**	**$205,715,282**		
	Lower Cost	*(Children/Parents; Other)*	124,245	84,256	39,989	-2,265	$52,341,336	$421	$399
	Higher Cost	*(Aged, Blind or Disabled; TEFRA; BCC & HCBS Waiver)*	111,197	5,038	106,159	-202	$153,373,946	$1,379	$1,292
SoonerPlan			**37,232**	**2,862**	**34,370**	**-1,095**	**$310,278**	$8	$8
Insure Oklahoma			**18,444**	**530**	**17,914**	**292**	**$6,214,078**		
	Employer-Sponsored Insurance		14,598	349	14,249	324	$3,992,371	$273	$281
	Individual Plan		3,846	181	3,665	-32	$2,221,707	$578	$501
TOTAL			**819,320**	**527,923**	**291,397**	**-6,740**	**$363,083,904**		

Enrollment totals include all members enrolled during the report month. Members may not have expenditure data. Children are members aged 0 - 20 or for Insure Oklahoma enrolled as Students or Dependents.

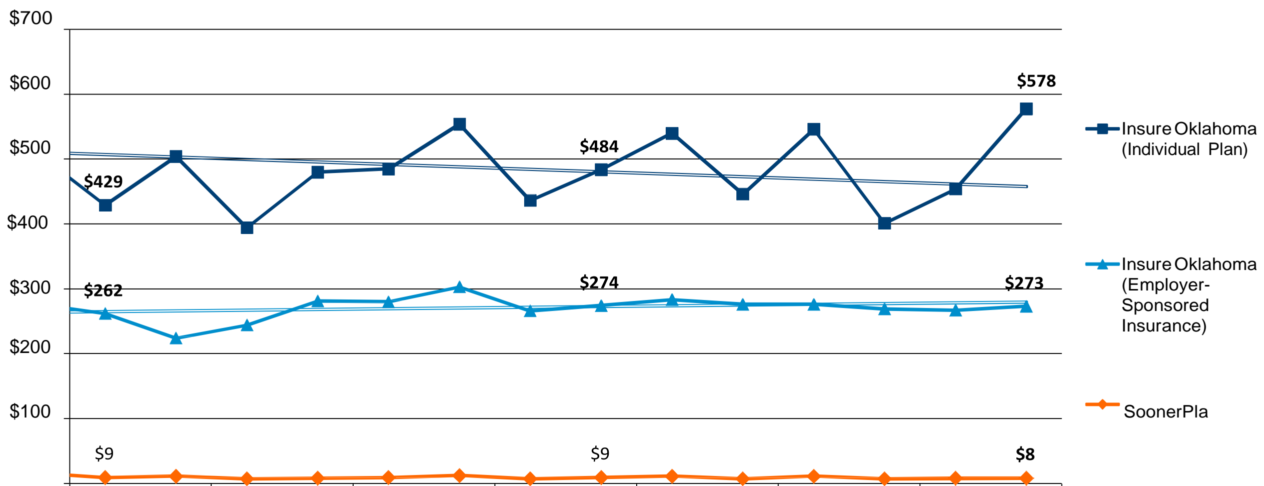
Total In-State Providers: 34,146 (+138) **(In-State Providers counted multiple times due to multiple locations, programs, types, and specialties)**

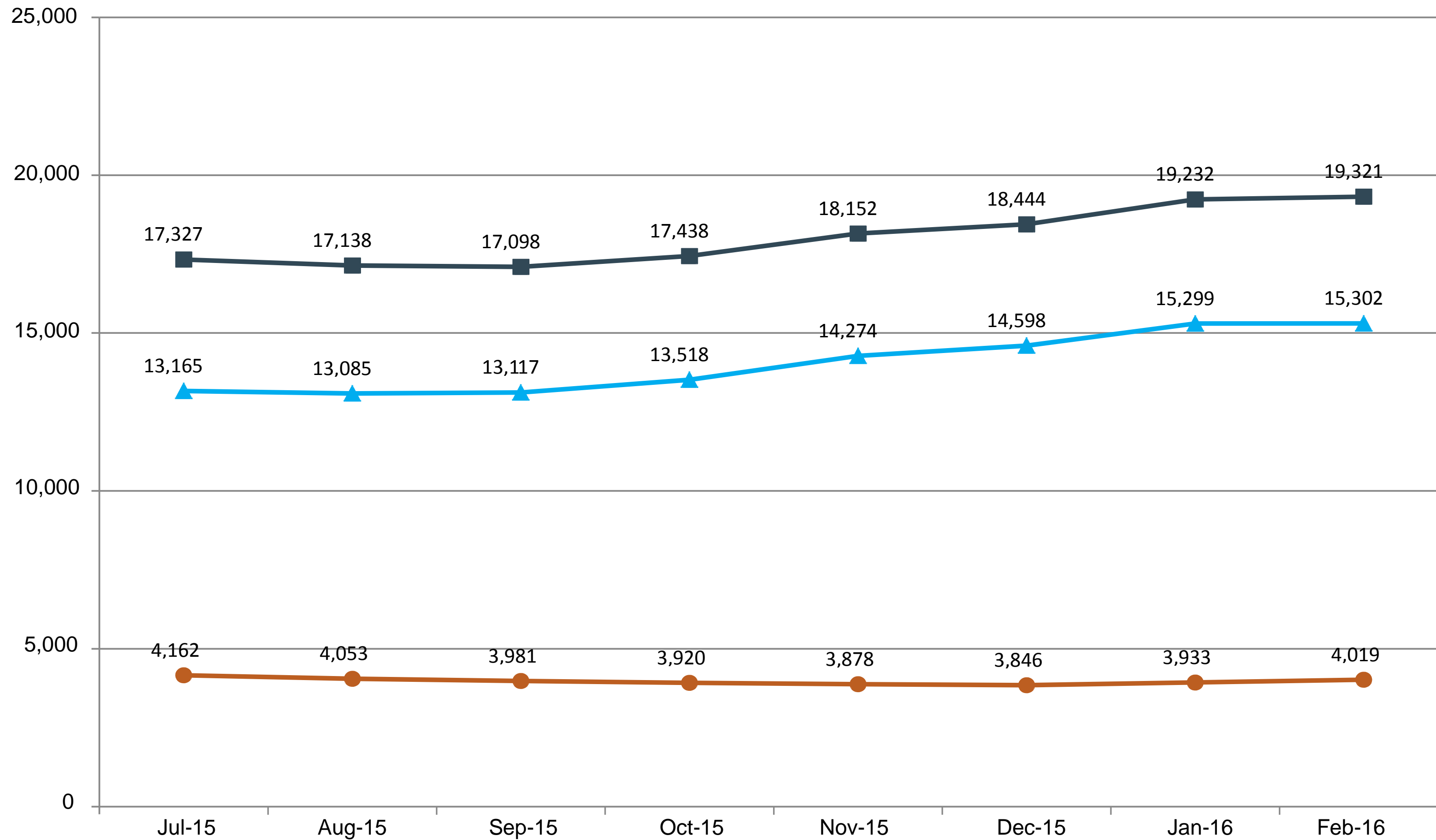
Physician	Pharmacy	Dentist	Hospital	Mental Health	Optometrist	Extended Care	Total PCPs	PCMH
9,758	942	1,220	197	5,437	642	236	6,710	2,552

PER MEMBER PER MONTH COST BY GROUP

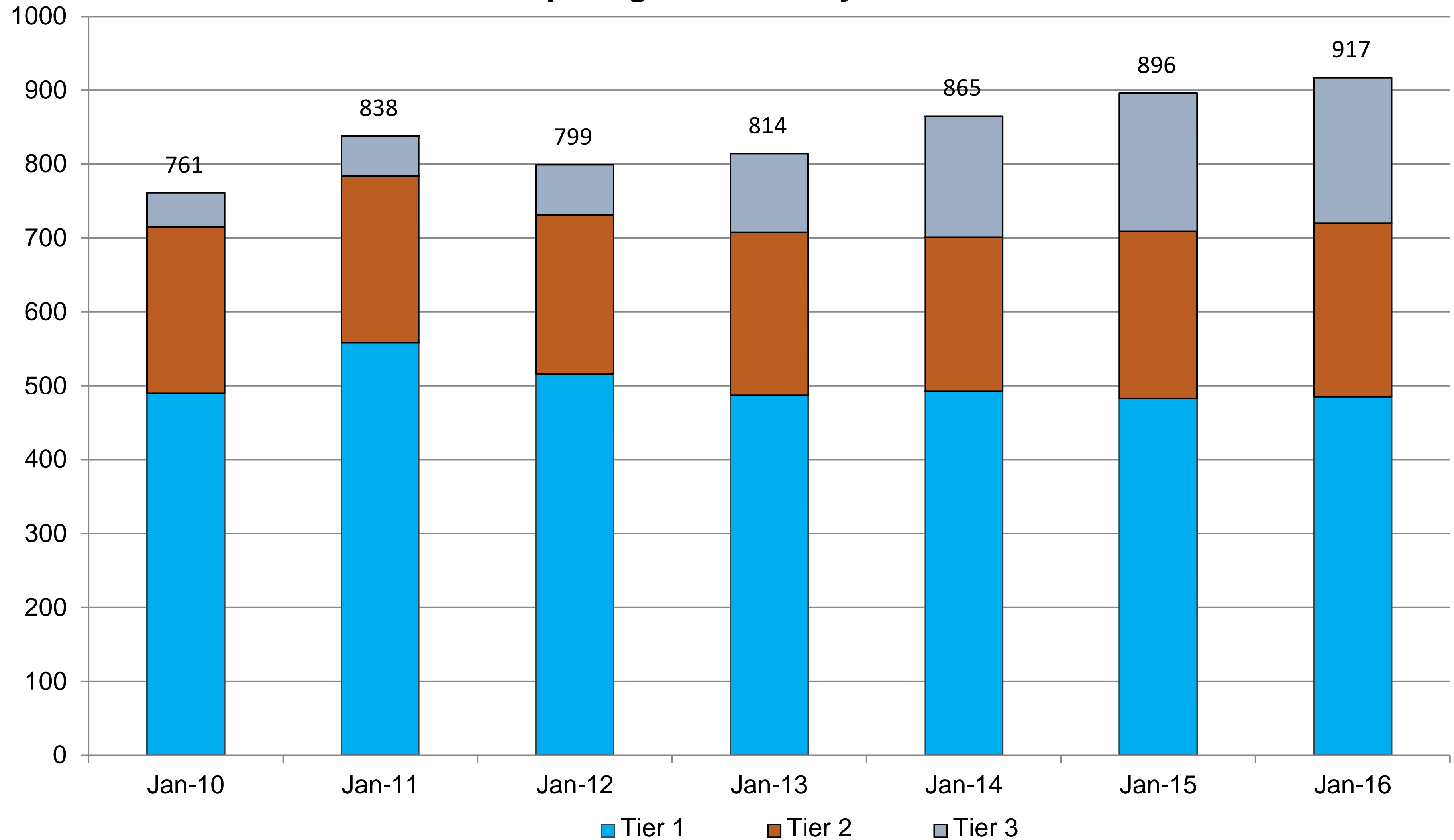


Low Cost includes members qualified under Children/Parents (TANF) and Other; High Cost members qualify under Aged, Blind or Disabled, Oklahoma Cares, TEFRA or a Home and Community-Based Services waiver.





Source: Insure Oklahoma Fast Facts



Note - Practices can include multiple providers.
Source: OHCA Provider Fast Facts

SoonerExcel Behavioral Health Screenings

SoonerExcel Behavioral Health Screenings

DOS	Month Paid	Behavioral Health	Behavioral Health Screens
SFY 2014 Q3	Jul 2014	$7,664	3,832
SFY 2014 Q4	Aug 2014	$12,554	6,277
SFY 2015 Q1	Feb 2015	$15,128	7,564
SFY 2015 Q2	May 2014	$11,676	5,838
SFY 2015 Q3	Jul 2015	$32,605	6,521
SFY 2015 Q4	Oct 2015	$46,330	9,266
SFY 2016 Q1	Jan 2016	$63,665	12,733
		$189,622	**52,031**

Data from OHCA Finance Department.
Prepared Thursday February 25, 2016

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AGENDA

Presentation, Discussion and Vote on Proposed Rule Changes

March MAC
Proposed Rule Amendment Summaries

Face to face tribal consultations regarding the following proposed changes were held Tuesday, November 3, 2015 and Tuesday, January 5, 2016 in the Board Room of the OHCA.

The following rules were posted for comment on January 15, 2016 through February 16, 2016.

15-01 Dental Coverage for Organ Transplant Clearance and Coverage for Emergency Oral Examinations — The proposed Dental policy is revised to mirror new terminology from the Code on Dental Procedures and Nomenclature (CDT) and to clean up outdated language. Revisions also include removing the 36 month language for comprehensive oral evaluations. Appropriate utilization parameters for comprehensive evaluations are identified in the CDT and eliminating limits in policy will allow the agency to continue to align with parameters set forth in the CDT without future promulgation of rules. In addition, a change includes removing language which restricts emergency examination/limited oral evaluation from being performed within two months, the new proposed language will allow dentist to perform emergency evaluations as medically necessary. Proposed revisions also clarify the separate note requirement must address the 5A's and that the signature is one office note signature provided at the end of the visit.
Budget Impact: The proposed rule to remove restrictions on when dentist can perform emergency examination/limited oral evaluation will result in additional costs to the agency. The rule change has total projected cost of: $130,597; a federal share of $79,155 and a state share of $51,442 for SFY 2017. The agency has identified administrative cost savings that could offset the cost of implementing the proposed policy change. There is an expenditure of approximately $42,000 a year in staff costs to manually process claims for emergency examination/limited oral evaluation. The impact of these administrative dollars could be better utilized by the agency permitting the Dental Services Unit to devote resources to other duties.

15-07A General Coverage and Obstetrical Reimbursement — The proposed policy revisions to the Obstetrical policy amend the reimbursement structure for OB services. Currently the agency utilizes the global care CPT codes for routine obstetrical care billing, which can be used if the provider provided care for a member for greater than one trimester. The proposed policy will require obstetrical care be billed using the appropriate evaluation and management codes for antepartum care, as well as the appropriate delivery only and postpartum care services when rendered. The change allows for more accurate tracking of each antepartum service provided as well as the postpartum service. Additionally, proposed General Coverage policy is amended to clarify the separate note and signature requirement for providers performing tobacco use cessation counseling. Proposed revisions clarify the separate note requirement must address the 5A's and that the signature is one office note signature provided at the end of the visit. Other revisions to General Coverage policy include striking reimbursement language for clinical fellows or chief residents in an outpatient academic setting. OHCA reimburses chief residents the same as residents and the separate payment distinction based on practice setting is not needed. Additional changes include general language clean-up to terms and services to ensure language is consistent throughout Chapter 30.
Budget Impact: Savings identified with decreasing the number of ultrasounds and biophysical profiles/non-stress test for pregnant women, revoking payment for the removal of benign skin lesions for adults, and elimination of coverage for adult sleep studies were approved during the promulgation of the emergency rule. No additional savings or cost will be incurred.

Restructuring the reimbursement for OB services will result in additional savings to the agency. There would be an estimated total savings for SFY 2016 of $3,831,661; total state savings are projected as $1,444,537.

15-07B Obstetrical Reimbursement — Proposed Obstetrical policy amends the reimbursement structure for OB services. Currently the agency utilizes the global care CPT codes for routine obstetrical care billing, which can be used if the provider had provided care for a member for greater than one trimester. The proposed policy will require obstetrical care be billed using the appropriate evaluation and management codes for antepartum care, as well as the appropriate delivery only and postpartum care services when rendered. The change allows for more accurate tracking of each antepartum service provided as well as the postpartum service.
Budget Impact: Restructuring the payment for OB services will result in savings to the agency which have been identified in WF 15-07A.

15-08 Urine Drug Screening and Testing — Proposed revisions to Urine Drug Screening policy clarifies the difference between quantitative and qualitative testing and when quantitative urine drug screening is an appropriate test to utilize. Changes are also proposed to general laboratory services policy to clarify appropriate billing for detection of individual infectious organisms.
Budget Impact: Budget neutral

15-17 Eyeglasses Cleanup — Proposed policy changes clarify that eyeglasses meant as a backup are not covered, clarify that high-index lenses require prior authorization and other minor changes for clarity. Proposed policy changes clarify that members can select eyeglasses with special features that exceed the SoonerCare allowable fee as long as the provider obtains signed consent from the member. The member will be responsible for the excess cost and the provider must be able to dispense standard eyeglasses for which SoonerCare would fully reimburse.
Budget Impact: Budget neutral

15-18 Policy Revision to Comply with State Legislation Dealing with Complex Rehabilitation Technology Products and Services — Proposed DME revisions establish focused regulations and policies for Complex Rehabilitation Technology (CRT) products and services to comply with state legislation. The proposed revisions designate specific HCPCS billing codes as CRT, and establish specific supplier standards for companies that provide CRT. The revisions establish requirements and restrict the provision of CRT to only qualified CRT suppliers.
Budget Impact: Budget neutral

15-21 Diagnostic Testing Facilities — The proposed Diagnostic Testing Facility policy is amended to define services that fall within the scope of authority for independent diagnostic testing facilities (IDTF). The proposed changes clarify reimbursement for the professional and technical components for rendered services and physician oversight. The language requires that IDTF supervising physicians must: oversee non-physician personnel, monitor the quality of the testing performed, and monitor the operation and calibration of equipment.
Budget Impact: Budget neutral

15-24 Dental Oversight Requirements for Supervision of Anesthetists and General Clean-up of Terms — The proposed Dental policy is amended to mirror new terminology from the Code on Dental Procedures and Nomenclature (CDT), to clean-up outdated terms, and to add oversight requirements for dentist who supervise certified registered nurse anesthetist during the administration of anesthesia to members. The oversight requirement would align OHCA policy with requirements set forth by the Oklahoma Board of Dentistry. In addition, revisions include updating policy to reflect that diagnosis codes must appear on the dental form when requesting a prior authorization and the removal of language for the recoupment of restoration services. The removal of recoupment language will mirror other policy sections concerning dental services that are silent to the recoupment process. Recoupment for inappropriate restorations will still occur as deemed appropriate by the agency's Program Integrity Division.
Budget Impact: Budget neutral

15-28 Indian Health Service, Tribal, and Urban Indian Language Update — Proposed Indian Health Services, Tribal Programs and Urban Indian Clinics (I/T/U) policy is revised for clarity and consistency with

other sections of Chapter 30. Proposed revisions update professional staff titles, clarify requirements for providers to contract with OHCA and appear on the IHS listing of tribal facilities, update language to include the use of OHCA's EPE system and clarify professional staff recognized by OHCA. Additional revisions would remove language on telemedicine originating site fees, define homebound individuals, require documentation of treatment and add requirements for licensure candidates. Proposed revisions include clean-up to remove outdated policy to align with current practice and to clarify I/T/U encounters and outpatient encounters, inpatient practitioner services and prior authorization procedures.
Budget Impact: Budget neutral

15-36 Policy Revision to Remove Specific Limits on Diabetic Testing Supplies — The proposed revisions remove specific quantity limits to diabetic testing supplies to replace with more general language about testing supplies being based on insulin use or type of diabetes. Proposed revisions also specify that a prior authorization may be required for supplies beyond the standard allowance.
Budget Impact: Budget neutral

15-38 Quality of Care Fund Reports — Proposed Quality of Care (QOC) policy revisions clarify procedures for the completion and submission of the QOC Report. Rules will be amended to correctly list the types of employee positions that are counted in staffing ratios and outline procedures for counting non-direct care workers when those employees are rendering direct care. Revisions eliminate references to outdated submission methods such as certified mail, diskettes and electronic mail, while adding a requirement to submit QOC reports via the provider portal. Proposed policy revisions clarify the types of information required in the QOC report and update staff unit terminology.
Budget Impact: Budget neutral

15-41 Third Party Liability — Proposed revisions to policy clarify the payer of last resort provisions when third party liability claims are involved. Revisions include adding exceptions to policy for medical expenses incurred in relation to a claim or lawsuit for which third party responsibility is involved. Policy revisions include clarification concerning certain denials by private insurance companies. Proposed revisions also include language to prohibit billing more than the Medicaid rate for a covered service and that the payments made by OHCA represent payment in full.
Budget Impact: Budget neutral

15-42 Audit Procedures — Proposed program integrity audit and review policy is revised to clarify OHCA audit procedures and address issues such as extrapolation, reconsideration and audits. Definitions will be expanded to include universe, sample and error rate. Language will be amended to clarify those items included in the audit/review process, the provider's options after an initial audit/review, and the process for selecting sample claims in a probability sample audit.
Budget Impact: Budget neutral

15-43 Appeals Procedures — Proposed OHCA policy changes clarify and make corrections to instructions for the submission of claim inquiries by providers. Proposed changes include title change of section from appeals procedures to claim inquiry procedures, removal of incorrect references to revoked policy, and updated guidance on proper form used for claim inquiries. Proposed policy changes should result in decreased confusion for providers inquiring about payment for services provided to members.
Budget Impact: Budget neutral

15-48 Service Quality Review — Proposed policy revisions replace Inspection of Care language with the more appropriate Service Quality Review language to mirror practice and other policy changes. In addition, minor cleanup changes were made and the term outpatient was removed where referenced regarding behavioral health services to minimize confusion for Therapeutic Foster Care (TFC) providers. Rules are also revised to broaden the definition of employment to align with TFC agencies' employment practices with Treatment Parent Specialist (TPS). Current policy language regarding employment status of TPS in a TFC is problematic for TFC agencies as there are different variations of “employment” among the agencies. Changing

policy language from "employment" to "employment relationship" will create more inclusive terminology which will reflect the various arrangements TFC agencies have with TPS (i.e. full-time employment, contractual employment, etc.).
Budget Impact: Budget neutral

15-50 Policy Revision to Amend Policy Regarding Home Property in a Revocable Trust as a Countable Resource — Proposed policy changes amend countable resource rules which stated that home property in a revocable trust retained certain exemptions outlined in another section of policy. Home property in a revocable trust does not retain those exemptions thus it was deleted from policy.
Budget Impact: Budget neutral

15-52 Amend Appeal Process to Clarify and Limit the Scope of the ALJ's Jurisdiction — Proposed policy changes correct citations and references to state statutes, specify that policy addresses appeals and not grievances which are addressed in other sections, remove provisions related to the Administrative Law Judge's jurisdiction to match other rules and statutes and language clean-up for clarity and accuracy.
Budget Impact: Budget neutral

15-53 Policy Revision to Streamline the Process of Program Integrity Audit Appeals and Rule Revocation of Nursing Home Provider Contract Appeals Policy — The proposed policy clarifies the purpose of the Program Integrity audit appeal hearings, clarifies which issues

are appealable, and streamlines the process of audit appeal hearings. In addition, OHCA proposes to revoke the rules in nursing home provider contract appeals policy.
Budget Impact: Budget neutral

15-54 Insure Oklahoma Clean Up — The proposed revisions to the Insure Oklahoma policy clarify inconsistent and conflicting language. Proposed revisions include clean-up to remove outdated policy to align with current business practices. Proposed revisions add coverage for emergency transportation for the Insure Oklahoma Individual Plan members.
Budget Impact: There is no budget impact for language clean up. To add emergency transportation the total budget impact is $16,164,048.22 at an average cost of $40.67 per adult.

15-55 Programs of All-Inclusive Care for the Elderly (PACE) Transfer Guidelines — The proposed PACE policy revisions are to provide clarification on enrollment standards for members who voluntarily dis-enroll and wish to transfer from one PACE site to another PACE site to align with current business practices.
Budget Impact: Budget neutral

15-56 Pharmacy Lock-In — The proposed policy revisions clarify and enhance lock-in procedures. Proposed revisions would strengthen the consequences of not adhering to the lock-in restrictions by sanctioning members who have been locked in with a single prescriber and pharmacy.
Budget Impact: Budget neutral

15-57 Long Term Care (LTC) Clean Up — The proposed LTC policy is revised to assure that the LTC waiver language and policy are the same. Additional revisions are to detail operation and procedural changes that have occurred since receiving the five year renewal.
Budget Impact: Budget neutral

15-58 DSM Reference Clean Up and Ad Hoc Reviews — Proposed policy revisions remove outdated references to Axis I and II diagnosis language to align with changes to the Diagnostic and Statistical Manual of Mental Disorders (DSM). Additional revisions clarify assessment and evaluation criterion and include cleanup to outdated language. Rules are also revised to remove outdated references to provider manual to reflect current procedures for out-of-state reviews. In addition policy is revised to include Service Quality Review requirements for Ad Hoc reviews.

Budget Impact: Budget neutral

15-61 Appeal Process for Contract Terminations — The proposed Grievance Procedures and Process policy amends language to clarify the appeals process for a 30 day for cause and immediate contract termination and removes references to suspended contracts. Proposed changes also add language to rules addressing 60 day without cause termination. The amendments makes clear that pursuant to contract terms, either party may terminate the contract with a 30 day written notice when it is a for cause termination, or with a 60 day notice if the termination is without cause. Additionally, changes detail the post-termination panel committee composition and its function and add language that specifies the timeframe for which a provider must submit a written response to OHCA requesting reconsideration.
Budget Impact: Budget neutral

15-62 Staffing Ratio — Proposed policy revisions clarify nurse staffing ratio, 24 hour nursing care requirements and to outline supervision requirements for psychiatric facilities. In addition, revisions clarify that any unit that does not allow clear line of site due to presence of walls or doors is a separate unit. Additionally, revisions include adding a requirement that admission assessments for inpatient psychiatric care both acute and residential levels must be provided in accordance to federal regulations.
Budget Impact: Budget neutral

15-65 Behavioral Health Admission Assessment and Evaluations — Proposed policy revisions clarify that candidates for licensure can perform assessments and psychosocial evaluations when appropriate and medically necessary. In addition, revisions clarify that for existing evaluations of 30 days or less, must be reviewed, when a member changes provider or level of care. The evaluation(s) must be updated as necessary and signed and dated by the appropriate level of professional.
Budget Impact: Budget neutral

15-66 Application Process for Military Personnel — The proposed rule amendment will allow active military personnel who applied for Home and Community-Based Services (HCBS) in another state to have the application date honored in the state of Oklahoma.
Budget Impact: Budget neutral

AGENDA

15-01 Dental Coverage for Organ Transplant Clearance and Coverage for Emergency Oral Examinations

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) medically necessary extractions and approved boney adjustments. Tooth extraction must have medical need documented;

(ii) Smoking and Tobacco Use Cessation Counseling; and

(iii) medical and surgical services performed by a dentist or physician to the extent such services may be performed under State law 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 Individuals with Intellectual Disabilities (ICF/IID) and who have been approved for ICF/IID level of care, similar to the scope of services available to individuals under age 21.

(C) Limited dental services are available for members who meet all medical criteria, but need dental clearance to obtain organ transplant approval. Providers must obtain prior authorization before delivery of dental service, with the exception of evaluation and extractions. All requests must be filed on the currently approved ADA form and must include diagnostic images, six-point periodontal charting, narratives and comprehensive treatment plans. The OHCA will notify the provider of determination using OHCA Prior Authorization Request Decision form. Prior authorized services must be billed exactly as they appear on the prior authorization request. The following dental services are available:

(i) Comprehensive oral evaluation,

(ii) two image bitewings,

(iii) prophylaxis,

(iv) fluoride application,

(v) limited restorative procedures, and

(vi) periodontal scaling/root planing.

(2) **Home and community based waiver services (HCBWS) for the 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 may be performed for any member every 36 months. An examination should precede any radiographs, and chart documentation must include radiographic interpretations, caries risk assessment and both medical and dental health history of member.~~ This procedure should precede any images, and chart documentation must include image interpretations, caries risk assessment and both medical and dental health history of member. The comprehensive treatment plan should be the final results of this procedure.

(B) **Periodic oral evaluation.** This procedure may be provided for a member of record if not seen by ~~a~~any dentist for more than six months. An examination should precede any ~~radiographs~~images, and chart documentation must include ~~radiographic~~images interpretations, caries risk assessment and both medical and dental health history of member. The comprehensive treatment plan should be the final results of this procedure.

(C) ~~**Emergency examination/limited oral evaluation**~~**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.~~ This procedure is only compensable to the same dentist or practice for two visits prior to ~~an~~a comprehensive or periodic evaluation examination being completed.

(D) ~~**Radiographs (x-rays)**~~**Images**. To be SoonerCare compensable, ~~x-rays~~images must be of diagnostic quality and medically necessary. A clinical examination must precede any ~~radiographs~~images, and chart documentation must include member history, prior ~~radiographs~~images, caries risk assessment and both dental and general health needs of the member. The referring dentist is responsible for providing properly identified ~~x-rays~~images of acceptable quality with a referral, if that provider chooses to expose and submit for reimbursement prior to referral. Periapical ~~radiograph~~images must include at least ~~3~~three millimeters beyond the apex of the tooth being ~~x-rayed~~imaged. ~~Panoramic films and full mouth radiographs (minimum of 12 periapical films and two posterior bitewings) are allowable once in a three year period and must be of diagnostic quality.~~ Panoramic films and two bitewings are considered full mouth images. Full mouth images as noted above or traditional (minimum of 12 periapical films and two posterior bitewings) are allowable once in a three year period and must be of diagnostic quality. Individually listed intraoral ~~radiographs~~images by the same dentist/dental office are considered a complete series if the ~~fee for~~number of individual ~~radiographs~~images equals or exceeds the ~~fee~~traditional number for a complete series. Panoramic films are only compensable when chart documentation clearly indicates reasons for the exposure based on clinical findings. This type of exposure is not to rule out or evaluate caries. 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 once every 36 months if medical necessity is documented.

(F) **Dental prophylaxis.** This procedure is provided once every 184 days including topical application of fluoride.

(G) **Stainless steel crowns for primary teeth.** The use of any 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 treated with pulpal therapy, 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) Preoperative periapical ~~x-rays~~<u>images</u> and/or written documentation explaining the extent of decay must be available for review, if requested.

(iv) Placement of a stainless steel crown is allowed once for a minimum period of 24 months. No other restoration 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.

(H) **Stainless steel crowns for permanent teeth.** The use of any stainless steel crowns is allowed as follows:

(i) Stainless steel crowns are the treatment of choice for:

(I) posterior permanent teeth that have completed endodontic therapy if three or more surfaces of tooth is destroyed;

(II) posterior permanent teeth that have three or more surfaces of extensive decay; or

(III) where cuspal occlusion is lost due to decay prior to age 16 years.

(ii) Preoperative periapical ~~x-rays~~<u>images</u> and/or written documentation explaining the extent of decay must be available for review, if requested.

(iii) Placement of a stainless steel crown excludes placement of any other type of crown for a period of 24 months. No other restoration 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.~~

(I) **Pulpotomies and pulpectomies.**

(i) Therapeutic pulpotomies and pulpal debridement are allowable

once per lifetime. Pre-and post-operative periapical ~~x-rays~~images must be available for review, if requested. Therapeutic pulpotomies and pulpal debridement is available for the following:

(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~~five years;

(III) Tooth numbers E and F before ~~6~~six years;

(IV) Tooth numbers N and Q before ~~5~~five years;

(V) Tooth numbers D and G before ~~5~~five years.

(ii) Therapeutic pulpotomies and pulpal debridement 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.

(J) **Endodontics.** Payment is made for the services provided in accordance with the following:

(i) This procedure is allowed when there are no other missing anterior teeth in the same arch requiring replacement.

(ii) The provider documents history of member's improved oral hygiene and flossing ability in records.

(iii) Prior authorization is required for members who have a treatment plan requiring more than two anterior and/or two posterior root canals.

(iv) Pre and post-operative periapical ~~x-rays~~images must be available for review.

(v) Pulpal debridement may be performed for the relief of pain while waiting for the decision from the OHCA.

(vi) Providers are responsible for any follow-up treatment required due to a failed root canal therapy for 24 month post completion.

(vii) Endodontically 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.

(K) **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.

(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 posterior 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~~images 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 the second primary molar (K or T) is missing in the same arch.

(II) The requirements are the same as for band and loop space maintainer.

(III) Pre and post-operative ~~x-rays~~images must be available.

(L) **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 medical need for this service must be documented in the member's record.

(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.

(M) **Pulp caps.** Indirect and direct pulp cap must be ADA accepted calcium hydroxide or Mineral Trioxide Aggregate materials, not a cavity liner or chemical used for dentinal hypersensitivity. 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.

(N) **Protective restorations.** This restoration includes removal of decay, if present, and is reimbursable for the same tooth on the same date of service with a direct or indirect pulp cap, if needed. Permanent restoration of the tooth is allowed after 60 days unless the tooth becomes symptomatic and requires pain relieving treatment.

(O) **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, Oklahoma State Health Department and FQHC nursing, and Maternal/Child Health Licensed Clinical Social Workers with a certification as a Tobacco Treatment Specialist Certification (CTTS) staff in addition to other appropriate services rendered. Chart documentation must include a separate note~~,~~ that addresses the 5A's, 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.

AGENDA

15-07A General Coverage by Category and Obstetrical Reimbursement

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 1. PHYSICIANS

317:30-5-2. General coverage by category

(a) **Adults.** Payment for adults is made to physicians for medical and surgical services within the scope of the Oklahoma Health Care Authority's (OHCA) SoonerCare program, provided the services are reasonable and necessary for the diagnosis and treatment of illness or injury, or to improve the functioning of a malformed body member. Coverage of certain services must be based on a determination made by the OHCA's medical consultant in individual circumstances.

(1) Coverage includes the following medically necessary services:

(A) Inpatient hospital visits for all SoonerCare covered stays. All inpatient services are subject to post-payment review by the OHCA, or its designated agent.

(B) Inpatient psychotherapy by a physician.

(C) Inpatient psychological testing by a physician.

(D) One inpatient visit per day, per physician.

(E) Certain surgical procedures performed in a Medicare certified free-standing ambulatory surgery center (ASC) or a Medicare certified hospital that offers outpatient surgical services.

(F) Therapeutic radiology or chemotherapy on an outpatient basis without limitation to the number of treatments per month for members with proven malignancies ~~or opportunistic infections~~.

(G) Direct physician services on an outpatient basis. A maximum of four visits are allowed per month per member in office or home regardless of the number of physicians providing treatment. Additional visits per month are allowed for those services related to emergency medical conditions and for services in connection with Family Planning.

(H) Direct physician services in a nursing facility for those members residing in a long-term care facility. A maximum of two nursing facility visits per month are allowed. To receive payment for a second nursing facility visit in a month denied by Medicare for a Medicare/SoonerCare member, attach the EOMB from Medicare showing denial and mark "carrier denied coverage".

(I) Diagnostic x-ray and laboratory services.

(J) Mammography screening and additional follow-up mammograms as per current guidelines.

(K) Obstetrical care.

(L) Pacemakers and prostheses inserted during the course of a surgical procedure.

(M) Prior authorized examinations for the purpose of determining medical eligibility for programs administered by OHCA. A copy of the authorization, OKDHS form 08MA016E, Authorization for Examination and Billing, must accompany the claim.
(N) If a physician renders direct care to a member on the same day as a dialysis treatment, payment is allowed for a separately identifiable service unrelated to the dialysis.
(O) Family planning includes sterilization procedures for legally competent members 21 years of age and over who voluntarily request such a procedure and execute the federally mandated consent form with his/her physician. A copy of the consent form must be attached to the claim form. Separate payment is allowed for the insertion and/or implantation of contraceptive devices during an office visit. Certain family planning products may be obtained through the Vendor Drug Program. Reversal of sterilization procedures for the purposes of conception is not allowed. Reversal of sterilization procedures are allowed when medically indicated and substantiating documentation is attached to the claim.
(P) Genetic counseling.
(Q) Laboratory testing ~~(such as complete blood count (CBC), platelet count, or urinalysis) for monitoring members receiving chemotherapy, radiation therapy, or medications that require monitoring during treatment~~.
(R) Payment for ultrasounds for pregnant women as specified in OAC 317:30-5-22.
(S) Payment to the attending physician in a teaching medical facility for compensable services when the physician signs as claimant and renders personal and identifiable services to the member in conformity with federal regulations.
~~(T) Payment to clinical fellow or chief resident in an outpatient academic setting when the following conditions are met:~~

~~(i) Recognition as clinical faculty with participation in such activities as faculty call, faculty meetings, and having hospital privileges;~~
~~(ii) Board certification or completion of an accredited residency program in the fellowship specialty area;~~
~~(iii) Hold unrestricted license to practice medicine in Oklahoma;~~
~~(iv)If Clinical Fellow, practicing during second or subsequent year of fellowship;~~
~~(v) Seeing members without supervision;~~
~~(vi) Services provided not for primary purpose of medical education for the clinical fellow or chief resident;~~
~~(vii) Submit billing in own name with appropriate Oklahoma SoonerCare provider number;~~
~~(viii) Additionally if a clinical fellow practicing during the first year of fellowship, the clinical fellow must be practicing within their area of primary training. The services must be performed within the context of their primary specialty and only to the extent as allowed by their accrediting body.~~

~~(U)~~ (T) Payment to the attending physician for the services of a currently Oklahoma licensed physician in training when the following conditions are met.

(i) Attending physician performs chart review and signs off on the billed encounter;

(ii) Attending physician is present in the clinic/or hospital setting and available for consultation;

(iii) Documentation of written policy and applicable training of physicians in the training program regarding when to seek the consultation of the attending physician.

~~(V)~~ (U) Payment to the attending physician for the outpatient services of an unlicensed physician in a training program when the following conditions are met:

(i) The member must be at least minimally examined by the attending physician or a licensed physician under the supervision of the attending physician;

(ii) The contact must be documented in the medical record.

~~(W)~~ (V) The payment to a physician for medically directing the services of a CRNA or for the direct supervision of the services of an Anesthesiologist Assistant (AA) is limited. The maximum allowable fee for the services of both providers combined is limited to the maximum allowable had the service been performed solely by the anesthesiologist.

~~(X) One pap smear per year for women of child bearing age. Two follow-up pap smears are covered when medically indicated.~~ (W) Screening and follow up Pap Smears as per current guidelines.

~~(Y)~~ (X) Medically necessary solid organ and bone marrow/stem cell transplantation services for children and adults are covered services based upon the conditions listed in (i)-(iv) of this subparagraph:

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

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

(iii) To be compensable under the SoonerCare program, all organ transplants must be performed at a facility which meets the requirements contained in Section 1138 of the Social Security Act.

(iv) Procedures considered experimental or investigational are not covered.

~~(Z)~~ (Y) Donor search and procurement services are covered for transplants consistent with the methods used by the Medicare program for organ acquisition costs.

~~(i) Donor expenses incurred for complications are covered only if they are directly and immediately attributable to the donation procedure.~~

~~(ii) Donor expenses that occur after the 90 day global reimbursement period must be submitted to the OHCA for review.~~

(Z) Donor expenses incurred for complications are covered only if they are directly and immediately attributable to the donation procedure. Donor expenses that occur after the 90 day global reimbursement period must be submitted to the OHCA for review.
(AA) Total parenteral nutritional therapy (TPN) for identified diagnoses and when prior authorized.
(BB) Ventilator equipment.
(CC) Home dialysis equipment and supplies.
(DD) Ambulatory services for treatment of members with tuberculosis (TB). This includes, but is not limited to, physician visits, outpatient hospital services, rural health clinic visits and prescriptions. Drugs prescribed for the treatment of TB beyond the prescriptions covered under SoonerCare require prior authorization by the University of Oklahoma College of Pharmacy Help Desk using form "Petition for TB Related Therapy". Ambulatory services to members infected with TB are not limited to the scope of the SoonerCare program, but require prior authorization when the scope is exceeded.
(EE) Smoking and Tobacco Use Cessation Counseling for treatment of ~~individuals~~members using tobacco.

(i) Smoking and Tobacco Use Cessation Counseling consists of the 5As:

(I) Asking the member to describe their smoking use;
(II) Advising the member to quit;
(III) Assessing the willingness of the member to quit;
(IV) Assisting the member with referrals and plans to quit; and
(V) Arranging for follow-up.

(ii) Up to eight sessions are covered per year per individual.
(iii) Smoking and Tobacco Use Cessation Counseling is a covered service when performed by physicians, physician assistants, advanced registered nurse practitioners, certified nurse midwives, dentists, Oklahoma State Health Department and FQHC nursing staff, and Maternal/Child Health Licensed Clinical Social Workers with a certification as a Tobacco Treatment Specialist Certification (CTTS). It is reimbursed in addition to any other appropriate ~~global payments~~claims for obstetrical care, PCP care coordination payments, evaluation and management codes, or other appropriate services rendered. It must be a significant, separately identifiable service, unique from any other service provided on the same day.
(iv) Chart documentation must include a separate note ~~and~~that addresses the 5A's and office note signature along with 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 and not separately billable.

(FF) Immunizations as specified by the Advisory Committee on

Immunization Practices (ACIP) guidelines.

(GG) Genetic testing is covered when medically necessary. Genetic testing may be considered medically necessary when the following conditions are met:

(i) The member displays clinical features of a suspected genetic condition or is at direct risk of inheriting the genetic condition in question (e.g., a causative familial variant has been identified); and

(ii) Clinical studies published in peer-reviewed literature have established strong evidence that the result of the test will positively impact the clinical decision-making or clinical outcome for the member; and

(iii) The testing method is proven to be scientifically valid for the identification of a specific genetically-linked inheritable disease or clinically important molecular marker; and

(iv) ~~Documentation is provided from a licensed genetic counselor or physician with genetic that supports the recommendation for testing based on a review of risk factors, clinical scenario, and family history.~~A medical geneticist physician or licensed genetic counselor provides documentation that supports the recommendation for testing based on a review of risk factors, clinical scenario, and family history.

(2) General coverage exclusions include the following:

(A) Inpatient admission for diagnostic studies that could be performed on an outpatient basis.

(B) Services or any expense incurred for cosmetic surgery.

(C) Services of two physicians for the same type of service to the same member on the same day, except when supplemental skills are required and different specialties are involved.

(D) ~~Refractions and visual aids.~~Routine eye examinations for the sole purpose of prescribing glasses or visual aids, determination of refractive state, treatment of refractive errors or purchase of lenses, frames or visual aids.

(E) Pre-operative care within 24 hours of the day of admission for surgery and routine post-operative care as defined under the global surgery guidelines promulgated by Current Procedural Terminology (CPT) and the Centers for Medicare and Medicaid Services (CMS).

(F) Payment to the same physician for both an outpatient visit and admission to hospital on the same date.

(G) Sterilization of members who are under 21 years of age, mentally incompetent, or institutionalized or reversal of sterilization procedures for the purposes of conception.

(H) Non-therapeutic hysterectomies.

(I)Medical services considered experimental or investigational.

(J) Payment for more than four outpatient visits per month (home or office) per member, except those visits in connection with family planning or related to emergency medical conditions.

(K) Payment for more than two nursing facility visits per month.

(L) More than one inpatient visit per day per physician.
(M) Physician services which are administrative in nature and not a direct service to the member including such items as quality assurance, utilization review, treatment staffing, tumor board review or multidisciplinary opinion, dictation, and similar functions.
(N) Charges for completion of insurance forms, abstracts, narrative reports or telephone calls.
(O) Payment for the services of social workers, licensed family counselors, registered nurses or other ancillary staff, except as specifically set out in OHCA rules.
(P) Induced abortions, except when certified in writing by a physician that the abortion was necessary due to a physical disorder, injury or illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would place the woman in danger of death unless an abortion is performed, or that the pregnancy is the result of an act of rape or incest. (Refer to OAC 317:30-5-6 or 317:30-5-50.)
(Q) Speech and Hearing services.
(R) Mileage.
(S) A routine hospital visit on the date of discharge unless the member expired.
(T) Direct payment to perfusionist as this is considered part of the hospital reimbursement.
(U) Inpatient chemical dependency treatment.
(V) Fertility treatment.
(W) Payment for removal of benign skin lesions~~ unless medically necessary~~.
(X) Sleep studies.

