Oklahoma Health Care Authority
MEDICAL ADVISORY COMMITTEE

AGENDA

January 18th, 2018
1:00 PM – 3:30 PM

Charles Ed McFall Board Room

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

II. Action Item: Approval of Minutes of the November 16th, 2017: **Medical Advisory Committee Meeting**

III. Public Comments (2 minute limit)

IV. MAC Member Comments/Discussion:

V. SoonerCare Operations Update: **Melissa McCully, Director of Insure Oklahoma**

VI. Legislative Update: **Cate Jeffries, Interim Legislative Liaison**

VII. Financial Report: **Carrie Evans, Chief Financial Officer**

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

- **A. 17-15 - Student Earned Income Exclusion for Aged, Blind and Disabled (ABD) Applicants**
- **B. 17-17 - Indian Health Services, Tribal Program and Urban Indian Clinics (I/T/U) Current Procedural Terminology (CPT) Language Removal**
- **C. 17-19 - Inpatient Behavioral Health Revisions**
- **D. 17-20 - Grandfathered CHIP children**
- **E. 17-23 - Breast and Cervical Cancer (BCC) Benefit Update**
- **F. 17–24A - ADvantage Waiver Revisions**
- **G. 17–24B - ADvantage Waiver Revisions**
- **H. 17–25A - Developmental Disabilities Services (DDS) Revisions**
- **I. 17–25B - Developmental Disabilities Services (DDS) Revisions**
- **J. 17-28 - Federally Qualified Health Center Services (FQHC) Alternative Payment Methodology (APM)**
- **K. 17-33 A and B - Nursing Home Supplemental Payment Program Revisions**

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

X. Discussion Items Only: **Tywanda Cox, Chief of Federal and State Policy**

- **A.** 1115(a) waiver amendment for supplemental payments for residency training programs and

B. loan repayment

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

XII. Future Meeting:
March 15th, 2018
May 17th, 2018
July 19th, 2018
September 20th, 2018
November 15th, 2018

XIII. Adjourn

Oklahoma Health Care Authority
MEDICAL ADVISORY COMMITTEE
MINUTES of the November 16th, 2017 Meeting
4345 N. Lincoln Blvd., Oklahoma City, OK 73105

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

Chairman Steven Crawford called the meeting to order at 1:45 PM.

***Delegates present were*:** Ms. Teresa Bierig, Ms. Debra Billingsley, Dr. Kenneth Calabrese, Dr. Joe Catalano, Mr. Victor Clay, Mr. Brett Coble, Dr. Steve Crawford, Ms. Wanda Felty, Dr. Don Flinn, Dr. Arlen Foulks, Dr. John Linck, Ms. Annette Mays, Dr. Ashley Orynich, Mr. James Patterson, Dr. Edd Rhoades, Dr. Jason Rhynes, Dr, Raymond Smith, Dr. Dwight Sublett, Mr. Rick Snyder, Mr. Jeff Tallent, and Dr. Paul Wright.

Alternates present were: Mr. Traylor Rains-Sims

***Delegates absent without an alternate were*:** Ms. Renee Banks, Ms. Mary Brinkley, Ms. Terri Fritz, Mr. Steve Goforth, Mr. Mark Jones, Dr. J. Daniel Post, and Ms. Toni Pratt-Reid.

II. Approval of the amended July 20th, 2017 Minutes

Medical Advisory Committee
The motion to approve the minutes was by Ms. Teresa Bierig and seconded by Dr. Dwight Sublett and passed unanimously.

Action Item: Approval of Minutes for the September 21st, 2017 meeting:
Medical Advisory Committee
The motion to approve the minutes was by Ms. Teresa Bierig and seconded by Dr. Dwight Sublett and passed unanimously.