(b) **Children.** Payment is made to physicians for medical and surgical services for members under the age of 21 within the scope of the Authority's SoonerCare program, provided the services are medically necessary for the diagnosis and treatment of illness or injury, or to improve the functioning of a malformed body member. Medical and surgical services for children are comparable to those listed for adults. For services rendered to a minor child, the child's parent or court-appointed legal guardian must provide written authorization prior to the service being rendered, unless there is an explicit state or federal exception to this requirement. In addition to those services listed for adults, the following services are covered for children.

(1) **Pre-authorization of inpatient psychiatric services.** All inpatient psychiatric services for members under 21 years of age must be prior authorized by an agency designated by the Oklahoma Health Care Authority. All psychiatric services are prior authorized for an approved length of stay. Non-authorized inpatient psychiatric services are not SoonerCare compensable.

(A) All residential and acute psychiatric services are authorized based on the medical necessity criteria as described in OAC 317:30-

5-95.25,317:30-5-95.27 and 317:30-5-95.29.

(B) Out of state placements are not authorized unless it is determined that the needed medical services are more readily available in another state or it is a general practice for members in a particular border locality to use resources in another state. If a medical emergency occurs while a member is out of the State, treatment for medical services is covered as if provided within the State. A prime consideration for placements is proximity to the family or guardian in order to involve the family or guardian in discharge and reintegration planning.

(2) **General acute care inpatient service limitations.** All general acute care inpatient hospital services for members under the age of 21 are not limited. All inpatient care must be medically necessary.

(3) **Procedures for requesting extensions for inpatient services.** The physician and/or facility must provide necessary justification to enable OHCA, or its designated agent, to make a determination of medical necessity and appropriateness of treatment options. Extension requests for psychiatric admissions must be submitted to the OHCA or its designated agent. Extension requests must contain the appropriate documentation validating the need for continued treatment in accordance with the medical necessity criteria described in OAC 317:30-5-95.26, 317:30-5-95.28 and 317:30-5-95.30. Requests must be made prior to the expiration of the approved inpatient stay. All decisions of OHCA or its designated agent are final.

(4) **Utilization control requirements for psychiatric beds.** Utilization control requirements for inpatient psychiatric services for members under 21 years of age apply to all hospitals and residential psychiatric treatment facilities.

(5) **Early and periodic screening diagnosis and treatment program.** Payment is made to eligible providers for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) of members under age 21. These services include medical, dental, vision, hearing and other necessary health care. Refer to OAC 317:30-3-65.2 through 317:30-3-65.11 for specific guidelines.

(6) **Child abuse/neglect findings.** Instances of child abuse and/or neglect discovered through screenings and regular exams are to be reported in accordance with State Law. Section 7103 of Title 10 of the Oklahoma Statutes mandates reporting suspected abuse or neglect to the Oklahoma Department of Human Services. Section 7104 of Title 10 of the Oklahoma Statutes further requires reporting of criminally injurious conduct to the nearest law enforcement agency.

(7) **General exclusions.** The following are excluded from coverage for members under the age of 21:

(A) Inpatient admission for diagnostic studies that could be performed on an outpatient basis.

(B) Services or any expense incurred for cosmetic surgery unless the physician certifies the procedure emotionally necessary.

(C) Services of two physicians for the same type of service to the same member on the same day, except when supplemental skills are

required and different specialties are involved.

(D) Pre-operative care within 24 hours of the day of admission for surgery and routine post-operative care as defined under the global surgery guidelines promulgated by Current Procedural Terminology (CPT) and the Centers for Medicare and Medicaid Services (CMS).

(E) Payment to the same physician for both an outpatient visit and admission to hospital on the same date.

(F) Sterilization of members who are under 21 years of age, mentally incompetent, or institutionalized or reversal of sterilization procedures for the purposes of conception.

(G) Non-therapeutic hysterectomies.

(H) Medical Services considered experimental or investigational.

(I) More than one inpatient visit per day per physician.

(J) Induced abortions, except when certified in writing by a physician that the abortion was necessary due to a physical disorder, injury or illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would place the woman in danger of death unless an abortion is performed, or that the pregnancy is the result of an act of rape or incest. (Refer to OAC 317:30-5-6 or 317:30-5-50.)

(K) Physician services which are administrative in nature and not a direct service to the member including such items as quality assurance, utilization review, treatment staffing, tumor board review or multidisciplinary opinion, dictation, and similar functions.

(L) Payment for the services of social workers, licensed family counselors, registered nurses or other ancillary staff, except as specifically set out in OHCA rules.

(M) Direct payment to perfusionist as this is considered part of the hospital reimbursement.

(N) Charges for completion of insurance forms, abstracts, narrative reports or telephone calls.

(O) Mileage.

(P) A routine hospital visit on date of discharge unless the member expired.

(c) **Individuals eligible for Part B of Medicare.** Payment is made utilizing the OHCA allowable for comparable services. Claims filed with Medicare Part B should automatically cross over to OHCA. The explanation of Medicare Benefits (EOMB) reflects a message that the claim was referred to SoonerCare. If such a message is not present, a claim for coinsurance and deductible must be filed with the OHCA within 90 days of the date of Medicare payment ~~or~~and within one year of the date of service in order to be considered timely filed.

(1) In certain circumstances, some claims do not automatically "cross over". Providers must file a claim for coinsurance and/or deductible to SoonerCare within 90 days of the Medicare payment ~~or~~and within one year from the date of service.

(2) If payment was denied by Medicare Part B and the service is a SoonerCare covered service, mark the claim "denied by Medicare" and

attach the Medicare EOMB showing the reason for the denial.

317:30-5-22. Obstetrical care

~~(a) Obstetrical (OB) care is billed using the appropriate CPT codes for Maternity Care and Delivery. The date of delivery is used as the date of service for charges for total obstetrical care. Inclusive dates of care should be indicated on the claim form as part of the description. Payment for total obstetrical care includes all routine care, and any ultrasounds performed by the attending physician provided during the maternity cycle unless otherwise specified in this Section. For payment of total OB care, a physician must have provided care for more than one trimester. To bill for prenatal care only, the claim is filed after the member leaves the provider's care. Payment for routine or minor medical problems will not be made separately to the OB physician outside of the ante partum visits. The ante partum care during the prenatal care period includes all care by the OB attending physician except major illness distinctly unrelated to the pregnancy.~~

~~(b)Procedures paid separately from total obstetrical care are listed in (1) - (8) of this subsection.~~

(a) Providers of obstetrical services must bill each antepartum visit separately, utilizing the appropriate evaluation and management service code. The OHCA does not recognize the codes for "global obstetrical care" which bundle these services under a single procedure code. Delivery only and postpartum care services are also billed separately by the rendering provider.

(b) The following routine obstetrical services are covered as detailed below:

(1) The completion of an American College of Obstetricians and Gynecologist (ACOG) assessment form or form covering same elements as ACOG and the most recent version of the Oklahoma Health Care Authority's Prenatal Psychosocial Assessment are reimbursable when both documents are included in the prenatal record. SoonerCare allows one assessment per provider and no more than two per pregnancy.

(2) Medically necessary real time ~~ante partum~~antepartum diagnostic ultrasounds will be paid ~~for~~ in addition to ~~ante partum~~antepartum care, delivery and ~~post partum~~postpartum obstetrical care under defined circumstances. To be eligible for payment,all ultrasound reports must meet the guideline standards published by the American Institute of Ultrasound Medicine (AIUM).

(A) One abdominal or vaginal ultrasound will be covered in the first trimester of pregnancy. The ultrasound must be performed by a ~~board certified~~Board Eligible/Board Certified Obstetrician-Gynecologist (OB-GYN), Radiologist, or a Board Eligible/Board Certified Maternal-Fetal Medicine specialist. In addition, this ultrasound may be performed by a Nurse Midwife, Family Practice Physician or Advance Practice Nurse Practitioner in Obstetrics with a certification in obstetrical ultrasonography.

(B)One ultrasound after the first trimester will be covered. This

ultrasound must be performed by a ~~board certified~~Board Eligible/Board Certified Obstetrician-Gynecologist (OB-GYN), Radiologist, or a Board Eligible/Board Certified Maternal-Fetal Medicine specialist. In addition, this ultrasound may be performed by a Nurse Midwife, Family Practice Physician or Advance Practice Nurse Practitioner in Obstetrics with certification in obstetrical ultrasonography.

~~(C) Additional ultrasounds, including detailed ultrasounds and re-evaluations of previously identified or suspected fetal or maternal anomalies must be performed by an active candidate or Board Certified diplomat in Maternal-Fetal Medicine, or Board Certified Obstetrician-Gynecologist (OB-GYN). Up to six repeat ultrasounds are allowed after which, prior authorization is required.~~

(C) One additional detailed ultrasound is allowed by a Board Eligible/Board Certified Maternal Fetal Specialist or general obstetrician with documented specialty training in performing detailed ultrasounds. This additional ultrasound is allowed to identify or confirm a suspected fetal/maternal anomaly. This additional ultrasound does not require prior authorization. Any subsequent ultrasounds will require prior authorization.

(3) Standby attendance at Cesarean Section (C-Section), for the purpose of attending the baby, is compensable when billed by a physician or qualified health care provider not participating in the delivery.

(4) ~~Spinal anesthesia~~Anesthesia administered by the attending physician is a compensable service and ~~is~~may be billed separately from the delivery.

(5) ~~Amniocentesis is not included in routine obstetrical care and is billed separately.~~ Payment may be made for an evaluation and management service and a medically indicated amniocentesis on the same date of service. This is an exception to general information regarding surgery found at OAC 317:30-5-8.

(6) Additional payment is not made for the delivery of ~~twins~~multiple gestations. If one ~~twin~~fetus is delivered vaginally and ~~one is~~additional fetus(es)are delivered by C-section by the same physician, the higher level procedure is paid. If one ~~twin~~fetus is delivered vaginally and ~~one twin is~~ additional fetus(es)are delivered by C-Section, by different physicians, each should bill the appropriate procedure codes without a modifier. Payment is not made to the same physician for both standby and assistant at C-Section.

~~(7) One non stress test and/or biophysical profile to confirm a suspected high risk pregnancy diagnosis. The non stress test and/or biophysical profile must be performed by an active candidate or Board Certified diplomate in Maternal Fetal Medicine, or Board Certified Obstetrician-Gynecologist (OB-GYN).~~

~~(8)~~(7) Reimbursement is allowed for nutritional counseling in a group setting for members with gestational diabetes. Refer to OAC 317:30-5-1076(5).

(c) Assistant surgeons are paid for C-Sections which include only in-hospital post-operative care. Family practitioners who provide prenatal

care and assist at C-Section may bill separately for the ~~prenatal~~antenatal and ~~the six weeks~~ postpartum office ~~visit~~visits.

(d) Procedures listed in (1) - (5) of this subsection are not ~~paid or not covered separately from total obstetrical care~~separately reimbursable.

(1) ~~Additional non stress tests~~Non stress test, unless the pregnancy is determined medically high risk. See OAC 317:30-5-22.1.

(2) Standby at C-Section is not compensable when billed by a physician participating in delivery.

~~(3) Payment is not made for an assistant surgeon for obstetrical procedures that include prenatal or post partum care.~~

(4) An additional allowance is not made for induction of labor, double set-up examinations, fetal stress tests, or pudendal anesthetic. Providers must not bill separately for these procedures.

(5) Fetal scalp blood sampling is considered part of ~~the total OB care~~DRG reimbursement.

(e) ~~Obstetrical coverage for children is the same as for adults with additional procedures being covered due to EPSDT provisions if determined to be medically necessary.~~Obstetrical coverage for children is the same as for adults. Additional procedures may be covered under EPSDT provisions if determined to be medically necessary.

(1) Services deemed medically necessary and allowable under federal Medicaid regulations are covered by the EPSDT/OHCA Child Health Program even though those services may not be part of the Oklahoma Health Care Authority SoonerCare program. Such services must be prior authorized.

(2) Federal Medicaid regulations also require the State to make the determination as to whether the service is medically necessary and do not require the provision of any items or services that the State determines are not safe and effective or which are considered experimental.

317:30-5-22.1. Enhanced services for medically high risk pregnancies

(a) **Enhanced services.** Enhanced services are available for pregnant women eligible for SoonerCare and are in addition to services for uncomplicated maternity cases. Women deemed high risk based on criteria established by the OHCA ~~may~~must receive prior authorization for medically necessary enhanced benefits which include:

(1) prenatal at risk ~~ante partum~~antepartum management;

(2) a combined maximum of ~~12~~five fetal non stress test(s) and biophysical profiles (additional units can be prior authorized for multiple fetuses)~~; and~~with one test per week beginning at 32 weeks gestation and continuing to 38 weeks; and

(3) a maximum of ~~6 repeat~~three follow-up ultrasounds not covered under OAC 317:30-5-22(b)(2).

(b) **Prior authorization.** To receive enhanced services, the following documentation must be received by the OHCA Medical Authorizations Unit for review and approval:

(1) ACOG or other comparable comprehensive prenatal assessment;
(2) chart note identifying and detailing the qualifying high risk condition; and
(3) an OHCA High Risk OB Treatment Plan/Prior Authorization Request (CH-17) signed by a Board Eligible/Board Certified Maternal Fetal Medicine (MFM) specialist, or Board Eligible/Board Certified Obstetrician-Gynecologist (OB-GYN).

(c) **Reimbursement.** When prior authorized, enhanced benefits will be reimbursed as follows:
(1) ~~Ante partum~~Antepartum management for high risk is reimbursed to the primary obstetrical provider. If the primary provider of obstetrical care is not the MFM and wishes to request authorization of the ~~ante partum~~antepartum management fee, the OHCA CH-17 must be signed by the primary provider of OB care. Additionally, reimbursement for enhanced at risk ~~ante partum~~antepartum management is not made during an in-patient hospital stay.
(2) Non stress tests, biophysical profiles and ultrasounds ~~(~~[in addition to those covered under OAC 317:30-5-22(a)(2) subparagraphs (A) through (C)] are reimbursed when prior authorized.
(3) Reimbursement for enhanced at risk ~~ante partum~~antepartum management is not available to physicians who already qualify for enhanced reimbursement as state employed physicians.

PART 19. CERTIFIED NURSE MIDWIVES

317:30-5-226. Coverage by category

(a) **Adults and children 21 and under**. Payment is made for certified nurse midwife services within the scope of practice as defined by state law including obstetrical care such as antepartum care, delivery, postpartum care, and care of the normal newborn during the first 28 days of life. Obstetrical care should be billed using the appropriate evaluation and management codes for antepartum care, as well as the appropriate delivery only and postpartum care services when rendered. Ultrasounds and other procedures for obstetrical care are paid in accordance with OAC 317:30-5-22(b).
~~(1) Providers must use OKDHS Form FSS-NB-1, or the eNB1 application on the Secure Website to notify the county DHS office of the child's birth. A claim may then be filed for charges for the baby under the case number and the baby's name and assigned person code.~~
~~(2) Charges billed on the mother's person code for services rendered to the child will be denied.~~
~~(3) Obstetrical care should be billed using the appropriate CPT codes for Maternity Care and Delivery. The date of delivery should be used as the date of service for charges for total obstetrical care. Inclusive dates of care should be indicated on the claim form as part of the description. The date the patient was first seen must be on the claim form. Payment for total obstetrical care includes all routine care. Ultrasounds and other procedures reimbursed separately from total obstetrical care are paid in accordance with provisions found at OAC~~

~~317:30-5-22(b). For payment of total OB care, the provider must have provided care for more than one trimester. To bill for prenatal care only, the claim is filed after the member leaves the provider's care. Payment for routine or minor medical problems will not be made separately to the OB provider outside of antepartum visits. The antepartum care during the prenatal care period includes all care by the OB provider except major illness distinctly unrelated to the pregnancy.~~

(b) **Newborn.** Payment to nurse midwives for services to newborn is the same as for adults and children under 21. A newborn is an infant during the first 28 days following birth.

(1) Providers must use OKDHS Form FSS-NB-1, or the eNB1 application on the Secure Website to notify the county DHS office of the child's birth. A claim may then be filed for charges for the baby under the case number and the baby's name and assigned person code.

(2) Charges billed on the mother's person code for services rendered to the child will be denied.

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

317:30-5-229. Reimbursement

In accordance with the Omnibus Budget Reconciliation Act of 1993, effective October 1, 1993, certified nurse midwife services include maternity services, as well as services outside the maternity cycle within the scope of their practice under state law.

(1) Medical verification of pregnancy is required. A ~~letter or~~ written statement from the physician or certified nurse midwife verifying the applicant is pregnant and the expected date of delivery is acceptable. Pregnancy may also be verified by submission of a copy of a laboratory report indicating the individual is pregnant.

(2) Newborn charges billed on the mother's person code will be denied.

(3) Providers must use OKDHS Form FSS-NB-1 to notify the county DHS office of the child's birth.

(4) ~~Obstetrical care should be billed using the appropriate CPT codes for Maternity Care and Delivery. The date of delivery should be used as the date of service for charges for total obstetrical care. Inclusive dates of care should be indicated on the claim form as part of the description. The date the patient was first seen must be on the claim form. Payment for total obstetrical care includes all routine care performed by the attending provider. For payment of total OB care, the provider must have provided care for more than one trimester. To bill for prenatal care only, the claim is filed after the member leaves the provider's care. Payment for routine or minor medical problems will not be made separately to the OB provider outside of antepartum visits. The antepartum care during the prenatal care period includes all care by the OB provider except major illness distinctly unrelated to the pregnancy.~~ Obstetrical care should be billed using the appropriate evaluation and management codes for antepartum care, as well as the appropriate delivery only and postpartum care services when rendered.

PART 35. RURAL HEALTH CLINICS

317:30-5-356. Coverage for adults

Payment is made to rural health clinics for adult services as set forth in this Section.

(1) **RHC services.** Payment is made for one encounter per member per day. Payment is also limited to four visits per member per month. Refer to OAC 317:30-1, General Provisions, and OAC 317:30-3-65.2 for exceptions to the four visit limit for children under the Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT). Additional preventive service exceptions include:

(A) **Obstetrical care.** A Rural Health Clinic should have a written contract with its physician, nurse midwife, advanced practice nurse, or physician assistant that specifically identifies how obstetrical care will be billed to SoonerCare, in order to avoid duplicative billing situations. The agreement should also specifically identify the physician's compensation for rural health and non-rural health clinic (other ambulatory) services.

(i) If the clinic compensates the physician, nurse midwife or advanced practice nurse to provide obstetrical care, then the clinic must bill the SoonerCare program for each prenatal visit using the appropriate CPT evaluation and management codes.

(ii)~~If the clinic does not compensate its practitioners to provide obstetrical care, then the independent practitioner must bill the OHCA for prenatal care according to the global method described in the SoonerCare provider specific rules for physicians, certified nurse midwives, physician assistants, and advanced practice nurses (refer to OAC 317:30-5-22).~~<u>If the clinic does not compensate its practitioners to provide obstetrical care, then the independent practitioner must bill the SoonerCare program for each prenatal visit using the appropriate CPT code described in the SoonerCare provider specific rules for physicians, certified nurse midwives, physician assistants, and advanced practice nurses (refer to OAC 317:30-5-22).</u>

~~(iii) Under both billing methods, payment for prenatal care includes all routine or minor medical problems. No additional payment is made to the prenatal provider except in the case of a major illness distinctly unrelated to pregnancy.~~

(B) **Family planning services.** Family planning services are available only to members with reproductive capability. Family planning visits do not count as one of the four RHC visits per month.

(2) **Other ambulatory services.** Services defined as "other ambulatory" services are not considered a part of a RHC visit and are therefore billable to the SoonerCare program by the RHC or provider of service on the appropriate claim forms. Other ambulatory services are subject to the same scope of coverage as other SoonerCare services billed to the program, i.e., limited adult services and some services for under 21 subject to same prior authorization process. Refer to OAC 317:30-1,

General Provisions, and OAC 317:30-3-57, 317:30-5-59, and 317:30-3-60 for general coverage and exclusions under the SoonerCare program. Some specific limitations are applicable to other ambulatory services as set forth in specific provider rules and excerpted as follows: Coverage under optometrists for adults is limited to treatment of eye disease not related to refractive errors. There is no coverage for eye exams for the purpose of prescribing eyeglasses, contact lenses or other visual aids. (See OAC 317:30-5-431.)

PART 75. FEDERALLY QUALIFIED HEALTH CENTERS

317:30-5-664.8. Obstetrical care provided by Health Centers

(a) **Billing written agreement.** In order to avoid duplicative billing situations, a Health Center must have a written agreement with its physician, certified nurse midwife, advanced practice nurse, or physician assistant that specifically identifies how obstetrical care will be billed. The agreement must specifically identify the service provider's compensation for Health Center core services and other health services that may be provided by the Center.

(b) **Prenatal or postpartum services.**

(1) If the Health Center compensates the physician, certified nurse midwife or advanced practice nurse for the provision of obstetrical care, then the Health Center bills the OHCA for each prenatal and postpartum visit separately using the appropriate CPT evaluation and management code(s) as provided in the Health Center billing manual.

(2) ~~If the clinic does not compensate the provider for the provision of obstetrical care, then the provider must bill the OHCA for prenatal care according to the global method described in the SoonerCare Traditional provider specific rules for physicians, certified nurse midwives, physician assistants, and advanced practice nurses (refer to OAC 317:30-5-22).~~ If the clinic does not compensate its practitioners to provide obstetrical care, then the independent practitioner must bill the SoonerCare program for each prenatal visit using the appropriate CPT code described in the SoonerCare provider specific rules for physicians, certified nurse midwives, physician assistants, and advanced practice nurses (refer to OAC 317:30-5-22).

~~(3) Under both billing methods, payment for prenatal care includes all routine or minor medical problems. No additional payment is made to the prenatal provider except in the case of a major illness distinctly unrelated to pregnancy.~~

(c) **Delivery services.** Delivery services are billed using the appropriate CPT codes for delivery. If the clinic does not compensate the provider for the provision of obstetrical care, then the provider must be individually enrolled and bill for those services using his or her assigned provider number. The costs associated with the delivery must be excluded from the cost settlement/encounter rate setting process (see OAC 317:300-5-664.11).

15-07B Obstetrical Reimbursement

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY

CHAPTER 35. MEDICAL ASSISTANCE FOR ADULTS AND CHILDREN-ELIGIBILITY

SUBCHAPTER 5. ELIGIBILITY AND COUNTABLE INCOME

PART 1. DETERMINATION OF QUALIFYING CATEGORICAL RELATIONSHIPS

317:35-5-2. Categorically related programs

(a) In order to be eligible for SoonerCare, an individual must first meet the description of a member eligibility group. For individuals related to the aged, blind, or disabled groups, 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, an adoption assistance or kinship guardianship assistance recipient, or is under age 19, categorical relationship is automatically established. Categorical relationship to the ~~pregnancygroup~~pregnancy group is established when the determination is made by medical evidence that the individual is or has been pregnant. Effective January 1, 2014, verification of pregnancy is only required if the individual's declaration that she is pregnant is not reasonably compatible with other information available to the agency. Pregnancy-related services include all medical services provided within the scope of the program during the prenatal, delivery and postpartum periods for women in this pregnancy group; see Subchapter 22 of this Chapter for services for unborn children covered under Title XXI. For an individual age 19 or over to be related to the parent and caretaker relative group, the individual must have a minor dependent child. For an individual to be related to the former foster care children group, the individual must not be eligible for the Title XIX pregnancy or parent or caretaker relative groups, must be aged 19-26, and must have been receiving SoonerCare as a foster care child when he/she aged out of foster care in Oklahoma. There is no income or resource test for the former foster care children group. 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 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 eligibility~~

~~groups:~~Benefits for pregnancies covered under Title XXI medical services are provided within the limited scope of this particular program for antenatal care and delivery only. Each service must be billed using the appropriate CPT codes. To be eligible for SoonerCare benefits, an individual must be related to one of the following eligibility groups:

(1) Aged
(2) Disabled
(3) Blind
(4) Pregnancy
(5) Children, also including
  (A) Newborns deemed eligible, and
  (B) Grandfathered CHIP children
(6) Parents and Caretaker Relatives
(7) Refugee
(8) Breast and Cervical Cancer Treatment program
(9) SoonerPlan Family Planning Program
(10) Benefits for pregnancies covered under Title XXI
(11) Former foster care children.

(b) The Authority may provide SoonerCare to reasonable categories of individuals under age 21.
(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.

SUBCHAPTER 22. PREGNANCY RELATED BENEFITS COVERED UNDER TITLE XXI

317:35-22-2. Scope of coverage for Title XXI Pregnancy

(a)~~Pregnancy related services provided are prenatal, delivery, postnatal care when included in the global delivery fee, and other related services that are medically necessary to optimize pregnancy outcomes within the defined program benefits.~~Pregnancy related services provided are for antepartum and delivery only.

(b) ~~Only two visits per month for other related services to evaluate and/or treat conditions that may adversely impact the pregnancy are covered.~~Only two additional visits per month to other medical consultants, such as a dietitian or licensed genetic counselor for related services to

evaluate and/or treat conditions that may adversely impact the fetus are covered.

AGENDA

15-08 Urine Drug Screening and Testing

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 1. PHYSICIANS

317:30-5-20. Laboratory services

This Section covers the guidelines for payment of laboratory services by a provider in his/her office, a certified laboratory and for a pathologist's interpretation of laboratory procedures.

(1) **~~Covered lab~~Compensable services.** Providers may be ~~paid~~reimbursed for ~~covered~~compensable clinical diagnostic laboratory services only when they personally perform or supervise the performance of the test. If a provider refers specimen to a certified laboratory or a hospital laboratory serving outpatients, the certified laboratory or the hospital must bill for performing the test.

(A) Reimbursement for lab services is made in accordance with the Clinical Laboratory Improvement Amendment of 1988 (CLIA). These regulations provide that payment may be made only for services furnished by a laboratory that meets CLIA conditions, including those furnished in physicians' offices. Eligible providers must be certified under the CLIA program and have obtained a CLIA ID number from CMS and have a current contract on file with the OHCA.

~~(B) Reimbursement rate for laboratory procedures is the lesser of the CMS National 60% fee or the local carrier's allowable (whichever is lower).~~

~~(C) Medically necessary laboratory services are covered~~.

(B) Only medically necessary laboratory services are compensable.

~~(2)~~ **~~Compensable outpatient laboratory services.~~** ~~Medically necessary laboratory services are covered.~~

~~(3)~~(2) **Non-compensable laboratory services.**

(A) Separate payment is not made for blood specimens obtained by venipuncture or urine specimens collected by a laboratory. These services are considered part of the laboratory analysis.

(B) Claims for inpatient full service laboratory procedures are not covered since this is considered a part of the hospital rate.

~~(C) Billing multiple units of nucleic acid detection, whether using the direct probe or amplified probe technique, for single infectious organisms when testing for more than one infectious organism in a specimen is not permissible.~~

(C) Billing multiple units of nucleic acid detection for individual infectious organisms when testing for more than one infectious organism in a specimen is not permissible. Instead, OHCA considers it appropriate to bill a single unit of a procedure code indicated for multiple organism testing.

(D) Laboratory services~~ not considered medically necessary are not~~

~~covered.~~ must be medically indicated to be compensable.

~~(4)~~(3) **Covered services by a pathologist.**

(A) A pathologist may be paid for the interpretation of inpatient surgical pathology specimen~~. The appropriate CPT procedure code and modifier is used.~~ when the appropriate CPT procedure code and modifier is used.

(B) Full service or interpretation of surgical pathology for outpatient surgery performed in an outpatient hospital or Ambulatory Surgery Center setting.

~~(5)~~(4) **Non-compensable services by a pathologist.** The following are non-compensable pathologist services:

~~(A) Tissue examinations for identification of teeth and foreign objects.~~

~~(B)~~(A) Experimental or investigational procedures.

~~(C)~~(B) Interpretation of clinical laboratory procedures.

317:30-5-20.1. Urine drug screening and testing

(a) **Purpose.** Urine Drug Testing (UDT) is performed for undisclosed drug use and/or abuse, and to verify compliance with treatment. Testing for drugs of abuse to monitor treatment compliance should be included in the treatment plan for pain management when chronic opioid therapy is involved.

(1) Qualitative (presumptive) drug testing may be used to determine the presence or absence of a drug or drug metabolite in the urine sample and is expressed as a positive or negative result. Qualitative testing can be performed by a CLIA waived or moderate complexity test, or by a high complexity testing method.

(2) Quantitative (definitive) drug testing is specific to the drug or metabolite being tested and is expressed as a numeric result or numeric level which verifies concentration.

(3) Specimen validity testing is used to determine if a urine specimen has been diluted, adulterated or substituted. Specimen validity tests include, but are not limited to, creatinine, oxidants, specific gravity, urine pH, nitrates and alkaloids.

(b) **Eligible providers**. Providers performing urine drug testing should have CLIA certification specific to the level of testing performed as described in 317:30-5-20(1)(A).

(c) **Compensable services.** Urine drug testing must be ordered by the physician or non-physician provider and must be individualized to the patient and the patient's medical history or assessment indicators as evidenced in the medical documentation.

(1) Compensable testing must be medically indicated as evidenced by patient specific indications in the medical record.

(A) Testing is only compensable if the results will affect patient care.

(B) Drugs or drug classes being tested should reflect only those likely to be present.

(2) The frequency of urine drug screening and/or testing is determined by the patient's history, patient's physical assessment, behavioral assessment, risk assessment, treatment plan and medication history.

(3) Quantitative (definitive) urine drug testing may be indicated for the following:

(A) To identify a specific substance or metabolite that is inadequately detected or undetectable by a qualitative (presumptive) test; or

(B) To definitively identify specific drugs in a large family of drugs; or

(C) To identify drugs when a definitive concentration of a drug is needed to guide management; or

(D) To identify a negative, or confirm a positive, qualitative (presumptive) result that is inconsistent with a patient's self-report, presentation, medical history or current prescribed medication plan; or

(E) To identify a non-prescribed medication or illicit use for ongoing safe prescribing of controlled substances.

(d) **Non-compensable services.** The following tests are not medically necessary and therefore not covered by the OHCA:

(1) Specimen validity testing is considered a quality control measure and is not separately compensable;

(2) Drug testing for patient sample sources of saliva, oral fluids, or hair;

(3) Testing of two different specimen types (urine and blood) from the same patient on the same date of service;

(4) Drug testing for medico-legal purposes (court ordered drug screening) or for employment purposes;

(5) Non-specific, blanket panel or standing orders for urine drug testing, custom panels specific for the ordering provider, routine testing of therapeutic drug levels or drug panels which have no impact to the member's plan of care;

(6) Scheduled and routine urine drug testing (i.e. testing should be random);

(7) Reflex testing for any drug is not medically indicated without specific documented indications;

(8) Confirmatory testing exceeding three specific drug classes at an interval of greater than every 30 days will require specific documentation in the medical record to justify the medical necessity of testing; and

(9) Quantitative (definitive) testing of multiple drug levels that are not specific to the patient's medical history and presentation are not allowed. Justification for testing for each individual drug or drug class level must be medically indicated as reflected in the medical record documentation.

(e) **Documentation requirements.** The medical record must contain documents to support the medical necessity of drug screening and/or testing. Medical records must be furnished on request and may include, but are not limited to, the following:

(1) A current treatment plan;
(2) Patient history and physical;
(3) Review of previous medical records if treated by a different physician for pain management;
(4) Review of all radiographs and/or laboratory studies pertinent to the patient's condition;
(5) Opioid agreement and informed consent of UDT, as applicable;
(6) List of prescribed medications;
(7) Risk assessment, as identified by use of a validated risk assessment tool/questionnaire, with appropriate risk stratification noted and utilized;
(8) Office/provider monitoring protocols, such as random pill counts; and
(9) Review of prescription drug monitoring data or pharmacy profile as warranted.

AGENDA

15-17 Eyeglasses Cleanup

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 45. OPTOMETRISTS

317:30-5-432.1. Corrective lenses and optical supplies

(a) ~~Payment will be made for children for lenses, frames, low vision aids and certain tints when medically necessary including to protect children with monocular vision. Coverage includes one set of lenses and frames per year. Payment is limited to two glasses per year. Any glasses beyond this limit must be prior authorized and determined to be medically necessary.~~When medically necessary, payment will be made for lenses, frames, low vision aids and certain tints for children. Coverage includes lenses and frames to protect children with monocular vision. Coverage includes two sets of non-high-index lenses and frames per year. Any glasses beyond this limit must be prior authorized and determined to be medically necessary. Payment is limited to two frames per year.

(b) Corrective lenses must be based on medical need. Medical need includes a significant change in prescription or replacement due to normal lens wear.

(c) SoonerCare provides frames when medically necessary. Frames are expected to last at least one year and must be reusable. If a lens prescription changes, the same frame must be used if possible. Payment for frames includes the dispensing fee.

(d) ~~SoonerCare reimbursement for frames or lenses represents payment in full. No difference can be collected from the patient, family or guardians.~~Providers must accept SoonerCare's payment as payment in full for services rendered, except when authorized by SoonerCare (e.g., copayments, other cost sharing arrangements authorized by the State).

(1) Providers must be able to dispense standard eyeglasses which SoonerCare would fully reimburse with no cost to the eligible member.

(2) If the member wishes to select eyeglasses with special features which exceed the SoonerCare allowable fee, the member may be billed the excess cost. The provider must obtain signed consent from the member acknowledging that they are selecting eyeglasses that will not be covered in full by SoonerCare and that they will be responsible to pay the excess cost. The signed consent must be included in the member's medical record.

(e) Replacement of or additional lenses and frames are allowed when medically necessary. The OHCA does not cover lenses or frames meant as a backup for the initial lenses/frames. Prior authorization is not required unless the number of glasses exceeds two per year. The provider must always document in the patient record the reason for the replacement or additional eyeglasses. The OHCA or its designated agent will conduct ongoing monitoring of replacement frequencies to ensure ~~guidelines are~~OHCA

policy is followed. Payment adjustments will be made on claims not meeting these requirements.
(f) Bifocal lenses for the treatment of accommodative esotropia are a covered benefit. Progressive lenses, trifocals, photochromic lenses and tints for children require prior authorization and must satisfy the medical necessity standard. Polycarbonate lenses are covered for children when medically necessary. Payment is limited to two glasses per year. Any glasses beyond this limit must be prior authorized and determined to be medically necessary.
(g) Progressive lenses, aspheric lenses, tints, coatings and photochromic lenses for adults are not compensable and may be billed to the patient.
(h) Replacement of lenses and frames due to abuse and neglect by the member is not covered.
(i) Bandage contact lenses are a covered benefit for adults and children. Contact lenses for medically necessary treatment of conditions such as aphakia, keratoconus, following keratoplasty, aniseikonia/anisometropia or albinism are a covered benefit for adults and children. Other contact lenses for children require prior authorization and must satisfy the medical necessity standard.

PART 47. OPTICAL ~~COMPANIES~~SUPPLIERS

317:30-5-450. Eligible providers

Payment can be made to optical suppliers who have a current ~~Memorandum of Agreement~~SoonerCare contract with ~~this Authority~~the OHCA.

AGENDA

15-18 Policy Revision to Comply with Senate Bill 494 dealing with Complex Rehabilitation Technology Products and Services

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 17. MEDICAL SUPPLIERS

317:30-5-210. Eligible providers

All eligible medical suppliers must have a current contract with the Oklahoma Health Care Authority. The supplier must comply with all applicable State and Federal laws. Effective January 1, 2011, all suppliers of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) must be accredited by a Medicare deemed accreditation organization for quality standards for DMEPOS suppliers in order to bill the SoonerCare program. OHCA may make exceptions to this standard based on the exemptions provided by the Centers for Medicare and Medicaid Services (CMS) for Medicare accreditation, if the provider is a government-owned entity, or at a provider's request and at the discretion of OHCA based on access issues and/or agency needs for SoonerCare members. Additionally, unless an exception is granted from the OHCA, all DMEPOS providers must meet the following criteria:

(1) DMEPOS providers are required to have a physical location in the State of Oklahoma, or within a designated range of the Oklahoma State border, as determined by the OHCA. The OHCA may make exceptions to this requirement if a DMEPOS provider provides a specialty item, product, or service, which is not otherwise available to SoonerCare members within the State of Oklahoma. Provider contracts for out-of-state DMEPOS providers will be reviewed on a case-by-case basis for specialty items only. The OHCA has discretion and the final authority to approve or deny any provider contract.

(2) DMEPOS providers are required to comply with Medicare DMEPOS Supplier Standards for DMEPOS provided to SoonerCare members, except the requirement to meet surety bond requirements, as specified in 42 C.F.R. 424.57(c).

(3) Complex Rehabilitation Technology (CRT) suppliers are considered DMEPOS providers. Only CRT suppliers may bill CRT procedure codes. A CRT supplier means a company or entity that:

(A) Is accredited by a recognized accrediting organization as a supplier of CRT;

(B) Is an enrolled Medicare supplier and meets the supplier and quality standards established for DME suppliers, including those for CRT, under the Medicare program;

(C) Employs as a W-2 employee at least one qualified CRT professional for each location to:

(i) Analyze the needs and capacities of complex-needs patients in consultation with qualified health care professionals;

(ii) Participate in selecting appropriate CRT items for such needs and capacities; and

(iii) Provide the complex-needs patient technology related training in the proper use and maintenance of the CRT items.

(D) Requires a qualified CRT professional be physically present for the evaluation and determination of the appropriate CRT;

(E) Has the capability to provide service and repair by qualified technicians for all CRT items it sells; and

(F) Provides written information to the complex-needs patient prior to ordering CRT as to how to access service and repair.

317:30-5-211.1. Definitions

The following words and terms, when used in this Part, have the following meaning, unless the context clearly indicates otherwise.

"Adaptive equipment" means devices, aids, controls, appliances or supplies of either a communication or adaptive type, determined necessary to enable the person to increase his or her ability to function in a home and community based setting or private Intermediate Care Facilities for Individuals with Intellectual Disabilities (IFC/IID) with independence and safety.

"Basic activities of daily living" means a series of activities performed on a day-to-day basis that are necessary to care for oneself (e.g., personal hygiene, dressing, eating, maintaining continence and transferring).

"Capped rental" means monthly payments for the use of the Durable Medical Equipment (DME) for a limited period of time not to exceed 13 months. Items are considered purchased after 13 months of continuous rental.

"Certificate of medical necessity (CMN)" means a certificate required to help document the medical necessity and other coverage criteria for selected items. Those items are defined in this Chapter. The physician's certification must include the member's diagnosis, the reason the equipment is required, and the physician's estimate, in months, of the duration of its need.

"Complex-needs patient" means an individual with a diagnosis or medical condition that results in significant physical or functional needs and capacities.

"Complex rehabilitation technology" means medically necessary durable medical equipment and items that are individually configured to meet specific and unique medical, physical, and functional needs and capacities for basic activities of daily living and instrumental activities of daily living of a complex needs patient. Such equipment and items include, but are not limited to, individually configured power wheelchairs and accessories, individually configured manual wheelchairs and accessories, adaptive seating and positioning systems and accessories, and other specialized equipment such as standing frames and gait trainers.

"Customized DME" means items of DME which have been uniquely constructed or substantially modified for a specific member according to the description and orders of the member's treating physician or other

qualified medical professional. For instance, a wheelchair would be considered "customized" if it has been:

(A) measured, fitted, or adapted in consideration of ~~the member's~~the member's body size, disability, period of need, or intended use;

(B) assembled by a supplier or ordered from a manufacturer who makes available customized features, modifications, or components for wheelchairs; and

(C) intended for an individual member's use in accordance with instructions from the member's physician.

"Durable medical equipment (DME)" means equipment that can withstand repeated use (e.g. a type of item that could normally be rented), is used to serve a medical purpose, is not useful to a person in the absence of an illness or injury, and is used in the most appropriate setting, including the home or workplace.

"Instrumental activities of daily living" means activities that are not necessarily required on a daily basis, but are important to being able to live independently (e.g., basic communication skills, transportation, meal preparation, shopping, housework, managing medication and managing personal finances).

"Invoice" means a document that provides the following information when applicable: the description of product, quantity, quantity in box, purchase price, NDC, strength, dosage, provider, seller's name and address, purchaser's name and address, and date of purchase. At times, visit notes will be required to determine how much of the supply was expended. When possible, the provider should identify the SoonerCare member receiving the equipment or supply on the invoice.

"Medical supplies" means an article used in the cure, mitigation, treatment, prevention, or diagnosis of illnesses. Disposable medical supplies are medical supplies consumed in a single usage and do not include skin care creams or cleansers. Medical supplies do not include surgical supplies or medical or surgical equipment.

"OHCA CMN" means a certificate required to help document the medical necessity and other coverage criteria for selected items. Those items are defined in this chapter. The physician's certification must include the member's diagnosis, the reason equipment is required, and the physician's estimate, in months, of the duration of its need. This certificate is used when the OHCA requires a CMN and one has not been established by CMS.

"Orthotics" means an item used for the correction or prevention of skeletal deformities.

"Prosthetic devices" means a replacement, corrective, or supportive device (including repair and replacement parts of the same) worn on or in the body to artificially replace a missing portion of the body, prevent or correct physical deformity or malfunction, or support a weak or deformed portion of the body.

"Qualified complex rehabilitation technology professional" means an individual who is certified as an Assistive Technology Professional (ATP) by the Rehabilitation Engineering and Assistive Technology Society of North America (RESNA).

AGENDA

15-21 Diagnostic Testing Facilities

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 90. DIAGNOSTIC TESTING ENTITIES

317:30-5-907. ~~Eligible providers~~ Provider requirements

~~Diagnostic testing entities must be Medicare certified as Mobile X-ray or Independent Diagnostic Testing Facilities (IDTF). Providers must have a current contract on file with the Oklahoma Health Care Authority.~~

(a) An Independent Diagnostic Testing Facility (IDTF) is either a fixed location or mobile entity independent of a hospital or physician's office where diagnostic services are performed by licensed certified non-physician personnel under appropriate physician supervision. Diagnostic testing entities must be Medicare certified as Mobile X-ray or an IDTF and have a current contract on file with the Oklahoma Health Care Authority.

(b) An IDTF must have one or more supervising physicians who are responsible for the direct and ongoing oversight of the quality of the testing performed, the proper operation and calibration of the equipment used to perform tests and the qualifications of non-physician personnel who use the equipment.

(c) An IDTF enrolled in the SoonerCare program must comply with all applicable federal regulations, including applicable provisions of 42 CFR 410.32 and 410.33.

317:30-5-907.1. ~~Coverage by category~~ Coverage and limitations

(a) **Adults.** ~~Payment is made for the technical component on outpatient diagnostic procedures in accordance with the guidelines set forth in OAC 317:30-5-24.~~ For IDTF services to be covered:

(1) Services must be medically necessary;

(2) The treating physician's order must specify the procedures to be performed and the reason for the service; and

(3) The IDTF may not add any procedures based on internal protocols without a written order by the treating physician.

(b) **Children.** Coverage is the same as adults.

317:30-5-907.3. Reimbursement

~~Reimbursement will be based on the current allowed charge for radiological procedures.~~

(a) Diagnostic procedure are reimbursable if the services were rendered to a non-hospital patient and the IDTF provided all services (professional and technical) associated with the total procedure as defined in the CPT. When separate CPT codes itemize a service by its professional and

technical components, the IDTF may bill and be reimbursed for the components of the procedure it actually performed.
(b) Payment is made for the technical component on outpatient diagnostic procedures in accordance with the guidelines set forth in OAC 317:30-5-24.

AGENDA

15-24 Dental Oversight Requirements for Supervision of Anesthetists and General Cleanup of Terms

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY

CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 79. DENTISTS

317:30-5-695. Eligible dental providers and definitions

(a) Eligible dental providers in Oklahoma's SoonerCare program are:

(1) individuals licensed as dentists under 59 Oklahoma Statutes §§ 328.21, 328.22, and 328.23 (licensed dentists, specialty dentists and out of state dentists);

(2) individuals issued permits as dental interns under 59 Oklahoma Statute § 328.26;

(3) individuals who are third and fourth year dental students at an accredited Oklahoma dental college; and

(4) any individual issued a license in another state as a dentist.

(b) All eligible providers must be in good standing with regard to their license. Any revocation or suspension status of a provider referenced in subsection (a) above renders the provider ineligible for payment or subject to recoupment under SoonerCare.

(c) Eligible providers must document and sign records of services rendered in accordance with guidelines found at OAC 317:30-3-15.

(d) The American Dental Association's version of ~~Current Dental Terminology (CDT)~~Code on Dental Procedures and Nomenclature (CDT) is used by the OHCA to communicate information related to codes, and procedures for administration. Definitions, nomenclature, and descriptors as listed in the CDT will apply, with the exception of more specific definitions or limitations set forth.

(1) "Decay" means carious lesions in a tooth; decomposition and/or dissolution of the calcified and organic components of the tooth structure.

(2) "Emergency Dental Care" includes, but is not limited to, the immediate service that must be provided to relieve the member from pain due to an acute infection, swelling, trismus or trauma.

(3) "Palliative Treatment" means action that relieves pain but is not curative. Palliative Treatment is an ~~all inclusive~~all-inclusive service. No other codes are reimbursable on the same date of service.

(4) "Radiographic Caries" means dissolution of the calcified and organic components of tooth tissue that has penetrated the enamel and is approaching the dentinoenamel junction.

(5) "Upcoding" means reporting a more complex and/or higher cost procedure than actually performed.

(6) "Unbinding" means billing separately for several individual procedures that are included within one Current Dental Terminology or

Current Procedural Terminology (CPT) code.

317:30-5-696.1. ~~Conscious Sedation~~Anesthesia

Payment is made for 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. Payment is made to Dentists who have received appropriate formal education in conscious ~~(moderate)~~ sedation~~, deep sedation,~~ and general anesthesia. ~~and are qualified to use these modalities in practice.~~

(1) Training to competency in conscious ~~(moderate)~~ sedation techniques may be acquired at the predoctoral, postgraduate, graduate, or continuing education level. Dentists who wish to utilize conscious ~~(moderate)~~ sedation are expected to successfully complete formal training which is structured in accordance with the American Dental Association's educational guidelines as well as the board of Dentistry for the State in which they practice.

(2) The knowledge and skills required for the administration of deep sedation and general anesthesia are beyond the scope of pre-doctoral and continuing education. Only dentists who have successfully completed an accredited/approved residency program in anesthesiology, for the administration of anesthetic agents will be permitted to provide and bill for this service.

(3) All anesthesia services must be provided in accordance with OAC 317:30-5-7.

(A) Dentists who provide or supervise deep sedation or general anesthesia are required to have training in anesthesiology, oral surgery or pediatric dentistry, such as in a residency curriculum.

(B) To be considered qualified to supervise the administration of general anesthesia or deep sedation, OHCA requires a minimum of eighteen (18) hours of courses related to the administration of anesthesia, deep sedation or medical emergencies in the dental office every three (3) years.

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)~~[See OAC 317:30-5-695(d)(2)]. Requests for dental services requiring prior authorization must be accompanied by sufficient documentation. Images with an indication of the left side of member, six point periodontal charting and copy of the comprehensive treatment plans are required. Study models are usually not required, but 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/IID residents. Minimum required records to be submitted with each request are right and left mounted ~~bitewing~~bitewings ~~x-rays or images~~ and periapical films or images of tooth/teeth involved or the edentulous areas if not visible in the bitewings. ~~X-rays~~Images must be submitted with film mounts and each film or print must be of diagnostic quality. ~~X-rays and/or images~~Images must be identified by the tooth number and include date of exposure, member name, member ID, provider name, and provider ID. All ~~x-rays or~~ images, regardless of the media, must be submitted together with a completed and signed comprehensive treatment plan that details all needed treatment at the time of examination, and a completed current ADA form requesting all treatments requiring prior authorization. The ~~film~~images, digital media, photographs, or ~~printout~~printouts 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.** Root canal therapy is not considered an emergency procedure unless due to trauma to an anterior tooth. The provider must document the member's oral hygiene and flossing ability ~~over a minimum of two months,~~ in the member's records.Pulpal debridement may be performed for the relief of pain while waiting for the decision from the OHCA on request for endodontics.

(A) Prior authorization is required for members who have a treatment plan requiring more than two ~~anterior and/or two posterior~~ root canals. All rampant, active caries must be removed prior to requesting anterior endodontics. Payment is made for services provided in accordance with the following:

(i) Permanent teeth only.

(ii) Accepted ADA materials must be used.

(iii) Pre and post-operative periapical ~~x-rays~~images 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.

(B) **Posterior endodontics.** The guidelines for this procedure are as follows:

(i) The provider must document the member's oral hygiene and flossing ability ~~over a minimum of two months,~~ in the member's records.

(ii) Teeth that 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~~images 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 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) an opposing tooth has super erupted;

(II) loss of tooth space is one third or greater;

(III) opposing second molars are involved unless prior authorized; or

(IV) the member has multiple teeth failing due to previous inadequate root canal therapy or follow-up;

(V) all rampant, active caries must be removed prior to requesting posterior endodontics.

(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.

(2) **Crowns for permanent teeth.** Crowns 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 Individuals with Intellectual Disabilities (ICF/IID) and who have been approved for (ICF/IID) level of care. Certain criteria and limitations apply.

(A) The following conditions must exist for approval of this procedure.

(i) ~~all~~All rampant, active caries must be removed prior to requesting any type of crown.

(ii) The tooth must be decayed to such an extent to prevent proper cuspal or incisal function.

(iii) The clinical crown is fractured or destroyed by one-half or

more.

(iv) Endodontically treated teeth must have three or more surfaces restored or lost due to carious activity to be considered for a crown.

(B) The conditions listed in (A)(i) through (A)(iv) of this paragraph should be clearly visible on the submitted ~~x-rays~~images 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. Non authorized restorative codes may be used if available.

(D) A crown will not be approved if adequate tooth structure does not remain to establish cleanable margins, there is invasion of the biologic width, poor crown to root ratio, or the tooth appears to retain insufficient amounts of natural tooth structure. Cast dowel cores are not allowed for molar or pre-molar teeth.

(E) Preformed post(s) and core build-up(s) are not routinely provided with crowns for endodontically treated teeth.

(F) Provider is responsible for replacement or repair of all crowns if failure is 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 missing anterior permanent teeth or two or more missing posterior teeth in the same arch for members 16 through 20 years of age. Provider must indicate which teeth will be replaced. ~~Members must have excellent oral hygiene documented for at least 18 months in the requesting provider's records and submitted with prior authorization request to be considered.~~ Members must have improved oral hygiene documented for at least 12 months in the provider's records and submitted with prior authorization request to be considered. Provider is responsible for any needed follow up for a period of two years post insertion.

(4) **Acrylic partial.** This appliance is the treatment of choice for replacement of three or more missing teeth in the same arch for members 12 through 16 years of age. Provider must indicate tooth numbers to be replaced. This appliance includes all necessary clasps and rests.

(5) **Occlusal guard.** Narrative of medical necessity must be sent with prior authorization. Model should not be made or sent unless requested.

(6) **Fixed cast non-precious metal or porcelain/metal bridges.** Only members 17 through 20 years of age will be considered for this treatment. Destruction of healthy teeth to replace a single missing tooth is not considered medically necessary. Members must have excellent oral hygiene documented for at least 18 months in the requesting provider's records and submitted with prior authorization request to be considered. Provider is responsible for any needed follow up until member loses eligibility.

(7) **Periodontal scaling and root planing.** Procedure is designed for the removal of calculus or tissue that is contaminated and requires anesthesia and some soft tissue removal. This procedure requires that each tooth have ~~3~~three or more of the six point measurements ~~5~~five

millimeters or greater, or have multiple areas of ~~radiographic~~image supported bone loss ~~and~~, subgingival calculus and must involve two or more teeth per quadrant for consideration. This procedure is not allowed on members under the age ~~10~~12. This procedure is not allowed in conjunction with any other periodontal surgery.

317:30-5-699. Restorations

(a) **Utilization parameters.** The Oklahoma Health Care Authority utilization parameters allow only one permanent restorative service to be provided per tooth per 24 months. Additional restorations may be authorized upon approval of OHCA in cases of trauma. Teeth receiving a restoration are eligible within three months for consideration of single crown if endodontically treated. Providers must document type of isolation used in treatment progress notes. The provider is responsible for follow-up or any required replacement of a failed restoration, if the member is currently SoonerCare eligible. ~~Fees paid for the original restorative services may be recouped if any additional treatments are required on the same tooth by a different provider within 12 months due to defective restoration or recurrent decay. If it is determined by the Dental Director that a member has received poorly rendered or insufficient treatment from a provider, the Dental Director may prior authorize corrective procedures by a second provider.~~

(b) **Coverage for dental restorations.** Restoration of incipient lesions is not considered medically necessary treatment. Any diagnosis not supported by ~~radiographs~~images requires documentation of the medical need on which the diagnosis was made. Services for dental restorations are covered as follows:

(1) If the mesial occlusal pit and the distal occlusal pit on an upper molar tooth are restored at the same appointment, this is a one surface restoration.

(2) If any two separate surfaces on a posterior tooth are restored at the same appointment, it is a two surface restoration.

(3) If any three separate surfaces on a posterior tooth are restored at the same appointment, it is a three surface restoration.

(4) If the mesial, distal, facial and/or lingual of an upper anterior tooth is restored at the same appointment, this is a four surface restoration.

(5) If any two separate surfaces on an anterior tooth are restored at the same appointment, it is a two surface restoration.

(6) If any three separate surfaces on an anterior tooth are restored at the same appointment, it is a three surface restoration.

(7) An incisal angle restoration is defined as one of the angles formed by the junction of the incisal and the mesial or distal surface of an anterior tooth. If any of these surfaces are restored at the same appointment, even if separate, it is considered as a single incisal angle restoration.

(8) When four or more separate surfaces on a posterior tooth are restored at the same appointment it is a four surface restoration.

(9) Wide embrasure cavity preparations do not become extra surfaces

unless at least one half of cusp or surface is involved in the restoration. An MODFL restoration would have to include the mesial-occlusal-distal surfaces as well as either the buccal groove pit or buccal surface or at least one half the surface of one of the buccal cusps. The same logic applies for the lingual surface.

317:30-5-700. Orthodontic services

(a) In order to be eligible for SoonerCare Orthodontic services, members must be referred through a primary care dentist; a member can receive a referral from a primary care dentist to the orthodontist only after meeting the following:

(1) the member has had a caries free initial visit; or

(2) has all decayed areas restored and has remained caries free for 12 months; and

(3) has demonstrated competency in maintaining an appropriate level of oral hygiene.

(b) Member with cleft palate can be referred directly by their treating physician without a dental referral and are exempt from above requirements.

(c) The Oklahoma SoonerCare Orthodontic Program limits orthodontic services to handicapping malocclusions determined to be severe enough to warrant medically necessary treatment. The orthodontic provider has the ability to determine if members may qualify with a visual screening. Diagnostic record accumulation and/or submission should only occur for members with high potential for acceptance. These orthodontic services include the following:

(1) a handicapping malocclusion, as measured on the Handicapping Labio-Lingual Deviation Index (HLD) with a minimum score of 30;

(2) any classification secondary to cleft palate or other maxillofacial deformity;

(3) if a single tooth or anterior crossbite is the only medical need finding, service will be limited to interceptive treatment;

(4) fixed appliances only; and

(5) permanent dentition with the exception of cleft defects.

(d) Reimbursement for Orthodontic services is limited to:

(1) Orthodontists, or

(2) General or Pediatric dental practitioners who have completed at least 200 certified hours of continuing education in the field of orthodontics practice and submit for review at least 25 successfully completed comprehensive cases. Of these 25 comprehensive cases, ten or more must be extraction cases. An applicant for this certification must practice in an OHCA deemed ~~under served~~under-served area. The comprehensive cases submitted should be of a complexity consistent with type of handicapping ~~Malocclusion~~malocclusion likely to be treated in the SoonerCare program.

(A) Cases submitted must include at least one of each of the following types:

(i) deep overbite where multiple teeth are impinging upon the soft tissue of the palate;

(ii) impacted canine or molar requiring surgical exposure;
(iii) bilateral posterior crossbite requiring fixed rapid palatal expansion; and
(iv) skeletal class II or III requiring orthognathic surgery.

(B) As with all dental or orthodontia treatment performed and reimbursed by SoonerCare, all pre and post orthodontic records must be available for review.

(C) The ~~Oklahoma Health Care Authority~~OHCA requires all ~~General~~general dentists providing comprehensive orthodontic care to submit a copy of the Oklahoma Board of Dentistry continuing education report and verification that at least 20 continuing education hours in the field of orthodontics has been completed per reporting period. All verification reports must be submitted to OHCA Dental unit every three years, no later than August 30. In addition, verification of adequate progress for all active orthodontic cases will be reviewed by the OHCA Dental Unit upon completion of 24 months of therapy.

(e) The following limitations apply to orthodontic services:

(1) Cosmetic orthodontic services are not a covered benefit of the SoonerCare Program and no requests should be submitted;
(2) All orthodontic procedures require prior authorization for payment;
(3) Prior authorization for orthodontic treatment is not a notification of the member's eligibility and does not guarantee payment. Payment for authorized services depends on the member's eligibility at the beginning of each treatment year. Treatment year is determined by date of banding;
(4) The member must be SoonerCare-eligible and under 18 years of age at the time the request for prior authorization for treatment is received by the OHCA. Services cannot be added or approved after eligibility has expired. It is the orthodontist's responsibility to verify that the member has current SoonerCare eligibility and the date of birth indicates the member is under age 18.

(f) Orthodontic services are an elective procedure. The orthodontist must interview the prospective member as to his/her understanding of and willingness to cooperate fully in a lengthy treatment program.

(g) The interview information is unavailable to OHCA except through the provider's recommendation of treatment. The interview process for OHCA members is equivalent to that of private pay patients.

(h) Providers are not obligated to accept a member when it appears that the member will not cooperate in the orthodontic hygiene treatment program, does not return to the general dentist for preventive visits or is not willing to keep eligibility for SoonerCare current.

317:30-5-700.1. Orthodontic prior authorization

(a) The following records and documentation, plainly labeled with the member's full name, recipient identification number (RID), and the orthodontist's name are required for prior authorization of orthodontic services and must be submitted to the Dental Unit of the OHCA when the member has a total score of not less than 30 points or meets other

eligibility criteria in paragraph (d).

(1) Completed currently approved ADA dental claim form;
(2) Complete and scored Handicapping Labio-Lingual Deviations Index with Diagnosis of Angle's classification;
(3) Detailed description of any oral maxillofacial anomaly;
(4) Estimated length of treatment;
(5) Intraoral photographs showing teeth in centric occlusion and/or photographs of trimmed anatomically occluded diagnostic casts. A lingual view of casts may be included to verify impinging overbites;
(6) Cephalometric ~~x-rays~~images with tracing, and panoramic film, with a request for prior authorization of comprehensive orthodontic treatment;
(7) If diagnosed as a surgical case, submit an oral surgeon's written opinion that orthognathic surgery is indicated and the surgeon is willing to provide this service;
(8) Additional pertinent information as determined necessary by the orthodontist or as requested by the OHCA.

(b) All images~~, x-rays,~~ and required documentation must be submitted in one package. OHCA is not responsible for lost or damaged materials.

(c) All records and documentation submitted in a request for prior authorization for orthodontic treatment are reviewed by the OHCA Orthodontic Consultant for compensability and length of treatment. Any documentation on which a decision is made will not be returned.

(d) Some children not receiving a minimum score of 30 on the Handicapping Labio-Lingual Deviation Index (HLD) may have other conditions to be considered. In the event an orthodontist believes there are other medical, social, or emotional conditions impacting the general health of the child, he/she refers to the conditions listed on the EPSDT exception section found on the HLD. The following guidelines and restrictions apply to other conditions:

(1) Other medical, social, or emotional conditions are limited to those conditions that affect the medical, social or emotional function of the child.
(2) Other medical, social, or emotional conditions are not scored if the sole condition sought to be improved is the cosmetic appearance of the child.
(3) Such other medical, social, or emotional conditions must be demonstrated by objective evidence such as supported documentation outside the child's immediate family (i.e., a child's teacher, primary care physician, behavioral health provider, school counselor).
(4) Objective evidence must be submitted with the HLD.
(5) When such other medical, social, or emotional conditions are reflected on the HLD, the OHCA Orthodontic Consultant must review the data and use his or her professional judgment to score the value of the conditions.
(6) The OHCA Orthodontic Consultant may consult with and utilize the opinion of the orthodontist who completes the form.

(e) If it is determined that the malocclusion is not severe enough to warrant medically necessary orthodontic services or the member's age precludes approval, a computer generated notice is issued to the provider

and member with notice of the denial, the reason for the denial, and appeal rights (see OAC 317:2-1 for grievance procedures and process).

(f) Orthodontic treatment and payment for the services are approved within the scope of SoonerCare. If orthodontic treatment is approved, a computer generated notice is issued authorizing the first year of treatment.

(1) Approval of orthodontic treatment is given in accordance with the following:

(A) Authorization for the first year begins on the date of banding and includes the placement of appliances, arch wires, and a minimum of six adjustments. It is expected that orthodontic members be seen every four to eight weeks for the duration of active treatment.

(B) Subsequent adjustments will be authorized in one year intervals and the treating orthodontist must provide a comprehensive progress report at the 24 month interval.

(C) All approved treatment is included on the original prior authorization and will include the total payment for that treatment year.

(2) Claim and payment are made as follows:

(A) Payment for comprehensive treatment includes the banding, wires, ~~and~~ adjustments as well as all ancillary services, including the removal of appliances, and the construction and placing of retainers.

(B) Payment is not made for comprehensive treatment beyond 36 months.

(g) If the member moves from the geographic area or shows a need to change their provider, then the provider who received the yearly payment is financially responsible until completion of that member's orthodontic treatment for the current year.

(h) If the provider who received yearly payment does not agree to be financially responsible, then the Oklahoma Health Care Authority will recoup funds paid for the member's orthodontic treatment.

(i) All orthodontic services are subject to post-utilization review. This review may include a request by the OHCA to submit medical documentation necessary to complete the review. After review is completed, these materials are returned to the orthodontist.

(j) Study models must be diagnostic and meet the following requirements:

(1) Study models must be properly poured and adequately trimmed without large voids or positive bubbles present.

(2) Centric occlusion must be clearly indicated by pencil lines on the study models, making it possible to occlude the teeth on the models in centric occlusion.

(3) 3-D model images are preferred.

(4) Study models not in compliance with the above described diagnostic guidelines are not accepted. The provider may send new images that meet these requirements. If the provider does not respond, the request for treatment is denied.

(5) All measurements are made or judged on the basis of greater than or more than the minimal criteria. Measurement, counting, recording, or consideration is performed only on teeth that have erupted and may be

seen on the study models.

317:30-5-704. Billing instructions

(a) **HCPCS Codes.** The Oklahoma Health Care Authority utilizes the Medicare Level II HCPCS Codes. All claim submissions must be in compliance with this coding system.

(b) **Prior authorization.** Where applicable, the appropriate arch, quadrant, or tooth surface and tooth number must be included on the claim. Diagnosis codes are requested to be listed in box 34 of ADA form 2012.

(c) ~~**X-rays.**~~**Images.** Any type of film or prints submitted will not be returned. All ~~x-rays~~images must be dated, mounted and have patient's name, recipient identification number (RID), provider name and provider number.

317:30-5-705. Billing

Billing for dental services may be submitted on the currently approved version of the American Dental Association (ADA) claim form. Diagnosis codes are requested to be listed in box 34 of ADA form 2012. Electronic submission must be made on the HIPPA compliant Form 837D.

AGENDA

15-28 Indian Health Service, Tribal, and Urban Indian Language Update

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

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

317:30-5-1085. General provisions

(a) Indian Health Services (IHS) provide health care to Certificate of Degree of Indian Blood (CDIB) eligible American Indian and Alaska Natives (AI/AN). The IHS is a division of the Department of Health and Human Services that administers a system of hospitals and Indian health outpatient services. Urban Indian Clinics are considered facilities of the IHS. Under the Indian Self-Determination Act, Public Law 93-638, as amended, Tribes may also provide health care to ~~CDIB~~IHS eligible AI/ANs.
(b) The rules at OAC 317:30-3 apply to IHS, Tribal, and Urban Indian facilities. Additionally, unless otherwise stated, all other SoonerCare rules apply to IHS, Tribal, and Urban Indian facilities.

317:30-5-1086. Eligible I/T/U providers

~~Indian Health Services, Tribal Programs, and Urban Indian Clinics (I/T/Us) are considered eligible for participation in the SoonerCare Program. To receive SoonerCare reimbursement, an I/T/U must have a current contract on file with the Oklahoma Health Care Authority (OHCA). OHCA recognizes that I/T/Us are the payer of last resort, and are not considered creditable health insurance.~~

Indian Health Services, Tribal Programs, and Urban Indian Clinics (I/T/Us) are considered eligible for participation in the SoonerCare Program. To receive SoonerCare reimbursement, an I/T/U must be contracted as a provider with the Oklahoma Health Care Authority and appear on the IHS maintained listing of IHS-operated and Indian health care facilities under a 638 agreement. OHCA recognizes that I/T/Us are the payer of last resort, and are not considered creditable health insurance. It is the sole responsibility of the facility to petition IHS for placement on the list of facilities operating under a 638 agreement.

317:30-5-1087. Terms and definitions

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

(1) **"American Indian/Alaska Native (AI/AN)"** means an individual of Native American descent who has or is eligible for a Certificate of Degree of Indian Blood (CDIB) card.
(2) **"Behavioral Health services"** means professional medical services for the treatment of a mental health and/or addiction disorder(s).
(3) **"CFR"** means the Code of Federal Regulations.
(4) **"CMS"** means the Centers for Medicare and Medicaid Services.

(5) **"Encounter"** means a face to face contact between a health care professional and ~~a CDIB card~~an IHS eligible SoonerCare member for the provision of medically necessary Title XIX or Title XXI covered services through an IHS or Tribal 638 facility or an urban Indian clinic within a 24-hour period ending at midnight, as documented in the patient's record.

(6) **"Licensed Behavioral Health Professional (LBHP)"** means a licensed psychologist, licensed clinical social worker ~~(LSW-C)~~(LCSW), licensed marital and family therapist (LMFT), licensed professional counselor (LPC), licensed behavioral practitioner (LBP) or licensed alcohol and drug counselor (LADC).

(7) **"OHCA"** means the Oklahoma Health Care Authority.

(8) **"OMB rate"** means the Medicaid reimbursement rate negotiated between CMS and IHS. Inpatient and outpatient Medicaid reimbursement rates for I/T/Us are published annually in the Federal Register or Federal Register Notices. The outpatient rate is also known as the I/T/U encounter rate. The encounter rate is available only to I/T/U facilities that appear on the IHS maintained listing of IHS-operated and Indian health care facilities operating under a 638 agreement. It is the sole responsibility of the facility to petition IHS for placement on this list.

(9) **"Physician"** means a doctor of medicine or osteopathy legally authorized to practice medicine and surgery or who is a licensed physician employed by the Federal Government in an IHS facility or who provides services in a 638 Tribal Facility.

(10) **"State Administering Agency (SAA)"** is the Oklahoma Health Care Authority.

(11) **"638 Tribal Facility"** is a facility that is operated by a tribe or tribal organization and funded by Title I or Title III of the Indian Self Determination and Education Assistance Act (Public Law 93-638).

317:30-5-1088. I/T/U provider participation requirements

(a) I/T/Us must ~~either~~ directly employ ~~or contract~~ the services of legally credentialed professional staff that are authorized within their scope of practice under state law to provide the services for which claims are submitted to SoonerCare; or I/T/U Physicians may meet all requirements for employment by the Federal Government as a physician and be employed by the Federal Government in an IHS facility or affiliated with a 638 Tribal Facility.

~~(b) The facility is required to report professional staff contracted or employed by the I/T/U to the OHCA. Participating I/T/Us are required to submit a list of names of all practitioners working within the facility and a list of all individual OHCA provider and National Provider Identifier (NPI) numbers. The reimbursement for the services rendered at or on behalf of the I/T/U will be made to the facility.~~

(b) The facility is required to contract with OHCA all professional staff employed by the I/T/U. Participating I/T/Us are required to submit contracts for all practitioners working within the facility via Oklahoma's Electronic Provider Enrollment (EPE) web-based system. The reimbursement

for services rendered at or on behalf of the I/T/U will be made to the facility.

~~(c) The following professional staff are recognized by OHCA:~~

~~(1) Physicians;~~
~~(2) Licensed Physician Assistants;~~
~~(3) Dentists;~~
~~(4) Pharmacists;~~
~~(5) Advanced Practice Nurses (APNs) which include:~~
~~(A) Advanced Registered Nurse Practitioners (ARNPs);~~
~~(B) Certified Nurse Midwives (CNMs);~~
~~(C) Certified Registered Nurse Anesthetists (CRNAs); and~~
~~(D) Clinical Nurse Specialists (CNSs);~~
~~(6) Registered nurses under the supervision of a licensed physician; and~~
~~(7) Practitioners who are actively and regularly receiving board approved supervision, or those receiving extended supervision by a fully licensed clinician if board's supervision requirement is met but the individual is not yet fully licensed for the services that are within the practitioner's scope of practice. This includes but is not limited to:~~
~~(A) licensed clinical social workers (LSW-C);~~
~~(B) marital and family therapists (LMFT);~~
~~(C) licensed professional counselors (LPC);~~
~~(D) licensed behavioral practitioners (LBP); and~~
~~(E) licensed alcohol and drug counselors (LADC).~~

(c) Only professional staff listed as eligible providers in OAC 317:30-5 are recognized by OHCA.

317:30-5-1089. I/T/U multiple sites

(a) I/T/Us may contract as a PCP/CM under SoonerCare Choice (See OAC 317:25-7-5).

~~(b) I/T/Us are required to submit a list of all clinics affiliated or owned by the facility including any clinics that do not have I/T/U status, along with all OHCA provider numbers assigned to these clinics.~~

(b) I/T/Us are required to contract with all facilities affiliated or owned by the I/T/U to be eligible for SoonerCare reimbursement.

317:30-5-1090. Provision of other health services outside of the I/T/U encounter

~~(a) An I/T/U outpatient facility may provide other items and services which are not part of an encounter. If covered, these services are separately billable to the SoonerCare program. Coverage of services will be based upon medical necessity and the scope of coverage under the SoonerCare program and subject to any limitations, restrictions or prior authorization requirements.~~

~~(b)~~(a) Medically necessary SoonerCare covered services that are not included in the I/T/U outpatient encounter rate may be billed outside the encounter rate within the scope of the SoonerCare fee-for-service ~~rate~~contract. The services will be reimbursed at the fee-for-service rate,

and will be subject to any limitations, restrictions or prior authorization requirements. Examples of these services include but are not limited to:

(1) pharmaceuticals/drugs;
(2) durable medical equipment;
(3) glasses;
(4) ambulance;
(5) home health;
(6) inpatient practitioner services;
(7) non-emergency transportation [refer to OAC 317:35-3-2];
(8) behavioral health case management [refer to ~~OAC 317:30-5-585 through 317:30-5-589 and OAC 317:30-5-595 through 317:30-5-599~~OAC 317:30-5-240 through 317:30-5-249];
(9) psychosocial rehabilitative services [refer to OAC 317:30-5-240 through ~~317:30-5-248~~317:30-5-249]; and
(10) psychiatric residential treatment facility services [refer to OAC 317:30-5-96.3].

~~(c)~~(b) If the I/T/U facility chooses to provide other SoonerCare State Plan covered health services which are not included in the I/T/U encounter definition, those service providers must be contracted with OHCA and bill for those services under their assigned provider number consistent with program coverage limitations and billing procedures described by the OHCA.

~~(d) The originating site facility fee for telemedicine services is not an I/T/U service. When an I/T/U serves as the originating site, the originating site facility fee is paid separately from the clinic's all-inclusive rate.~~

317:30-5-1091. Definition of I/T/U services

(a) As described in ~~Title 42 of the Code of Federal Regulations (CFR) 136.11(a)~~42 CFR 136.11(a), the I/T/U services may include hospital and medical care, dental care, public health nursing, ~~and~~ preventive care (including immunizations)~~, and health examination of special groups such as school children~~.

(b) Further, ~~Title~~ 42 CFR 136.11(c) allows that the scope and availability of I/T/U services will depend upon the resources of the facility.

(c) I/T/U services may be covered when furnished to a patient at the clinic or other location, including a mobile clinic, or the patient's place of residence. Provider contracts must meet the provider participation requirements found at OAC 317:30-5-1096.

(d) I/T/U outpatient encounters include but are not limited to:

(1) Physicians' services and supplies incidental to a physician's services;
(2) Within limitations as to the specific services furnished, a doctor of dentistry or oral surgery, a doctor of optometry, or a doctor of podiatry [Refer to Section 1861(r) of the Act for specific limitations];
~~(3) The services of a resident as defined in OAC 317:25-7-5(4) who meets the requirements for payment under SoonerCare and the supplies incidental to a resident's services;~~

~~(4)~~(3) Services of advanced practice nurses (APNs), physician assistants (PAs), certified nurse midwives (CNMs), or specialized advanced practice nurse practitioners;
~~(5)~~(4) Services and supplies incidental to the services of APNs and PAs (including services furnished by certified nurse midwives);
~~(6)~~(5) Public health nursing services, within the scope of their licensure, include but are not limited to services in the following areas:
(A) Phlebotomy;
(B) Wound care;
(C) Public health education;
(D) Administration of immunizations;
(E) Administration of medication;
(F) Child health screenings meeting EPSDT criteria;
(G) Smoking and Tobacco Use Cessation Counseling;
(H) Prenatal, newborn and postpartum assessments, including case management services for first time mothers; and
(I) General health assessments and management of conditions such as tuberculosis, diabetes and hypertension.
~~(7)~~(6) Visiting nurse services to the homebound;
~~(8)~~(7) Behavioral health professional services and services and supplies incidental to the services of LBHPs; and
~~(9)~~(8) Dental services.

317:30-5-1093. I/T/U visiting nurses services

(a) Visiting nurse services may be covered if:
(1) The services are rendered to a homebound individual~~;~~ who is permanently or temporarily confined to his or her place of residence because of a medical or health condition. The individual may be considered homebound if he or she leaves the place of residence infrequently. For this purpose, place of residence does not include a hospital or long term care facility; and
(2) The services are furnished by a registered nurse, licensed practical nurse, or licensed vocational nurse who is employed by, ~~or~~and receives compensation for the services from the I/T/U; and
(3) The services are furnished under a written plan of treatment that is:
(A) established and reviewed at least every 60 days by a supervising physician of the I/T/U or established by a nurse practitioner, physician assistant, nurse midwife, or specialized nurse practitioner and reviewed at least every 60 days by a supervising physician; and
(B) signed by the nurse practitioner, physician assistant, nurse midwife, specialized nurse practitioner, or the supervising physician of the clinic.
(b) The nursing care covered in this Section includes:
(1) Services that must be performed by a registered nurse, licensed practical nurse, or licensed vocational nurse if the safety of the

patient ~~is to be assured~~can be assured in the home and the medically desired results achieved; and

(2) Personal care services, to the extent covered under Medicare as home health services. These services include helping the patient to bathe, to get in and out of bed, to exercise and to take medications.

(c) This benefit does not cover household and housekeeping services or other services that would constitute custodial care.

~~(d) For purposes of this Section, homebound means an individual who is permanently or temporarily confined to his or her place of residence because of a medical or health condition. The individual may be considered homebound if he or she leaves the place of residence infrequently. For this purpose, place of residence does not include a hospital or long term care facility.~~

317:30-5-1094. Behavioral health services provided at I/T/Us

(a) Behavioral health services that are primary, preventive, and therapeutic and would be covered if provided in another setting may be provided by I/T/U providers. Services provided by an I/T/U (refer to OAC 317:30-5-241 for a description of services) must meet the same requirements as services provided by another provider. Services include:

(1) Mental Health Assessment/Evaluation Testing;

(2) Alcohol and/or Substance Abuse Services Assessment and Treatment Plan Development;

(3) Crisis Intervention Services;

(4) Medication Training and Support;

(5) Individual/interactive Psychotherapy;

(6) Group Psychotherapy; and

(7) Family Psychotherapy.

(b) Behavioral health professional therapy services are covered when provided in accordance with a documented individualized treatment plan, developed to treat the identified mental health and/or substance abuse disorder(s). A minimum of a 45 to 50 minute standard clinical session must be completed by an I/T/U in order to bill an encounter for the session. Treatment must be documented in accordance with OAC 317:30-5-248.

(c) In order to support access to mental health services, these services may be provided in settings outside of the I/T/U. Offsite services must take place in a confidential setting.

(d) The outpatient behavioral health services' provider enrollment and reimbursement process in no way changes the OHCA's policy with regard to reimbursement of practitioners. Licensed clinical social workers ~~(LSW-C)~~(LCSW), licensed marital and family therapists (LMFT), licensed professional counselors (LPC), licensed behavioral practitioners (LBP), ~~and~~ licensed alcohol and drug counselors (LADC), and licensure candidates are not eligible for direct reimbursement as practitioners. Their services are compensable only when billed by their employers and when provided in those clinical settings in which they are currently approved to render services. Licensure candidates must meet the requirements contained in OAC 317:30-5-240.3.

(e) For the provision of behavioral health related case management services, I/T/U providers must meet the requirements found at OAC ~~317:30-5-585 through 317:30-5-589 and OAC 317:30-5-595 through 317:30-5-599~~317:30-5-240 through 317:30-5-249, and be contracted as such. The provision of these services is considered to be outside of the I/T/U encounter. Contracted behavioral health case management providers are responsible for obtaining all necessary prior authorizations, if needed, and will be paid at the current fee-for-service rate.

(f) For the provision of psychosocial rehabilitation services, I/T/U facilities meet the requirements found at OAC 317:30-5-240 through ~~317:30-5-248~~317:30-5-249, and must contract as an outpatient behavioral health agency. The provision of these services is considered to be outside of the I/T/U encounter. Contracted psychosocial rehabilitation service providers are responsible for obtaining all necessary prior authorizations, if needed, and will be paid at the current fee-for-service rate.

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

~~(a)~~ I/T/U services that are not compensable under outpatient encounters include:

(1) group or mass information programs, health education classes, or group education activities, including media productions and publications;
(2) vaccines covered by the Vaccines for Children program [refer to OAC 317:30-5-14(a)(1)];
(3) group or sports physicals and medical reports;
(4) drug samples or other prescription drugs provided to the clinic free of charge;
(5) administrative medical examinations and report services; and
(6) gauze, band-aids, or other disposable products used during an office visit.

~~(b) Exclusions from the definition of I/T/U encounters include but are not limited to:~~

~~(1) Durable medical equipment or medical supplies not generally provided during the course of a clinic visit such as diabetic supplies;~~
~~(2) Pharmaceutical or biologicals not generally provided during the clinic visit. For example, sample medications are part of the encounter but dispensing a prescription is billed separately under the fee-for-service pharmacy program;~~
~~(3) Other services that are not defined in this rule or the State Plan under Title XIX or Title XXI of the Social Security Act.~~
~~(4) Eyeglasses (refer to OAC 317:30-5-450);~~
~~(5) Emergency ambulance transportation (refer to OAC 317:30-5-335);~~
~~(6) Non-emergency transportation;~~
~~(7) Prosthetic devices (other than dental) which replace all or part of an internal body organ (including colostomy bags) and supplies directly related to colostomy care and the replacement of such devices;~~
~~(8) Behavioral health rehabilitative services [see OAC 317:30-5-241];~~
~~(9) hearing aids; and~~

~~(10) Behavioral health case management service [refer to OAC 317:30-585 through 317:30-589 and OAC 317:30-5-595 through 317:30-5-599].~~

317:30-5-1096. I/T/U off-site services

I/T/U covered services provided off-site or outside of the I/T/U setting, including mobile clinics or places of residence, are compensable when billed by the I/T/U. ~~The I/T/U must have a written contract with the physician and other practitioners that specifies that the I/T/U will bill SoonerCare for services provided off-site and how such providers will be compensated.~~ The I/T/U must meet provider participation requirements listed in 317:30-5-1088. I/T/U off-site services may be covered if the services rendered were within the provider's scope of practice and are of the same integrity of services rendered at the I/T/U facility.

317:30-5-1098. I/T/U outpatient encounters

(a) I/T/U outpatient encounters that are billed to the OHCA must meet the definition in this Section and are limited to services covered by the OHCA. These services include health services included in the State Plan under Title XIX or Title XXI of the Social Security Act.
(b) The following words and terms have the following meaning unless the context clearly indicates otherwise:

~~(1) An I/T/U outpatient encounter is a face-to-face contact between a health care professional and a CDIB card eligible SoonerCare member for the provision of Title XIX and Title XXI covered outpatient services in an I/T/U facility within a 24-hour period ending at midnight, as documented in the patient's medical record.~~

(1) An I/T/U encounter means a face to face or telemedicine contact between a health care professional and an IHS eligible SoonerCare member for the provision of medically necessary Title XIX or Title XXI covered services through an IHS or Tribal 638 facility or an urban Indian clinic within a 24-hour period ending at midnight, as documented in the patient's record.

~~(2) An I/T/U encounter means outpatient services that may be covered when furnished to a patient by employees of the I/T/U facility at the I/T/U facility or other location, including the patient's place of residence.~~

(2) An I/T/U outpatient encounter means outpatient services that may be covered when furnished to a patient by a contracted SoonerCare provider employed by the I/T/U facility and rendered at the I/T/U facility or other location, including the patient's place of residence.

(c) The following services may be considered reimbursable encounters subject to the limitations of the Oklahoma State Plan and include any related medical supplies provided during the course of the encounter:

(1) Medical;
(2) Diagnostic;
(3) Behavioral Health services [refer to OAC 317:30-5-1094];
(4) Dental, Medical and Mental Health Screenings;
(5) Vision;
(6) Physical Therapy;

(7) Occupational Therapy;
(8) Podiatry;
(9) Speech;
(10) Hearing;
(11) Visiting Nurse Service [refer to OAC 317:30-5-1093];
(12) Smoking and Tobacco Use Cessation Counseling
(13) Other Title XIX or XXI services as allowed under OHCA's SoonerCare State Plan and OHCA Administrative Rules;
(14) Drugs or medication treatments provided during a clinic visit are part of the encounter rate. For example, a member has come into the clinic with high blood pressure and is treated at the clinic with a hypertensive drug or drug sample. Drug samples are included in the encounter rate. Prescriptions are not included in the encounter rate and must be billed through the pharmacy program by a qualified enrolled pharmacy;
(15) Encounters with a registered professional nurse or a licensed practical nurse and related medical supplies (other than drugs and biologicals) furnished on a part-time or intermittent basis to home-bound members; and
(16) I/T/U Multiple Outpatient Encounters.

(A) OHCA will cover one medically necessary outpatient medical encounter per member per day unless if due to an emergency, the same member returns on the same day for a second visit with a different diagnosis. Then, a second encounter is allowed.

(B) OHCA will cover one dental encounter per member per day regardless of how many procedures are done or how many providers are seen unless if due to an emergency, the same member returns on the same day for a second visit and has a different diagnosis. Then, a second encounter is allowed.

(C) OHCA will cover one behavioral health professional outpatient encounter per member per day unless if due to an emergency, the same member returns on the same day for a second visit and has a different diagnosis. Then, a second encounter is allowed.

(D) Each service must have distinctly different diagnoses in order to meet the criteria for multiple I/T/U outpatient encounters.~~ For example, a medical visit and a dental visit on the same day are considered different services with distinctly different diagnoses.~~

~~(E) Similar services, even when provided by two different I/T/U health care practitioners, are not considered multiple encounters. Situations that would not be considered multiple encounters provided on the same date of service include, but are not limited to:~~

~~(i) A well child check and an immunization;~~

~~(ii) A preventive dental screen and fluoride varnish application in a single setting;~~

~~(iii) A medical encounter with a mental health or addiction diagnosis on the same day as a mental health or addiction encounter;~~

~~(iv) A mental health and addiction encounter with similar diagnosis;~~

~~(v) Any time a member receives only a partial service with one provider and partial service from another provider. This would be considered a single encounter.~~

~~(d) More than one outpatient visit with a medical professional within a 24-hour period for distinctly different diagnoses may be reported as two encounters. This does not imply that if a member is seen at a single office visit with multiple problems that multiple encounters can be billed. For example, a member comes to the clinic in the morning for an immunization, and in the afternoon, the member falls and breaks an arm. This would be considered multiple medical encounters and can be billed as two encounters. However, a member who comes to the I/T/U facility for a prenatal visit in the morning and delivers in the afternoon would not be considered a distinctly different diagnosis and can only be billed as a single encounter.~~

<u>(d) More than one outpatient visit with a medical professional within a 24-hour period for distinctly different diagnoses may be reported as two encounters. This does not imply that if a member is seen at a single office visit with multiple problems that multiple encounters can be billed. For example, a member comes to the clinic in the morning for an immunization, and in the afternoon, the member falls and breaks an arm. This would be considered multiple medical encounters and can be billed as two encounters. However, a member who comes to the I/T/U facility for a diabetic wellness screening and is then referred to a podiatrist within the clinic for diabetes-related follow-up on the same date of service would not be considered a distinctly different diagnosis and can only be billed as a single encounter.</u>

(e) The following services may be considered as separate or multiple encounters when two or more services are provided on the same date of service with distinctly different diagnoses:

(1) Medical Services;

(2) Dental Services;

(3) Mental Health and addiction services with similar diagnoses can only be billed as one encounter. In addition, if the member is also seen for a medical office visit with a mental health or addiction diagnosis, then it is considered a single encounter;

(4) Physical or occupational therapy (PT/OT). If this service is also performed on the same date of service as the medical encounter that determined the need for PT/OT (initial referral), then it is considered a single encounter;

(5) Administration of immunizations. If no other medical office visit occurs on the same date of services; and

(6) Tobacco cessation limited to state plan services. If no other medical or addiction encounter occurs on the same date of service.