III. Financial Update:

Gloria Hudson, Director of General Accounting

Ms. Gloria Hudson reported on the state's Fiscal Year 2018 financial transactions through the month of September. She reported that the state budget variance is a positive $ 0.6 million dollars. On the expenditure side, Medicaid Program is under budget $0.8 million state dollars and in administration $1.2 million state dollars. On the revenue side, OHCA is at budget in both drug rebate collections and settlements/ overpayment's and over budget in tobacco tax collections and fees for $1.4 million state dollars.

Currently, the State of Oklahoma is facing a multi-million ($215 million) budget shortfall. Legislative leaders are meeting in special session to address this. At present, no agreement has been reached and the loss of state share appropriations to OHCA remains at $70 million dollars. In October, OHCA filed an amended 2018 budget as required. (Article 10, Section 23 of the Oklahoma Constitution)

In the amended budget, our August positive variance of $8.2 million dollars, $12 million in prior year carryover, and 2017 General Revenue Return of $4.6 million dollars and other cost saving measures were presented. In addition, effective December 1, 2017, provider rate reductions of 9% with certain exclusions, elimination of payments for Medicare Part A and B coinsurance and deductibles on crossover claims for nursing facilities, and approximately 4% rate reduction to nursing facilities were also presented to fill the deficit.

IV. SoonerCare Operations Update:

Casey Dunham, Director of Provider Services

Mr. Dunham presented the SoonerCare Operations Update to the committee. He presented information based on data for September of 2017. Patient Centered Medical Home enrollment is at 538,419 which is 3,448 less than May. Sooner Care Traditional has a current enrollment of 234,075 which is 2,384 less than May. SoonerPlan is down by 1,685, giving a total of 32,075. Insure Oklahoma has a total enrollment of 19,263 of which 5,187 are in the Individual Plan and 14,076 are in the Employee Sponsored Plan. In total, SoonerCare enrollment is at 823,832 for September which is a decrease of 8,066.

A. **TSET Update**: Della Gregg, Population Care Management; Kelly Parker, SoonerQuit Health Promotion Supervisor
Adult smoking rates in Oklahoma are down 19%, which means 72,000 fewer adults are smoking. We have also moved from 45th place up to 36th place. The Medicaid adult smoking rate is at 34%, which is down from 36%. For more detailed information see agenda item 4A.

V. Legislative Update:

Cate Jeffries, Interim Legislative Liaison

Ms. Jeffries provided an update on a new appropriations bill that was introduced in the legislative Special Session. House Bill 1019 would collect dollars from various revolving funds and redistribute the funds to some state agencies and trigger cuts to others. HB 1019 passed both House and Senate Joint Committees on Appropriations & Budget on Tuesday, Nov. 14. It was heard on the House floor on Wednesday, Nov. 15, and passed 56-38. The Senate is expected to take up the bill on Friday, Nov. 17.

If HB 1019 passes the Senate and is signed by the Governor, it appears OHCA's state fiscal year (SFY) 2018 base will be reduced by approximately $15 million as opposed to the $70 million that was planned for in light of the Supreme Court's overturning the smoking cessation fee.

In anticipation of the $70 million reduction and in order to submit a balanced budget, the OHCA has already taken several budget balancing actions. First, the agency developed several program changes to be implemented in SFY18 that produced savings of approximately $3.2 million for SFY18. In addition, $4.65 million in 2017 general revenue was returned to the agency in 2018. The agency had $12 million in carryover from SFY17 to use. These combined savings equate to approximately $19.85 million.

Last week, the OHCA board approved across-the-board provider rate reductions of 9 percent and 4 percent for nursing facilities as well as eliminating Medicare crossover coinsurance and deductible payments for nursing facilities to be effective Dec. 1. These actions were taken to help cover the remainder of the $70 million base reduction.

If the OHCA's SFY18 base is reduced by $15 million, the program changes and SFY17 savings and revenue return are sufficient to cover the reduction.

The OHCA has scheduled a State Plan Amendment Rate Committee (SPARC) meeting for Dec. 1 to amend provider rate reductions if needed. The agency anticipates we will be able to reverse each of the rate reductions approved last week.