(f) I/T/U outpatient encounters for ~~CDIB~~<u>IHS</u> eligible SoonerCare members whether medical, dental, or behavioral health, are not subject to prior authorization. Other State Plan covered services that the I/T/U facility chooses to provide but which are not part of the I/T/U encounter are subject to all applicable SoonerCare regulations which govern the provision and coverage for that service.

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

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

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

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

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

317:30-5-1100. Inpatient care provided by IHS facilities

Inpatient practitioner services are separately contracted and paid at a fee-for-service rate. Each individual inpatient practitioner must be contracted with SoorerCare and attached to a SoonerCare contracted medical group. The Inpatient hospital per diem rate for inpatient medical care provided by IHS facilities is published annually in the Federal Register or Federal Register Notices. In order to receive the inpatient hospital per diem rate, the IHS or Tribal 638 facility must:

(1) be contracted as a provider with the Oklahoma Health Care Authority; and

(2) appear on the IHS maintained listing of IHS-operated and Indian health care facilities operating under a 638 agreement. It is the sole responsibility of the facility to petition IHS for placement on this list.

AGENDA

15-36 Policy Revision to Remove Specific Limits on Diabetic Testing Supplies

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 17. MEDICAL SUPPLIERS

317:30-5-211.15. Supplies

~~(a)~~ The OHCA provides coverage for medically necessary supplies that are prescribed by the appropriate medical provider~~,~~ ~~medically necessary~~ and meet the special requirements below~~.~~:

~~(b) Special requirements:~~

(1) **Intravenous therapy.** Supplies for intravenous therapy are covered items. Drugs for IV therapy are covered items only as specified by the Vendor Drug program.

(2) **Diabetic supplies.** Glucose test strips and lancets are covered when medically necessary and prescribed by a physician, physician assistant, or an advanced practice nurse. ~~A maximum of 100 glucose test strips and 100 lancets per month are covered items for insulin dependent members and a maximum of 100 glucose test strips and 100 lancets per 90 days are covered for non-insulin dependent members. Members diagnosed with gestational diabetes may receive a maximum of 150 glucose test strips and 150 lancets per month when the appropriate diagnostic classification for gestational diabetes is used. Diabetic supplies in excess of these parameters must be prior authorized.~~Testing supplies may be limited based on insulin use or type of diabetes. Prior authorization may be required for supplies beyond the standard allowance.

(3) **Catheters.** Permanent indwelling catheters, male external catheters, drain bags and irrigation trays are covered items. Single use self catheters when the member has a history of urinary tract infections is a covered item. The prescription from the attending physician must indicate such documentation is available in the member's medical record.

(4) **Colostomy and urostomy supplies.** Colostomy and urostomy bags and accessories are covered items.

AGENDA

15-38 Quality of Care Fund Reports

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 9. LONG TERM CARE FACILITIES

317:30-5-131.2. Quality of care fund requirements and report

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

(1) **"Nursing Facility and Intermediate Care Facility for Individuals with Intellectual Disabilities"** means any home, establishment, or institution or any portion thereof, licensed by the State Department of Health as defined in Section 1-1902 of Title 63 of the Oklahoma Statutes.

(2) **"Quality of Care Fee"** means the fee assessment created for the purpose of quality care enhancements pursuant to Section 2002 of Title 56 of the Oklahoma Statutes upon each nursing facility and intermediate care facility for individuals with intellectual disabilities licensed in this State.

(3) **"Quality of Care Fund"** means a revolving fund established in the State Treasury pursuant to Section 2002 of Title 56 of the Oklahoma Statutes.

(4) **"Quality of Care Report"** means the monthly report developed by the Oklahoma Health Care Authority to document the staffing ratios, total patient gross receipts, total patient days, and minimum wage compliance for specified staff for each nursing facility and intermediate care facility for individuals with intellectual disabilities licensed in the State.

(5) **"Staffing ratios"** means the minimum direct-care-staff-to-resident ratios pursuant to Section 1-1925.2 of Title 63 of the Oklahoma Statutes and pursuant to OAC 310:675-1 et seq.

(6) **"Peak In-House Resident Count"** means the maximum number of in-house residents at any point in time during the applicable shift.

(7) **"Staff Hours worked by Shift"** means the number of hours worked during the applicable shift by direct-care staff.

(8) **"Direct-Care Staff"** means any nursing or therapy staff who provides direct, hands-on care to residents in a nursing facility and intermediate care facility for individuals with intellectual disabilities pursuant to Section 1-1925.2 of Title 63 of the Oklahoma Statues, pursuant to OAC 310:675-1 et seq., and as defined in subsection (c) of this Section.

(9) **"Major Fraction Thereof"** is defined as an additional threshold for direct-care-staff-to-resident ratios at which another direct-care staff person(s) is required due to the peak in-house resident count exceeding

one-half of the minimum direct-care-staff-to-resident ratio pursuant to Section 1-1925.2 of Title 63 of the Oklahoma Statutes.

(10) **"Minimum wage"** means the amount paid per hour to specified staff pursuant to Section 5022.1 of Title 63 of the Oklahoma Statutes.

(11) **"Specified staff"** means the employee positions listed in the Oklahoma Statutes under Section 5022.1 of Title 63 and as defined in subsection (d) of this Section.

(12) **"Total Patient Days"** means the monthly patient days that are compensable for the current monthly Quality of Care Report.

(13) **"Total Gross Receipts"** means all cash received in the current Quality of Care Report month for services rendered to all residents in the facility. Receipts should include all Medicaid, Medicare, Private Pay and Insurance including receipts for items not in the normal per diem rate. Charitable contributions received by the nursing facility are not included.

(14) **"Service rate"** means the minimum direct-care-staff-to-resident rate pursuant to Section 1-1925.2 of Title 63 of Oklahoma Statutes and pursuant to OAC 310:675-1 et seq.

(b) **Quality of care fund assessments.**

(1) The Oklahoma Health Care Authority (OHCA) was mandated by the Oklahoma Legislature to assess a monthly service fee to each Licensed Nursing Facility in the State. The fee is assessed on a per patient day basis. The amount of the fee is uniform for each facility type. The fee is determined as six percent (6%) of the average total gross receipts divided by the total days for each facility type.

(2) In determination of the fee for the time period beginning October 1, 2000, a survey was mailed to each licensed nursing facility requesting calendar year 1999 Total Patient Days, Gross Revenues and Contractual Allowances and Discounts. This data is used to determine the amount of the fee to be assessed for the period of 10-01-00 through 06-30-01. The fee is determined by totaling the "annualized" gross revenue and dividing by the "annualized" total days of service. "Annualized" means that the surveys received that do not cover the whole year of 1999 are divided by the total number of days that are covered and multiplied by 365.

(3) The fee for subsequent State Fiscal Years is determined by using the monthly gross receipts and census reports for the six month period October 1 through March 31 of the prior fiscal year, annualizing those figures, and then determining the fee as defined above. As per 56 O.S. Section 2002, as amended, the fees are frozen at the amount in effect at July 1, 2004. Also, the fee will be monitored to never surpass the federal maximum.

(4) The fee is authorized through the Medicaid State Plan and by the Centers for Medicare and Medicaid Services (CMS) regarding waiver of uniformity requirements related to the fee.

(5) Monthly reports of Gross Receipts and Census are included in the monthly Quality of Care Report. The data required includes, but is not limited to, the Total Gross Receipts and Total Patient Days for the current monthly report.

(6) The method of collection is as follows:

(A) The Oklahoma Health Care Authority assesses each facility monthly based on the reported patient days from the Quality of Care Report filed two months prior to the month of the fee assessment billing. As defined in this subsection, the total assessment is the fee times the total days of service. The Oklahoma Health Care Authority notifies the facility of its assessment by the end of the month of the Quality of Care Report submission date.

(B) Payment is due to the Oklahoma Health Care Authority by the 15th of the following month. Failure to pay the amount by the 15th or failure to have the payment mailing postmarked by the 13th will result in a debt to the State of Oklahoma and is subject to penalties of 10% of the amount and interest of 1.25% per month. The Quality of Care Fee must be submitted no later than the 15th of the month. If the 15th falls upon a holiday or weekend (Saturday-Sunday), the fee is due by 5 p.m. (Central Standard Time) of the following business day (Monday-Friday).

(C) The monthly assessment including applicable penalties and interest must be paid regardless of any appeals action requested by the facility. If a provider fails to pay the Authority the assessment within the time frames noted on the second invoice to the provider, the assessment, applicable penalty, and interest will be deducted from the facility's payment. Any change in payment amount resulting from an appeals decision will be adjusted in future payments. Adjustments to prior months' reported amounts for gross receipts or patient days may be made by filing an amended part C of the Quality of Care Report.

(D) The Quality of Care fee assessments excluding penalties and interest are an allowable cost for Oklahoma Health Care Authority Cost Reporting purposes.

(E) The Quality of Care fund which contains assessments collected excluding penalties and interest as described in this subsection and any interest attributable to investment of any money in the fund must be deposited in a revolving fund established in the State Treasury. The funds will be used pursuant to Section 2002 of Title 56 of the Oklahoma Statutes.

(c) **Quality of care direct-care-staff-to resident-ratios.**

(1) Effective September 1, 2000, all nursing facilities and intermediate care facilities for individuals with intellectual disabilities (ICFs/IID) subject to the Nursing Home Care Act, in addition to other state and federal staffing requirements, must maintain the minimum direct-care-staff-to-resident ratios or direct-care service rates as cited in Section 1-1925.2 of Title 63 of the Oklahoma Statutes and pursuant to OAC 310:675-1 et seq.

(2) For purposes of staff-to-resident ratios, direct-care staff are limited to the following employee positions:

(A) Registered Nurse

(B) Licensed Practical Nurse
(C) Nurse Aide
(D) Certified Medication Aide
(E) Qualified Intellectual Disability Professional (ICFs/IID only)
(F) Physical Therapist
(G) Occupational Therapist
(H) Respiratory Therapist
(I) Speech Therapist
(J) Therapy Aide/Assistant
~~(K) Social Services Director/Social Worker~~
~~(L) Other Social Services Staff~~
~~(M) Activities Director~~
~~(N) Other Activities Staff~~
~~(O) Combined Social Services/Activities~~

(3) ~~Prior to September 1, 2003, activity and social services staff who did not provide direct, hands-on care may be included in the direct-care-staff-to-resident ratio in any shift or direct-care service rates. On and after September 1, 2003, such persons are not included in the direct-care-staff-to-resident ratio or direct-care service rates.~~The hours of direct care rendered by persons filling non-direct care positions may be used when those persons are certified and rendering direct care in the positions listed in OAC 317:30-5-131.2(c)(2) when documented in the records and time sheets of the facility.

(4) In any shift when the direct-care-staff-to-resident ratio computation results in a major fraction thereof, direct-care staff is rounded to the next higher whole number.

(5) To document and report compliance with the provisions of this subsection, nursing facilities and intermediate care facilities for individuals with intellectual disabilities must submit the monthly Quality of Care Report pursuant to subsection (e) of this Section.

(d) **Quality of care minimum wage for specified staff.** Effective November 1, 2000, all nursing facilities and private intermediate care facilities for individuals with intellectual disabilities receiving Medicaid payments, in addition to other federal and state regulations, must pay specified staff not less than in the amount of $6.65 per hour. Employee positions included for purposes of minimum wage for specified staff are as follows:

(1) Registered Nurse
(2) Licensed Practical Nurse
(3) Nurse Aide
(4) Certified Medication Aide
(5) Other Social Service Staff
(6) Other Activities Staff
(7) Combined Social Services/Activities
(8) Other Dietary Staff
(9) Housekeeping Supervisor and Staff
(10) Maintenance Supervisor and Staff
(11) Laundry Supervisor and Staff

(e) **Quality of care reports.** Effective September 1, 2000, all nursing facilities and intermediate care facilities for individuals with intellectual disabilities must submit a monthly report developed by the Oklahoma Health Care Authority, the Quality of Care Report, for the purposes of documenting the extent to which such facilities are compliant with the minimum direct-care-staff-to-resident ratios or direct-care service rates.

(1) The monthly report must be signed by the preparer and by the Owner, authorized Corporate Officer or Administrator of the facility for verification and attestation that the reports were compiled in accordance with this section.

(2) The Owner or authorized Corporate Officer of the facility must retain full accountability for the report's accuracy and completeness regardless of report submission method.

(3) Penalties for false statements or misrepresentation made by or on behalf of the provider are provided at 42 U.S.C. Section 1320a-7b which states, in part, "*Whoever...(2) at any time knowingly and willfully makes or causes to be made any false statement of a material fact for use in determining rights to such benefit or payment...shall (i) in the case of such statement, representation, concealment, failure, or conversion by any person in connection with furnishing (by that person) of items or services for which payment is or may be made under this title (42 U.S.C. '1320 et seq.), be guilty of a felony and upon conviction thereof fined not more than $25,000 or imprisoned for not more than five years or both, or (ii) in the case of such a statement, representation, concealment, failure or conversion by any other person, be guilty of a misdemeanor and upon conviction thereof fined not more than $10,000 or imprisoned for not more than one year, or both.*"

(4) The Quality of Care Report must be submitted by 5 p.m. (CST) on the 15th of the following month. If the 15th falls upon a holiday or a weekend (Saturday-Sunday), the report is due by 5 p.m. (CST) of the following business day (Monday - Friday).

(5) The Quality of Care Report will be made available in an electronic version for uniform submission of the required data elements.

(6) Facilities must submit the monthly report ~~either through electronic mail to the Opportunities for Living Life Division, Long Term Care Quality Initiatives Unit or send the monthly report in disk or paper format by certified mail and pursuant to subsection (e)(14) of this section. The submission date is determined by the date and time recorded through electronic mail or the postmark date and the date recorded on the certified mail receipt~~through the OHCA Provider Portal.

(7) Should a facility discover an error in its submitted report for the previous month only, the facility must provide to the ~~Opportunities for Living Life Division, Long Term Care Quality Initiatives Unit~~Long Term Care Financial Management Unit written notification with adequate, objective and substantive documentation within five business days following the submission deadline. Any documentation received after the five business day period

will not be considered in determining compliance and for reporting purposes by the Oklahoma Health Care Authority.

(8) An initial administrative penalty of $150.00 is imposed upon the facility for incomplete, unauthorized, or non-timely filing of the Quality of Care Report. Additionally, a daily administrative penalty will begin upon the Authority notifying the facility in writing that the report was not complete or not timely submitted as required. The $150.00 daily administrative penalty accrues for each calendar day after the date the notification is received. The penalties are deducted from the Medicaid facility's payment. For 100% private pay facilities, the penalty amount(s) is included and collected in the fee assessment billings process. Imposed penalties for incomplete reports or non-timely filing are not considered for Oklahoma Health Care Authority Cost Reporting purposes.

(9) The Quality of Care Report includes, but is not limited to, information pertaining to the necessary reporting requirements in order to determine the facility's compliance with subsections (b) and (c) of this Section. Such reported information includes, but is not limited to: ~~staffing ratios; peak in-house resident count; staff hours worked by shift; total patient days; available bed days; Medicare bed days; Medicaid bed days; and total gross receipts~~total gross receipts, patient days, available bed days, direct care hours, Medicare days, Medicaid days, number of employees, monthly resident census, and tenure of Certified Nursing Assistants, nurses, directors of nursing, and administrators.

(10) Audits may be performed to determine compliance pursuant to subsections (b), (c) and (d) of this Section. Announced/unannounced on-site audits of reported information may also be performed.

(11) Direct-care-staff-to-resident information and on-site audit findings pursuant to subsection (c), will be reported to the Oklahoma State Department of Health for their review in order to determine "willful" non-compliance and assess penalties accordingly pursuant to Title 63 Section 1-1912 through Section 1-1917 of the Oklahoma Statutes. The Oklahoma State Department of Health informs the Oklahoma Health Care Authority of all final penalties as required in order to deduct from the Medicaid facility's payment. Imposed penalties are not considered for Oklahoma Health Care Authority Cost Reporting purposes.

(12) If a Medicaid provider is found non-compliant pursuant to subsection (d) based upon a desk audit and/or an on-site audit, for each hour paid to specified staff that does not meet the regulatory minimum wage of $6.65, the facility must reimburse the employee(s) retroactively to meet the regulatory wage for hours worked. Additionally, an administrative penalty of $25.00 is imposed for each non-compliant staff hour worked. For Medicaid facilities, a deduction is made to their payment. Imposed penalties for non-compliance with minimum wage requirements are not considered for Oklahoma Health Care Authority Cost Reporting purposes.

(13) Under OAC 317:2-1-2, Long Term Care facility providers may appeal the administrative penalty described in (b)(5)(B) and (e)(8) and (e)(12) of this section.
(14) Facilities that have been authorized by the Oklahoma State Department of Health (OSDH) to implement flexible staff scheduling must comply with OAC 310:675-1 et seq. The authorized facility is required to complete the flexible staff scheduling section of Part A of the Quality of Care Report. The Owner, authorized Corporate Officer or Administrator of the facility must complete the flexible staff scheduling signature block, acknowledging their OSDH authorization for Flexible Staff Scheduling.

AGENDA

15-41 Third Party Liability

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

SUBCHAPTER 3. GENERAL PROVIDER POLICIES

PART 1. GENERAL SCOPE AND ADMINISTRATION

317:30-3-24. Third party liability

~~As the Medicaid Agency, OHCA is the payer of last resort, with few exceptions. When other resources are available, those resources must first be utilized. Exceptions to this policy are those receiving medical treatment through Indian Health Services and those eligible for the Crime Victims Compensation Act. Guidance for third party liability under the Insure Oklahoma program is found in OAC 317:45, Insure Oklahoma.~~

As the Medicaid Agency, OHCA is the payer of last resort, with few exceptions. When other resources are available, those resources must first be utilized. Exceptions to this policy include, but are not limited to, those receiving medical treatment through Indian Health Services, those eligible for the Crime Victims Compensation Act, and those medical expenses incurred in relation to a claim or lawsuit for which a third party may be responsible and for which the OHCA will have a right to subrogation of medical expense payments. Guidance for third party liability under the Insure Oklahoma program is found in OAC 317:45, Insure Oklahoma.

(1) If a member has healthcare coverage by an absent parent's insurance program or any other policy holder, that insurance resource must be used prior to filing a SoonerCare claim. This includes Health Maintenance Organizations (HMO), Preferred Provider Organizations (PPO) and any other insuring arrangements that provide a member access to healthcare. Members must comply with all requirements of their primary insurance as well as SoonerCare requirements in order to take advantage of both coverages. ~~For example, a member must comply with the network restrictions of both the primary and SoonerCare plans as well as prior authorization requirements.~~For example, a member must comply with all healthcare network restrictions, as well as prior authorization requirements. If the member does not comply with the requirements of the primary plan, he/she will be responsible for the charges incurred. Denials by private insurance companies because the member did not secure a ~~preauthorization~~necessary prior authorization or use a network or participating provider is not a sufficient reason for SoonerCare to make payment. If the provider is aware of private healthcare insurance or healthcare liability, a claim must first be filed with that source. When private insurance information is known to the OHCA, the eligibility verification system will reflect that information. If payment is denied by the primary insurance, except as stated above, the provider must attach the Explanation of Benefits (EOB), stating the reason for the denial, to the claim submitted to the Fiscal Agent. When payment is received from another source, that payment amount must be reflected on the claim form.

(2) It is possible that other resources are available but are unknown to OHCA. Providers will routinely question SoonerCare members to

determine whether any other resources are available. In some instances, coverage may not be obvious, for example, the member may be covered by a policy on which he/she is not the subscriber (e.g., a child whose absent parent maintains medical and hospital coverage).
(3) If the provider receives payment from another source after OHCA has made payment, it is necessary that the provider reimburse OHCA for the SoonerCare payment. The provider may retain the primary insurance payment, if any, that represents payment for services that are not covered services under SoonerCare. By accepting the OHCA's payment, the provider agrees to accept it as payment in full and, therefore, cannot retain any portion of other resource money as payment for reduced charges on covered services. Other than SoonerCare copayments, a provider cannot bill a member for any unpaid portion of the bill or for a claim that is not paid because of provider administrative error. If, after reimbursing OHCA and retaining a portion of the other payment in satisfaction of any non-covered services there is money remaining, it must be refunded to the member.
(4) If a member is covered by a private health insurance policy or plan, he/she is required to inform medical providers of the coverage, including:

(A) provision of applicable policy numbers;
(B) assignment payments to medical providers;
(C) provision of information to OHCA of any coverage changes; and
(D) release of money received from a health insurance plan to the provider if the provider has not already received payment or to the OHCA if the provider has already been paid by the OHCA.

(5) Members are responsible for notifying their providers of the intent to make application for SoonerCare coverage and of any retroactive eligibility determinations. Members may be responsible for any financial liability if they fail to notify the provider of the eligibility determinations and as a result, the provider is unable to secure payment from OHCA.
(6) Members must present evidence of SoonerCare and any other health insurance coverage to a medical provider each time services are requested. Members may be responsible for any financial liability if they fail to furnish the necessary information before the receipt of services and as a result, the provider is unable to secure payment from OHCA.
(7) Regarding SoonerCare compensable services, when there is a third party (whether an individual, entity or insurance carrier) who may be liable for the medical expenses incurred by a member (based upon injury and/or damages, whether or not a claim for damages or a lawsuit have been pursued by the member), the medical provider rendering the medical services can elect to bill the third party liability carrier directly or to bill SoonerCare directly. However, the provider cannot bill more than the SoonerCare rate for that covered service. Otherwise, the subrogation rights of the OHCA against that third party may be adversely affected. Those having Provider Agreements with the OHCA are prohibited from recovering more than the SoonerCare rate. See 42 CFR 447.15. The Medical providers are prohibited from recovering an amount exceeding the SoonerCare rate for SoonerCare compensable services even when the provider does not seek payment from the OHCA. As a result of the claimant/member utilizing SoonerCare for healthcare, medical providers who contract with the OHCA are paid significantly less than they ordinarily bill and prohibited by state and federal law from

pursuing additional payments from the claimant/member. Regarding SoonerCare compensable services, providers who seek to collect an amount greater than the SoonerCare allowable from a member may be subjected to penalties pursuant to 42 CFR 447.21. Penalties can be a reduction in SoonerCare payments due the provider, which is equal to three times the amount the provider sought to collect. Pursuant to 42 CFR 447.15, payments made by the OHCA shall be considered payment in full for all covered services provided to a SoonerCare member. Medical Providers shall not bill a SoonerCare member for such service and shall not be relieved of this provision by electing not to bill OHCA for the service. This provision shall not apply to co-payments allowed by OHCA.

AGENDA

15-42 Audit Procedures

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

SUBCHAPTER 3. GENERAL PROVIDER POLICIES

PART 1. GENERAL SCOPE AND ADMINISTRATION

317:30-3-2.1. Program Integrity Audits/Reviews

(a) This section applies to all contractors/providers:

(1) **"Contractor/provider"** means any person or organization that has signed a provider agreement with the Oklahoma Health Care Authority (OHCA).

(2) **"Extrapolation"** means the methodology of estimating an unknown value by projecting, with a calculated precision (i.e., margin of error), the results of a probability sample to the universe from which the sample was drawn.

(3) **"Probability sample"** means the standard statistical methodology in which a sample is selected based on the theory of probability (a mathematical theory used to study the occurrence of random events).

(4) **"Universe"** means all paid claims or types of paid claims audited/reviewed during a specified timeframe.

(5) **"Sample"** means a statistically valid number of claims obtained from the universe of claims audited/reviewed.

(6) **"Error Rate"** means the percentage of dollars of audited claims found to be billed in error.

(b) An OHCA audit/review includes the following:

~~(1) An examination of provider records, by either an on-site or desk audit. Claims may be examined for compliance with relevant federal and state laws and regulations, written provider billing instructions, numbered memoranda, and/or medical necessity.~~

(1) An examination of provider records, by either an on-site or desk audit. Claims may be examined for compliance with provider contracts, relevant federal and state laws and regulations, including but not limited to the Oklahoma Administrative Code.

~~(2) A draft audit/initial review report, which contains preliminary findings.~~

(2) An initial audit/review report contains preliminary findings. Upon receipt of the findings, a provider may elect to:

(A) Remit the identified overpayment to OHCA;

(B) Request informal reconsideration of the initial report per OAC 317:30-3-2.1(b)(3); or

(C) Request a formal appeal of the initial report per OAC 317:30-3-2.1(b)(4).

~~(3) An informal reconsideration period in which the provider may supply relevant information to clear any misunderstandings and/or findings.~~

(3) An informal reconsideration period. If a provider requests an informal reconsideration, the provider shall provide any and all

documentation or relevant information to clear any misunderstandings and/or findings identified in the initial report. Only claims identified by the provider for reconsideration will be reviewed by the OHCA. Any claims or findings not identified by the provider for reconsideration will be deemed waived by the provider if the provider chooses to later appeal the reconsideration finding. The reconsideration findings will replace the initial findings and be identified as the final report.

~~(4) The right to a formal appeal, if the contractor/provider requests it.~~

(4) The right to a formal appeal, if requested by the provider. A request for reconsideration does not limit a provider's right to a formal appeal. However, all claims not specifically identified by the provider for further audit/review at reconsideration will be deemed waived by the provider for purposes of a formal audit appeal. Additionally, the provider must specifically identify each claim to be contested on appeal and any claim not identified in the appeal will be deemed waived on appeal.

~~(5) A final audit/review report.~~

(5) If the provider does not request either a reconsideration or a formal appeal within the specified timeframe, the initial report will become the final report and the provider will be obligated to reimburse OHCA for any identified overpayment, which amount shall be immediately due and payable to OHCA.

~~(c) When OHCA conducts a probability sample audit, the sample claims are selected on the basis of recognized and generally accepted sampling methods. If audit reveals patterns of inappropriate coding, failure to adhere to SoonerCare policies, issues related to medical necessity, consistent patterns of overcharging, lack of appropriate documentation, or other fiscal abuse of the SoonerCare program, with an error rate of more than 10%, the provider may be required to reimburse OHCA the extrapolated amount.~~

(c) When OHCA conducts a probability sample audit, the sample claims are selected on the basis of recognized and generally accepted sampling methods. If an audit reveals an error rate exceeding 10%, OHCA shall extrapolate the error rate to the universe of the dollar amount of the audited paid claims.

~~(1) When projecting the overpayment, using statistical sampling, OHCA uses a sample that is sufficient to ensure a minimum 95% confidence level.~~

(1) When using statistical sampling, OHCA uses a sample that is sufficient to ensure a minimum confidence level of 95%.

(2) When calculating the amount to be recovered, OHCA ensures that all overpayments and underpayments reflected in the probability sample are totaled and extrapolated to the universe from which the sample was drawn.

(3) OHCA does not consider non-billed services or supplies when calculating underpayments and overpayments.

~~(d) If sampling reveals an error rate of 10% or less, the provider will be required to reimburse OHCA for any overpayments noted during the review.~~
(d) If a probability sample audit reveals an error rate of 10% or less, the provider will be required to reimburse OHCA for any overpayments noted during the audit/review.
~~(e) In those instances when the probability sample results in an error rate in excess of 10%, the results of a probability sample may be used by OHCA to extrapolate the amount to be recovered.~~
~~(f) SoonerCare contracted providers shall have the option of requesting OHCA perform a full-scope audit or utilize an extrapolation method to determine overpayments, if during a review a statistical sample indicates an error rate greater than 10% of paid claims.~~

~~(1) The provider must select the overpayment determination method, full-scope audit or extrapolation, within the time constraints of the designated appeal.~~

~~(A) The additional labor cost to perform a full-scope audit will be carried by the OHCA if the review produces an error rate less than the initial error rate.~~

~~(B) The provider will be charged the cost of the full-scope audit if the review produces an error rate equal to or greater than the initial error rate.~~

~~(C) Cost will be determined through OHCA billable time plus all applicable overhead and/or the cost of contracted services.~~

~~(D) The provider must choose an independent contactor from an OHCA approved list of qualified contractors to perform the full-scope audit.~~

~~(2) The provider will be responsible for repayment of any identified overpayment resulting from the review method chosen.~~

AGENDA

15-43 Appeal Procedures

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

SUBCHAPTER 3. GENERAL PROVIDER POLICIES

PART 1. GENERAL SCOPE AND ADMINISTRATION

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

~~OHCA has established administrative procedures whereby a~~A medical provider may request a review of the decision of the amount paid or the non-payment of medical services provided an eligible ~~recipient~~member. If the medical provider does not agree with the original payment from the Fiscal Agent, he/she may submit a written explanation on HCA-17 (Claim Inquiry Form) as to why the adjustment is being requested and what action is to be taken, a copy of the paid remittance statement and/or detailed explanation of the paid information and a copy of the original claim with the corrections to be made for consideration of additional payment. The claim should be ~~filed~~submitted in accordance with the instructions in the ~~OAC 317:30-7 for the type of medical provider involved~~OHCA Provider Billing and Procedures Manual.

AGENDA

15-48 Service Quality Review

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 83. RESIDENTIAL BEHAVIOR MANAGEMENT SERVICES IN FOSTER CARE SETTINGS

317:30-5-740. Eligible providers

(a) **Definitions.** The following words or terms used in this Part shall have the following meaning, unless the context clearly indicates otherwise:

(1) **Therapeutic foster care (TFC) agencies.** A foster care agency is an agency that provides foster care as defined in the Code of Federal Regulations (CFR) as "24-hour substitute care for children outside their own homes." Therapeutic foster care settings are foster family homes.

(2) **Therapeutic foster care homes.** Agency-supervised private family homes in which foster parents have been trained to provide individualized, structured services in a safe, nurturing family living environment for children and adolescents with significant emotional or behavioral problems who require a higher level of care than is found in a conventional foster home but do not require placement in a more restrictive setting. Therapeutic foster care homes are considered the least restrictive out-of-home placement for children with severe emotional disorders.

(b) **TFC Agency Requirements.** Eligible TFC agencies must have:

(1) a current certification from the Oklahoma Department of Human services (OKDHS) as a child placing agency;

(2) a contract with the Division of Children and Family Services of the Oklahoma Department of Human Services, or OJA;

(3) a contract with the Oklahoma Health Care Authority; and

(4) a current accreditation status appropriate to provide ~~outpatient~~ behavioral health services in a foster care setting from:

(A) The Joint Commission formerly the Joint Commission on Accreditation (JCAHO), or

(B) the Rehabilitation Accreditation Commission (CARF), or

(C) the Council on Accreditation (COA), or

(D) the American Osteopathic Association (AOA).

317:30-5-740.1. Provider qualifications and requirements

(a) **Therapeutic foster care model.** Children in the TFC environment receive intensive individualized behavioral health and other support services from qualified staff. Because TFC children require exceptional levels of skill, time and supervision, the number of unrelated children placed per home is limited; no more than two TFC children in a home at any one time unless additional cases are specifically authorized by OKDHS, Division of Children and Family Services or OJA.

(b) **Treatment team.** TFC agencies are primarily responsible for treatment planning and coordination of the child's treatment team. This team is typically composed of an OKDHS or OJA caseworker, the child, the child's parents, others closely involved with the child and family. It also includes the following:

(1) **Certified Behavioral Health Case Manager II (CM).** A bachelors level team member that may provide support services and case management. In addition to the minimum requirements at OAC 317:30-5-240.3 (c), the CM must have:

(A) a minimum of one year of experience in providing direct care and/or treatment to children and/or families, and

(B) have access to weekly consultation with a licensed behavioral health professional or Licensure Candidate.

(C) CM must also follow requirements at OAC 317:30-5-241.3 for providing psychosocial rehabilitation services.

(2) **Licensed Behavioral Health Professional (LBHP).** A masters level professional that provides treatment and supervision for the treatment staff to maintain clinical standards of care and provide direct clinical services. In addition to the requirements at OAC 317:30-5-240.3(a) and (b), the LBHP or Licensure Candidate in a TFC setting must demonstrate a general professional or educational background in the following areas:

(A) case management, assessment and treatment planning;

(B) treatment of victims of physical, emotional, and sexual abuse;

(C) treatment of children with attachment disorders;

(D) treatment of children with hyperactivity or attention deficit disorders;

(E) treatment methodologies for emotionally disturbed children and youth;

(F) normal childhood development and the effect of abuse and/or neglect on childhood development;

(G) anger management;

(H) crisis intervention; and

(I) trauma informed methodology.

(3) **Licensed Psychiatrist and/or psychologist.** TFC agencies must provide staff with access to professional psychiatric or psychological consultation as deemed necessary for the planning, implementation and appropriate management of the resident's treatment. See OAC 317:30-5-240.3(a) and OAC 317:25-275.

(4) **Treatment Parent Specialist (TPS).** The TPS serve as integral members of the team of professionals providing services for the child. The TPS receives special training in mental health issues, behavior management and parenting techniques; and implements the in-home portion of the treatment plan with close supervision and support. They provide services for the child, get the child to therapy and other treatment appointments, write daily notes about interventions and attend treatment team meetings. The TPS must be under the supervision of a licensed behavioral health professional of the foster care agency and meet the following criteria:

(A) have a high school diploma or equivalent;
~~(B) be employed by the foster care agency as a foster parent complete with OSBI and OKDHS background screening;~~
(B) have an employment relationship with the foster care agency as a foster parent complete with OSBI and OKDHS background screening;
(C) completion of therapeutic foster parent training outlined in this section;
(D) have a minimum of twice monthly face to face supervision with the licensed, or under-supervision for licensure, LBHP, independent of the child's family therapy;
(E) have weekly contact with the foster care agency professional staff; and
(F) complete required annual trainings.

(c) **Agency assurances.** The TFC agency must ensure that each individual that renders treatment services (whether employed by or contracted by the agency) meets the minimum provider qualifications for the service. Individuals eligible for direct enrollment must have a contract on file with the Oklahoma Health Care Authority.

(d) **Policies and Procedures.** Eligible TFC agency providers that are defined in section OAC 317:30-5-740(a) shall have written policies and procedures for the orientation of new staff and foster parents which is reviewed and updated annually, for the following:
(1) pre-service training of foster parents in treatment methodologies and service needs of emotionally and behaviorally disturbed children;
(2) treatment of victims of physical, emotional, and sexual abuse;
(3) treatment of children with attachment disorders;
(4) treatment of children with hyperactive or attention deficit disorders;
(5) normal childhood development and the effect of abuse and/or neglect on childhood development;
(6) treatment of children and families with substance use disorders;
(7) the Inpatient Mental Health and Substance Abuse Treatment of Minors Act;
(8) anger management;
(9) inpatient authorization procedures;
(10) crisis intervention;
(11) grief and loss issues for children in foster care;
(12) the significance/value of birth families to children receiving ~~outpatient~~ behavioral health services in a foster care setting; and
(13) trauma informed methodology.

317:30-5-741. Coverage by category

(a) **Adults.** ~~Outpatient Behavioral Health Services~~Behavioral health services in ~~Therapeutic Foster~~ therapeutic foster care settings are not covered for adults.

(b) **Children.** ~~Outpatient behavioral~~Behavioral health services are allowed in therapeutic foster care settings for certain children and youth as medically necessary. The children and youth receiving 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.

(c) **Medical necessity criteria.** Medical necessity criteria is delineated as follows:

(1) A 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) or Licensure Candidate as defined in OAC 317:30-5-240.3(a) and (b) within the 30 day period resulting in a diagnosis from the most recent edition of "the Diagnostic and Statistical Manual of Mental Disorders"(DSM) 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.

317:30-5-742. Description of services

(a) Treatment services must be provided in the least restrictive, non-institutional therapeutic milieu. The foster care setting is restorative in nature, allowing children with emotional and psychological problems to develop the necessary control to function in a less restrictive setting.

(b) ~~Outpatient behavioral~~Behavioral health services must include an individual plan of care for each member served. The individual plan of care requirements are set out in OAC 317:30-5-742.2(b)(1). Treatment services in a therapeutic foster care setting may include an array of services listed in (1) - (6) of this subsection as provided in the individual plan of care. Services include, but may not be limited to:

(1) Individual, family and group therapy;

(2) Substance abuse/chemical dependency education, prevention, and therapy;

(3) Psychosocial rehabilitation and support services;

(4) Behavior management
(5) Crisis intervention; and
(6) Case Management.

317:30-5-742.2. Individual plan of care and prior authorization of services

(a) All ~~outpatient~~ behavioral health services must be prior authorized by the designated agent of the Oklahoma Health Care Authority before the service is rendered by an eligible service provider. Without prior authorization, payment is not authorized.

(b) All ~~outpatient~~ behavioral health services in a foster care setting are provided as a result of an individual assessment of the members needs and documented in the individual plan of care.

(1) **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 or Licensure Candidate.

(C) **Time requirements.** The minimum face-to-face time spent in assessment session(s) with the member and others for a low complexity Behavioral Health Assessment by a Non-Physician is one and one half hours.

(D) **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 child and parent or guardian. The child's level of participation is based on age, developmental and clinical appropriateness. The assessment must include all related diagnoses 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 or 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 use; 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, including 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, (e.g. 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 but not limited to the following:

(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) All related diagnoses from the most recent addition of the DSM.

(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 the qualified practitioner who performed the face-to-face behavioral assessment.

(2) **Individual plan of care requirement.**

(A) **Signature Requirement.** A written individual plan of care following a comprehensive evaluation for each member must be formulated by the provider agency staff within 30 days of admission with documented input from the member, legal guardian (OKDHS/OJA) staff, the foster parent (when applicable) and the treatment provider(s). It is acceptable in circumstances where it is necessary to fax a service plan to someone for review and have them fax back their signature; however, the provider must obtain the original signature for the clinical file within 30 days. No stamped or photocopied signatures are allowed. This plan must be revised and updated ~~each 90 days~~every three months with documented involvement of the legal guardian and resident.

(B) **Individualization.** The individual plan of care must be individualized and take into account the member's age, history, diagnosis, assessed functional levels, culture, and the effect of past and current traumatic experiences in the life of the member. It includes the member's documented diagnosis, appropriate goals, and corresponding reasonable and attainable objectives and action steps within the expected time lines. Each member's individual plan of care is to also address the provider agency's plans with regard to the provision of services. Each plan of care must clearly identify the type of services required to meet the child's treatment needs and frequency over a given period of time.

~~(C) Requests for outpatient behavioral services in a foster care setting will be approved for a maximum of three months.~~

~~(D)~~(C) **Qualified professional.** This service is performed by an LBHP or Licensure Candidate.

~~(E)~~(D) **Time requirements.** Individual plan of care updates must be conducted face-to-face and are required every three months during active treatment. Services will be approved for a maximum of three months. Updates can be conducted whenever it is clinically needed as determined by the qualified practitioner and member.

~~(F)~~(E) **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) updates to goals, objectives, service provider, services, and

service frequency, must be documented within the individual plan of care until the review/update is due.

(xi) individual plan of care updates must address the following:

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

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

(III) a statement documenting a review of the current individual plan of care and an explanation if no changes are to be made to the individual plan of care and a statement addressing the status of identified problem behaviors that lead to placement must be included;

(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.

(3) **Description of Services.** Agency services include:

(A) **Individual, family and group therapy.** See OAC 317:30-5-241.2(a), (b), and (c).

(B) **Crisis/behavior management and redirection.** The provider agency must provide crisis/behavior redirection by agency staff as needed 24 hours per day, 7 days per week. The agency must ensure staff availability to respond to the residential foster parents in a crisis to stabilize members' behavior and prevent placement disruption. This service is to be provided to the member by an LBHP.

(C) **Discharge planning.** The provider agency must develop a discharge plan for each member. The discharge plan must be individualized, child-specific and include an after care plan that is appropriate to the member's needs, identifies the member's needs, includes specific recommendations for follow-up care and outlines plans that are in place at the time of discharge. The plan for children in parental custody must include, when appropriate, reunification plans with the parent(s)/legal guardian. The plan for children who remain in the custody of the Oklahoma Department of Human Services or the Office of Juvenile Affairs must be developed in collaboration with the case worker and in place at the time of discharge. The discharge plan is to include at a minimum, recommendations for continued treatment services, educational services, and other appropriate community resources. Discharge planning provides a transition from foster care placement into a lesser restrictive setting within the community.

(D) **Substance use /chemical dependency use therapy.** Substance

use/chemical dependency therapy can be provided if a member is identified by diagnosis or documented social history as having emotional or behavioral problems directly related to substance use and/or chemical dependency. The modalities employed are provided in order to begin, maintain and enhance recovery from alcoholism, problem drinking, addiction or nicotine use and addiction. This service is to be provided to the member by an LBHP or Licensure Candidate.

(E) **Substance Use Rehabilitation Services.**
~~Definition.~~ Covered ~~outpatient~~ substance use rehabilitation services are provided in non-residential settings in regularly scheduled sessions intended for individuals not requiring a more intensive level of care or those who require continuing services following more intensive treatment regimes. The purpose of substance use rehabilitation services is to begin, maintain, and/or enhance recovery from alcoholism, problem drinking, drug use, drug dependency addiction or nicotine use and addiction. Rehabilitation services may be provided individually or in group sessions, and they take the format of an agency approved curriculum based education and skills training. This service is to be provided to the member by a CM II.

(F) **Psychosocial rehabilitation (PSR).**

(i) ~~Definition.~~ PSR services are face-to-face Behavioral Health Rehabilitation services which are necessary to improve the member's ability to function in the community. They are performed to improve the skills and abilities of members to live interdependently in the community, improve self-care and social skills, and promote lifestyle change and recovery practices. Rehabilitation services may be provided individually or in group sessions, and they take the format of an agency approved curriculum based education and skills training.

(ii) ~~Clinical restrictions.~~ This service is generally performed with only the members and the qualified provider, but may include a member and the member's family/support system group that focuses on the member's diagnosis, symptom management, and recovery based curriculum. 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. Family involvement is allowed for support of the member and education regarding his/her recovery, but does not constitute family therapy, which requires a licensed provider.

(iii) ~~Qualified providers.~~ CM II, LBHP or a Licensure Candidate and LBHP may perform PSR, following development of an individual plan of care curriculum approved by an LBHP or Licensure Candidate. PSR staff must be appropriately and currently trained in a recognized behavioral/ management intervention program such as MANDT or CAPE or trauma informed methodology. The CM II must have immediate access to an LBHP who can provide clinical

oversight of the CM II and collaborate with the CM II in the provision of services. A minimum of one monthly face-to-face consultation with an LBHP is required.

(iv) ~~Group sizes.~~ The maximum staffing ratio is eight to one for children under the age of eighteen.

(v) Limitations.

(I) ~~Location.~~ In order to develop and improve the member's community and interpersonal functioning and self-care abilities, PSR services may take place in settings away from the ~~outpatient~~ behavioral health agency site as long as the setting protects and assures confidentiality. When this occurs, the qualified provider must be present and interacting, teaching, or supporting the defined learning objectives of the member for the entire claimed time.

(II) ~~Eligibility for PSR services.~~ PSR services are intended for children with Serious Emotional Disturbance (SED), and children with other emotional or behavioral disorders. Children under age 6, unless a prior authorization for children ages 4 and 5 has been granted by OHCA or its designated agent based on a finding of medical necessity, are not eligible for PSR services.

(III) ~~Billing limits.~~ PSR services are time-limited services designed to be provided over the briefest and most effective period possible and as adjunct (enhancing) interventions to compliment more intensive behavioral health therapies. Service limits are based on the member's needs according to the CAR or other approved tool, the requested placement based on the level of functioning rating, medical necessity, and best practice. Service limitations are designed to help prevent rehabilitation diminishing return by remaining within reasonable age and developmentally appropriate daily limits.

(vi) ~~Progress Notes.~~ In accordance with OAC 317:30-5-241.1, the behavioral health individual plan of care developed by the LBHP must include 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. When PSR services are prescribed, the plan must address objectives that are specific, attainable, realistic, measurable, and time-limited. The plan must include the appropriate treatment coordination to achieve the maximum reduction of the mental and/or behavioral health disability and to restore the member to their best possible functional level.

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

(II) Specific goal(s) and objectives addressed during the session/group;

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

(IV) Member satisfaction with staff intervention(s);
(V) Progress, or barriers made towards goals, objectives;
(VI) New goal(s) or objective(s) identified;
(VII) Signature of the qualified provider; and
(VIII) Credentials of the qualified provider;

(vii) Additional documentation requirements. Documentation of ongoing consultation and/or collaboration with an LBHP or Licensure Candidate related to the provision of PSR services.

(viii) Non-Covered Services. The following services are not considered PSR and are not reimbursable:
(I) room and board;
(II) educational costs;
(III) supported employment; and
(IV) respite.

(G) **Social skills redevelopment.** Goal directed activities for each member to restore, retain and improve the self-help, communication, socialization, and adaptive skills necessary to reside successfully in home and community based settings. These will be daily activities that are age appropriate, culturally sensitive and relevant to the goals of the individual plan of care. These may include self-esteem enhancement, violence alternatives, communication skills or other related skill development. This service is to be provided to the member by the Treatment Parent Specialist (TPS). Services rendered by the TPS are limited to 1.5 hours daily.

317:30-5-743.1. ~~Inspection of Care~~Service Quality Review

~~There will be an on site Inspection of Care of each Therapeutic Foster Care (TFC) agency that provides care to members which will be performed by the OHCA or its designated agent. The OHCA will designate the members of the Inspection of Care Team. This team will consist of two team members and will be comprised of Licensed Behavioral Health Professionals and/or Registered Nurses. The Inspection may include observation and contact with members. The Inspection of Care (IOC) review will consist of members present or listed as facility residents at the beginning of the Inspection of Care visit as well as members on which claims have been filed with OHCA for TFC services. The review includes validation of certain factors, all of which must be met for the services to be compensable. Following the on-site inspection, the Inspection of Care Team will report its findings to the agency. The agency will be provided with written notification if the findings of the Inspection of Care have resulted in any deficiencies. A copy of the final report will be sent to the agency's accrediting agency. Deficiencies found during the IOC may result in a recoupment of the compensation received for that service. The individual plan of care is considered to be critical to the integrity of care and treatment and must be completed within the time lines designated at OAC 317:30-5-742.2. If the individual plan of care is missing or it is found that the child did not meet medical necessity criteria at any time, all paid services will be recouped for each day the individual plan of care was missing from the date the plan of care was due for completion.~~

There will be an on-site Service Quality Review (SQR) performed by the OHCA or its designated agent of each Therapeutic Foster Care (TFC) agency that provides care to members. The OHCA will designate the members of the SQR Team. This team will consist of at least two team members and will be comprised of Licensed Behavioral Health Professionals and/or Registered Nurses. The SQR will consist of a survey of current members receiving services as well as members for which claims have been filed with OHCA for TFC services. Observation and contact with members may be incorporated. The review includes validation of certain factors, all of which must be met for the services to be compensable. Following the on-site inspection, the SQR Team will report its findings to the agency. The agency will be provided with written notification if the findings of the SQR have resulted in any deficiencies. A copy of the final report will be sent to the agency's accrediting body. Deficiencies found during the SQR may result in a recoupment of the compensation received for that service. The individual plan of care is considered to be critical to the integrity of care and treatment and must be completed within the time lines designated at OAC 317:30-5-742.2. If the individual plan of care is missing or it is found that the child did not meet medical necessity criteria at any time, all paid services will be recouped for each day the individual plan of care was missing from the date the plan of care was due for completion or the date from which medical necessity criteria was no longer met.

AGENDA

15-50 Policy Revision to Amend Policy Regarding Home Property in a Revocable Trust as a Countable Resource

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

317:35-5-41.1. Home/real property

(a) Home property is excluded from resources regardless of value unless the individual is applying for long-term care services. [See 317:35-5-41.8(a) (relating to eligibility for long-term care services)]

(b) For purposes of the home property resource exclusion, a home is defined as any shelter in which the individual has an ownership interest and which is used by the individual as his/her principal place of residence. The home may be either real or personal property, fixed or mobile. Home property includes all property which is adjacent to the home. ~~Home property in a revocable trust under the direct control of the individual, spouse, or legal representative retains the exemption as outlined in OAC 317:35-5-41.8(a)(2).~~ Property has a value regardless of whether there is an actual offer to purchase. Verification of home/real property value is established by collateral contacts with specialized individuals knowledgeable in the type and location of property being considered.

(1) The home may be retained without affecting eligibility during periods when it is necessary to be absent for illness or other necessity. When it is determined that the member does not have a feasible plan for and cannot be expected to return to his/her home, the market value of the property is considered in relation to the resource. The member is responsible for taking all steps necessary to convert the resource for use in meeting current needs. If the member is making an effort to make the resource available, a reasonable period of time is given (not to exceed 90 days) to convert the resource. He/she is advised in writing that the 90-day period begins with the determination that the property be considered in relation to the resource. The 90-day period is given only if efforts are in progress to make the resource available. Any extension beyond the initial 90-day period is justified only after interviewing the member, determining that a good faith effort to sell is still being made and failure to sell is due to circumstances beyond the control of the member. A written notification is also provided to the member at any time an extension is allowed. Detailed documentation in the case record is required.

(2) If the member fails or is unwilling to take steps necessary to convert the resource for use in meeting current needs, continuing

eligibility cannot be established and the member is advised as to the effective date of closure and of the right to receive assistance when the resources are within the maximum allowable resources provided other conditions of eligibility continue to be met.

(3) When a member sells his/her home with the intention of purchasing another home or when an insurance payment for damage to the home is received, a reasonable period of time is given to reinvest the money in another home. A reasonable period of time is considered to be not in excess of a 90-day period. Extensions beyond the 90 days may be justified only after interviewing the member, determining that a good faith effort is still being made and that completion of the transaction is beyond his/her control. This must be documented in the case record.

(4) At the point a member decides not to reinvest the proceeds from the sale of his/her home in another home, the member's plan for use of the proceeds is evaluated in relation to rules on resources disposed of while receiving assistance.

(5) A home traded for another home of equal value does not affect the member's eligibility status. If the home is traded for a home of lesser value, the difference may be invested in improvement of the new home.

(6) Absences from home for up to 90 days for trips or visits or six months for medical care (other than nursing facilities) do not affect receipt of assistance or the home exclusion as long as the individual intends to return home. Such absences, if they extend beyond those limits, may indicate the home no longer serves as the principal place of residence.

(7) Mineral rights associated with the home property are considered along with the surface rights and are excluded as a resource. However, mineral rights which are not associated with the home property are considered as a resource. Since evaluation and scalability of mineral rights fluctuate, the establishment of the value of mineral rights are established based on the opinion of collateral sources. Actual offers of purchase are used when established as a legitimate offer through a collateral source. Mineral rights not associated with home property which are income producing are considered in the same way as income producing property. Refer to (11)(B) of this subsection for treatment of mineral rights as non-trade or non-business property.

(8) The market value of real estate other than home property owned by the member or legal dependent and encumbrances against such property are ascertained in determining the equity (including the cost to the member of a merchantable title to be determined when the resource approaches the maximum). The market value of real estate other than the home owned by the applicant is established on the basis of oral or written information which the applicant has on hand ~~**and**~~and counsel with persons who have specialized knowledge about this kind of resource. Refer to (11) of this subsection for exclusion of real estate that produces income.

(9) Land which is held by an enrolled member of an Indian tribe is excluded from resources as it cannot be sold or transferred without the

permission of other individuals, the tribe, or a federal agency. If permission is needed, the land is excluded as a resource.

(10) A life estate conveys upon an individual or individuals for his/her lifetime, certain rights in property. Its duration is measured by the lifetime of the tenant or of another person; or by the occurrence of some specific event, such as remarriage of the tenant. The owner of a life estate has the right of possession, the right to use the property, the right to obtain profits from the property and the right to sell his/her life estate interest. However, the contract establishing the life estate may restrain one or more rights of the individual. The individual does not have title to all interest in the property and does not have the right to sell the property other than the interest owned during his/her lifetime. He/she may not usually pass it on to heirs in the form of an inheritance.

(A) When a life estate in property is not used as the member's home, it is necessary to establish the value. A computer procedure is available to compute the value of a life estate by input of the current market value of the property and the age of the life estate owner.

(B) The value of a life estate on mortgaged property is based on equity rather than market value and the age of the individual.

(C) In the event the member does not accept as valid the value of the life estate as established through this method, the member must secure written appraisal by two persons who are familiar with current values. If there is substantial unexplained divergence between these appraisals, the worker and the member will jointly arrange for the market value to be established by an appraisal made by a third person who is familiar with current market values and who is acceptable to both the member and the worker.

(11) Real and/or personal property which produces income is excluded if it meets the following conditions.

(A) **Trade or business property**. The existence of a trade or business may be established through business tax returns that would be used to compute self-employment earnings. If the current business tax return is unavailable, the existence of the business may be determined through other business forms, records, partnership, a detailed description of the business and its activities, etc. Once it is established that a trade or business exists, any property (real or personal) connected to it and in current use is excluded. This exclusion includes liquid assets, such as a bank account(s) necessary for the business operation. All property used by a trade or business and all property used by an employee in connection with employment is excluded as property essential to self support. The income from the trade or business is determined as any other self-employment income.

(B) **Non-trade or non-business property**. Property which produces income but is not used in a trade or business is excluded if the total equity value does not exceed $6000, and the net return equals at least 6% of the equity annually. An equity value in excess of

$6000 is a countable resource. If the equity exceeds $6000 and 6% return is received on the total equity, only the amount in excess of $6000 is a countable resource. An annual return of less than 6% is acceptable if it is beyond the individual's control, and there is a reasonable expectation of a future 6% return. Liquid resources cannot be excluded as income producing property or meeting the $6000/6% rule (mortgages, including contract for deed, and notes which are income producing are considered as liquid resources). The $6000/6% rule applies to all resources in total, and not separately. Examples of non-business income producing property are rental property, timber rights, mineral rights, etc.

317:35-5-41.6. Trust accounts

Monies held in trust for an individual applying for or receiving SoonerCare must have the availability of the funds determined. Funds held in trust are considered available when they are under the direct control of the individual or his/her spouse, and disbursement is at their sole discretion. Funds may also be held in trust and under the control of someone other than the individual or his/her spouse, such as the courts, agencies, other individuals, etc., or the Bureau of Indian Affairs (BIA).

(1) **Availability determinations.** The worker should be able to determine the availability of a trust using the definitions and explanations listed in (2) of this subsection. However, in some cases, the worker may wish to submit a trust to the OKDHS State Office for determination of availability. In these instances, all pertinent data is submitted to Family Support Services Division, Attention: Health Related and Medical Services Section, for a decision.

(2) **Definition of terms.** The following words and terms, when used in this paragraph, have the following meaning, unless the context clearly indicates otherwise:

(A) **Beneficiary.** Beneficiary means the person(s) who is to receive distributions of either income or principal, or on behalf of whom the trustee is to make payments.

(B) **Corpus/principal.** Corpus/principal means the body of the trust or the original asset used to establish the trust, such as a sum of money or real property.

(C) **Discretionary powers.** Discretionary powers means the grantor gives the trustee the power to make an independent determination whether to distribute income and/or principal to the beneficiary(ies) or to retain the income and add it to the principal of the trust.

(D) **Distributions.** Distributions means payments or allocations made from the trust from the principal or from the income produced by the principal (e.g., interest on a bank account).

(E) **Grantor (trustor/settlor).** Grantor (trustor/settlor) means the individual who establishes the trust by transferring certain assets.

(F) **Irrevocable trust.** Irrevocable trust means a trust in which the grantor has expressly not retained the right to terminate or revoke the trust and reclaim the trust principal and income.

(G) **Pour over or open trust.** Pour over or open trust means a trust which may be expanded from time to time by the addition to the trust principal (e.g., a trust established to receive the monthly payment of an annuity, a workers' compensation settlement, a disability benefit or other periodic receivable). The principal may accumulate or grow depending upon whether the trustee distributes the receivable or permits it to accumulate. Generally, the terms of the trust will determine the availability of the income in the month of receipt and the availability of the principal in subsequent months.

(H) **Primary beneficiary.** Primary beneficiary means the first person or class of persons to receive the benefits of the trust.

(I) **Revocable trust.** Revocable trust means a trust in which the grantor has retained the right to terminate or revoke the trust and reclaim the trust principal and income. Unless a trust is specifically made irrevocable, it is revocable. Even an irrevocable trust is revocable upon the written consent of all living persons with an interest in the trust.

(J) **Secondary beneficiary.** Secondary beneficiary means the person or class of persons who will receive the benefits of the trust after the primary beneficiary has died or is otherwise no longer entitled to benefits.

(K) **Testamentary trust.** Testamentary trust means a trust created by a will and effective upon the death of the individual making the will.

(L) **Trustee.** Trustee means an individual, individuals, a corporation, court, bank or combination thereof with responsibility for carrying out the terms of the trust.

(3) **Documents needed.** To determine the availability of a trust for an individual applying for or receiving SoonerCare, copies of the following documents are obtained:

(A) Trust document;

(B) When applicable, all relevant court documents including the Order establishing the trust, Settlement Agreement, Journal Entry, etc.; and

(C) Documentation reflecting prior disbursements (date, amount, purpose).

(4) **Trust accounts established on or before August 10, 1993.** The rules found in (A) - (C) of this paragraph apply to trust accounts established on or before August 10, 1993.

(A) **Support trust.** The purpose of a support trust is the provision of support or care of a beneficiary. A support trust will generally contain language such as "to provide for the care, support and maintenance of ...", "to provide as necessary for the support of ...", or "as my trustee may deem necessary for the support, maintenance, medical expenses, care, comfort and general welfare." Except as provided in (i)-(iii) of this subparagraph, the amount from a support trust deemed available to the beneficiary is the maximum amount of payments that may be permitted under the terms of the trust to be distributed to the beneficiary, assuming the full

exercise of discretion by the trustee(s) for distribution of the maximum amount to the beneficiary. The beneficiary of a support trust, under which the distribution of payments to the beneficiary is determined by one or more trustees who are permitted to exercise discretion with respect to distributions, may show that the amounts deemed available are not actually available by:

(i) Commencing proceedings against the trustee(s) in a court of competent jurisdiction;

(ii) Diligently and in good faith asserting in the proceedings that the trustee(s) is required to provide support out of the trust; and

(iii) Showing that the court has made a determination, not reasonably subject to appeal, that the trustee must pay some amount less than the amount deemed available. If the beneficiary makes the showing, the amount deemed available from the trust is the amount determined by the court. Any action by a beneficiary or the beneficiary's representative, or by the trustee or the trustee's representative, in attempting a showing to make the Agency or the State of Oklahoma a party to the proceeding, or to show to the court that SoonerCare benefits may be available if the court limits the amounts deemed available under the trust, precludes the showing of good faith required.

(B) **Medicaid Qualifying Trust (MQT).** A Medicaid Qualifying Trust is a trust, or similar legal device, established (other than by will) by an individual or an individual's spouse, under which the individual may be the beneficiary of all or part of the distributions from the trust and such distributions are determined by one or more trustees who are permitted to exercise any discretion with respect to distributions to the individual. A trust established by an individual or an individual's spouse includes trusts created or approved by a representative of the individual (parent, guardian or person holding power of attorney) or the court where the property placed in trust is intended to satisfy or settle a claim made by or on behalf of the individual or the individual's spouse. This includes trust accounts or similar devices established for a minor child pursuant to 12 O.S. 83. In addition, a trust established jointly by at least one of the individuals who can establish an MQT and another party or parties (who do not qualify as one of these individuals) is an MQT as long as it meets the other MQT criteria. The amount from an irrevocable MQT deemed available to the individual is the maximum amount of payments that may be permitted under the terms of the trust to be distributed to the individual assuming the full exercise of discretion by the trustee(s). The provisions regarding MQT apply even though an MQT is irrevocable or is established for purposes other than enabling an individual to qualify for SoonerCare, and, whether or not discretion is actually exercised.

(i) **Similar legal device.** MQT rules listed in this subsection also apply to "similar legal devices" or arrangements having all

the characteristics of an MQT except that there is no actual trust document. An example is the member petitioning the court to irrevocably assign all or part of his/her income to another party (usually the spouse). The determination whether a given document or arrangement constitutes a "similar legal device" should be made by the OKDHS Office of General Counsel, Legal Unit.

(ii) **MQT resource treatment.** For revocable MQTs, the entire principal is an available resource to the member. Resources comprising the principal are subject to the individual resource exclusions (e.g., the home property exclusion) since the member can access those resource items without the intervention of the trustee. For irrevocable MQTs, the countable amount of the principal is the maximum amount the trustee can disburse to (or for the benefit of) the member, using his/her full discretionary powers under the terms of the trust. If the trustee has unrestricted access to the principal and has discretionary power to disburse the entire principal to the member (or to use it for the member's benefit), the entire principal is an available resource to the member. Resources transferred to such a trust lose individual resource consideration (e.g., home property transferred to such a trust is no longer home property and the home property exclusions do not apply). The value of the property is included in the value of the principal. If the MQT permits a specified amount of trust income to be distributed periodically to the member (or to be used for his/her benefit), but those distributions are not made, the member's countable resources increase cumulatively by the undistributed amount.

(iii) **Income treatment.** Amounts of MQT income distributed to the member are countable income when distributed. Amounts of income distributed to third parties for the member's benefit are countable income when distributed.

(iv) **Transfer of resources.** If the MQT is irrevocable, a transfer of resources has occurred to the extent that the trustee's access to the principal (for purposes of distributing it to the member or using it for the member's benefit) is restricted (e.g., if the trust stipulates that the trustee cannot access the principal but must distribute the income produced by that principal to the member, the principal is not an available resource and has, therefore, been transferred).

(C) **Special needs trusts.** Some trusts may provide that trust benefits are intended only for a beneficiary's "special needs" and require the trustee to take into consideration the availability of public benefits and resources, including SoonerCare benefits. Some trusts may provide that the trust is not to be used to supplant or replace public benefits, including SoonerCare benefits. If a trust contains such terms and is not an MQT, the trust is not an available resource.

(5) **Trust accounts established after August 10, 1993.** The rules found

in (A) - (C) of this paragraph apply to trust accounts established after August 10, 1993.

(A) For purposes of this subparagraph, the term "trust" includes any legal document or device that is similar to a trust. An individual is considered to have established a trust if assets of the individual were used to form all or part of the principal of the trust and if the trust was established other than by will and by any of the following individuals:

(i) the individual;

(ii) the individual's spouse;

(iii) a person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual or the individual's spouse; or

(iv) a person, including a court or administrative body, acting at the direction or upon the request of the individual or the individual's spouse.

(B) Where trust principal includes assets of an individual described in this subparagraph and assets of any other person(s), the provisions of this subparagraph apply to the portion of the trust attributable to the assets of the individual. This subparagraph applies without regard to the purposes for which the trust is established, whether the trustees have or exercise any discretion under the trust, and restrictions on when or whether distributions may be made from the trust, or any restrictions on the use of the distribution from the trust.

(C) There are two types of trusts, revocable trusts and irrevocable trusts.

(i) In the case of a revocable trust, the principal is considered an available resource to the individual. ~~Home property in a revocable trust under the direct control of the individual, spouse or legal representative retains the exemption as outlined in OAC 317:35-5-41.8(a)(2).~~ Payments from the trust to or for the benefit of the individual are considered income of the individual. Other payments from the trust are considered assets disposed of by the individual for purposes of the transfer of assets rule and are subject to the 60 months look back period.

(ii) In the case of an irrevocable trust, if there are any circumstances under which payments from the trust could be made to or for the benefit of the individual, the portion of the principal of the trust, or the income on the principal, from which payment to the individual could be made is considered available resources. Payments from the principal or income of the trust is considered income of the individual. Payments for any other purpose are considered a transfer of assets by the individual and are subject to the 60 months look back period. Any portion of the trust from which, or any income on the principal from which no payment could under any circumstances be made to the individual is considered as of the date of establishment of the trust (or if later, the date on which payment to the

individual was foreclosed) to be assets disposed by the individual for purposes of the asset transfer rules and are subject to the 60 months look back period.

(6) **Exempt trusts.** Paragraph (5) of this subsection does not apply to the following trusts:

(A) A trust containing the assets of a disabled individual under the age of 65 which was established for the benefit of such individual by the parent, grandparent, legal guardian of the individual or a court if the State receives all amounts remaining in the trust on the death of the individual up to an amount equal to the total medical assistance paid on behalf of the individual. This type of trust requires:

(i) The trust may only contain the assets of the disabled individual.

(ii) The trust must be irrevocable and cannot be amended or dissolved without the written agreement of the Oklahoma Department of Human Services or the Oklahoma Health Care Authority.

(iii) Trust records must be open at all reasonable times to inspection by an authorized representative of the OHCA or OKDHS.

(iv) The exception for the trust continues after the disabled individual reaches age 65. However, any addition or augmentation after age 65 involves assets that were not the assets of an individual under age 65; therefore, those assets are not subject to the exemption.

(v) Establishment of this type of trust does not constitute a transfer of assets for less than fair market value if the transfer is made into a trust established solely for the benefit of a disabled individual under the age of 65.

(vi) Payments from the trust are counted according to SSI rules. According to these rules, countable income is anything the individual receives in cash or in kind that can be used to meet the individual's needs for food, clothing and shelter. Accordingly, any payments made directly to the individual are counted as income to the individual because the payments could be used for food, clothing, or shelter for the individual. This rule applies whether or not the payments are actually used for these purposes, as long as there is no legal impediment which would prevent the individual from using the payments in this way. In addition, any payments made by the trustee to a third party to purchase food, clothing, or shelter for the individual can also count as income to the individual. For example, if the trustee makes a mortgage payment for the individual, that payment is a shelter expense and counts as income.

(vii) A corporate trustee may charge a reasonable fee for services in accordance with its published fee schedule.

(viii) The OKDHS Form 08MA018E, Supplemental Needs Trust, is an example of the trust. Workers may give the sample form to the

member or his/her representative to use or for their attorney's use.

(ix) To terminate or dissolve a Supplemental Needs Trust, the worker sends a copy of the trust instrument and a memorandum to OKDHS Family Support Services Division, Attention: Health Related and Medical Services (HR&MS) explaining the reason for the requested termination or dissolution of the Supplemental Needs Trust, and giving the name and address of the trustee. The name and address of the financial institution and current balance are also required. Health Related and Medical Services notifies OHCA/TPL to initiate the recovery process.

(B) A trust (known as the Medicaid Income Pension Trust) established for the benefit of an individual if:

(i) The individual is in need of long-term care and has countable income above the categorically needy standard for long-term care (OKDHS Appendix C-1 Schedule VIII.B) but less than the average cost of nursing home care per month (OKDHS Appendix C-1 Schedule VIII.B).

(ii) The Trust is composed only of pension, social security, or other income of the individual along with accumulated income in the trust. Resources cannot be included in the trust.

(iii) All income is paid into the trust and the applicant is not eligible until the trust is established and the monthly income has been paid into the trust.

(iv) The trust must retain an amount equal to the member's gross monthly income less the current categorically needy standard of OKDHS Appendix C-1. The Trustee distributes the remainder.

(v) The income disbursed from the trust is considered as the monthly income to determine the cost of their care, and can be used in the computations for spousal diversion.

(vi) The trust must be irrevocable and cannot be amended or dissolved without the written agreement of the OHCA. Trust records must be open at all reasonable times to inspection by an authorized representative of the OHCA or OKDHS.

(vii) The State will receive all amounts remaining in the trust up to an amount equal to the total SoonerCare benefits paid on behalf of the individual subsequent to the date of establishment of the trust.

(viii) Accumulated funds in the trust may only be used for medically necessary items not covered by SoonerCare, or other health programs or health insurance and a reasonable cost of administrating the trust. Reimbursements cannot be made for any medical items to be furnished by the nursing facility. Use of the accumulated funds in the trust for any other reason will be considered as a transfer of assets and would be subject to a penalty period.

(ix) The trustee may claim a fee of up to 3% of the funds added to the trust that month as compensation.

(x) An example trust is included on OKDHS Form 08MA011E. Workers

may give this to the member or his/her representative to use or for their attorney's use as a guide for the Medicaid Income Pension Trust.

(xi) To terminate or dissolve a Medicaid Income Pension Trust, the worker sends a memorandum with a copy of the trust to OKDHS Family Support Services Division, Attention: HR&MS, explaining the reason and effective date for the requested termination or dissolution of the Medicaid Income Pension Trust, and giving the name and address of the trustee. The name and address of the financial institution, account number, and current balance are also required. Health Related and Medical Services notifies OHCA/TPL to initiate the recovery process.

(C) A trust containing the assets of a disabled individual when all of the following are met:

(i) The trust is established and managed by a non-profit association;

(ii) The trust must be made irrevocable;

(iii) The trust must be approved by the Oklahoma Department of Human Services and may not be amended without the permission of the Oklahoma Department of Human Services;

(iv) The disabled person has no ability to control the spending in the trust;

(v) A separate account is maintained for each beneficiary of the trust but for the purposes of investment and management of funds, the trust pools these accounts;

(vi) The separate account on behalf of the disabled person may not be liquidated without payment to OHCA for the medical expenses incurred by the members;

(vii) Accounts in the trust are established by the parent, grandparent, legal guardian of the individual, the individual, or by a court;

(viii) To the extent that amounts remaining in the beneficiary's account on the death of the beneficiary are not retained by the trust, the trust pays to the State from such remaining amounts an amount equal to the total medical assistance paid on behalf of the individual. A maximum of 30% of the amount remaining in the beneficiary's account at the time of the beneficiary's death may be retained by the trust.

(7) **Funds held in trust by Bureau of Indian Affairs (BIA).** Interests of individual Indians in trust or restricted lands are not considered in determining eligibility for assistance under the Social Security Act or any other federal or federally assisted program.

(8) **Disbursement of trust.** At any point that disbursement occurs, the amount disbursed is counted as a non-recurring lump sum payment in the month received. Some trusts generate income on a regular basis and the income is sent to the beneficiary. In those instances, the income is treated as unearned income in the month received.

AGENDA

15-52 Amend Appeal Process to Clarify and Limit the Scope of the Administrative Law Judge's Jurisdiction

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

317:2-1-2. Appeals

(a) **Member Process Overview**

(1) The appeals process allows a member to appeal a decision which adversely affects their rights. Examples are decisions involving medical services, prior authorizations for medical services, or discrimination complaints.

(2) In order to file an appeal, the member files a LD-1 form within 20 days of the triggering event. The triggering event occurs at the time when the Appellant (Appellant is the person who files a grievance) knew or should have known of such condition or circumstance for appeal.

(3) If the LD-1 form is not received within 20 days of the triggering event, OHCA sends the Appellant a letter stating the appeal will not be heard because it is untimely. In the case of tax warrant intercept appeals, if the LD-1 form is not received by OHCA within ~~30 days of written notice sent by OHCAaccording~~ the timeframe pursuant to Title 68 ~~Okla. Stat.~~O.S. § 205.2, OHCA sends the Appellant a letter stating the appeal will not be heard because it is untimely.

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

(5) The staff advises the Appellant that if there is a need for assistance in reading or completing the grievance form that arrangements will be made.

(6) Upon receipt of the member's appeal, a fair hearing before the Administrative Law Judge (ALJ) will be scheduled. The member will be notified in writing of the date and time for this procedure. The member must appear at this hearing and it is conducted according to 317:2-1-5. The ALJ's decision may be appealed to the Chief Executive Officer of the OHCA, which is a record review at which the parties do not appear (317:2-1-13).

(7) Member appeals are ordinarily decided within 90 days from the date OHCA receives the member's timely request for a fair hearing unless the member waives this requirement. [Title 42 ~~C.F.R. Section~~CFR 431.244(f)]

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

(b) **Provider Process Overview.**

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

(2) All provider appeals are initially heard by the OHCA Administrative Law Judge under 317:2-1-2(c)(2).

(A) The Appellant (Appellant is the provider who files ~~a grievance~~an appeal) files an LD form requesting ~~a grievance~~an appeal hearing

within 20 days of the triggering event. The triggering event occurs at the time when the Appellant knew or should have known of such condition or circumstance for appeal. (LD-2 forms are for provider ~~grievances~~appeals and LD-3 forms are for nursing home wage enhancement grievances.)

(B) If the LD form is not received within 20 days of the triggering event, OHCA sends the Appellant a letter stating the appeal will not be heard because it is untimely.

~~(C) The staff advises the Appellant that if there is a need for assistance in reading or completing the grievance form that arrangements will be made.~~

~~(D)~~(C) A decision will be rendered by the ALJ ordinarily within 45 days of the close of all evidence in the case.

~~(E)~~(D) Unless an exception is provided in 317:2-1-13, the Administrative Law Judge's decision is appealable to OHCA's CEO under 317:2-1-13.

(c) **ALJ jurisdiction.** The ~~administrative law judge~~Administrative Law Judge has jurisdiction of the following matters:

(1) Member Appeals:

(A) Discrimination complaints regarding the SoonerCare program;

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

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

(D) Appeals which relate to the tax warrant intercept system through the Oklahoma Health Care Authority. Tax warrant intercept appeals will be heard directly by the ALJ. A decision will be rendered by the Administrative Law Judge within 20 days of the hearing before the ALJ;

~~(E) Complaints regarding the possible violation of the Health Insurance Portability and Accountability Act of 1996 (HIPAA);~~

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

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

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

(2) Provider Appeals:

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

(B) Denial of request to disenroll member from provider's SoonerCare Choice panel;

(C) Appeals by Long Term Care facilities for nonpayment of wage enhancements, determinations of overpayment or underpayment of wage

enhancements, and administrative penalty determinations as a result of findings made under 317:30-5-131.2(b)(5), (e)(8), and (e)(12);

~~(D) Petitions for Rulemaking;~~

~~(E)~~(D) ~~Appeals to the decision made by the Contracts manager related to reports of supplier non-compliance to the Central Purchasing Division, Oklahoma Department of Central Services and other appeal rights granted by contract;~~Appeals of Professional Service Contract awards and other matters related to the Central Purchasing Act pursuant to Title 74 O. S. § 85.1;

~~(F)~~(E) Drug rebate appeals;

~~(G) Nursing home contracts which are terminated, denied, or non-renewed;~~

~~(H)~~(F) Proposed administrative sanction appeals pursuant to 317:30-3-19. Proposed administrative sanction appeals will be heard directly by the ALJ. A decision will normally be rendered by the ALJ within 20 days of the hearing before the ALJ. This is the final and only appeals process for proposed administrative sanctions;

~~(I) Contract award appeals;~~

~~(J)~~(G) Provider appeals of OHCA audit findings pursuant to 317:2-1-7. This is the final and only appeals process for appeals of OHCA audits; and

~~(K)~~(H) Oklahoma Electronic Health Records Incentive program appeals related only to incentive payments, incentive payment amounts, provider eligibility determinations, and demonstration of adopting, implementing, upgrading, and meaningful use eligibility for incentives.

~~(L)~~(I) Supplemental Hospital Offset Payment Program (SHOPP) annual assessment, Supplemental Payment, fees or penalties as specifically provided in OAC 317:2-1-15.

317:2-1-13. Appeal to the Chief Executive Officer

(a) The Oklahoma Health Care Authority offers approximately 40 different types of administrative appeals. Some of the appeals are appealable to the Chief Executive Officer~~,~~ and some are not. The following appeals may be heard by the Chief Executive Officer following the decision of an Administrative Law Judge:

(1) Appeals under 317:2-1-2(c)(1)(A) to (c)(1)~~(H)~~(G), with the exception of ~~Subsection (F)~~subsection (c)(1)(E);

(2) Appeals under 317:2-1-2(c)(2)(A) to (c)(2)~~(K)~~(I), with the exceptions of ~~Subsections (H)~~subsections (c)(2)(F) and ~~(J)~~(G); and

(3) Appeals under 317:2-1-8 and 317:2-1-10.

(b) Appeals to the Chief Executive Officer must be filed with the OHCA within ~~twenty (20)~~20 days of the date of the Order, or decision by OHCA.

(c) No new evidence may be presented to the Chief Executive Officer.

(d) Appeals to the Chief Executive Officer under (a) of this Section may be filed by the provider, member, or agency. The Chief Executive Officer will ordinarily render decisions within ~~sixty (60)~~60 days of the receipt of the appeal.

AGENDA

15-53 Policy Revision to Streamline the Process of Program Integrity Audit Appeals and Rule Revocation of Nursing Home Provider Contract Appeals Policy

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

317:2-1-7. Program Integrity Audit Appeals

All appeals related to audits originating from Program Integrity resulting in overpayments are heard by an Administrative Law Judge (ALJ) ~~per~~pursuant to 56 ~~Okla. Stat.~~O.S. § 1011.9.

(1) ~~If a provider disagrees with a decision of an OHCA audit, which has determined that the provider has received an overpayment, the provider may appeal, within 20 days of the date of that decision by submitting an LD-2 form to OHCA's docket clerk.~~If the OHCA determines a provider received an overpayment based upon audit findings issued pursuant to OAC 317:30-3-2.1, the provider may appeal the audit findings. If a provider elects to appeal the audit findings, the provider must file its appeal with the OHCA's Legal Docket Clerk, using Form LD-2. The LD-2 must be received by the OHCA Legal Docket Clerk within 20 days of the date of the initial audit findings or within 20 days of the date of the audit findings following reconsideration. The computation of time shall be calculated in accordance with 12 O.S. § 2006.

(2) ~~The appeal will be commenced by the receipt of an LD-2 form from the appellant provider. The form must set out with specificity the overpayment finding to which the provider objects along with the grounds for the appeal. The provider shall explain in detail the factual and/or legal basis for disagreement with the alledged erroneous decision. The provider shall attach to the LD-2 form all relevant exhibits the provider believes necessary to decide the appeal, including the following:~~The provider must attach a statement to the LD-2 that specifies what findings and/or claims are being appealed, as well as all factual and legal bases for the appeal. The provider shall attach the following to the LD-2 form:

(A) Citations for any statute or rule that the provider contends has been violated;

(B) The provider's name, address, e-mail address, and telephone number;

(C) The name, address, e-mail address, and ~~phone~~telephone number of the provider's authorized representative, if any; and

(D) The LD-2 must be signed by the provider or provider's authorized representative.

(i) For purposes of this section, "provider" means the person or entity against ~~which~~whom the overpayment is sought.

(ii) ~~If someone other than an individual provider or entity's authorized representative is representing the provider, he/she must be licensed to practice law within the State of Oklahoma.~~ Consistent with Oklahoma rules of practice, an individual provider may appear on his/her own behalf or may be represented

by an attorney licensed to practice law within the State of Oklahoma. In the case of an entity, the provider entity must be represented by an attorney licensed to practice within the State of Oklahoma. Attorneys not licensed to practice in Oklahoma must comply with 5 ~~Okla. Stat.~~O.S. Art II, Sec. 5, and rules of the Oklahoma Bar Association.

(3) ~~The burden of proof during the hearing will be upon the provider and the Administrative Law Judge will decide the case based upon a preponderance of evidence standard as defined by the Oklahoma Supreme Court.~~A provider or the provider's authorized representative shall immediately report any change in contact information during the course of the appeal to the OHCA Legal Docket Clerk.

(4) ~~Within approximately 45 days of receiving the LD-2, the docket clerk will schedule a pre-hearing conference before an Administrative Law Judge. This period of time is intended to allow parties an opportunity to settle the dispute prior to the pre-hearing. Settlement or mediation of audit disputes is encouraged and can begin at any time of the audit process between the provider and OHCA's legal division. If settlement is reached, the terms shall be set out in writing and signed by both parties and/or their representatives. Upon the finalization and signature of the settlement agreement, the appeal(s) shall be dismissed with prejudice.~~The OHCA, on its own initiative or upon written request of a party, may consolidate or join appeals if to do so will expedite the processing of the appeals and not adversely affect the interest of the parties.

(5) ~~Any change in contact information during the course of the appeal should be immediately reported to the OHCA docket clerk.~~
The provider has the burden of proof to prove that the overpayment determination and the errors identified in the audit findings are inaccurate. The provider must prove the relief sought by a preponderance of the evidence standard, as defined by the Oklahoma Supreme Court. In adjudicating an appeal under the preponderance of the evidence standard, the ALJ will examine each piece of evidence for relevance, probative value, and credibility, to determine whether the fact to be proven is proved by the greater weight of the evidence.

(6) ~~The OHCA, on its own initiative or upon written request of a party, may consolidate or join appeals if to do so will expedite the processing of the appeals and not adversely affect the interest of the parties.~~Within approximately 45 days of receiving the LD-2, the Legal Docket Clerk will schedule a prehearing conference before an ALJ. This period of time is intended to provide the parties an opportunity to settle the dispute prior to the prehearing. Settlement of audit appeals is encouraged and can begin at any time of the audit appeal process between the provider and OHCA's Legal Division. If a settlement is reached, the terms shall be set out in writing and signed by both parties and/or their authorized representatives. Unless otherwise warranted, an Agreed Order setting out the terms of the settlement shall be presented to the ALJ for approval. In limited situations, a settlement may be agreed to be a confidential settlement

by the parties and will not be submitted as an Agreed Order to the ALJ. In the case of confidential settlements, the Appellant shall file a motion to dismiss the appeal with prejudice which informs the ALJ that the matter has been settled and that the audit appeal is moot.

(7) Audit appeals which are not settled will commence with a prehearing conference before the assigned ~~administrative law judge~~ALJ as follows:

(A) ~~At the conference the parties shall clarify and isolate the legal and factual issues involved in the audit appeal.~~The prehearing conference shall be informal, structured by the ALJ, and not open to the public. The ALJ shall record the prehearing conference by digital recording.

(i) Each party shall be notified of the date of the prehearing conference at least 30 calendar days prior to the scheduled prehearing conference.

(ii) Each party shall appear in person or through their authorized representative.

(iii) Witnesses, not including a named party, shall not appear at the prehearing conference. Nor shall any witness testimony be presented at the prehearing conference.

(B) ~~Each party shall be present, on time and prepared. Failure to do so may result in dismissal of the appeal or other sanctions unless good cause is shown.~~A request for continuance of a prehearing conference can be made up to three (3) business days prior to the scheduled prehearing conference date. A lesser period of time may be permitted for good cause shown. The ALJ shall rule on the request and in no case shall a combination of continuance exceed a total of 30 calendar days except for good cause shown.

(C) Within ~~fifteen~~20 days prior to the prehearing conference, the Appellant provider shall file a prehearing conference statement with the ~~docket clerk~~Legal Docket Clerk and provide a copy to the other party; and within 10 days prior to the prehearing conference, the OHCA shall file a prehearing conference statement with the docket clerk and provide a copy to the other party. Each party's prehearing conference statement shall include:

(i) A brief statement of ~~his or her~~its case, ~~to include~~including a list of stipulations and legal and factual issues to be heard;

(ii) A list of any witnesses who have direct knowledge of the facts surrounding the issues of the appeal and who are expected to be called at the hearing. The list shall include a brief statement of the testimony each witness will offer;

(iii) A list of ~~any documents and exhibits and the original, or a copy, of each document or exhibit~~all exhibits, together with a copy thereof, which each party intends to ~~be offered~~ offer into evidence ~~or presented~~ at the hearing; and

(iv) Any ~~requirements or~~ requests for discovery.

~~(D) The prehearing conference shall be informal, structured by the administrative law judge, and not open to the public. The administrative law judge shall record the prehearing conference by digital recording.~~

~~(i) Each party shall be notified of the date of the prehearing conference at least 20 calendar days prior to the scheduled prehearing conference.~~

~~(ii) Witnesses, not including a named party, shall not appear at the prehearing conference. Nor shall any witness testimony be presented at the prehearing conference.~~

(D) At the prehearing conference, the parties shall clarify and isolate the legal and factual issues involved in the audit appeal.

(E) ~~A request for continuance of a prehearing conference can be made up to three days prior to the scheduled prehearing conference date. A lesser period of time may be permitted for good cause shown. The administrative judge shall rule on the request and in no case shall a combination of continuances exceed a total of 30 calendar days except for good cause shown.~~ Each party shall be present, on time, and prepared. Failure to do so may result in dismissal of the appeal or other sanctions unless good cause is shown. A prehearing conference shall not be continued if a party fails to be prepared to identify issues, propose witnesses, or provide exhibits, unless the ALJ finds good cause is shown.

(F) Following the prehearing conference, the ~~administrative judge~~ALJ shall issue ~~an~~a Scheduling Order setting ~~out the witnesses, exhibits, documents, and issues to be presented at the hearing; the hearing date; the decisions reviewed and made during the prehearing conference; other scheduling deadlines as may be needed; and any stipulations agreed to by the parties. The administrative judge should attempt to issue the Order within two weeks of the prehearing conference.~~forth deadlines for parties to complete discovery, submit briefs as directed by the ALJ, submit prehearing motions, and other deadlines as may be needed. The ALJ should attempt to issue the Scheduling Order within two (2) weeks of the prehearing conference. Upon completion of discovery and the submission of any motions or briefs, the ALJ shall issue a Prehearing Order that shall identify all issues to be presented at the hearing; a final list of witnesses to be called by each party; a final list of exhibits to be used by each party; and the hearing date and anticipated duration of the hearing. The Prehearing Order should be filed by the ALJ no later than 10 days prior to the hearing.

(8) ~~Administrative Law Judge~~The ALJ shall:

(A) Limit all decisions, rulings, and orders to matters directly related to the contested overpayment determination resulting from the audit findings issued pursuant to OAC 317:30-3-2.1 and procedural matters set forth within OAC 317:2-1-7;

~~(A)~~(B) Hear and rule on pending requests or motions as expeditiously as possible. This includes setting filing and responsive deadlines in accordance with Title 12 of the Oklahoma Statutes and the Rules for District Courts of Oklahoma. To preserve judicial efficiency, a reply to a response to a motion shall not be filed by a party

without leave of Court to do so and such permission shall not be routinely granted;

(B)(C) Rule on whether witnesses have knowledge of the facts at issue;

(C) Rule on whether a witness shall produce a report to detail proposed testimony as described in Rule 26 of the Federal Rules of Procedure;

(D) Rule on whether discovery requests and other motions and requests are relevant;

(E) Rule on whether to grant a party's request to depose a witness. To preserve judicial efficiency, depositions shall not be routinely permitted and shall only be permitted by order of the ALJ;

(F) Strike or deny witnesses, documents, exhibits, discovery requests, and other requests or motions which are cumulative, not relevant, not material, used as a means of harassment, unduly burdensome, or not timely filed; and

(G) Identify and rule on errors being appealed and issues to be heard at the administrative hearing.

(9) The hearing shall be digitally recorded and closed to the public.As the purpose of the administrative process is to expedite a limited appellate review of the audit findings, the ALJ shall ensure a timely resolution of the appeal. The ALJ shall schedule a hearing within 90 days of the prehearing conference. A party may request a continuance of the hearing by motion, which shall only be permitted if the ALJ finds good cause exists and neither party shall be prejudiced by the continuation.

(10) At the hearing:

(A) Each party shall appear in person or through their authorized representative.