We are still awaiting a reauthorization on CHIP at the federal level. A bill was passed by the House a couple of weeks ago; however, it's unclear if the Senate will it hear because there are some disagreements. The agency does expect to be able to operate the program through April. That would require OHCA to request redistributed funds from CMS in January. OHCA is looking at a stand-alone program called Soon-to-be-Sooners for pregnant women and the CHIP-funded portion of Insure Oklahoma Employer-Sponsored Insurance subsidies for dependent children.

VI. <u>Proposed Rule Changes:</u>

Tywanda Cox, Chief of Federal and State Policy

Face-to-face tribal consultations regarding the following proposed changes were held on Tuesday, September 5, 2017, Thursday, October 19, 2017, and Tuesday, November 7, 2017 in the Board Room of the Oklahoma Health Care Authority (OHCA).

APA work folders 17-10A and 17-10B were posted on the OHCA public website for a comment period from September 26, 2017 through October 26, 2017. APA work folder 17-12 was posted on the OHCA public website for a comment period from October 3, 2017 through November 2, 2017. APA work folder 17-18 was posted on the OHCA public website for a comment period from October 17, 2017 through November 16, 2017.

17-10A Expedited Appeals Revisions — The proposed revisions will clarify timelines for appeal decisions and add a new section outlining expedited appeals which are required by new regulations in cases when an appellant's life or health could be in jeopardy. The timelines and process for expedited appeals will be outlined in the new section of policy. In addition, language referring to nursing home wage enhancement will be deleted due to changes in state statute that resulted in the policy being obsolete.

Budget Impact: Budget neutral

The rule change motion to approve was by Mr. Jeff Tallent and seconded by Dr. Joe Catalano and passed unanimously.

17-10B Notification Policy Revisions — In order to avoid violation of state and/or federal law, the proposed revisions will move two sections, regarding notification processes, from the "SoonerCare for Pregnant Women and Families with Children" section to the "Eligibility and Countable Income" section of policy, as the notification policy applies to all SoonerCare programs. Federal regulations require the agency to communicate with members through the members' choice of electronic format or regular mail.

Budget Impact: Budget neutral

The rule change motion to approve was by Mr. Jeff Tallent and seconded by Dr. Joe Catalano and passed unanimously.

17-12 Wage Enhancement Policy Revisions — The proposed revisions will remove wage enhancement language and requirements for specified employees in nursing facilities (NF) serving adults and intermediate care facilities for individuals with intellectual disabilities (ICFs/IIDs). The revisions are necessary to comply with changes in state statute which repealed Title 63 Section 5022 and 5022.1. The change in state statue became effective July 1, 2017. The federal minimum wage and the change in rate setting methodology increased the wages for employees of NFs serving adults and ICFs/IIDs, resulting in the policy being obsolete.

Budget Impact: Budget neutral

The rule change motion to approve was by Dr. Arlen Foulks and seconded by Dr. Joe Catalano and passed unanimously.

17-18 Therapeutic Leave Days Revisions — The proposed revisions will eliminate therapeutic leave days for children and adults who reside in long-term care facilities with the exception of Intermediate Care Facilities serving Individuals with Intellectual Disabilities. Without the recommended revisions, the OHCA is at risk of exhausting its State appropriated dollars required to maintain the SoonerCare program.

Budget Impact: The OHCA anticipates that the proposed changes would result in approximately $24,541 state share savings for SFY2018, which would enable OHCA to file a balanced budget.

The rule change motion to approve was by Mr. Jeff Tallent and seconded by Dr. Arlen Foulks and passed unanimously.

VII. Discussion Item Only:

Tywanda Cox, Chief of Federal and State Policy

A. Nursing Facility Supplemental Payment Program

Ms. Cox gave an update on the Nursing facility supplemental payment program. MAC approved the rules, and a state plan amendment was submitted, however, it was denied. We were unable to implement the program. Since being denied we have been working with nursing home associations and NSGOs to develop a new program and resubmit a state plan that can be approved. We will submit the new rules to the members of the MAC for your feedback and consideration.

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

A. Election of Chairman and Co-Chairman

Dr. Steven Crawford made a motion for the election of officers for 2018. Dr. Steven Crawford was nominated for Chair by Dr. Paul Wright and seconded by Dr. Jason Rhynes and passed unanimously. Mr. Steve Goforth was nominated as Vice-Chair by Dr. Paul Wright and seconded by Dr. Joe Catalano, and passed unanimously.

IX. Future Meeting

January 18th, 2018

X. Adjournment

Dr. Crawford asked for a motion to adjourn. Motion was provided by Dr. Joe Catalano and seconded by Ms. Annette Mays. There was no dissent and the meeting was adjourned at 3:01p.m.

OHCA MAC Meeting
January 18, 2018
(November 2017 Data)

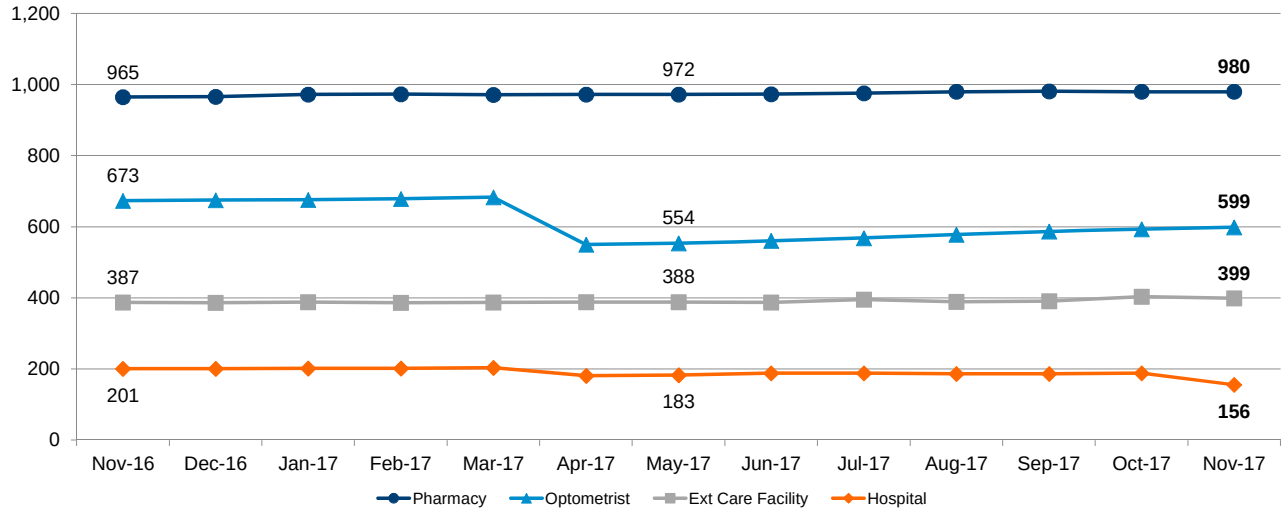
SOONERCARE ENROLLMENT/EXPENDITURES

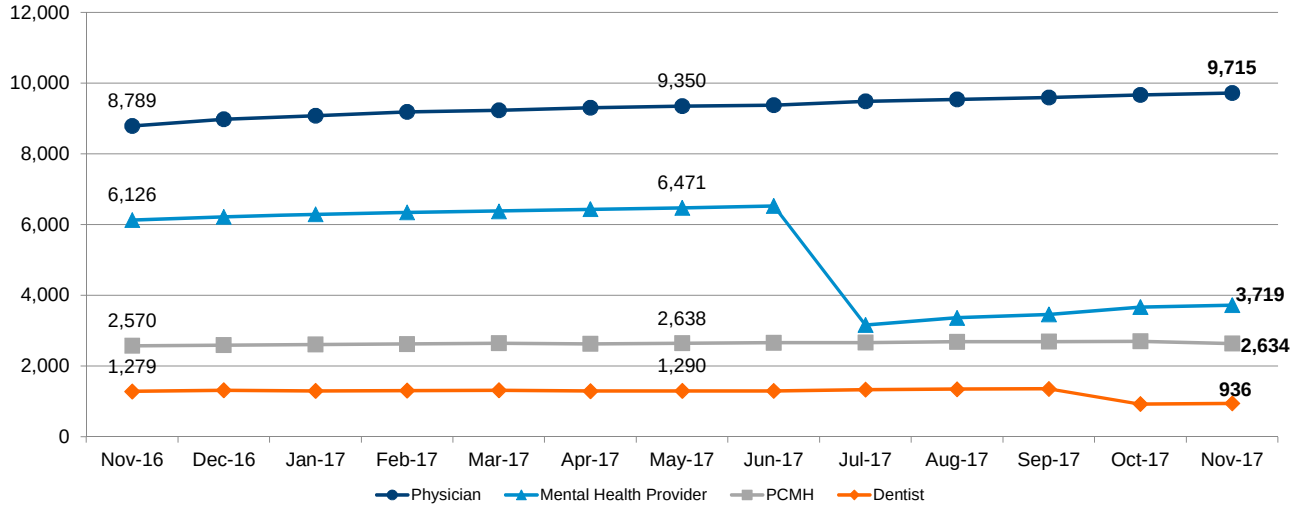
Delivery System			Enrollment November 2017	Children November 2017	Adults November 2017	Enrollment Change	Total Expenditures November	PMPM November 2017	Forecasted Nov 2017 Trend PMPM
SoonerCare Choice Patient-Centered Medical Home			**538,365**	**444,045**	**94,320**	**-652**	**$185,793,449**		