(B) All witnesses must appear in person to provide testimony.

(C) All relevant exhibits provided with each party's prehearing conference statement or final exhibit list, that have not been objected to or stricken by the ALJ, shall be deemed admissible at the hearing.

(D) Each party is responsible to provide a sufficient number of copies of its own exhibits at the hearing.

(E) The hearing will be limited to one (1) day. Each side will be allowed four (4) hours to present its case-in-chief, which is inclusive of any time needed for cross-examination of witnesses by the opposing party. For good cause shown, the ALJ may increase or decrease the time limit for each party to present its case-in-chief, taking into account the time limits of the entire appeal process.

(10)(11) The administrative law judgeALJ should attempt to make the final hearing decision within 18090 days from the date of the prehearing conferencehearing. The final order shall be the entire record of the appeal. Pursuant to Administrative Procedures Act, the Order does not need to contain findings of fact or conclusions of law. The final order is the final decision and is not appealable to the CEO.Any appeal of the final order pursuant to 12 O.S. § 951 must be

filed with the District Court of Oklahoma County within 30 days.
(A) The following items shall constitute the record on appeal:
(i) all motions and orders filed with the Legal Docket Clerk;
(ii) all exhibits admitted during the hearing; and
(iii) the transcripts of proceedings, if any.
(B) It shall be the duty of the Appellant in any District Court appeal to order a written transcript of proceedings to be used on appeal. The transcript must be ordered within 30 days of the filing of an appeal in the District Court and any costs associated with the preparation of the transcript shall be borne by the Appellant.
(12) All orders and settlements are non-precedential decisions.
(13) The prehearing conference, the hearing, and any supplementary hearings or conferences shall be digitally recorded and closed to the public.
(14) The record of the appeal, confidential settlements, and any audio recordings shall remain confidential.

317:2-1-8. Nursing home provider contract appeals [REVOKED]

~~This Section explains the appeal process to be accorded all nursing home providers whose contracts are terminated, denied or non-renewed. No procedure is afforded a nursing facility whose contract is limited in any other fashion.~~

~~(1) If a nursing home provider's contract is terminated, non-renewed or denied prior to the action's effective date, the provider will be afforded an informal reconsideration in accordance with 42 C.F.R. 421.153.~~

~~(2) The notice of termination, non-renewal or, denial of contract will include the findings it was based upon. The letter will be sent by certified mail to the provider.~~

~~(3) The provider will have 60 days to respond to the notice unless there is a finding of immediate jeopardy or a determination that the facility's SoonerCare certification has been cancelled prior to 60 days. The response should outline the reasons why the OHCA's decision to terminate, non-renew, or deny the contract is wrong. The response by the provider must include a detailed position addressing the findings set out in the OHCA's letter. In the event that less than a 60 day notice is provided for either reason stated above, the provider will be afforded a notice in as much time before decertification as possible.~~

~~(4) Based upon the provider's response, the OHCA will affirm or deny the notice of non-renewal, termination or denial.~~

AGENDA

15-54 Insure Oklahoma Clean Up

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 45. INSURE OKLAHOMA

SUBCHAPTER 1. GENERAL PROVISIONS

317:45-1-3. Definitions

The following words or terms, when used in this Chapter, will have the following meanings unless the context clearly indicates otherwise:

"**Carrier**" means:

(A) an insurance company, insurance service, insurance organization, or group health service, which is licensed to engage in the business of insurance in the State of Oklahoma and is subject to State law which regulates insurance, or Health Maintenance Organization (HMO) which provides or arranges for the delivery of basic health care services to enrollees on a prepaid basis, except for copayments or deductibles for which the enrollee is responsible, or both and is subject to State law which regulates Health Maintenance Organizations (HMOs);

(B) a Multiple Employer Welfare Arrangement (MEWA) licensed by the Oklahoma Insurance Department;

(C) a domestic MEWA exempt from licensing pursuant to Title 36 O.S., Section 634(B) that otherwise meets or exceeds all of the licensing and financial requirements of MEWAs as set out in Article 6A of Title 36; or

(D) any entity organized pursuant to the Interlocal Cooperation Act, Section 1001 et seq. of Title 74 of the Oklahoma Statutes as authorized by Title 36 Section 607.1 of the Oklahoma Statutes and which is eligible to qualify for and hold a certificate of authority to transact insurance in this State and annually submits on or before March 1st a financial statement to the Oklahoma Insurance Department in a form acceptable to the Insurance Commissioner covering the period ending December 31st of the immediately preceding fiscal year.

"**Child Care Center**" means a facility licensed by OKDHS which provides care and supervision of children and meets all the requirements in OAC 340:110-3-1 through OAC 340:110-3-33.3.

"**College Student**" means an Oklahoma resident between the age of 19 through 22 that is a full-time student at an Oklahoma accredited University or College.

"**~~Covered~~ Dependent**" means the spouse of the approved applicant and/or child under 19 years of age or his or her child 19 years through 22 years of age who is attending an Oklahoma qualified institution of higher education and relying upon the insured employee or member for financial support.

"**Eligibility period**" means the period of eligibility extending from an approval date to an end date.

"Employee" means a person who works for an employer in exchange for earned income. This includes the owners of a business.

"Employer" means the business entity that pays earned income to employees.

"Employer Sponsored Insurance (ESI)" means the program that provides premium assistance to qualified businesses for approved applicants.

~~**"EOB"** means an Explanation of Benefits.~~

"Explanation of Benefit (EOB)" means a statement issued by a carrier that indicates services rendered and financial responsibilities for the carrier and Insure Oklahoma member.

"Full-time Employment" means a normal work week of 24 or more hours.

"Full-time Employer" means the employer who employs an employee for 24 hours or more per week to perform work in exchange for wages or salary.

"Individual Plan (IP)" means the safety net program for those qualified individuals who do not have access to Insure Oklahoma ESI.

"In-network" means providers or health care facilities that are part of a ~~health~~benefit plan's network of providers with which it has negotiated a discount, and services provided by a physician or other health care provider with a contractual agreement with the insurance company paid at the highest benefit level.

"Insure Oklahoma (IO)" means a ~~health~~benefit plan purchasing strategy in which the State uses public funds to pay for a portion of the costs of ~~health~~benefit plan coverage for eligible populations.

~~**"Insure Oklahoma IP"** means the Individual Plan program.~~

~~**"Insure Oklahoma ESI"** means the Employer Sponsored Insurance program.~~

"Member" means an individual enrolled in the Insure Oklahoma ESI or IP program.

"Modified Adjusted Gross Income (MAGI)" means the financial eligibility determination methodology established by the Patient Protection and Affordable Care Act (PPACA) in 2009.

"OESC" means the Oklahoma Employment Security Commission.

"OHCA" means the Oklahoma Health Care Authority.

"OKDHS" means the Oklahoma Department of Human Services.

~~**"PCP"** means Primary Care Provider.~~

~~**"PEO" or**~~ **"Professional Employer Organization (PEO)"** means any person engaged in the business of providing professional employer services. A person engaged in the business of providing professional employer services shall be subject to registration under the Oklahoma Professional Employer Organization Recognition and Registration Act as provided in Title 40, Chapter 16 of Oklahoma Statutes, Section 600.1 et.seq.

"Primary Care Provider (PCP)" means a provider under contract with the Oklahoma Health Care Authority to provide primary care services, including all medically necessary referrals.

"Premium" means a monthly payment to a carrier or a self-funded plan for ~~health~~benefit plan coverage.

"Qualified Benefit Plan ~~(QHP)~~(QBP)" means a ~~health~~benefit plan that has been approved by the OHCA for participation in the Insure Oklahoma program.

"Qualifying Event" means the occurrence of an event that permits

individuals to join a group ~~health~~benefit plan outside of the "open enrollment period" and/or that allows individuals to modify the coverage they have had in effect. Qualifying events are defined by the employer's ~~health~~benefit plan and meet federal requirements under Public Law 104-191 (HIPAA), and 42 U.S.C. 300bb-3.

"Self-funded Plan" means or meets the definition of an "employee welfare benefit plan" or "benefit plan" as authorized in 29 US Code, Section 1002. The term carrier can be replaced with self-funded plan if applicable in these rules.

"State" means the State of Oklahoma, acting by and through the Oklahoma Health Care Authority.

317:45-1-4. Reimbursement for out-of-pocket ~~medical~~ expenses

(a) Out-of-pocket ~~medical~~ expenses for all approved and eligible members (and/or their approved and eligible dependents) will be limited to 5 percent of their annual gross household income. The OHCA will provide reimbursement for out-of-pocket ~~medical~~ expenses in excess of the 5 percent annual gross household income. A ~~medical~~ expense must be for an allowed and covered service by a qualified ~~health~~benefit plan ~~(QHP)~~ (QBP) to be eligible for reimbursement. For the purpose of this Section, an allowed and covered service is defined as an in-network service covered in accordance with a qualified ~~health~~benefit plan's benefit summary and policies. For instance, if a ~~QHP~~QBP has multiple in-network reimbursement percentage methodologies (80% for level 1 provider and 70% for level 2 provider) the OHCA will only reimburse expenses related to the highest percentage network.

(b) For all eligible ~~medical~~ expenses as defined above in OAC 317:45-1-4(a), the member must submit the OHCA required form and all OHCA required documentation to support that the member incurred and paid the out-of-pocket ~~medical~~ expense. ~~The required documentation must be submitted no later than 90 days after the close of the member's eligibility period.~~ The OHCA required documentation must substantiate that the member actually incurred and paid the eligible out-of-pocket expense. The OHCA may request additional documentation at any time to support a member's request for reimbursement of eligible out-of-pocket ~~medical~~ expenses.

SUBCHAPTER 3. INSURE OKLAHOMA CARRIERS

317:45-3-1. Carrier eligibility

Carriers must be able to submit all required and requested information and documentation to OHCA for each ~~health~~benefit plan to be considered for qualification. Carriers must be able to supply specific claim payment scenarios as requested by OHCA. Carriers must also provide the name, address, telephone number, and, if available, email address of a contact individual who is able to verify employer enrollment status in a qualified ~~health~~benefit plan.

317:45-3-2. ~~Audits~~Reviews

Carriers are subject to ~~audits~~reviews related to ~~health~~benefit plan

qualifications. These ~~audits~~reviews may be conducted periodically to determine if each qualified ~~health~~benefit plan continues to meet all requirements as defined in 317:45-5-1.

SUBCHAPTER 5. INSURE OKLAHOMA QUALIFIED ~~HEALTH~~BENEFIT PLANS

317:45-5-1. Qualified ~~Health~~Benefit Plan requirements

(a) Participating qualified ~~health~~benefit plans must offer, at a minimum, benefits that include:

(1) hospital services;
(2) physician services;
(3) clinical laboratory and radiology;
(4) pharmacy;
(5) office visits;
(6) well baby/well child exams;
(7) age appropriate immunizations as required by law; and
(8) emergency services as required by law.

(b) The ~~health~~benefit plan, if required, must be approved by the Oklahoma Insurance Department for participation in the Oklahoma market or a self-funded plan. All ~~health~~benefit plans must share in the cost of covered services and pharmacy products in addition to any negotiated discounts with network providers, pharmacies, or pharmaceutical manufacturers. If the ~~health~~benefit plan requires co-payments or deductibles, the co-payments or deductibles cannot exceed the limits described in this subsection.

(1) An annual in-network out-of-pocket maximum cannot exceed $3,000 per individual, excluding separate pharmacy deductibles.
(2) Office visits cannot require a co-payment exceeding $50 per visit.
(3) Annual in-network pharmacy deductibles cannot exceed $500 per individual.

(c) Qualified ~~health~~benefit plans will provide an EOB, an expense summary, or required documentation for paid and/or denied claims subject to member co-insurance or member deductible calculations. The required documentation must contain, at a minimum, the:

(1) provider's name;
(2) patient's name;
(3) date(s) of service;
(4) code(s) and/or description(s) indicating the service(s) rendered, the amount(s) paid or the denied status of the claim(s);
(5) reason code(s) and description(s) for any denied service(s);
(6) amount due and/or paid from the patient or responsible party; and
(7) provider network status (in-network or out-of-network provider).

317:45-5-2. Closure criteria for ~~health~~benefit plans

Eligibility for the carrier's ~~health~~benefit plans ends when:

(1) changes are made to the design ~~or benefits~~ of the ~~health~~benefit plan such that it no longer meets the requirements to be considered a qualified ~~health~~benefit plan. Carriers are required to report to OHCA

any changes in health plans potentially affecting their qualification for participation in the program not less than 90 days prior to the effective date of such change(s).

(2) the carrier no longer meets the definition set forth in 317:45-1-3.

(3) the ~~health~~benefit plan is no longer an available product in the Oklahoma market.

(4) the ~~health~~benefit plan fails to meet or comply with all requirements for a qualified ~~health~~benefit plan as defined in 317 : 45-5-1.

SUBCHAPTER 7. INSURE OKLAHOMA ESI EMPLOYER ELIGIBILITY

317:45-7-1. Employer application and eligibility requirements for Insure Oklahoma ESI

(a) In order for an employer to be eligible to participate in the Insure Oklahoma program the employer must:

(1) have no more than a total of 250 employees on its payroll if the employer is a for-profit business entity. Not-for-profit businesses may participate if the employer has no more than a total of 500 employees on its payroll. The increase in the number of employees from ~~50~~250 to ~~250~~500 will be phased in over ~~a period of~~ time as determined by the Oklahoma Health Care Authority. The number of employees is determined based on the third month employee count of the most recently filed OES-3 form with the Oklahoma Employment Security Commission (OESC). Employers may provide additional documentation confirming terminated employees that will be excluded from the OESC employee count. If the employer is exempt from filing an OES-3 form or is contracted with a PEO or is a Child Care Center in accordance with OHCA rules, this determination is based on appropriate supporting documentation~~, such as the W-2 Summary Wage and Tax form~~ to verify employee count. Employers must be in compliance with all OESC requirements to be eligible for the program. As requested by the OHCA, employers that do not file with the OESC must submit documentation that proves compliance with state law;

(2) have a business that is physically located in Oklahoma;

(3) be currently offering, or at the contracting stage to offer a qualified ~~health~~benefit plan. The qualified ~~health~~benefit plan coverage must begin on the first day of the month and continue through the last day of the month;

(4) offer qualified ~~health~~benefit plan coverage to employees; and

(5) contribute a minimum 25 percent of the eligible employee monthly ~~health~~benefit plan premium or an equivalent 40 percent of premiums for ~~covered~~ dependent children.

(b) An employer who meets all of the requirements listed in OAC 317:45-7-1(a) must complete and submit the OHCA required forms and application to be considered for participation in the program.

(c) The employer must provide its Federal Employee Identification Number (FEIN).

(d) It is the employer's responsibility to notify the OHCA of any changes that might impact eligibility in the program. Employers must notify the

OHCA of any participating employee terminations, resignations, or new hires within five working
days of the occurrence.

317:45-7-3. Employer cost sharing

Employers are responsible for a portion of the eligible employee's monthly ~~health~~benefit plan premium as defined in 317:45-7-1.

317:45-7-5. Reimbursement

In order to receive a premium subsidy, the employer must submit all pages of the current ~~health~~benefit plan invoice.

317:45-7-7. ~~Audits~~Reviews

Employers are subject to ~~audits~~reviews related to program eligibility requirements found at OAC 317:45-7-1 and subsidy payments. Eligibility may be revoked at any time if inconsistencies are found. Any monies paid in error are subject to recoupment.

317:45-7-8. Closure

Eligibility provided under the Insure Oklahoma ESI program may end during the eligibility period when:

(1) the employer no longer meets the eligibility requirements in 317:45-7-1;
(2) the employer fails to pay premiums to the carrier;
(3) the employer fails to provide an invoice verifying the monthly ~~health~~benefit plan premium has been paid; or
(4) ~~an audit~~a review indicates a discrepancy that makes the employer ineligible.

SUBCHAPTER 9. INSURE OKLAHOMA ESI EMPLOYEE ELIGIBILITY

317:45-9-1. Employee eligibility requirements

(a) Employees must complete and submit the OHCA required forms and application to be considered for participation in the program.
(b) The eligibility determination will be processed within 30 days from the date the application is received. The employee will be notified in writing of the eligibility decision.
(c) All eligible employees described in this section must be enrolled in their employer's qualified ~~health~~benefit plan. Eligible employees must:

(1) have countable income at or below the appropriate standard according to the family size on the Insure Oklahoma ESI Income Guidelines form;

(A) Effective January 1, 2016, financial eligibility for Insure Oklahoma ESI ~~health~~ benefits is determined using the MAGI methodology. Unless questionable, the income of applicants does not require verification. See OAC 317:35-6-39 through OAC 317:35-6-54 for the applicable MAGI rules for determining household composition and countable income.

(B) Income is evaluated on a monthly basis for all individuals included in the case for Insure Oklahoma ESI ~~Health~~ Benefits.

(2) be a US citizen or alien as described in 317:35-5-25;
(3) be Oklahoma residents;
(4) furnish, or show documentation of an application for, a Social Security number at the time of application for Insure Oklahoma ESI ~~health~~ benefits;
(5) not be receiving benefits from SoonerCare or Medicare;
(6) be employed with a qualified employer at a business location in Oklahoma;
(7) be age 19 through age 64
(8) be eligible for enrollment in the employer's qualified ~~health~~benefit plan;
(9) not have full-time employment with any employer who does not meet the eligible employer guidelines listed in 317:45-7-1(a) (1)-(2);
(10) select one of the qualified ~~health~~benefit plans the employer is offering; and
(11) provide in a timely manner any and all documentation that is requested by the Insure Oklahoma program by the specified due date.

(d) An employee's ~~covered~~ dependents are eligible when:
(1) the employer's ~~health~~benefit plan includes coverage for dependents;
(2) the employee is eligible;
(3) if employed, the spouse may not have full-time employment with any employer who does not meet the eligible employer guidelines listed in 317:45-7-1 (a) (1)-(2); and
(4) the ~~covered~~ dependents are enrolled in the same ~~health~~benefit plan as the employee.

(e) If an employee or their ~~covered~~ dependents are eligible for multiple qualified ~~health~~benefit plans, each may receive a subsidy under only one ~~health~~benefit plan.

(f) College students may enroll in the Insure Oklahoma ESI program as ~~covered~~ dependents. Effective January 1, 2016, financial eligibility for Insure Oklahoma ESI ~~health~~ benefits for college students is determined using the MAGI methodology. See OAC 317:35-6-39 through OAC 317:35-6-54 for the applicable MAGI rules for determining household composition and countable income.

(g) ~~Covered~~Dependent children must have countable income at the appropriate standard according to the family size on the Insure Oklahoma ESI Income Limits Guidelines form. Effective January 1, 2016, financial eligibility for Insure Oklahoma ESI ~~health~~ benefits is determined using the MAGI methodology. See OAC 317:35-6-39 through OAC 317:35-6-54 for the applicable MAGI rules for determining household composition and countable income.
(1) Children found to be eligible for SoonerCare may not receive coverage through Insure Oklahoma.
(2) Children are not eligible for Insure Oklahoma if they are a member of a family eligible for employer-sponsored dependent ~~health~~ insurance

coverage under any Oklahoma State Employee ~~Health~~ Insurance Plan.

(h) ESI approved individuals must notify the OHCA of any changes, including household status and income, that might impact individual and/or dependent eligibility in the program within 10 days of the change.

(i) When the agency responsible for determining eligibility for the member becomes aware of a change in the member's circumstances, the agency will promptly redetermine eligibility for all household members whose eligibility is affected by the change.

317:45-9-4. Employee cost sharing

Employees are responsible for up to 15 percent of their ~~health~~benefit plan premium. The employees are also responsible for up to 15 percent of their dependent's ~~health~~benefit plan premium if the dependent is included in the program. The combined portion of the employee's cost sharing for ~~health~~benefit plan premiums cannot exceed three percent of his/her annual gross household income computed monthly. Native American children providing documentation of ethnicity are exempt from cost-sharing requirements, including premium payments and out-of-pocket expenses.

317:45-9-6. ~~Audits~~Reviews

Individuals participating in the Insure Oklahoma program are subject to ~~audits~~reviews related to their eligibility, subsidy payments, and out-of-pocket reimbursements. Eligibility may be reversed at any time if inconsistencies are found. Any monies paid in error will be subject to recoupment.

317:45-9-7. Closure

(a) Employer and employee eligibility are tied together. If the employer is no longer eligible, then the associated employees enrolled under that employer are also ineligible. Employees are mailed a notice 10 days prior to closure of eligibility.

(b) The employee's certification period may be terminated when:

(1) termination of employment, either voluntary or involuntary, occurs;
(2) the employee moves out-of-state;
(3) the covered employee dies;
(4) the employer ends its contract with the qualified ~~health~~benefit plan;
(5) the employer's eligibility ends;
(6) ~~an audit~~a review indicates a discrepancy that makes the employee or employer ineligible;
(7) the employer is terminated from the program;
(8) the employer fails to pay the premium;
(9) the qualified ~~health~~benefit plan or carrier no longer meets the requirements set forth in this Chapter;
(10) the employee becomes eligible for SoonerCare or Medicare;
(11) the employee or employer reports any change affecting eligibility;
(12) the employee is no longer listed as a covered person on the employer's ~~health~~benefit plan invoice;
(13) the employee requests closure; or

(14) the employee no longer meets the eligibility criteria set forth in this Chapter.

317:45-9-8. Appeals

~~(a)~~ Employee appeal procedures based on denial of eligibility due to income are described at OAC 317:2-1-2.
~~(b) Employee appeals regarding out-of-pocket medical expense reimbursements may be made to the OHCA. The OHCA may request documentation to support the out-of-pocket appeal. The decision of the OHCA is final.~~

SUBCHAPTER 11. INSURE OKLAHOMA IP
PART 3. INSURE OKLAHOMA IP MEMBER HEALTH CARE BENEFITS

317:45-11-11. Insure Oklahoma IP non-covered services

Certain health care services are not covered in the Insure Oklahoma IP adult benefit package listed in 317:45-11-10. These services include, but are not limited to:

(1) services not considered medically necessary;
(2) any medical service when the member refuses to authorize release of information needed to make a medical decision;
(3) organ and tissue transplant services;
(4) weight loss intervention and treatment including, but not limited to, bariatric surgical procedures or any other weight loss surgery or procedure, drugs used primarily for the treatment of weight loss including appetite suppressants and supplements, and/or nutritional services prescribed only for the treatment of weight loss;
(5) procedures, services and supplies related to sex transformation;
(6) supportive devices for the feet (orthotics) except for the diagnosis of diabetes;
(7) cosmetic surgery, except as medically necessary and as covered in 317:30-3-59(19);
(8) over-the-counter drugs, medicines and supplies except contraceptive devices and products, and diabetic supplies;
(9) experimental procedures, drugs or treatments;
(10) dental services (preventive, basic, major, orthodontia, extractions or services related to dental accident) except for pregnant women and as covered in 317:30-5-696;
(11) vision care and services (including glasses), except services treating diseases or injuries to the eye;
(12) physical medicine including chiropractic and acupuncture therapy;
(13) hearing services;
(14) <u>non-emergency and emergency air</u> transportation ~~[emergency or non-emergency (air or ground)]~~;
(15) allergy testing and treatment;
(16) hospice regardless of location;
(17) Temporomandibular Joint Dysfunction (TMD) (TMJ);
(18) genetic counseling;
(19) fertility evaluation/treatment/and services;
(20) sterilization reversal;

(21) Christian Science Nurse;
(22) Christian Science Practitioner;
(23) skilled nursing facility;
(24) long-term care;
(25) stand by services;
(26) thermograms;
(27) abortions (for exceptions, refer to 317:30-5-6);
(28) services of a Lactation Consultant;
(29) services of a Maternal and Infant Health Licensed Clinical Social Worker;
(30) enhanced services for medically high risk pregnancies as found in 317:30-5-22.1;
(31) ultraviolet treatment-actinotherapy;~~ and~~
(32) private duty nursing~~.~~;
(33) Payment for removal of benign skin lesions; and
(34) Sleep studies.

PART 5. INSURE OKLAHOMA IP MEMBER ELIGIBILITY

317:45-11-20. Insure Oklahoma IP eligibility requirements

(a) Oklahoma employed working adults not eligible to participate in an employer's qualified ~~health~~benefit plan, employees of non-participating employers, self-employed, unemployed seeking work, workers with a disability, and qualified college students may apply for the Individual Plan. Applicants cannot obtain IP coverage if they are eligible for ESI. Applicants, unless a qualified college student, must be engaged in employment as defined under state law, must be considered self-employed as defined under federal and/or state law, or must be considered unemployed as defined under state law.
(b) The eligibility determination will be processed within 30 days from the date the complete application is received. The applicant will be notified of the eligibility decision.
(c) In order to be eligible for the IP, the applicant must:

(1) choose a valid PCP according to the guidelines listed in 317:45-11-22, at the time he/she completes application;
(2) be a US citizen or alien as described in 317:35-5-25;
(3) be an Oklahoma resident;
(4) furnish, or show documentation of an application for, a Social Security number at the time of application for Insure Oklahoma IP ~~health~~ benefits;
(5) be not currently enrolled in~~SoonerCare or Medicare;~~, or have an open application for SoonerCare or Medicare;
(6) be age 19 through 64;
(7) make premium payments by the due date on the invoice;
(8) not have full-time employment with any employer who does not meet the eligible employer guidelines listed in 317:45-7-1(a) (1)-(2);
(9) be not currently covered by a private ~~health~~ insurance policy or plan; and
(10) provide in a timely manner any and all documentation that is

requested by the Insure Oklahoma program by the specified due date.

(d) If employed and working for an approved Insure Oklahoma employer who offers a qualified ~~health~~<u>benefit</u> plan, the applicant must meet the requirements in subsection (c) of this Section and:

(1) have countable income at or below the appropriate standard according to the family size on the Insure Oklahoma IP Income Guidelines form.

(A) Effective January 1, 2016, financial eligibility for Insure Oklahoma IP ~~health~~ benefits is determined using the MAGI methodology. Unless questionable, the income of applicants do not require verification. See OAC 317:35-6-39 through OAC 317:35-6-54 for the applicable MAGI rules for determining household composition and countable income.

(B) Income is evaluated on a monthly basis for all individuals included in the case for Insure Oklahoma IP ~~Health~~ Benefits;

(2) be ineligible for participation in their employer's qualified ~~health~~<u>benefit</u> plan due to number of hours worked.

(e) If employed and working for an employer who does not offer a qualified ~~health~~<u>benefit</u> plan, the applicant must meet the requirements in subsection (c) of this Section and have countable income at or below the appropriate standard according to the family size on the Insure Oklahoma IP Income Guidelines form.

(1) Effective January 1, 2016, financial eligibility for Insure Oklahoma IP ~~health~~ benefits is determined using the MAGI methodology. Unless questionable, the income of applicants does not require verification. See OAC 317:35-6-39 through OAC 317:35-6-54 for the applicable MAGI rules for determining household composition and countable income.

(2) Income is evaluated on a monthly basis for all individuals included in the case for Insure Oklahoma IP ~~Health~~ Benefits.

(f) If self-employed, the applicant must meet the requirements in subsection (c) of this Section and:

(1) have countable income at or below the appropriate standard according to the family size on the Insure Oklahoma IP Income Guidelines form.

(A) Effective January 1, 2016, financial eligibility for Insure Oklahoma IP ~~health~~ benefits is determined using the MAGI methodology. Unless questionable, the income of applicants does not require verification. See OAC 317:35-6-39 through OAC 317:35-6-54 for the applicable MAGI rules for determining household composition and countable income.

(B) Income is evaluated on a monthly basis for all individuals included in the case for Insure Oklahoma IP ~~Health~~ Benefits.

(2) must not have full-time employment with any employer who does not meet the eligible employer guidelines listed in 317:45-7-1(a)(1)-(2).

(g) If unemployed seeking work, the applicant must meet the requirements in subsection(c) of this Section and the following:

(1) Applicants must have countable income at or below the appropriate standard according to the family size on the Insure Oklahoma IP Income

Guidelines form.

(2) Effective January 1, 2016, financial eligibility for Insure Oklahoma IP ~~health~~ benefits is determined using the MAGI methodology. Unless questionable, the income of applicants does not require verification. See OAC 317:35-6-39 through OAC 317:35-6-54 for the applicable MAGI rules for determining household composition and countable income.

(3) Income is evaluated on a monthly basis for all individuals included in the case for Insure Oklahoma IP ~~Health~~ Benefits.

(h) If working with a disability, the applicant must meet the requirements in subsection (c) of this Section and the following:

(1) Applicants must have countable income at or below the appropriate standard according to the family size on the Insure Oklahoma IP Income Guidelines form.

(2) Applicants may need to verify eligibility of their enrollment in the Ticket to Work program.

(3) Effective January 1, 2016, financial eligibility for Insure Oklahoma IP ~~health~~ benefits is determined using the MAGI methodology. Unless questionable, the income of applicants does not require verification. See OAC 317:35-6-39 through OAC 317:35-6-54 for the applicable MAGI rules for determining household composition and countable income.

(4) Income is evaluated on a monthly basis for all individuals included in the case for Insure Oklahoma IP ~~Health~~ Benefits.

(i) IP approved individuals must notify the OHCA of any changes, including household status and income, that might impact individual and/or dependent eligibility in the program within 10 days of the change.

(j) When the agency responsible for determining eligibility for the member becomes aware of a change in the member's circumstances, the agency will promptly redetermine eligibility for all household members whose eligibility is affected by the change.

317:45-11-21. Dependent eligibility

(a) If the spouse of an Insure Oklahoma IP approved individual is eligible for Insure Oklahoma ESI, they must apply for Insure Oklahoma ESI. Spouses cannot obtain Insure Oklahoma IP coverage if they are eligible for Insure Oklahoma ESI.

(b) The employed or self-employed spouse of an approved applicant must meet the guidelines listed in 317:45-11-20 (a) through (g) to be eligible for Insure Oklahoma IP.

(c) The ~~covered~~ dependent of an applicant approved according to the guidelines listed in 317:45-11-20(h) does not become automatically eligible for Insure Oklahoma IP.

(d) The applicant and the dependents' eligibility are tied together. If the applicant no longer meets the requirements for Insure Oklahoma IP, then the associated ~~covered~~ dependent enrolled under that applicant is also ineligible.

(e) College students may enroll in the Insure Oklahoma IP program. Effective January 1, 2016, financial eligibility for Insure Oklahoma IP

~~health~~ benefits for college ~~students is~~students' are determined using the MAGI methodology. See OAC 317:35-6-39 through OAC 317:35-6-54 for the applicable MAGI rules for determining household composition and countable income.
(f) IP approved individuals must notify the OHCA of any changes, including household status and income, that might impact individual and/or dependent eligibility in the program within 10 days of the change.
(g) When the agency responsible for determining eligibility for the member becomes aware of a change in the ~~covered~~ dependents circumstances, the agency will promptly redetermine eligibility for all household members whose eligibility is affected by the change.

317:45-11-23. ~~Employee~~Member eligibility period
(a) The rules in this subsection apply to ~~applicants eligible~~members eligibility according to 317:45-11-20(a) through (e).
(1) The ~~employee's coverage~~member's eligibility period begins only after approval of the application and receipt of the premium payment.
(A) ~~If the application is received and approved before the 15th of the month, eligibility begins the first day of the second consecutive month. If the application is not received or approved before the 15th of the month, eligibility begins the first day of the 3rd consecutive month. (Examples: An application is received and approved on January 14th and the premium is received before February 15th, eligibility begins March 1st; or an application is received and approved January 15th and the premium is received on March 15th, eligibility~~
~~begins April 1st.)~~If the application is approved and the premium payment is not made by the last day of the same month, eligibility will begin the first day of the next month.
(B) ~~If premiums are paid early, eligibility still begins as scheduled.~~If the application is approved and the premium payment is made between the first and 15th day of the next month, eligibility will begin the first day of the second consecutive month.
(C) If the application is approved and the premium payment is not made within 45 days, eligibility will not begin.
(2) Employee eligibility is contingent upon the employer meeting the program guidelines.
(3) The employee's eligibility is determined using the eligibility requirements listed in 317:45-9-1 or 317:45-11-20 (a) through (e).
(4) If the employee is determined eligible for Insure Oklahoma IP, he/she is approved for a period not greater than 12 months.
(b) The rules in this subsection apply to applicants eligible according to 317:45-11-20(a) through (c) and 317:45-11-20(f) through (h).
(1) The applicant's eligibility is determined using the eligibility requirements listed in 317:45-11-20(a) through (c) and 317:45-11-20(f) through (h).
(2) If the applicant is determined eligible for Insure Oklahoma IP, he/she is approved for a period not greater than 12 months.
(3) The applicant's eligibility period begins only after receipt of the

premium payment.

~~(A) If the application is received and approved before the 15th of the month, eligibility begins the first day of the second consecutive month. If the application is not received or approved before the 15th of the month, eligibility begins the first day of the 3rd consecutive month. (Examples: An application is approved on January 14th and the premium is received before February 15th, eligibility begins March 1st; or an application is approved January 15th and the premium is received on March 15th, eligibility begins April 1st.)~~

~~(B) If premiums are paid early, eligibility still begins as scheduled.~~

317:45-11-24. Member cost sharing

(a) Members are given monthly invoices for ~~health~~their benefit plan premiums. IP health plan premiums are established by the OHCA. The premiums are due~~,~~ monthly and must be paid in full~~, no later than the 15th day of the month prior to the month of IP coverage~~.

(1) Members are responsible for their monthly premiums, in an amount not to exceed four percent of their monthly gross household income.

(2) Working disabled individuals are responsible for their monthly premiums in an amount not to exceed four percent of their monthly gross household income, based on a family size of one and capped at 100 percent of the Federal Poverty Level.

(3) Native Americans providing documentation of ethnicity are exempt from premium payments.

(b) IP coverage is not provided until the premium and any other amounts due are paid in full. Other amounts due may include but are not limited to any fees, charges, or other costs incurred as a result of ~~Insufficient/Non-sufficient funds~~returned payments.

317:45-11-26. ~~Audits~~Reviews

Members participating in the Insure Oklahoma program are subject to ~~audits~~reviews related to their eligibility, subsidy payments, premium payments and out-of-pocket reimbursements. Eligibility may be reversed at any time if inconsistencies are found. Any monies paid in error will be subject to recoupment.

317:45-11-27. Closure

(a) Members are mailed a notice 10 days prior to closure of eligibility.

(b) The employer and employees' eligibility are tied together. If the employer no longer meets the requirements for Insure Oklahoma then eligibility for the associated employees enrolled under that employer are also ineligible.

(c) The employee's certification period may be terminated when:

(1) the member requests closure;

(2) the member moves out-of-state;

(3) the covered member dies;

(4) the employer's eligibility ends;

(5) ~~an audit~~a review indicates a discrepancy that makes the member or employer ineligible;
(6) the employer is terminated from Insure Oklahoma;
(7) the member fails to pay ~~the amount due within 60 days of the date on the bill;~~their premium;
(8) the qualified ~~health~~benefit plan or carrier no longer meets the requirements set forth in this chapter;
(9) the member begins receiving SoonerCare or Medicare benefits;
(10) the member begins receiving coverage by a private ~~health~~benefit ~~insurance~~ policy or plan;
(11) the member or employer reports any change affecting eligibility; or
(12) the member no longer meets the eligibility criteria set forth in this Chapter.

(d) This subsection applies to applicants eligible according to 317:45-11-20(a) through (c) and 317:45-11-20(f) through (h). The member's certification period may be terminated when:
(1) the member requests closure;
(2) the member moves out-of-state;
(3) the covered member dies;
(4) the employer's eligibility ends;
(5) ~~an audit~~a review indicates a discrepancy that makes the member or employer ineligible;
(6) the member fails to pay ~~the amount due within 60 days of the date on the bill~~their premium;
(7) the member becomes eligible for SoonerCare or Medicare;
(8) the member begins receiving coverage by a private ~~health~~benefit ~~insurance~~ policy or plan;
(9) the member or employer reports any change affecting eligibility; or
(10) the member no longer meets the eligibility criteria set forth in this Chapter.

317:45-11-28. Appeals

~~(a)~~ Member appeal procedures based on denial of eligibility due to income are described at 317:2-1-2.

~~(b) Member appeals regarding out-of-pocket medical expense reimbursements may be made to the OHCA. The OHCA may request documentation to support the out-of-pocket appeal. The decision of the OHCA is final.~~

AGENDA

15-55 Programs of the All-Inclusive Care for the Elderly (PACE) Transfer Guidelines

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY

CHAPTER 35. MEDICAL ASSISTANCE FOR ADULTS AND CHILDREN-ELIGIBILITY

SUBCHAPTER 18. PROGRAMS OF ALL-INCLUSIVE CARE FOR THE ELDERLY

317:35-18-5. Eligibility criteria

(a) To be eligible for participation in PACE, the applicant must:
(1) be age 55 years or older
(2) live in a PACE service area;
(3) be determined by the state to meet nursing facility level of care~~.~~; and
(4) be determined by the PACE Interdisciplinary team as able to be safely served in the community at the time of enrollment. If the PACE provider denies enrollment because the IDT determines that the applicant cannot be served safely in the community, the PACE provider must:
(A) notify the applicant in writing of the reason for the denial;
(B) refer the applicant to alternative services as appropriate;
(C) maintain supporting documentation for the denial and notify CMS and OHCA of the denial and make the supporting documentation available for review; and
(D) advise the applicant orally and in writing of the grievance and appeals process.

(b) To be eligible for SoonerCare capitated payments, the individual must:
(1) meet categorical relationship to disability (reference OAC 317:35-5-4).
(2)be eligible for Title XIX services if institutionalized as determined by the Oklahoma Department of Human Services;
(3) be eligible for SoonerCare State Plan services;
(4) meet the same financial eligibility criteria as set forth for the SoonerCare Advantage program per OAC 317:35-17-10 and 317:30-17-11;and
(5) meet appropriate medical eligibility criteria.

(c) Medical determination of ~~Eligibility~~eligibility. The nurse designee makes the medical determination utilizing professional judgment, the Uniform Comprehensive Assessment Tool (UCAT) I, Part III, and other available medical information.
(1) When PACE services are requested:
(A) The PACE nurse or OKDHS nurse is responsible for completing the UCAT assessment.
(B) The PACE intake staff is responsible for aiding the PACE enrollee in contacting OKDHS to initiate the financial eligibility application process.
(2) The nurse completes the UCAT, Part III visit with the PACE enrollee

within 10 days of receipt of the referral for PACE services.

(3) The nurse sends the UCAT, Part III to the designated OHCA nurse staff member for review and level of care determination.

(4) A new medical level of care determination may be required when a member requests any of the following changes in service programs:

(A) From PACE to Advantage.

(B) From ~~Pace~~PACE to State Plan Personal Care Services.

(C) From Nursing Facility to PACE.

(D) From Advantage to PACE if previous UCAT was completed more than 6 months prior to member requesting PACE enrollment.

(E) From PACE site to PACE site.

(d) To obtain and maintain eligibility, the individual must agree to accept the PACE providers and its contractors as the individual's only service provider. The individual may be held financially liable for services received without prior authorization except for emergency medical care.

317:35-18-8. Enrollment

(a) The provider determines whether the applicant meets PACE enrollment requirements.

(b) The enrollment effective date is the first day of the month after the provider receives the signed enrollment form.

(c) Enrollment continues until the participant's death, regardless of changes in health status, unless either of the following actions occur:

(1) The participant voluntarily disenrolls and/or elects to transfer to other eligible PACE program.

(2) The participant is involuntarily disenrolled.

AGENDA

15-56 Pharmacy Lock-In

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY

CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE

SUBCHAPTER 3. GENERAL PROVIDER POLICIES

PART 1. GENERAL SCOPE AND ADMINISTRATION

317:30-3-14. Freedom of choice

(a) **Any Qualified provider.** The Oklahoma Health Care Authority (OHCA) assures that any individual eligible for SoonerCare, may obtain services from any institution, agency, pharmacy, person, or organization that is contracted with OHCA and qualified to perform the services.

(b) **Member lock-in.** SoonerCare members who have demonstrated utilization above the statistical norm, during a 6-month period, may be "locked-in" to a prescriber and/or one pharmacy for medications classified as controlled dangerous substances in accordance with ~~Federal Regulation~~ 42 CFR 431.54.

(1) Over-utilization patterns by SoonerCare members may be identified either by referral or by OHCA automated computer systems. SoonerCare records, for a 6-month period, of those identified members are then reviewed. Medical and pharmacy claim histories are reviewed by OHCA pharmacy consultants to determine if ~~high usage is medically justified~~the member has unreasonably utilized SoonerCare provider and/or prescription services.

(2) If it is determined that SoonerCare has been over-utilized, the member may be notified, by letter, of the need to select a prescriber and/or pharmacy and of their opportunity for a fair hearing in accordance with OAC 317:2-1-2. If ~~they do~~the member does not select a prescriber or pharmacy, one ~~is~~will be selected for ~~them. In some cases, members may be sanctioned under OAC 317:35-13-7.~~the member.

(3) The prescriber and/or pharmacy of choice, unless the aforementioned providers have been identified as having problems with over-utilization, are notified by letter and given an opportunity to accept or decline to be the member's prescriber and/or pharmacy.

(4) When the provider accepts, a confirmation letter is sent to both member and provider showing the effective date of the arrangement.

(5) After the lock-in arrangement is made, the provider may file claims for services provided in accordance with OHCA guidelines.

(6) Locked-in members may obtain emergency services from an emergency room facility for an emergency medical condition or as part of an inpatient admission.

(7) If a claim for a controlled dangerous substance is filed by another pharmacy, the claim will be denied.

(8) ~~When a member is enrolled into the lock-in program, usage is monitored periodically and reviewed every 24 months. A provider may send a written request for member review. If review indicates~~

~~utilization patterns meet lock-in removal criteria, the member may be removed from lock-in at the discretion of OHCA staff.~~A member placed in the lock-in program will remain in lock-in status for a minimum of 24 months. While in lock-in status, the member's usage shall be monitored periodically and shall be reviewed at the end of 24 months.

(9) ~~During~~Following a review, OHCA may elect to continue lock-in for an additional period of up to 24 months, remove the member from lock-in ~~because of~~based upon medical necessity, or remove ~~them because of decreased utilization, or impose sanctions under OAC 317:35-13-7.~~the member based upon program compliance. The member will be provided written notice of OHCA's decision and afforded an opportunity to appeal. OHCA retains the right at any time to impose sanctions in an appropriate case pursuant to OAC 317:35-13-7 or to take other appropriate action for abusive conduct.

(10) The member in the lock-in program may make a request to change providers after the initial three months; when the member moves to a different city or if the member feels irreconcilable differences will prevent necessary medical care. Change of providers based on irreconcilable differences must be approved by OHCA staff or contractor.

(11) OHCA may make a provider change when the provider makes a request for change or may initiate a change anytime it is determined necessary to meet program goals.

AGENDA

15-57 Long Term Care (LTC) Clean Up

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY

CHAPTER 50. HOME AND COMMUNITY BASED SERVICES WAIVERS

SUBCHAPTER 1. MEDICALLY FRAGILE WAIVER SERVICES

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~~DHS form 08AX001E, Schedule VIII. B. 1) and without such services would be institutionalized. Services provided through the Medically Fragile Waiver are approved based on medical necessity.
(c) Services provided through the Medically Fragile Waiver are:
(1) case management;
(2) institutional transition services;

(3) respite;
(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) Medically Fragile Waiver personal care;
(13) Personal Emergency Response System (PERS);
(14) Self Directed personal care, respite and advanced supportive/restorative assistance;
(15) Self Directed Goods and Services (SD-GS); ~~and~~
(16) ~~SoonerCare medical services within the scope of the State Plan.~~Transitional Case Management Services; and
(17) 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 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.~~Redetermination of program eligibility can be requested for the following reasons:

(1) if the member fails to comply with the community service plan;

(2) if the member's health and safety cannot be ensured;

(3) if the member is unable or unwilling to accept the negotiated risk of living in the community; or

(4) as deemed necessary by waiver review staff or the member's case manager.

(h) Individuals determined ineligible for Medically Fragile Waiver program services are notified in writing of the determination and of their right to appeal the decision.

317:50-1-4. Application for Medically Fragile Waiver services

(a) ~~If waiver slots are available, the~~The application process is initiated by the receipt of a UCAT, Part I or by ~~an oral request for services.~~receipt of the initial waiver referral form. A written financial application is not required for an individual who is a SoonerCare member at the time of application. A financial application for Medically Fragile Waiver services consists of the Medical Assistance Application form. The form is signed by the applicant, parent, spouse, guardian or someone else acting on the applicant's behalf.

(1) All conditions of financial eligibility must be verified and documented in the case record. When current information is already available that establishes financial 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) An individual residing in a NF or requesting waiver services, or the individual's community spouse may request an assessment of resources available to each spouse by using ~~OKDHS~~DHS form 08MA011E, Assessment of Assets, when SoonerCare application is not being made. The individual and/or spouse must provide documentation of resources. The 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 SoonerCare long-term care eligibility is made.

(3) When SoonerCare application is being made, an assessment of resources must be completed if it was not completed when the individual entered the NF or began receiving waiver services. For applicants of the Medically Fragile waiver, those resources owned by the couple the month the application was made determines the spousal share of resources. If the individual applies for SoonerCare at the time of entry into the Medically Fragile Waiver, Form 08MA011E is not appropriate. However, the spousal share must be determined using the resource information provided on the SoonerCare application form and computed using ~~OKDHS~~DHS form 08MA12E, Title XIX Worksheet.

(b) **Date of application.** The date of application is the date the signed application is received or the date when the request for SoonerCare is made orally and the financial application form is signed later. The date of the oral request is noted above the date the form is signed.

(c) **Medically Fragile Waiver waiting list procedures.** Medically Fragile Waiver Program capacity is the number of members that may be enrolled in the Program without exceeding, on an annualized basis, the maximum number authorized by the waiver to be served in the waiver year. If available waiver capacity has been realized, requests for services are not processed as applications, but placed on a waiting list. As available capacity permits, the OHCA selects in chronological order (first on, first off) requests for services from the waiting list to forward for application processing. When waiver capacity exceeds the number on the waiting list and after all persons on the waiting list have been processed, waiting list procedures are suspended.

317:50-1-5. Medically Fragile Waiver program medical eligibility determination

A medical eligibility determination is made for Medically Fragile Waiver program services based on the Uniform Comprehensive Assessment Tool (UCAT) III assessment, professional judgment and the determination that the member has unmet care needs that require Medically Fragile Waiver Program, SNF or hospital services to assure member health and safety. Medically Fragile Waiver services are initiated to support the informal care that is being provided in the member's home, or, that based on the UCAT, can be expected to be provided in the member's home upon discharge of the member from a SNF 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, Medically Fragile Waiver service provision will supplement the system within the limitations of Medically Fragile Waiver Program policy.

(1) Categorical relationship must be established for determination of eligibility for Medically Fragile Waiver services. If categorical relationship to disability has not already been established, the Level of Care Evaluation Unit (LOCEU) will render a decision on categorical relationship to the disabled using the same definition used by Social Security Administration. A follow-up is required with the Social Security Administration to be sure their disability decision agrees with the decision of LOCEU.

(2) Community agencies complete the UCAT, Part I and forward the form to the OHCA. If the UCAT, Part I indicates that the applicant does not qualify for SoonerCare long-term care services, the applicant is referred to appropriate community resources.

(3) The member and family are informed of agencies certified to deliver Medically Fragile Waiver case management and in-home care services in the local area to obtain the member's primary and secondary informed choices.

(A) If the member and/or family declines to make a provider choice, that decision is documented on the member choice form.

(B) A rotating system is used to select an agency for the member from a list of all local certified case management and in-home care agencies.

(4) The names of the chosen agencies and the agreement (by dated signature) of the member to receive services provided by the agencies are documented.

(5) If the needs of the member require an immediate interdisciplinary team (IDT) meeting with home health agency nurse participation to develop a care plan and service plan, the need is documented.

(6) If, based upon the information obtained during the assessment, the nurse determines that the member may be at risk for health and safety, ~~OKDHS~~DHS Adult Protective Services (APS) staff are notified immediately and the referral is documented on the UCAT.

(7) Within ten working days of receipt of a complete Medically Fragile Waiver application, medical eligibility is determined using level of care criteria and service eligibility criteria.

(8) Once eligibility has been established, notification is given to the member and the case management provider so that care plan and service plan development may begin. The member's case management provider is notified of the member's name, address, case number and social security number, the units of case management and, if applicable, the number of units of home health agency nurse evaluation authorized for care plan and service plan development, whether the needs of the member require an immediate IDT meeting with home health agency nurse participation and the effective date for member entry into the Medically Fragile Waiver Program.

(9) ~~If the services must be in place to ensure the health and safety of the member upon discharge to the home from the NF, the member will be provided administrative case management to develop and implement the care plan and service plan. The provider of administrative case management follows Medically Fragile Waiver case management procedures for care plan and service plan development and implementation. Once the member returns home, case management is transitioned to the Medically Fragile Waiver case management provider chosen by the member.~~If the member has a current certification and requests a change to Medically Fragile Waiver services, a new UCAT is required. The UCAT is updated when a member requests a change from Medically Fragile Waiver services to Personal Care services. If a member is receiving Medically Fragile Waiver services and requests to go to a nursing facility, a new medical level of care decision is not needed.

(10) ~~If the member has a current certification and requests a change to Medically Fragile Waiver services, a new UCAT is required. The UCAT is updated when a member requests a change from Medically Fragile Waiver services to Personal Care services, or when a member requests a change from the nursing facility to Medically Fragile Waiver services. If a member is receiving Medically Fragile Waiver services and requests to go to a nursing facility, a new medical level of care decision is not needed.~~When a UCAT assessment has been completed more than 90 days prior to submission for determination of a medical decision, a new assessment is required.

~~(11) When a UCAT assessment has been completed more than 90 days prior to submission for determination of a medical decision, a new assessment is required.~~

317:50-1-10. Medically Fragile Waiver services during hospitalization or NF placement

If a member requires hospital or nursing facility services, the case manager assists the member in accessing institutional care, periodically monitors the member's progress during the institutional stay and, as appropriate, updates the service plan and prepares services to start on the date the member is discharged from the institution and returns home.

(1) **Hospital discharge.** When the member returns home from a hospital or when notified of the member's anticipated discharge date, the case manager notifies relevant providers and coordinates the resumption of services.

(2) **NF placement of less than 30 days.** When the member returns home from a NF stay of 30 days or less or when notified of the member's anticipated discharge date the case manager notifies relevant providers and coordinates the resumption of Medically Fragile Waiver services in the home.

(3) **NF placement greater than 30 days.** When the member is scheduled to be discharged and return home from a ~~SNF~~NF stay that is greater than 30 days, the member's case manager expedites the restart of Medically Fragile Waiver services for the member.

317:50-1-13. Coverage

Individuals receiving Waiver services must have been determined to be eligible for the program and must have an approved ~~plan of care.~~service plan. Any Medically Fragile Program service provided must be listed on the approved ~~plan of care~~service plan and must be necessary to prevent institutionalization of the member. Waiver services which are expansions of Oklahoma Medicaid State Plan services may only be provided after the member has exhausted these services available under the State Plan.

~~(1) To allow for development of administrative structures and provider capacity to adequately deliver Self-Directed services and Supports, availability of Self-Direction is limited to Medically Fragile Program members that reside in counties that have sufficient provider capacity to offer the Self-Directed Service option as determined by OHCA.~~

~~(2)~~(1) Case Managers within the Self-Directed Services approved area will provide information and materials that explain the service option to the members. The OHCA provides information and material on Self-Direction to Case Managers for distribution to members.

~~(3)~~(2) The member may request to Self-Direct their services from their Case Manager or call the Medically Fragile Program toll-free number to request the Self-Directed Services option.

317:50-1-14. Description of services

Services included in the Medically Fragile Waiver Program are as follows:

(1) **Case Management.**

(A) Case Management services are services that assist a member in gaining access to medical, social, educational or other services, regardless of payment source of services, that may benefit the member in maintaining health and safety. Case managers initiate and oversee necessary assessments and reassessments to establish or reestablish Waiver program eligibility. Case managers develop the member's comprehensive ~~plan of care,~~service plan, listing only services which are necessary to prevent institutionalization of the member, as determined through assessments. Case managers initiate the addition of necessary services or deletion of unnecessary services, as dictated by the member's condition and available support. Case managers monitor the member's condition to ensure delivery and appropriateness of services and initiate ~~plan of care~~service plan reviews. If a member requires hospital or skilled nursing facility services, the case manager assists the member in accessing institutional care and, as appropriate, periodically monitors the member's progress during the institutional stay and helps the member transition from institution to home by updating the service plan and preparing services to start on the date the member is discharged from the institution. Case Managers must meet Medically Fragile Waiver Program minimum requirements for qualification and training prior to providing services to members. Prior to providing services to members choosing to Self-Direct their services, Case Managers are required to receive training and

demonstrate knowledge regarding the Self-Directed Service delivery model.

(B) Providers may only claim time for billable Case Management activities described as follows:

(i) A billable case management activity is any task or function defined under OAC 317:50-1-15(1)(A)that only a Medically Fragile case manager because of skill, training or authority, can perform on behalf of a member;

(ii) Ancillary activities such as clerical tasks like mailing, copying, filing, faxing, drive time or supervisory/administrative activities are not billable case management activities, although the administrative cost of these activities and other normal and customary business overhead costs have been included in the reimbursement rate for billable activities. Payment is not allowed for written reports or record documentation.

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

(i) Standard Rate: Case Management services are billed using a Standard rate for reimbursement for billable service activities provided to a member who resides in a county with population density greater than 25 persons per square mile.

(ii) Very Rural/Difficult Service Area Rate: Case Management services are billed using a Very Rural/Difficult Service Area rate for billable service activities provided to a member who resides in a county with population density equal to or less than 25 persons per square mile. An exception would be services to members that reside in OHCA identified zip codes in Osage County adjacent to metropolitan areas of Tulsa and Washington Counties. Services to these members are prior authorized and billed using the Standard rate.

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

(D) ~~Providers of Home and Community Based Services (HCBS) for the member, or those who have an interest in or are employed by a provider of HCBS for the member, must not provide case management or develop the person-centered service plan, except when the State demonstrates that the only willing and qualified entity to provide case management and/or develop person-centered service plans in a geographic area also provides HCBS.~~Case Managers providing Case Management services to Medically Fragile waiver members must submit monthly monitoring case notes on a monthly basis to the OHCA Medically Fragile Waiver Staff.

(E) Providers of Home and Community Based Services (HCBS) for the member, or those who have an interest in or are employed by a provider of HCBS for the member, must not provide case management or

develop the person-centered service plan, except when the State demonstrates that the only willing and qualified entity to provide case management and/or develop person-centered service plans in a geographic area also provides HCBS.

(2) ~~**Institutional Transition Services.**~~**Institutional Transition Case Management.**

(A) Institutional Transition Case Management Services are Services required by the member's ~~plan of care,~~service plan, which are necessary to ensure the health, welfare and safety of the member, or to enable the member to function with greater independence in the home, and without which, the member would continue to require institutionalization.

(B) Institutional Transition Case Management services assist institutionalized members that are eligible to receive waiver services in gaining access to needed waiver and other State plan services, as well as needed medical, social, educational and other services to assist the transition, regardless of the funding source for the services which access is gained.

(C) Institutional Transition Case Management services may be authorized for periodic monitoring of a waiver member's progress during an institutional stay, and for assisting the member transition from institution to home by updating the services plan, including preparing for necessary services and supports to be in place or to start on the date the member is discharged from the institution.

(3) **Respite.**

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

(B) In-Home Respite services are billed per 15-minute unit service. Within any one-day period, a minimum of eight units must be provided with a maximum of 28 units provided. The service is provided in the member's home.

(C) Facility-Based Extended Respite is filed for a per diem rate, if provided in Nursing Facility. Extended Respite must be at least eight hours in duration.

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

(4) **Environmental Modifications.**

(A) Environmental Modifications are physical adaptations to the home, required by the member's ~~plan of care,~~service plan, which are necessary to ensure the health, welfare and safety of the

individual, or which enable the individual to function with greater independence in the home and without which, the member would require institutionalization. Adaptations or improvements to the home which are not of direct medical or remedial benefit to the Waiver member are excluded.

(B) All services require prior authorization.

(5) **Specialized Medical Equipment and Supplies.**

(A) Specialized Medical Equipment and Supplies are devices, controls, or appliances specified in the ~~plan of care,~~service plan, which enable members to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live. Also included are items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid state plan. This service excludes any equipment and/or supply items which are not of direct medical or remedial benefit to the Waiver member. This service is necessary to prevent institutionalization.

(B) Specialized Medical Equipment and Supplies are billed using the appropriate HCPC procedure code. Reoccurring supplies which are shipped to the member are compensable only when the member remains eligible for Waiver services, continues to reside in the home and is not institutionalized in a hospital, skilled nursing facility or nursing home. It is the provider's responsibility to verify the member's status prior to shipping these items. Payment for medical supplies is limited to the Medicare rate, or the SoonerCare rate, or is determined through manual pricing. If manual pricing is used, the provider is reimbursed at the provider's documented Manufacturer's Suggested Retail Price (MSRP) minus 30% or invoice cost plus 30%, whichever is the lesser of the two. OHCA may establish a fair market price through claims review and analysis.

(6) **Advanced Supportive/Restorative Assistance.**

(A) Advanced Supportive/Restorative Assistance services are maintenance services to assist a member who has a chronic, yet stable, condition. These services assist with activities of daily living which require devices and procedures related to altered body functions. This service is for maintenance only and is not utilized as a treatment service.

(B) Advanced Supportive/Restorative Assistance service is billed per 15-minute unit of service. The number of units of this service a member may receive is limited to the number of units approved on the ~~plan of care.~~service plan.

(7) **Nursing.**

(A) Nursing services are services listed in the ~~plan of care~~service plan which are within the scope of the Oklahoma Nursing Practice Act and are provided by a registered professional nurse, or licensed practical or vocational nurse under the supervision of a registered nurse, licensed to practice in the State. Nursing services includes skilled nursing and/or private duty nursing. Skilled nursing is

provided on an intermittent or part-time basis. Private duty nursing is individual and continuous care provided to a participant at home by licensed nurses. The provision of the nursing service will work to prevent or postpone the institutionalization of the member.

(B) Nursing services are services of a maintenance or preventive nature provided to members with stable, chronic conditions. These services are not intended to treat an acute health condition and may not include services which would be reimbursable under either Medicaid or Medicare's Home Health Program. This service primarily provides nurse supervision to the Personal Care Assistant or to the Advanced Supportive/Restorative Assistance Aide and assesses the member's health and prescribed medical services to ensure that they meet the member's needs as specified in the ~~plan of care.~~service plan. A skilled nursing assessment/evaluation on-site visit is made to each member for whom Advanced Supportive/Restorative Assistance services are authorized to evaluate the condition of the member and medical appropriateness of services. An assessment/evaluation visit report will be made to the Medically Fragile Waiver case manager in accordance with review schedule determined in consultation between the Case Manager and the Skilled Nurse, to report the member's condition or other significant information concerning each advanced supportive/restorative care member.

(i) The case manager may recommend authorization of Skilled Nursing services as part of the interdisciplinary team planning for the member's service plan and/or assessment/evaluation of:

(I) the member's general health, functional ability and needs and/or

(II) the adequacy of personal care and/or advanced supportive/restorative assistance services to meet the member's needs including providing on-the-job training and competency testing for personal care or advanced supportive/restorative care aides in accordance with rules and regulations for delegation of nursing tasks as established by the Oklahoma Board of Nursing.

(ii) In addition to assessment/evaluation, the case manager may recommend authorization of Skilled Nursing services for the following:

(I) preparing a one-week supply of insulin syringes for a blind diabetic, who can safely self-inject the medication but cannot fill his/her own syringe. This service would include monitoring the member's continued ability to self-administer the insulin;

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

(III) monitoring a member's skin condition when a member is at risk for skin breakdown due to immobility or incontinence, or

the member has a chronic stage II decubitus ulcer requiring maintenance care and monitoring;

(IV) providing nail care for the diabetic member or member with circulatory or neurological compromise;

(V) providing consultation and education to the member, member's family and/or other informal caregivers identified in the service plan, regarding the nature of the member's chronic condition. Provide skills training (including return skills demonstration to establish competency) to the member, family and/or other informal caregivers as specified in the service plan for preventive and rehabilitative care procedures.

(C) Nursing service can be billed for service plan development and/or assessment/evaluation services or, for other services within the scope of the Oklahoma Nursing Practice Act including private duty nursing. Nursing services are billed per 15-minute unit of service. A specific procedure code is used to bill for assessment/evaluation/service plan development skilled nursing services and other procedure codes are used to bill for all other authorized nursing services. A maximum of eight units per day of skilled nursing for assessment/evaluation and/or service plan development are allowed. An agreement by a provider to perform a nurse evaluation is also an agreement, to provide the nurse assessment identified in the Medicaid in-home care services for which the provider is certified and contracted. Reimbursement for a nurse evaluation is denied if the provider that produced the nurse evaluation fails to provide the nurse assessment identified in the Medicaid in-home care services for which the provider is certified and contracted.

(8) **Home Delivered Meals.**

(A) Home Delivered Meals provide one meal per day. A home delivered meal is a meal prepared in advance and brought to the member's home. Each meal must have a nutritional content equal to at least one third of the Recommended Daily Allowance as established by the Food and Nutrition Board of the National Academy of Sciences. Meals are only provided to members who are unable to prepare meals and lack an informal provider to do meal preparation.

(B) Home Delivered Meals are billed per meal, with one meal equaling one unit of service. The limit of the number of units a member is allowed to receive is limited on the member's ~~plan of care.~~service plan. The provider must obtain a signature from the member or the member's representative at the time the meals are delivered. In the event that the member is temporarily unavailable (i.e., doctor's appointment, etc.) and the meal is left, the provider must document the reason a signature is not obtained. The signature logs must be available for review.

(9) **Occupational Therapy services.**

(A) Occupational Therapy services are those services that increase functional independence by enhancing the development of adaptive skills and performance capacities of members with physical

disabilities and related psychological and cognitive impairments. Services are provided in the member's home and are intended to help the member achieve greater independence to reside and participate in the community. Treatment involves the therapeutic use of self-care, work and play activities and may include modification of the tasks or environment to enable the member to achieve maximum independence, prevent further disability, and maintain health. Under a physician's order, a licensed occupational therapist evaluates the member's rehabilitation potential and develops an appropriate written therapeutic regimen. The regimen utilizes paraprofessional occupational therapy assistant services, within the limits of their practice, working under the supervision of the licensed occupational therapist. The regimen includes education and training for informal caregivers to assist with and/or maintain services, where appropriate. The therapist will ensure monitoring and documentation of the member's rehabilitative progress and will report to the member's case manager and physician to coordinate necessary addition and/or deletion of services, based on the member's condition and ongoing rehabilitation potential.

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

(10) **Physical Therapy services.**

(A) Physical Therapy services are those services that prevent physical disability through the evaluation and rehabilitation of members disabled by pain, disease or injury. Services are provided in the member's home and are intended to help the member achieve greater independence to reside and participate in the community. Treatment involves use of physical therapeutic means such as massage, manipulation, therapeutic exercise, cold or heat therapy, hydrotherapy, electrical stimulation and light therapy. Under a physician's order, a licensed physical therapist evaluates the member's rehabilitation potential and develops an appropriate, written therapeutic regimen. The regimen utilizes paraprofessional physical therapy assistant services, within the limits of their practice, working under the supervision of the licensed physical therapist. The regimen includes education and training for informal caregivers to assist with and/or maintain services, where appropriate. The therapist will ensure monitoring and documentation of the member's rehabilitative progress and will report to the member's case manager and physician to coordinate necessary addition and/or deletion of services, based on the member's condition and ongoing rehabilitation potential.

(B) Physical Therapy services are billed per 15-minute units of service. Payment is not allowed solely for written reports or record documentation.

(11) **Speech and Language Therapy services.**

(A) Speech/Language Therapy services are those that prevent speech and language communication disability through the evaluation and

rehabilitation of members disabled by pain, disease or injury. Services are provided in the member's home and are intended to help the member achieve greater independence to reside and participate in the community. Services involve use of therapeutic means such as evaluation, specialized treatment, and/or development and oversight of a therapeutic maintenance program. Under a physician's order, a licensed Speech/Language Pathologist evaluates the member's rehabilitation potential and develops an appropriate, written therapeutic regimen. The regimen utilizes paraprofessional therapy assistant services within the limits of their practice, working under the supervision of the licensed Speech/Language Pathologist. The regimen includes education and training for informal caregivers to assist with and/or maintain services, where appropriate. The Pathologist will ensure monitoring and documentation of the member's rehabilitative progress and will report to the member's case manager and physician to coordinate necessary addition and/or deletion of services, based on the member's condition and ongoing rehabilitation potential.

(B) Speech/Language Therapy services are billed per 15-minute unit of service. Payment is not allowed solely for written reports or record documentation.

(12) **Respiratory Therapy Services.**

(A) Respiratory therapy services are provided for a member who, but for the availability of in-home respiratory services, would require respiratory care as an inpatient in a hospital or nursing facility. Services are provided in the member's home under the care of a physician who is familiar with the technical and medical components of home ventilator support and the physician must determine medically that in-home respiratory care is safe and feasible for the member. Treatment involves use of therapeutic means such as: evaluation, respiratory treatments, chest physiotherapy, and/or development and oversight of a therapeutic maintenance program. Under a physician's order, a registered respiratory therapist evaluates the member and develops an appropriate, written therapeutic regimen. The regimen includes education and training for informal caregivers to assist with and/or maintain services, where appropriate. The therapist will ensure monitoring and documentation of the member's progress and will report to the member's case manager and physician to coordinate necessary addition and/or deletion of services, based on the member's condition and ongoing rehabilitation potential.

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

(13) **Hospice Services.**

(A) Hospice is palliative and/or comfort care provided to the member and his/her family when a physician certifies that the member has a terminal illness and has six months or less to live and orders hospice Care. Medically Fragile Waiver Hospice Care is authorized

for a six month period and requires a physician certification of a terminal illness and orders of hospice care. If the member requires more than six months of hospice care, a physician or nurse practitioner must have a face-to-face visit with the member thirty days prior to the initial hospice authorization end date and re-certify that the member has a terminal illness and has six months or less to live and orders additional hospice care. After the initial authorization period, additional periods of hospice may be authorized for a maximum of 60 day increments with physician certification that the member has a terminal illness and has six months or less to live. A member's service plan that includes hospice care must comply with waiver requirements to be within total service plan cost limits.

(B) A hospice program offers palliative and supportive care to meet the special needs arising out of the physical, emotional and spiritual stresses which are experienced during the final stages of illness and during dying and bereavement. The member signs a statement choosing hospice care instead of routine medical care that has the objective to treat and cure the member's illness. Once the member has elected hospice care, the hospice medical team assumes responsibility for the member's medical care for the terminal illness in the home environment. Hospice care services include nursing care, physician services, medical equipment and supplies, drugs for symptom control and pain relief, home health aide and personal care services, physical, occupational and/or speech therapy, medical social services, dietary counseling and grief and bereavement counseling to the member and/or family. A Hospice plan of care must be developed by the hospice team in conjunction with the member's case manager before hospice services are provided. The hospice services must be related to the palliation or management of the member's terminal illness, symptom control, or to enable the individual to maintain activities of daily living and basic functional skills. Hospice may be provided to the member in a Nursing Facility (NF) only when the member is placed in the NF for Medically Fragile Facility Based Extended Respite. Hospice provided as part of Facility Based Extended Respite may not be reimbursed for more than five days during any 30 day period. A member that is eligible for Medicare Hospice provided as a Medicare Part A benefit, is not eligible to receive Medically Fragile Hospice services.

(C) Hospice services are billed per diem of service for days covered by a Hospice plan of care and during which the hospice provider is responsible for providing hospice services as needed by the member or member's family.

(14) **Medically Fragile Waiver Personal Care.**

(A) Medically Fragile Personal Care is assistance to a member in carrying out activities of daily living such as bathing, grooming and toileting, or in carrying out instrumental activities of daily living, such as preparing meals and doing laundry, to assure personal health and safety of the individual or to prevent or

minimize physical health regression or deterioration. Personal Care services do not include service provision of a technical nature, i.e. tracheal suctioning, bladder catheterization, colostomy irrigation, and operation/maintenance of equipment of a technical nature.

(B) Medically Fragile Home Care Agency Skilled Nursing staff working in coordination with a Case Manager are responsible for development and monitoring of the member's Personal Care plan.

(C) Medically Fragile Personal Care services are prior authorized and billed per 15-minute unit of service with units of service limited to the number of units on the approved ~~plan of care.~~service plan.

(15) **Personal Emergency Response System.**

(A) Personal Emergency Response System (PERS) is an electronic device which enables certain individuals at high risk of institutionalization to secure help in an emergency. The individual may also wear a portable "help" button to allow for mobility. The system is connected to the person's phone and programmed to signal, in accordance with member preference, a friend, a relative or a response center once a "help" button is activated. The response center is staffed by trained professionals. For an Medically Fragile Program member to be eligible to receive PERS service, the member must meet all of the following service criteria:

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

(ii) lives alone and has no regular caregiver, paid or unpaid, and therefore is left alone for long periods of time;

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

(iv) has a health and safety plan detailing the interventions beyond the PERS to assure the member's health and safety in his/her home;

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

(vi) the service avoids premature or unnecessary institutionalization of the member.

(B) PERS services are billed using the appropriate HCPC procedure code for installation, monthly service or purchase of PERS. All services are prior authorized in accordance with the Medically Fragile approved ~~plan of care.~~service plan.

(16) **Prescription drugs.** Members are eligible for a maximum of six prescriptions per month with a limit of three brand name prescriptions. Seven additional generic prescriptions per month are allowed if medically necessary. Medically necessary prescriptions beyond the three brand name or thirteen total prescriptions will be covered with prior authorization. More information on prescription drugs is provided at 317:30-5-72.

(17) **Self-Direction.**

(A) Self-Direction is a method of service delivery that allows waiver members to determine supports and services they need to live successfully in a home or community based setting. A member choosing Self-Direction is the employer of record for his/her Personal Care and Advanced Supportive/Restorative Care service providers and must have an approved ~~plan of care~~service plan prior to initiation of any Self-Directed activities.

(B) The OHCA uses the following criteria to determine a member's service eligibility to participate in the Self-Directed Services program:

(i) residence in the Self-Directed services approved area;

(ii) member's health and safety with Self-Directed services can reasonably be assured based on a review of service history records and a review of member capacity and readiness to assume employer responsibilities under Self-Direction with any one of the following findings as basis to deny a request for Self-Direction due to inability to assure member health and safety;

(I) the member does not have the ability to make decisions about his/her care or service planning and the member's "authorized representative" is not willing to assume Self-Directed services responsibilities, or

(II) the member is not willing to assume responsibility, or to enlist an "authorized representative" to assume responsibility, in one or more areas of Self-Direction such as in service planning, or in assuming the role of employer of the ~~Personal Services Assistant (PSA) or Advanced Personal Services Assistant (APSA)~~Personal Care Assistant (PCA) or Advanced Supportive/Restorative (ASR) service provider, or in monitoring and managing health or in preparation for emergency backup, or

(III) the member has a recent history of self-neglect or self-abuse as evidenced by Adult Protective Services intervention within the past 12 months and does not have an "authorized representative" with capacity to assist with Self-Direction responsibilities;

(C) The member voluntarily makes an informed choice to Self-Direct services. As part of the informed choice, decision making process for Self-Direction, the OHCA staff or the Case Manager provides consultation and assistance as the member completes a self-assessment of preparedness to assume the role of employer for their ~~Personal Services Assistant.~~Personal Care Assistant. The orientation and enrollment process will provide the member with a basic understanding of what will be expected of them under Self-Direction, the supports available to assist them to successfully perform employer responsibilities and an overview of the potential risks involved.

(D) The OHCA uses the following criteria to determine that based upon documentation, a person is no longer allowed to participate in the Self-Directed Services option:

(i) the member does not have the ability to make decisions about his/her care or service planning and the member's "authorized representative" is not willing to assume Self-Direction responsibilities; or

(ii) the member is not willing to assume responsibility, or to enlist an "authorized representative" to assume responsibility, in one or more areas of Self-Direction such as in service planning, or in assuming the role of employer of the ~~PSA~~PCA or ~~APSA~~ASR service providers, or in monitoring and managing health or in preparation for emergency backup; or

(iii) the member has a recent history of self-neglect or self-abuse as evidenced by Adult Protective Services intervention and does not have an "authorized representative" with capacity to assist with Self-Direction responsibilities; or

(iv) the member abuses or exploits their employee; or

(v) the member falsifies time-sheets or other work records; or

(vi) the member, even with Case Manager and Financial Management Services assistance, is unable to operate successfully within their Individual Budget Allocation; or

(vii) inferior quality of services provided by member/employer's employee, or the inability of the member/employer's employee to provide the number of service units the member requires, jeopardizes the member's health and/or safety.

(E) The member may designate a family member or friend as an "authorized representative" to assist in the service planning process and in executing member employer responsibilities. If the member chooses to designate an "authorized representative", the designation and agreement identifying the "willing adult" to assume this role and responsibility is documented with dated signatures of the member, the designee and the member's Case Manager or the OHCA staff.

(i) A person having guardianship or power of attorney or other court sanctioned authorization to make decisions on behalf of the member has legal standing to be the member's designated "authorized representative".

(ii) An individual hired to provide Personal Services Assistance to a member may not be designated the "authorized representative" for the member.

(F) Self-Directed Services are delivered as authorized on the service plan and are limited to Personal Care, Respite and Advanced Supportive/Restorative Care. The member employs the Respite or ~~Personal Services Assistant (PSA) and/or the Advanced Personal Services Assistant (APSA)~~PCA and/or the ASR provider and is responsible, with assistance from the Administrative Financial Management Services (FMS), for ensuring that the employment complies with State and Federal Labor Law requirements. The member:

(i) recruits, hires and, as necessary, discharges the ~~PSA~~PCA and ~~APSA;~~ASR

(ii) provides instruction and training to the ~~PSA~~PCA or ~~APSA~~ASR on tasks to be done and works with the Case Manager to obtain skilled nursing services assistance with training when necessary. Prior to performing an ~~Advanced Personal Services Assistance~~ASR provider task for the first time, the ~~APSA~~ASR must demonstrate competency in the tasks in an on-the-job training session conducted by the member and the member must document the attendant's competency in performing each task in the ~~APSA's~~ASR provider personnel file;

(iii) determines where and how the ~~PSA~~PCA or ~~APSA~~ASR works, hours of work, what is to be accomplished and, within Individual Budget Allocation limits, wages to be paid for the work;

(iv) supervises and documents employee work time; and,

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

(G) Financial Management Services are program administrative services provided to participating Self-Directed Service employer/members by agencies contracted with the OHCA. Financial Management Services are employer related assistance that provides Internal Revenue Service (IRS) fiscal reporting agent and other financial management tasks and functions including, but not limited to:

(i) employer payroll, at a minimum of semi monthly, and associated withholding for taxes, or for other payroll withholdings performed on behalf of the member as employer of the ~~PSA or APSA;~~PCA or ASR provider;

(ii) other employer related payment disbursements as agreed to with the member and in accordance with the member's Individual Budget Allocation;

(iii) responsibility for obtaining criminal and abuse registry background checks, on behalf of the member, on prospective hires for ~~PSAs or APSAs;~~PCA or ASR provider;

(iv) providing to the member, as needed, assistance with employer related cognitive tasks, decision-making and specialized skills that may include assistance with Individual Budget Allocation planning and support for making decisions including training and providing reference material and consultation regarding employee management tasks such as recruiting, hiring, training and supervising the member's Respite or ~~Personal Services Assistant or Advanced Personal Services Assistant; and~~PCA or ASR provider; and

(H) The service of Respite or ~~Personal Services Assistance~~PCA is billed per 15-minute unit of service. The number of units of ~~PSA~~PCA a member may receive is limited to the number of units approved on the Service Plan.

(I) ~~The service of Advanced Personal Services Assistance is billed per 15-minute unit of service.~~ASR services are billed per 15-minute unit of service. The number of units of ~~APSA~~ASR a member may

receive is limited to the number of units approved on the Service Plan.

(J) Self-Directed Services rates are determined using the Individual Budget Allocation (IBA) Expenditure Accounts Determination process for each member. The IBA Expenditure Accounts Determination process includes consideration and decisions about the following:

(i) The Individual Budget Allocation (IBA) Expenditure Accounts Determination constrains total SoonerCare reimbursement for Self-Directed services to be less than expenditures for equivalent services using agency providers.

(ii) The ~~PSA~~PCA and ~~APSA~~ASR service unit rates are calculated by the OHCA during the Self-Directed service eligibility determination process. ~~The OHCA sets the PSA and APSA unit rates at a level that is not less than 80 percent and not more than 95 percent of the comparable Agency Personal Care (for PSA) or Advanced Supportive/Restorative (for APSA) service rate.~~ The allocation of portions of the ~~PSA~~PCA and/or ~~APSA~~ASR rate to cover salary, mandatory taxes, and optional benefits (including Worker's Compensation insurance, if available) is determined individually for each member using the Self-Directed Services Individualized Budget Allocation Expenditure Accounts Determination Process.

(iii) The IBA Expenditure Accounts Determination process defines the level of program financial resources required to meet the member's need for Self-Directed services. If the member's need for services changes due to a change in health/disability status and/or a change in the level of support available from other sources, the Case Manager, based upon an updated assessment, amends the service plan to increase Self-Directed service units appropriate to meet additional member need. The OHCA, upon favorable review, authorizes the amended plan and updates the member's IBA. Service amendments based on changes in member need for services do not change an existing ~~PSA~~PCA or ~~APSA~~ASR rate. The member, with assistance from the FMS, reviews and revises the IBA Expenditure Accounts calculation annually or more often to the extent appropriate and necessary.

(18) **Self-Directed Goods and Services (SD-GS).**

(A) Self-Directed Goods and Services (SD-GS) are incidental, non-routine goods and services that promote the member's self-care, daily living, adaptive functioning, general household activity, meal preparation and leisure skills needed to reside successfully in the community and do not duplicate other services authorized in the member's ~~plan of care~~service plan.

(B) These goods and services are purchased from the self-directed budget.All goods and services must be approved by the Medically Fragile wavier staff. Documentation must be available upon request.

(19) **Transitional Case Management Services.**

(A) Transitional Case Management Services are one-time billable expenses for members who transition from within the community to the Medically Fragile waiver.

(B) Transitional Case Management Services must be reasonable and necessary as determined through the transition plan development process and must be clearly identified in the plan.

(C) Transitional Case Management Services assist members that are eligible to receive waiver services in gaining access to needed waiver and other State plan services, as well as needed medical, social, educational, and other services to assist the transition, regardless of the funding source for the services which access is gained.

Transitional Case Management Services may be authorized for assisting the member transition to the Medically Fragile Waiver by updating the service plan, including preparing for necessary services and supports to be in place or to start on the date the member is effective with the waiver.

317:50-1-16. Billing procedures for Medically Fragile Waiver services

(a) Billing procedures for long-term care medical services are contained in the OKMMIS Billing and Procedure Manual. Questions regarding billing procedures which cannot be resolved through a study of the manual should be referred to the OHCA.

(b) The approved Medically Fragile Waiver service plan is the basis for the MMIS service prior authorization, specifying:

(1) service;

(2) service provider;

(3) units authorized; and

(4) begin and end dates of service authorization.

(c) As part of Medically Fragile Waiver quality assurance, provider audits are used to evaluate whether paid claims are consistent with service plan authorizations and documentation of service provision. Evidence of paid claims that are not supported by service plan authorization and/or documentation of service provision will be turned over to the OHCA Provider Audit Unit for follow-up investigation.

~~(d) Service time of Personal Care, Case Management, Nursing, Advanced Supportive/ Restorative Assistance, In-Home Respite and Self Direction may be documented through the Interactive Voice Response Authentication (IVRA) system when provided in the home. Providers are required to use the IVRA system after access to the system is made available by OKDHS. The IVRA system provides alternate backup solutions should the automated system be unavailable. In the event of IVRA backup system failure, the provider will document time in accordance with their agency backup plan. The agency=s backup procedures are only permitted when the IVRA system is unavailable.~~

AGENDA

15-58 DSM Reference Clean up and Ad Hoc Reviews

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 6. INPATIENT PSYCHIATRIC HOSPITALS

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

Acute psychiatric admissions for children 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~~<u>A</u> 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~~ <u>a</u> 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

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~~A 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~~ a 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.

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

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

(1) **"Licensed Behavioral Health Professional (LBHP)"** means licensed psychologists, licensed clinical social workers (LCSW), licensed marital and family therapists (LMFT), licensed professional counselors (LPC), licensed behavioral practitioners (LBP), licensed alcohol and drug counselors (LADC), and advanced practice nurses (APN).

(2) **"Licensure Candidate"** means practitioners actively and regularly receiving board approved supervision, and extended supervision by a fully licensed clinician if board's supervision requirement is met but the individual is not yet licensed, to become licensed by one of the following licensing boards:

(A) Psychology,
(B) Social Work (clinical specialty only),
(C) Professional Counselor,
(D) Marriage and Family Therapist,
(E) Behavioral Practitioner, or
(F) Alcohol and Drug Counselor.

(3) **"Individual plan of Care (IPC)"** means a written plan developed for each member within four calendar days of any admission to an acute psychiatric facility or a PRTF and is the document that directs the care and treatment of that member. In Community Based Transitional

RTC, the IPC must be completed within 7 days. The individual plan of care must be recovery focused, trauma informed, and specific to culture, age and gender and includes:

(A) A 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. Children 18-20 years of age may have a diagnosis of any personality disorder. Adjustment or substance related disorders may be a secondary diagnosis.

(B) the current functional level of the individual;

(C) treatment goals and measurable time limited objectives;

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

(E) plans for continuing care, including review and modification to the plan of care; and

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

(b) The individual plan of care:

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

(2) must be developed by a team of professionals as specified in OAC 317:30-5-95.35 in collaboration with the member, and his/her parents for members under the age of 18, legal guardians, or others in whose care he/she will be released after discharge;

(3) must establish treatment goals that are general outcome statements and reflective of informed choices of the member served. Additionally, the treatment goal must be appropriate to the member's age, culture, strengths, needs, abilities, preferences and limitations;

(4) must establish measurable and time limited treatment objectives that reflect the expectations of the member served and parent/legal guardian (when applicable) as well as being age, developmentally and culturally appropriate. When modifications are being made to accommodate age, developmental level or a cultural issue, the documentation must be reflected on the individual plan of care. The treatment objectives must be achievable and understandable to the member and the parent/guardian (when applicable). The treatment objectives also must be appropriate to the treatment setting and list the frequency of the service;

(5) must prescribe an integrated program of therapies, activities and experiences designed to meet the objectives;

(6) must include specific discharge and after care plans that are appropriate to the member's needs and effective on the day of

discharge. At the time of discharge, after care plans will include referral to medication management, out-patient behavioral health counseling and case management to include the specific appointment date(s), names and addresses of service provider(s) and related community services to ensure continuity of care and reintegration for the member into their family, school, and community;

(7) must be reviewed every five to nine calendar days when in acute care and a regular PRTF, every 11 to 16 calendar days in the OHCA approved longer term treatment programs or specialty PRTF and every 30 days in Community Based Transitional treatment programs by the team specified to determine that services are being appropriately provided and to recommend changes in the individual plan of care as indicated by the member's overall adjustment, progress, symptoms, behavior, and response to treatment;

(8) development and review must satisfy the utilization control requirements for physician re-certification and establishment of periodic reviews of the individual plan of care; and,

(9) each individual plan of care and plan of care review must be clearly identified as such and be signed and dated individually by the physician, LBHP or licensure candidate, member, parent/guardian (for members under the age of 18), registered nurse, and other required team members. All plans of care and plan of care reviews must be signed by the member upon completion, except when a member is too physically ill or ~~their~~ the member's acuity level precludes ~~them~~ him/her from signing. If the member ~~was~~ is too physically ill or ~~their~~ the member's acuity level ~~precluded them~~ precludes him/her from signing the plan of care and/or the plan of care review at the time of completion, the member must sign the plan when ~~their~~ his/her condition improves but before discharge. The documentation should indicate the reason the member was unable to sign and when the next review will occur to obtain the signature. Individual plans of care and individual plan of care reviews are not valid until completed and appropriately signed and dated. All requirements for the individual plan of care or individual plan of care reviews must be met or a partial per diem recoupment will be merited. If the member's parent/guardian is unable to sign the IPC or IPC review on the date it is completed, then within 72 hours the ~~Provider~~provider must in good faith and with due diligence attempt to telephonically notify the parent/guardian of the document's completion and review it with them. Documentation of reasonable efforts to make contact with the member's parent/guardian must be included in the clinical file. In those instances where it is necessary to mail or fax an ~~Individual Plan of Care or Individual Plan of Care~~IPC or IPC review to a parent or OKDHS/OJA worker for review, the parent and/or OKDHS/OJA worker may fax back their signature. The ~~Provider~~provider must obtain the original signature for the clinical file within 30 days. Stamped or photocopied signatures are not allowed for any parent or member of the treatment team.

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

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

(1) **"Discharge/Transition Planning"** means a patient-centered, interdisciplinary process that begins with an initial assessment of the patient's potential needs at the time of admission and continues throughout the patient's stay. Active collaboration with the patient, family and all involved outpatient practitioners and agencies should be ongoing throughout treatment so that effective connections remain intact. Needed services may consist of the ~~Wraparound~~wraparound process through Systems of Care, counseling, case management and other supports in their community. The linkages with these supports should be made prior to discharge to allow for a smooth transition.

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

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

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

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

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

(7) **"Process group therapy"** means a method of treating existing primary behavioral health disorders and/or secondary AOD disorders using the interaction between an LBHP or licensure candidate as defined in OAC 317:30-5-240.3, and two or more members to promote positive emotional and/or behavioral change.

(b) Inpatient psychiatric programs must provide "Active Treatment". Active Treatment involves the member and their family or guardian from the time of an admission throughout the treatment and discharge process. Families and/or guardians must be notified of the dates and times of treatment team meetings and be welcomed to attend. Family members must attend family therapy weekly for continued SoonerCare reimbursement. Reasons for exceptions to this requirement must be well documented in the member's

treatment plan. For individuals in the age range of 18 up to 21, it is understood that family members and guardians will not always be involved in the member's treatment. Active Treatment also includes an ongoing program of assessment, diagnosis, intervention, evaluation of care and treatment, and planning for discharge and aftercare under the direction of a physician. Evidence based practices such as trauma informed methodology should be utilized to minimize the use of seclusion and restraint.