	Lower Cost	*(Children/Parents; Other)*	493,849	429,836	64,013	-806	$135,420,085	$274	$232
	Higher Cost	*(Aged, Blind or Disabled; TEFRA; BCC)*	44,516	14,209	30,307	154	$50,373,363	$1,132	$1,059
SoonerCare Traditional			**237,120**	**89,005**	**148,115**	**2,017**	**$205,007,651**		
	Lower Cost	*(Children/Parents; Other; Q1; SLMB)*	121,522	84,010	37,512	1,824	$46,951,816	$386	$433
	Higher Cost	*(Aged, Blind or Disabled; LTC; TEFRA; BCC & HCBS Waiver)*	115,598	4,995	110,603	193	$158,055,836	$1,367	$1,231
SoonerPlan			**32,325**	**2,685**	**29,640**	**178**	**$321,685**	$10	$10
Insure Oklahoma			**19,587**	**490**	**19,097**	**216**	**$7,913,197**		
	Employer-Sponsored Insurance		14,351	301	14,050	175	$5,028,543	$350	$345
	Individual Plan		5,236	189	5,047	41	$2,884,654	$551	$467
TOTAL			**827,397**	**536,225**	**291,172**	**1,759**	**$399,035,983**		

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.
Dual Eligibles (Medicare & Medicaid) are in the Traditional delivery system in both the Low Cost (Q1 & SLMB) and High Cost (ABD) groups. OTHER includes DDSD, PKU, Q1, Refugee, SLMB, STBS and TB.

IN-STATE CONTRACTED PROVIDERS

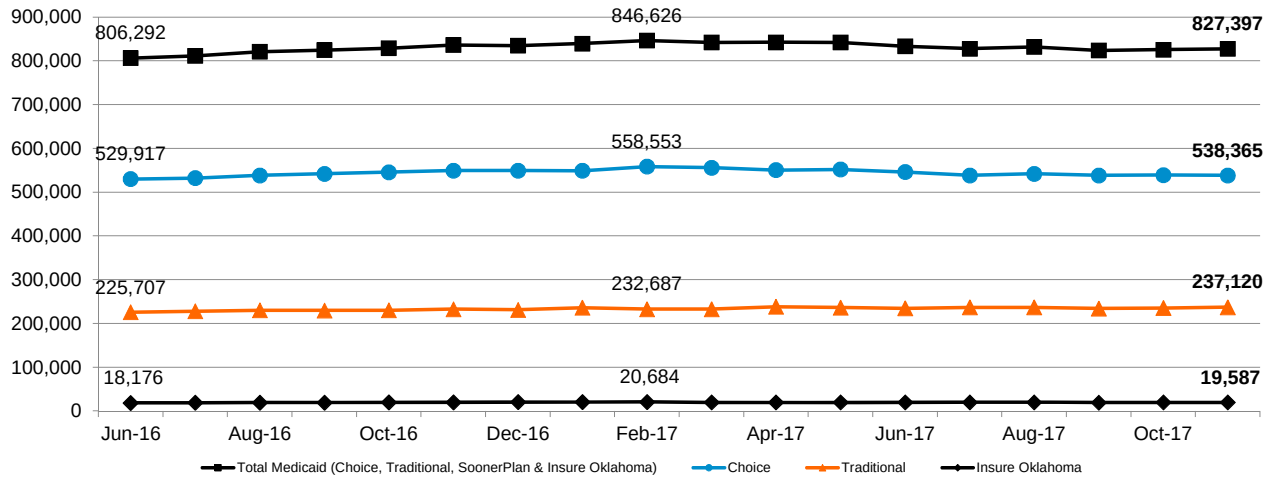
Total In-State Providers: 32,262 (+229) **(In-State Providers counted multiple times due to multiple locations, programs, types, and specialties)**



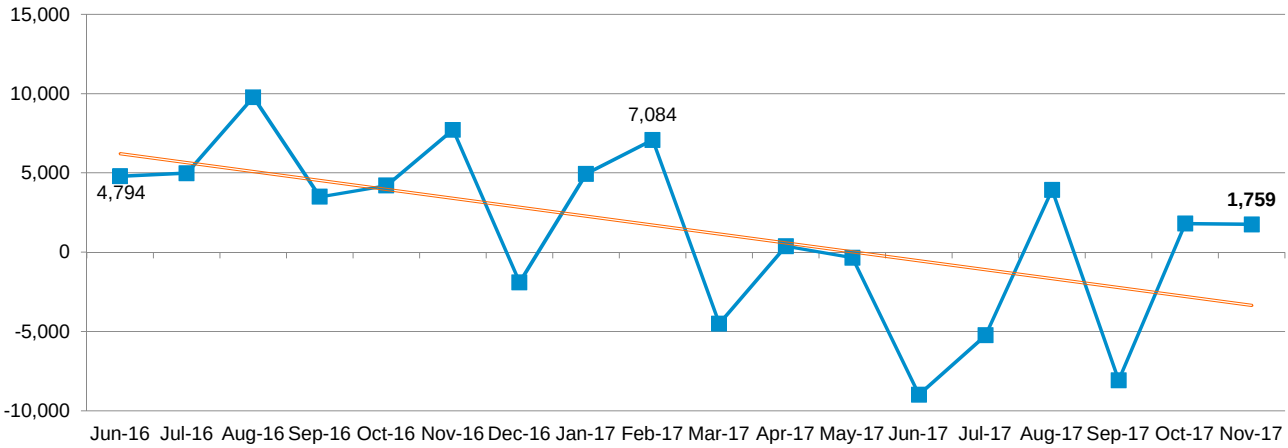


*In general, decreases are due to contract renewal. Decrease during contract renewal period is typical during all renewal periods. Hospital decrease in November 2017 is due to psychiatric hospitals and residential treatment centers changing from provider type hospital to provider type inpatient psychiatric facility.