(c) For individuals age 18 up to 21, the Active Treatment program must be appropriate to the needs of the member and be directed toward restoring and maintaining optimal levels of physical and psychiatric-social functioning. The services and individual plan of care must be recovery focused, trauma informed, specific to culture, age and gender, and provided face-to-face. Services, including type and frequency, will be specified in the Individual Plan of Care.

(d) For individuals under age 18, the components of Active Treatment consist of face-to-face integrated therapies that are provided on a regular basis and will remain consistent with the member's ongoing need for care. The services and individual plan of care must be recovery focused, trauma informed, and specific to culture, age, and gender. Individuals in acute care must receive seventeen (17) hours of documented active treatment services each week, with seven (7) of those hours being dedicated to core services as described in (1) below. Individuals in PRTFs must receive fourteen (14) hours of documented active treatment services each week, with four and a half (4.5) of those hours being dedicated to core services as described in (1) below. Individuals in Community Based Transitional (CBT) must receive ten (10) hours of documented active treatment services each week, with 4 of those hours being dedicated to core services as described in (1) below. The remainder of the active treatment services may include any or all of the elective services listed in (2) below or additional hours of any of the core services. Sixty minutes is the expectation to equal one hour of treatment. When appropriate to meet the needs of the child, the 60 minute timeframe may be split into sessions of no less than 15 minutes each on the condition that the Active Treatment requirements are fully met by the end of the treatment week. The following components meet the minimum standards required for Active Treatment, although an individual child's needs for treatment may exceed this minimum standard:

(1) **Core Services.**

(A) **Individual treatment provided by the physician.** Individual treatment provided by the physician is required three times per week for acute care and one time a week in Residential Treatment Facilities. Individual treatment provided by the physician will never exceed ten calendar days between sessions in PRTFs, never exceed seven calendar days in a specialty PRTF and never exceed 30 calendar days in CBTs. Individual treatment provided by the physician may consist of therapy or medication management intervention for acute and residential programs.

(B) **Individual therapy.** LBHPs or licensure candidates performing this service must use and document an approach to treatment such as

cognitive behavioral treatment, narrative therapy, solution focused brief therapy or another widely accepted theoretical framework for treatment. Ongoing assessment of the member's status and response to treatment as well as psycho-educational intervention are appropriate components of individual therapy. Individual therapy must be provided in a confidential setting. The therapy must be goal directed utilizing techniques appropriate to the individual member's plan of care and the member's developmental and cognitive abilities. Individual therapy must be provided two hours per week in acute care and one hour per week in residential treatment by an LBHP or licensure candidate as described in OAC 317:30-5-240.3. One hour of family therapy may be substituted for one hour of individual therapy at the treatment team's discretion.

(C) **Family therapy.** The focus of family therapy must be directly related to the goals and objectives on the individual member's plan of care. Family therapy must be provided one hour per week for acute care and residential. One hour of individual therapy addressing relevant family issues may be substituted for a family session in an instance in which the family is unable to attend a scheduled session by an LBHP or licensure candidate as described in OAC 317:30-5-240.3.

(D) **Process group therapy.** The focus of process group therapy must be directly related to goals and objectives on the individual member's plan of care. The individual member's behavior and the focus of the group must be included in each member's medical record. This service does not include social skills development or daily living skills activities and must take place in an appropriate confidential setting, limited to the therapist, appropriate hospital staff, and group members. Group therapy must be provided three hours per week in acute care and two hours per week in residential treatment by an LBHP or licensure candidate as defined in OAC 317:30-5-240.3. In lieu of one hour of process group therapy, one hour of expressive group therapy provided by an LBHP, licensure candidate, or Licensed Therapeutic Recreation Specialist may be substituted.

(E) **Transition/Discharge Planning.** Transition/discharge planning must be provided one hour per week in acute care and thirty minutes per week in residential and CBT. Transition/Discharge planning can be provided by any level of inpatient staff.

(2) **Elective services.**

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

with relevant training, experience, or certification to facilitate the therapy.

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

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

(D) **Recreation therapy.** Services will be provided to reduce psychiatric and behavioral impairment as well as to restore, remediate and rehabilitate an individual's level of functioning and independence in life activities. Services will also be provided in such a way as to promote health and wellness as well as reduce or eliminate the activity limitations and restrictions to participation in life situations caused by an illness or disabling condition. Recreational therapy can be provided in an individual or group setting. If the only activities prescribed for the individual are primarily diversional in nature, (i.e. to provide some social or recreational outlet for the individual), it will not be regarded as active treatment. If provided, recreational therapy must be a planned therapeutic activity, facilitated by a Licensed Therapeutic Recreation Specialist.

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

(F) **Wellness resource skills development.** Services include providing direction and coordinating support activities that promote good physical health. The focus of these activities should include areas such as nutrition, exercise, support with averting or managing physical health concerns like heart disease, diabetes, and cholesterol, and support regarding the effects of medications have on physical health. Services can include support groups, exercise

groups, and individual physical wellness plan development, implementation assistance and support.

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

(e) The expectation is that active treatment will occur regularly throughout the treatment week. A treatment week in Acute is based on the number of days of acute service, beginning the day of admission (day 1). Required active treatment components will be based upon the length of stay as described below. A treatment week in RTC, PRTF and CBT is considered to be a calendar week (i.e. Sunday through Saturday). When a child is admitted to RTC, PRTF or CBT level of care on a day other than Sunday, or discharges on a day other than Saturday, the week will be considered a partial week and services will be required as described below. Active treatment components ~~do not~~ may include assessments/evaluations to serve as the initial individual or family session if completed by an LBHP or licensure candidate. Start and stop time must be documented. Active treatment begins the day of admission. Days noted are calendar days.

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

(A) In acute, by day two, 1 visit is required. By day 4, 2 visits are required. By day 7, 3 visits are required.

(B) In RTC, PRTF or CBT, one visit during admission week is required. In RTCs, 1 visit during the admission week is required, then once a week thereafter. In PRTFs, one visit during the admission week is required, then once a week thereafter. In CBT, 1 visit is required within 7 days of admission. Individual treatment provided by the physician will never exceed 10 days between sessions in PRTFs, never exceed 7 days in a specialty PRTF and never exceed 30 days in CBTs. The completion of a psychiatric evaluation or a combined psychiatric evaluation and a History and Physical (H&P) evaluation may count as the first visit by the physician if the evaluation was personally rendered by the psychiatrist. If the member is admitted on the last day of the admission week, then the member must be seen by a physician within 24 hours of admission time.

(2) **Individual therapy.**

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

(B) In residential treatment (including PRTF and CBT), by day 6, 30 minutes of treatment must be documented. Beginning on day 7, 1 hour of treatment is required each week. The treatment week is defined as Sunday through Saturday. Individual therapy may not exceed a total of 10 days between sessions. This does not include admission

assessment/ evaluation or Psychosocial Evaluations unless personally (face to face) rendered by the LBHP or licensure candidate.

(3) **Family therapy.**

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

(B) In residential treatment (including PRTF and CBT), by day 6, 30 minutes of treatment must be documented. Beginning on day 7, 1 hour of treatment is required each week. This does not include admissions assessment/evaluation or Psychosocial Evaluations unless personally (face to face) rendered by the LBHP or licensure candidate and the assessment/evaluation or Psychosocial Evaluation has not been used to substitute the initial individual therapy requirement. Family therapy provided by the LBHP or licensure candidate should not exceed 10 days in between sessions.

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

317:30-5-95.41. Documentation of records for children's inpatient services

(a) All documentation for services provided under active treatment must be documented in an individual note and reflect the content of each session provided. Individual, Family, Process Group, Expressive Group, Individual Rehabilitative and Group Rehabilitative Services documentation must include, at a minimum, the following:

(1) date;
(2) start and stop time for each session;
(3) dated signature of the therapist and/or staff that provided the service;
(4) credentials of the therapist;
(5) specific problem(s) addressed (problems must be identified on the plan of care);
(6) method(s) used to address problems;
(7) progress made towards goals;
(8) member's response to the session or intervention; and
(9) any new problem(s) identified during the session.

(b) Signatures of the member, parent/guardian for members under the age of 18, doctor, Licensed Behavioral Health Professional (LBHP), and RN are required on the individual plan of care and all plan of care reviews. The individual plan of care and plan of care review are not valid until signed and separately dated by the member, parent/legal guardian for members under the age of 18, doctor, RN, LBHP, and all other requirements are met. All treatment team staff providing individual therapy, family therapy and process group therapy must sign the individual plan of care and all plan

of care reviews. All plans of care and plan of care reviews must be signed by the member upon completion, except when a member is too physically ill, or the member's acuity level precludes him/her from signing. If the member is too physically ill or the member's acuity level precludes him/her from signing the plan of care and/or the plan of care review at the time of completion, the member must sign the plan when his/her condition improves but before discharge. Documentation should indicate the reason the member was unable to sign and when the next review will occur to obtain the signature.

317:30-5-95.42. Service quality review of psychiatric facilities providing services to children

(a) The Service Quality Review conducted by OHCA or its designated agent meets the utilization control requirements as set forth in 42 CFR 456.

(b) There will be an on-site Service Quality Review (SQR) of each in-state psychiatric facility that provides care to SoonerCare eligible children which will be performed by the OHCA or its designated agent. Out-of-state psychiatric facilities that provide care to SoonerCare eligible children will be reviewed according to the procedures outlined in the ~~provider manual. The Oklahoma Health Care Authority will designate the members of the Service Quality Review team.~~ Medical Necessity Manual. OHCA or its designated agent may conduct ad hoc reviews. Ad hoc reviews may be conducted at the discretion of the agency.

(c) The Oklahoma Health Care Authority will designate the members of the Service Quality Review team. The SQR team will consist of one to three team members and will be comprised of Licensed Behavioral Health Professionals (LBHP) or Registered Nurses.

(d) The review will include observation and contact with members. The Service Quality Review will consist of members present or listed as facility residents at the beginning of the Service Quality Review visit as well as members on which claims have been filed with OHCA for acute or PRTF levels of care. The review includes validation of certain factors, all of which must be met for the services to be compensable.

(e) Following the on-site inspection, the SQR Team will report its findings to the facility. The facility will be provided with written notification if the findings of the review have resulted in any deficiencies. A copy of the final report will be sent to the facility's accrediting agency.

(f) Deficiencies found during the SQR may result in a partial per-diem recoupment or a full per-diem recoupment of the compensation received. The following documents are considered to be critical to the integrity of care and treatment, must be completed within the time lines designated in OAC 317:30-5-95.37, and cannot be substituted with any other evaluation/assessments not specifically mentioned:

(1) History and physical evaluation;
(2) Psychiatric evaluation;
(3) Psychosocial evaluation; and
(4) Individual Plan of Care.

(g) For each day that the History and Physical evaluation, Psychiatric evaluation, Psychosocial evaluation and/or Individual Plan of Care are not contained within the member's records, those days will warrant a partial per-diem recoupment.
(h) If the review findings have resulted in a partial per-diem recoupment of $50.00 per event, the days of service involved will be reported in the notification. If the review findings have resulted in full per-diem recoupment status, the non-compensable days of service will be reported in the notification. In the case of non-compensable days full per diem or partial per diem, the facility will be required to refund the amount.
(i) In the event that CMS recoups from OHCA an amount that exceeds the provider's liability for findings described in this Section, the provider will not be held harmless and will be required to reimburse OHCA the total federal amount identified by CMS and/or its designated audit contractor.
~~(j)Penalties of non-compensable days which are the result of the facility's failure to appropriately provide and document the services described herein, or adhere to applicable accreditation, certification, and/or state licensing standards, are not compensable or billable to the member or the member's family.~~(j)Penalties of non-compensable days which are the result of the facility's failure to appropriately provide and document the services described herein, or adhere to applicable accreditation, certification, and/or state licensing standards, are not compensable or billable to the member or the member's family.

AGENDA

15-61 Appeal process for contract terminations

TITLE 317: OKLAHOMA HEALTH CARE AUTHORITY

CHAPTER 2. GRIEVANCE PROCEDURES AND PROCESS

317:2-1-12. ~~For Cause provider contract suspension/termination appeals process~~For Cause and Immediate provider contract termination appeals process

This ~~Section~~section explains the appeals process for providers whose SoonerCare contracts have been ~~suspended/~~terminated by the OHCA for cause. ~~Those providers whose contracts have been affected by other OHCA actions cannot request an appeal of those measures. Contracts terminated or suspended for cause are either timed terminations (30, 60, or 90 day) or immediate terminations/suspensions. Paragraphs (1) and (2) apply to timed terminations/suspensions and paragraph (3) applies to immediate terminations.~~

(1) **~~Procedure for suspending/terminating provider's contract.~~30 day for cause termination.** Pursuant to the terms of all provider contracts with the OHCA, either party may terminate the contract for cause with a 30 day written notice to the other party.

(A) **Notice of proposed ~~suspension or~~ termination.** The OHCA will provide notice to the ~~medical services~~ provider of the proposed ~~suspension or~~ termination of ~~provider~~the provider's contract. The written notice of ~~suspension/~~termination will state:

(i) the reasons for the proposed ~~suspension/~~termination;

(ii) the date upon which the ~~suspension/~~termination will be effective; and

(iii) a statement that the ~~medical services~~ provider has a right to OHCA review prior to the ~~suspension/~~termination of the provider's contract (~~refer to subparagraph (B) of this paragraph)~~.

(B) **Right to OHCA review prior to ~~suspension/~~termination of provider contract.** Before the ~~medical services~~ provider's contract is ~~suspended or~~ terminated, the OHCA will give the ~~medical services~~ provider the opportunity to submit documents and written arguments against the ~~suspension/~~termination of the provider's contract. The provider's written response requesting a review must be submitted within 20 days from the date of the notice. If a written response is not received within 20 days, the notice of termination will become final and there will be no further right to review or appeal post-termination.

(C) **Notice of ~~suspension or~~ termination.**

(i) ~~After the review of the medical services provider's written response, the OHCA will make a final administrative decision subject to a post-suspension or termination hearing.~~After the OHCA review of the provider's written response, the OHCA will make a final administrative decision regarding the contract

termination.

(ii) ~~After the review of the medical services provider's written response, the OHCA will make a final administrative decision subject to a post-sanction hearing.~~ Should the OHCA decide ~~not to suspend or terminate~~that the provider's contract should not be terminated, the ~~medical services~~ provider will be notified in writing of the reasons for the OHCA's decision.

(iii) Should the OHCA make a decision to ~~suspend or~~ terminate the ~~medical services~~ provider's contract, the OHCA will send a subsequent notice stating:

(I) the reasons for the decision;

(II) the effective date of the ~~suspension or~~ termination of the contract; and

~~(III) the medical services provider's right to request a post-suspension or termination hearing; and~~

(III) the provider's right to request a post termination panel committee desk review within 20 days of the date of the termination letter.

~~(IV) the requirements and procedures for reinstatement.~~

~~(2) **Post-suspension/termination hearing**. After the effective date of the suspension or termination of the provider's contract, the medical services provider is entitled to receive a post-suspension or termination hearing. The hearing committee for the OHCA will be comprised of three members of the OHCA and two other members as appointed. The representative who investigated the case will not be a representative if an investigation was initiated or completed.~~

~~(A) After the provider's request for the post-suspension/termination hearing is made, a hearing date will be established. A certified letter will be sent to the provider giving notification of the hearing date and naming the contact person. The contact person will answer procedural questions about the hearing.~~

~~(B) Ten days prior to the hearing, the medical services provider will submit a brief written statement detailing the evidence which will be presented by the provider at the hearing. Such statement must detail the facts which will be refuted by the provider. The purpose of the hearing will be limited to issues raised in the letter of suspension or termination as the cause of suspending or terminating the provider contract.~~

~~(C) The provider may be represented by an authorized representative, with documentation to that effect, at the informal hearing and/or the provider may present testimony himself or herself and have witnesses present.~~

~~(D) At the conclusion of the hearing, a decision will be made by the Hearing Committee. The provider will be notified in writing of the decision within 20 days of the final day of the hearing. The decision letter will constitute the agency's final decision regarding the matter.~~

~~(3) **Notice of immediate suspension or termination**. The process below will be followed in the event of an immediate suspension or~~

~~termination:~~

~~(A) A notice described in paragraph (1)(A) will be sent to the provider, except there is no right to review prior to an immediate termination or suspension.~~

~~(B) A post suspension termination review will be conducted in accordance with paragraph (2) above.~~

(2) **Immediate termination.** The OHCA will provide notice to the provider of the termination of the provider's contract. The written notice of termination will state:

(A) the reasons for the proposed termination;

(B) the date upon which the termination will be effective; and

(C) a statement that the provider has a right to appeal the termination of the provider's contract in a post-termination panel committee desk review within 20 days of the date of the termination letter.

(3) **Post-termination panel committee desk review.** After the effective date of the termination of the provider's contract, the provider is entitled to receive a post-termination panel committee desk review. The panel review committee for the OHCA will be comprised of three (3) employees of the OHCA as designated by the Chief Executive Officer or his/her designee. Any OHCA employee who was involved with the underlying investigation of the provider's case for purpose of the termination will not be a panel review committee member. The purpose and scope of the panel committee desk review will be limited to issues raised in the OHCA's letter of termination as the basis of terminating the provider's contract. The panel committee does not have jurisdiction to hear issues not addressed in the termination notice.

(A) The provider must request a panel committee desk review within 20 days of the date of the termination letter. The provider must submit a brief written statement detailing the facts which are refuted by the provider. Any documentation the provider requests consideration of by the panel review committee must also be submitted with the written statement.

(B) The OHCA may submit any additional documents to the panel committee for the desk review that may contradict the documents submitted by the provider for the purposes of the desk review. Any additional information that OHCA submits to the panel review committee will also be provided to the provider.

(C) The panel review committee will issue a written decision regarding the provider's contract termination approximately 60 days from receipt of the provider's written statement and documentation.

(4) 60 day without cause termination. Pursuant to the terms of all provider contracts with the OHCA, either party may terminate the contract without cause with a 60 day written notice to the other party. As such, there is no right to appeal or review of a 60 day contract termination.

AGENDA

15-62 Staffing Ratio

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. 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. Admission requirements for services must be provided in accordance with 42 CFR 441.152 and 42 CFR 456.170. Additional information will be required for a SoonerCare compensable approval on enhanced treatment units or in special population programs.

(b) Staffing ratios shall always be present for each individual unit not by facility or program. Patients shall be grouped for accommodation by gender, age, and treatment needs. At a minimum, children, adolescent, and adult treatment programs shall be separate with distinct units for each population. A unit is determined by separate and distinct sleeping, living, and treatment areas often separated by walls and/or doors. A unit that does not allow clear line of site due to the presence of walls or doors is considered a separate unit. Each individual unit shall have assigned staff to allow for appropriate and safe monitoring of patients and to provide active treatment.

(c) In an acute care setting, at least one Registered Nurse (RN) must be on duty per unit at all times, with additional RNs to meet program needs. RNs must adhere to Oklahoma Department of Health policy at OAC 310:667-15-3 and OAC 310:667-33-2(a)(3).

~~(c)~~(d) Regular residential treatment programs require a staffing ratio of 1:6 during routine waking hours and 1:8 during time residents are asleep with 24 hour nursing care supervised by an RN for management of behaviors and medical complications. At a minimum, the supervising RN must be available by phone and on-site within one hour. If the supervising RN is off-site, then an RN or LPN must be on-site to adhere to a 24 hour nursing care coverage ratio of 1:30 during routine waking hours and 1:40 during time residents are asleep.

~~(d)~~(e) Specialty residential treatment at this level is a longer term treatment that requires a higher staff to member ratio because of the need for 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.

~~(e)~~(f) A PRTF will not be considered a specialty treatment program for SoonerCare without prior approval of the OHCA behavioral health unit.
~~(f)~~(g) 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.
~~(g)~~(h) Criteria for classification as a specialized PRTF will require a staffing ratio of 1:3 at a minimum during routine waking 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).

~~(h)~~(i) Non-authorized inpatient psychiatric services will not be SoonerCare compensable.

~~(i)~~(j) The designated agent will prior authorize all services for an approved length of stay based on the medical necessity criteria described in OAC 317:30-5-95.25 through 317:30-5-95.31.

~~(j)~~(k) 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.

~~(k)~~(l) 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 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®) 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.

AGENDA

15-65 Behavioral Health Admission Assessment and Evaluations

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 6. Inpatient Psychiatric Hospital

317:30-5-95.35. Credentialing requirements for treatment team members for children

(a) The team developing the individual plan of care for the child must include, at a minimum, the following:

(1) Allopathic or Osteopathic Physician with a current license and a board certification/eligible in psychiatry, or a current resident in psychiatry practicing as described in OAC 317:30-5-2(a)(1)(U), and

(2) a behavioral health professional licensed to practice by one of the following boards: Psychology (health service specialty only); Social Work (clinical specialty only); Licensed Professional Counselor, Licensed Behavioral Practitioner; Licensed Alcohol and Drug Counselor (LADC), (or) Licensed Marital and Family Therapist or Advanced Practice Nurse (certified in a psychiatric mental health specialty, licensed as a registered nurse with a current certification of recognition from the Board of Nursing in the state in which the services are provided), and

(3) a registered nurse with a minimum of two years of experience in a mental health treatment setting.

(b) Candidates for licensure for Licensed Professional Counselor, Social Work (clinical specialty only), Licensed Marital and Family Therapist, Licensed Behavioral Practitioner, Licensed Alcohol and Drug Counselor and Psychology (health services specialty only) can provide assessments, psychosocial evaluations, individual therapy, family therapy and process group therapy as long as they are involved in the supervision that complies with their respective approved licensing regulations and the Department of Health and their work must be co-signed and dated by a licensed LBHP who is additionally a member on the treatment team. Individuals who have met their supervision requirements and are waiting to be licensed by one of the licensing boards in OAC 317:30-5-95.35(a)(1) must have their work co-signed by a licensed MHP who is additionally a member on the treatment team. All co-signatures by fully licensed LBHPs must be accompanied by the date that the co-signature was made. Documentation of the service is not considered complete until it is signed and dated by a fully licensed LBHP.

(c) Services provided by treatment team members not meeting the above credentialing requirements are not SoonerCare compensable and can not be billed to the SoonerCare member.

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

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

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

(A) History and physical evaluation must be completed within 24 hours of admission by a licensed independent practitioner (M.D., D.O., A.P.N., or P.A.) and within 7 days in a CBT.

(B) Psychiatric evaluation must be completed within 60 hours of admission by an allopathic or osteopathic physician with a current license and a board certification/eligible in psychiatry and within 7 calendar days in a CBT.

(C) Psychosocial evaluation must be completed within 72 hours of an acute admission, within seven calendar days of admission to a PRTF and within 7 calendar days in a CBT by a licensed independent practitioner (M.D., D.O., A.P.N., or P.A.), a licensed behavioral health professional (LBHP), or Licensure Candidate as defined in OAC 317:30-5-240.3.

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

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

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

AGENDA

15-66 Application Process for Military Personnel

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 or certain persons with related conditions

(a) **Applicability.** The rules in this Section apply to services funded through Medicaid HCBS Waivers per Oklahoma Administrative Code (OAC) 317:35-9-5 and per Section 1915(c) of the Social Security Act. The specific ~~waivers~~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 an HCBS Waiver and his or her family or guardian are responsible for:

(1) accessing, with the assistance of ~~OKDHS~~the Oklahoma Department of Human Services (DHS) 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;

(3) choosing between services provided through ~~a~~an HCBS Waiver and institutional care; and

(4) reporting to DHS within 30 calendar days of moving any changes in address or other contact information.

(c) **Waiver ~~Eligibility~~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 (1)(A),(B), or (C) of this Subsection.

(1) Services provided through an 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 (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 per Section 1-819 of Title 63 of the Oklahoma Statutes (63 O.S. § 1-819), or Intermediate Care facility for individuals with intellectual disabilities (ICF/IID). The individual may not be receiving

Developmental Disabilities Services (DDS) 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~~Waiver supports per OAC 340:100-5-22.2. The individual must also meet other Waiver-specific eligibility criteria.

(A) **In-Home Supports Waivers(IHSW).** To be eligible for services funded through the ~~In-Home Supports Waiver (IHSW)~~IHSW, a person must:

(i) meet all criteria listed in (c) of this Section; and

(ii) be determined to have a disability and a diagnosis of intellectual disability by the Social Security Administration (SSA); or

(iii) be determined to have a disability, and a diagnosis of intellectual disability as defined in the Diagnostic and Statistical Manual of Mental Disorders by the ~~OHCA~~Oklahoma Health Care Authority (OHCA) Level of Care Evaluation Unit (LOCEU);

(iv) be ~~three~~3 years of age or older;

(v) be determined by the OHCA/LOCEU to meet the ICF/IID 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) a DHS Child Welfare ~~Service~~Services (CWS) foster home or shelter; or

(IV) a CWS 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 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 listed in (c) of this Section;

(ii) be determined to have a disability and a diagnosis of intellectual disability by the SSA; or

(iii) have an intellectual disability as defined in the Diagnostic and Statistical Manual of Mental Disorders or a related condition by DDS and 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 as defined in the Diagnostic and Statistical Manual of Mental Disorders or the OHCA/LOCEU; and

(v) be ~~three~~3 years of age or older; and

(vi) be determined by the OHCA/LOCEU, to meet the ICF/IID 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 DDS 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 listed in (c) of this Section; and

(iii) be determined to have a disability and a diagnosis of intellectual disability by SSA; or

(iv) have an intellectual disability as defined in the Diagnostic and Statistical Manual of Mental Disorders or a related condition per OAC 317:35-9-45 by DDS, 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 as defined in the Diagnostic and Statistical Manual of Mental Disorders by the OHCA/LOCEU; and

(vi) meet ICF/IID 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 (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 that includes:

(i) a ~~full scale~~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~~full-scale, intelligence quotient.

(I) Intelligence testing results obtained at 16 years of age or older are considered valid of the current status, provided they are compatible with current behavior. Intelligence testing results obtained between 7 to 16 years of age are considered current for four years when the full scale intelligence quotient is less than 40, and for two years when the intelligence quotient is 40 or above.

(II) DDS may require a current psychological evaluation when a significant change of condition, disability, or psychological status is noted;

(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 calendar~~90-calendar days of requested approval date; and

(D) a completed ICF/IID Level of Care Assessment form (LTC-300); and

(E) proof of disability according to SSA guidelines. ~~If~~When a disability determination ~~has~~is not ~~been~~ made by SSA, OHCA/LOCEU may make a disability determination using the same guidelines as SSA.

(3) OHCA reviews the diagnostic reports listed in (2) of this subsection and makes a determination of eligibility for DDS HCBS Waivers.

(4) For individuals who are determined to have an intellectual disability or a related condition by DDS ~~in accordance with~~per the State's alternative disposition plan adopted under Section 1919(e)(7)(E) of the Social Security Act, DDS reviews the diagnostic reports listed in (2) of this subsection and, on behalf of ~~the~~ OHCA, makes a determination of eligibility for DDS HCBS Waiver services and ICF/IID level of care.

(5) A determination of need for ICF/IID 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 DDS resources are unavailable for new persons to be added to services funded through an 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 on Form 06MP001E, Request for Developmental Disabilities Services. The applicant must submit the required documentation per Form 06MP001E, Request for Developmental Disabilities Services for initial consideration of potential eligibility. Active United States Armed Forces personnel, who have a pending HCBS Waiver application in another state for an immediate family member, may be placed on the list in accordance with the date they applied in the other state. The person's name is added to the list when they provide proof of application date from the other state.

(2) The Request for Waiver Services List for persons requesting services provided through an HCBS Waiver is administered by DDS uniformly throughout the state.

(3) An individual is removed from the Request for Waiver Services List when the individual:

(A) is found to be ineligible for services;

(B) cannot be located by DHS;

(C) fails to respond or does not provide requested information to DHS;

(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.

(4) An individual removed from the Request for Waiver Services List due to the inability to locate the individual by DHS, may later submit the DDS a written request to be returned to the Request for Waiver Services List. The individual ~~will be~~is returned at the same chronological place on the Request for Waiver Services List that the individual had prior to removal, provided ~~that~~ the individual was on the list prior to

January 1, 2015.

(e) **Applications.** When resources are sufficient for initiation of HCBS Waiver services, DDS ensures action regarding a request for services occurs within ~~45 calendar~~45-calendar days. When action is not taken within the required ~~45 calendar~~45-calendar days, the applicant may seek resolution per OAC 340:2-5.

(1) Applicants are allowed ~~60 calendar~~60-calendar days to provide information requested by DDS to determine eligibility for services.

(2) When requested information is not provided within ~~60 calendar~~60-calendar days, the applicant is notified that the request was denied, and the individual is removed from the Request for Waiver Services List.

(f) **Admission protocol.** Initiation of services funded through an HCBS Waiver occurs in chronological order from the Request for Waiver Services List ~~in accordance with~~per (d) of this Section based on the date of DDS receipt of a completed request for services, as a result of the informed choice of the person requesting services or the individual acting on the member's behalf, and upon determination of eligibility, ~~in accordance with~~per (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:~~per 43A O.S. § 10-103:

(I) is hospitalized;

(II) 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) DHS finds 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 an HCBS Waiver;

(3) Waiver services are required for people who transition to the community from a public ~~or~~ ICF/IID or who are children in the State's custody receiving services from DHS. 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/IID and enters the Waiver;

(4) individuals subject to the provisions of Public Law 100-203 residing in nursing facilities for at least ~~30 continuous~~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~~per Title 42 Section 483.100 of the Federal Code of Regulations to have an intellectual disability 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 DDS HCBS Waiver programs.** A person's movement from services funded through one DDS-administered HCBS Waiver, to services funded through another DDS-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 health and safety support needs that cannot be met by IHSW services, non-Waiver services, or other resources as determined by the DDS 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~~was within the IHSW 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~~was 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 the level of care per OAC 317:30-5-122 and confirms a diagnosis of intellectual disability ~~as defined in~~per the Diagnostic and Statistical Manual of Mental Disorders. DDS may require a new psychological evaluation and re-determination of eligibility at any time when a significant change of condition, disability, or psychological status ~~has~~

~~been~~is noted.

(i) **HCBS Waiver services case closure.** Services provided through an HCBS Waiver are terminated, when:

(1) a member or the individual action on the member's behalf chooses to no longer receive Waiver services;
(2) a member is incarcerated;
(3) a member is financially ineligible to receive Waiver services;
(4) a member is determined by the Social Security Administration to no longer have a disability qualifying the individual for services under these Waivers;
(5) a member is determined by the OHCA/LOCEU to no longer be eligible;
(6) a member moves out of state, or the custodial parent or guardian of a member who is a minor moves out of state;
(7) a member is admitted to a nursing facility, ICF/IID, residential care facility, hospital, rehabilitation facility, or mental health facility for more than 30 consecutive calendar days;
(8) the guardian of a member who is a minor or adjudicated adult fails to cooperate during the annual review process per OAC 340:100-5-50 through 340:100-5-58;
(9) the guardian of a member who is a minor or adjudicated adult fails to cooperate in the implementation of DHS 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~~were not ~~been~~ effective;
(10) the member is determined to no longer be SoonerCare eligible; ~~or~~
(11) there is sufficient evidence the member or the individual acting on the member's behalf ~~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) the member or the individual action on the member's behalf either cannot be located, ~~has~~did not ~~responded~~respond to, or ~~has~~did not ~~allowed~~allow case management to complete plan development or monitoring activities as required by policy and the member or the individual action on the member's behalf:
  (A) does not respond to the notice of intent to terminate; or
  (B) the response prohibits the case manager from being able to complete plan development or monitoring activities as required by policy;
(13) the member or the individual action on the member's behalf fails to cooperate with the case manager to implement a Fair Hearing decision;
(14) it is determined ~~that~~ services provided through an HCBS Waiver are no longer necessary to meet the member's needs and professional documentation provides assurance the member's health, safety, and welfare can be maintained without Waiver supports;
(15) the member or the individual acting on the member's behalf fails to cooperate with service delivery;
(16) a family member, the individual acting on the member's behalf, other individual in the member's household, or persons who routinely

visit, pose a threat of harm or injury to provider staff or official DHS representatives; or

(17) a member no longer receives a minimum of one Waiver service per month and DDS 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 calendar~~90-calendar days or less;

(3) a member is admitted to a nursing facility, ICF/IID, residential care facility, hospital, rehabilitation facility, or mental health facility for ~~90 calendar~~ 90-calendar days or less; or

(4) a member's SoonerCare eligibility is re-established within ~~90 calendar~~90-calendar days of the ~~date of~~ SoonerCare ineligibility~~.~~date.

AGENDA

Informational Items Only

Access Monitoring Review Plan

CMS recently issued a final rule directing State Medicaid programs to analyze and monitor access to care for Medicaid fee-for-service programs. Through an access monitoring review plan, the State will demonstrate access to care by measuring the following: enrollee needs; the availability of care and providers; utilization of services; characteristics of the enrolled members, and estimated levels of provider payment from other payers. The plan must be created in consultation with the Medical Advisory Committee and be published and made available to the public for a period of no less than 30 days prior to being submitted to CMS. The final rule instructs the State to submit the initial access monitoring review plan on July 1, 2016; the State will have to provide CMS a renewed plan noting any access issues and how the State resolved the issues every 5 years. Further, the state must conduct and submit an access monitoring review plan when promulgating a State Plan Amendment that affects payment methodology and/or rates.

AGENDA

<u>Oklahoma Health Care Authority</u>
Medical Advisory Committee

March 10, 2016

Access Monitoring Review Plan Outline

The OHCA's access monitoring review plan (AMRP) analyzes and evaluates access to care for services covered through the Medicaid state plan and reimbursed on a Fee-for-Service basis. The final report will be submitted to CMS on Friday, July 1, 2016 pursuant to 42 CFR 447.203 through 42 CFR 447.205 (attached). A list of the contents within the AMRP is listed below.

- Executive Summary
    - Conclusion
- Overview
    - Methodology
- Beneficiary Population
    - Access concerns raised by beneficiaries
    - Beneficiary perceptions of access to care
    - Comparison analysis of Medicaid payment rates to Medicare and other payers
- Review Analysis of Primary Care Services
- Review Analysis of Physician Specialists
- Review Analysis of Behavioral Health Services
- Review Analysis of Pre- and Post-Natal Obstetric Services
- Review Analysis of Home Health Services
    - SoonerRide
- Review Analysis of Hospital Services

PART 447—PAYMENTS FOR SERVICES

1.The authority citation for part 447 continues to read as follows:

Authority: Sec. 1102 of the Social Security Act (42 U.S.C. 1302).

2.Section 447.203 is amended by revising the section heading and paragraph (b) to read as follows:

§ 447.203 Documentation of access to care and service payment rates.

* * * * *

(b) In consultation with the medical care advisory committee under § 431.12 of this chapter, the agency must develop a medical assistance access monitoring review plan and update it, in accordance with the timeline established in paragraph (b)(5) of this section. The plan must be published and made available to the public for review and comment for a period of no less than 30 days, prior to being finalized and submitted to CMS for review.

(1) *Access monitoring review plan data requirements.* The access monitoring review plan must include an access monitoring analysis that includes: Data sources, methodologies, baselines, assumptions, trends and factors, and thresholds that analyze and inform determinations of the sufficiency of access to care which may vary by geographic location within the state and will be used to inform state policies affecting access to Medicaid services such as provider payment rates, as well as the items specified in this section. The access monitoring review plan must specify data elements that will support the state's analysis of whether beneficiaries have sufficient access to care. The plan and monitoring analysis will consider:

(i) The extent to which beneficiary needs are fully met;

(ii) The availability of care through enrolled providers to beneficiaries in each geographic area, by provider type and site of service;

(iii) Changes in beneficiary utilization of covered services in each geographic area.

(iv) The characteristics of the beneficiary population (including considerations for care, service and payment variations for pediatric and adult populations and for individuals with disabilities); and

(v) Actual or estimated levels of provider payment available from other payers, including other public and private payers, by provider type and site of service.

(2) *Access monitoring review plan beneficiary and provider input.* The access monitoring review plan must include an analysis of data and the state's conclusion of the sufficiency of access to care that will consider relevant provider and beneficiary information, including information obtained through public rate-setting processes, the medical care advisory committees established under § 431.12 of this chapter, the processes described in paragraph (b)(7) of this section, and other mechanisms (such as letters from providers and beneficiaries to State or Federal officials), which describe access to care concerns or suggestions for improvement in access to care.

(3) *Access monitoring review plan comparative payment rate review.* For each of the services reviewed, by the provider types and sites of service (e.g. primary care physicians in office settings) described within the access monitoring analysis, the access monitoring review plan must include an analysis of the percentage

comparison of Medicaid payment rates to other public (including, as practical, Medicaid managed care rates) and private health insurer payment rates within geographic areas of the state.

(4) *Access monitoring review plan standards and methodologies.* The access monitoring review plan and analysis must, at a minimum, include: The specific measures that the state uses to analyze access to care (such as, but not limited to: Time and distance standards, providers participating in the Medicaid program, providers with open panels, providers accepting new Medicaid beneficiaries, service utilization patterns, identified beneficiary needs, data on beneficiary and provider feedback and suggestions for improvement, the availability of telemedicine and telehealth, and other similar measures), how the measures relate to the access monitoring review plan described in paragraph (b)(1) of this section, baseline and updated data associated with the measures, any issues with access that are discovered as a result of the review, and the state agency's recommendations on the sufficiency of access to care based on the review. In addition, the access monitoring review plan must include procedures to periodically monitor access for at least 3 years after the implementation of a provider rate reduction or restructuring, as discussed in paragraph (b)(6)(ii) of this section.

(5) *Access monitoring review plan timeframe.* Beginning July 1, 2016 the State agency must:

(i) Develop its access monitoring review plan by July 1 of the first review year, and update this plan by July 1 of each subsequent review period;

(ii) For all of the following, complete an analysis of the data collected using the methodology specified in the access monitoring review plan in paragraphs (b)(1) through (4) of this section, with a separate analysis for each provider type and site of service furnishing the type of service at least once every 3 years:

(A) Primary care services (including those provided by a physician, FQHC, clinic, or dental care).

(B) Physician specialist services (for example, cardiology, urology, radiology).

(C) Behavioral health services (including mental health and substance use disorder).

(D) Pre- and post-natal obstetric services including labor and delivery.

(E) Home health services.

(F) Any additional types of services for which a review is required under paragraph (b)(6) of this section;

(G) Additional types of services for which the state or CMS has received a significantly higher than usual volume of beneficiary, provider or other stakeholder access complaints for a geographic area, including complaints received through the mechanisms for beneficiary input consistent with paragraph (b)(7) of this section; and

(H) Additional types of services selected by the state.

(6) *Special provisions for proposed provider rate reductions or restructuring*— (i) Compliance with access requirements. The State shall submit with any State plan amendment that proposes to reduce provider payment rates or restructure provider payments in circumstances when the changes could result in diminished access, an access review, in accordance with the access monitoring review plan, for each service affected by the State plan amendments as described under paragraph (b)(1) of this section completed within the prior 12 months.That access review must demonstrate sufficient access for any service for which the state agency proposes to reduce payment rates or restructure provider payments to demonstrate compliance with the access requirements at section 1902(a)(30)(A) of the Act.

(ii) *Monitoring procedures.* In addition to the analysis conducted through paragraphs (b)(1) through (4) of this section that demonstrates access to care is sufficient as of the effective date of the State plan amendment, a state must establish procedures in its access monitoring review plan to monitor continued access to care after implementation of state plan service rate reduction or payment restructuring. The frequency of monitoring should be informed by the public review described in paragraph (b) of this section and should be conducted no less frequently than annually.

(A) The procedures must provide for a periodic review of state determined and clearly defined measures, baseline data, and thresholds that will serve to demonstrate continued sustained service access, consistent with efficiency, economy, and quality of care.

(B) The monitoring procedures must be in place for a period of at least 3 years after the effective date of the state plan amendment that authorizes the payment reductions or restructuring.

(7) *Mechanisms for ongoing beneficiary and provider input.* (i) States must have ongoing mechanisms for beneficiary and provider input on access to care (through hotlines, surveys, ombudsman, review of grievance and appeals data, or another equivalent mechanisms), consistent with the access requirements and public process described in § 447.204.

(ii) States should promptly respond to public input through these mechanisms citing specific access problems, with an appropriate investigation, analysis, and response.

(iii) States must maintain a record of data on public input and how the state responded to this input. This record will be made available to CMS upon request.

(8) *Addressing access questions and remediation of inadequate access to care.* When access deficiencies are identified, the state must, within 90 days after discovery, submit a corrective action plan with specific steps and timelines to address those issues. While the corrective action plan may include longer-term objectives, remediation of the access deficiency should take place within 12 months.

(i) The state's corrective actions may address the access deficiencies through a variety of approaches, including, but not limited to: Increasing payment rates, improving outreach to providers, reducing barriers to provider enrollment, proving additional transportation to services, providing for telemedicine delivery and telehealth, or improving care coordination.

(ii) The resulting improvements in access must be measured and sustainable.

3.Section 447.204 is revised to read as follows:

§ 447.204 Medicaid provider participation and public process to inform access to care.

(a) The agency's payments must be consistent with efficiency, economy, and quality of care and sufficient to enlist enough providers so that services under the plan are available to beneficiaries at least to the extent that those services are available to the general population. In reviewing payment sufficiency, states are required to consider, prior to the submission of any state plan amendment that proposes to reduce or restructure Medicaid service payment rates:

(1) The data collected, and the analysis performed, under § 447.203.

(2) Input from beneficiaries, providers and other affected stakeholders on beneficiary access to the affected services and the impact that the proposed rate change will have, if any, on continued service access. The state should maintain a record of the public input and how it responded to such input.

(b) The state must submit to CMS with any such proposed state plan amendment affecting payment rates:

(1) Its most recent access monitoring review plan performed under § 447.203(b)(6) for the services at issue;

(2) An analysis of the effect of the change in payment rates on access; and

(3) A specific analysis of the information and concerns expressed in input from affected stakeholders.

(c) CMS may disapprove a proposed state plan amendment affecting payment rates if the state does not include in its submission the supporting documentation described in paragraph (b) of this section, for failure to document compliance with statutory access requirements. Any such disapproval would follow the procedures described at part 430 Subpart B of this title.

(d) To remedy an access deficiency, CMS may take a compliance action using the procedures described at § 430.35 of this chapter.

4.Section 447.205 is amended by adding paragraph (d)(2)(iv) to read as follows:

§ 447.205 Public notice of changes in Statewide methods and standards for setting payment rates.

* * * * *

(d) * * *

(2) * * *

(iv) A Web site developed and maintained by the single State agency or other responsible State agency that is accessible to the general public, provided that the Web site:

(A) Is clearly titled and can be easily reached from a hyperlink included on Web sites that provide general information to beneficiaries and providers, and included on the State-specific page on the Federal Medicaid Web site.

(B) Is updated for bulletins on a regular and known basis (for example, the first day of each month), and the public notice is issued as part of the regular update;

(C) Includes the actual date it was released to the public on the Web site; or

(D) Complies with national standards to ensure access to individuals with disabilities; and

(E) Includes protections to ensure that the content of the issued notice is not modified after the initial publication and is maintained on the Web site for no less than a 3-year period.

AGENDA