ENROLLMENT BY MONTH



MONTHLY CHANGE IN ENROLLMENT



FINANCIAL REPORT

For the Five Months Ended November 30, 2017
Submitted to the CEO & Board

- Revenues for OHCA through November, accounting for receivables, were **$1,788,261,540** or **.3% over** budget.
- Expenditures for OHCA, accounting for encumbrances, were **$1,754,125,540** or **.1% over** budget.
- The state dollar budget variance through November is a **positive $2,060,688.**
- The budget variance is primarily attributable to the following (in millions):

Expenditures:		
Medicaid Program Variance		(2.9)
Administration		2.0
Revenues:		
Drug Rebate		(.1)
Taxes and Fees		2.7
Overpayments/Settlements		.4
Total FY 18 Variance	**$**	**2.1**

ATTACHMENTS

OKLAHOMA HEALTH CARE AUTHORITY
Summary of Revenues & Expenditures: OHCA
SFY 2018, For the Five Month Period Ending November 30, 2017

REVENUES	FY18 Budget YTD	FY18 Actual YTD	Variance	% Over/ (Under)
State Appropriations	$ 465,983,442	$ 465,983,442	$ -	0.0%
Federal Funds	984,976,168	986,131,877	1,155,710	0.1%
Tobacco Tax Collections	20,496,560	23,208,252	2,711,692	13.2%
Quality of Care Collections	32,764,925	32,716,427	(48,498)	(0.1)%
Prior Year Carryover	39,249,967	39,249,967	-	0.0%
Federal Deferral - Interest	110,617	110,617	-	0.0%
Drug Rebates	98,003,233	97,888,289	(114,944)	(0.1)%
Medical Refunds	13,702,808	14,658,114	955,306	7.0%
Supplemental Hospital Offset Payment Program	120,795,486	120,795,486	-	0.0%
Other Revenues	7,504,991	7,519,069	14,078	0.2%
TOTAL REVENUES	**$ 1,783,588,196**	**$ 1,788,261,540**	**$ 4,673,344**	**0.3%**

EXPENDITURES	FY18 Budget YTD	FY18 Actual YTD	Variance	% (Over)/ Under
ADMINISTRATION - OPERATING	**$ 23,234,316**	**$ 20,905,162**	**$ 2,329,154**	**10.0%**
ADMINISTRATION - CONTRACTS	**$ 42,960,715**	**$ 41,185,036**	**$ 1,775,679**	**4.1%**
MEDICAID PROGRAMS				
Managed Care:				
SoonerCare Choice	19,212,841	18,239,264	973,577	5.1%
Acute Fee for Service Payments:				
Hospital Services	373,580,014	378,847,057	(5,267,043)	(1.4)%
Behavioral Health	8,478,525	8,793,029	(314,504)	(3.7)%
Physicians	165,855,879	165,018,998	836,881	0.5%
Dentists	53,273,177	55,103,181	(1,830,004)	(3.4)%
Other Practitioners	23,245,971	22,904,472	341,499	1.5%
Home Health Care	7,106,171	7,672,140	(565,969)	(8.0)%
Lab & Radiology	13,421,779	11,673,264	1,748,515	13.0%
Medical Supplies	20,932,162	21,152,923	(220,761)	(1.1)%
Ambulatory/Clinics	83,218,294	86,041,688	(2,823,394)	(3.4)%
Prescription Drugs	247,600,782	246,655,906	944,876	0.4%
OHCA Therapeutic Foster Care	5,000	751	4,249	0.0%
Other Payments:				
Nursing Facilities	232,021,486	231,879,537	141,949	0.1%
Intermediate Care Facilities for Individuals with Intellectual Disabilities Private	26,117,828	25,681,487	436,341	1.7%
Medicare Buy-In	72,090,331	72,482,031	(391,700)	(0.5)%
Transportation	27,347,167	27,239,457	107,710	0.4%
Money Follows the Person-OHCA	100,188	119,190	(19,002)	0.0%
Electonic Health Records-Incentive Payments	4,410,924	4,410,924	-	0.0%
Part D Phase-In Contribution	45,146,141	45,253,282	(107,142)	(0.2)%
Supplemental Hospital Offset Payment Program	257,655,663	257,655,663	-	0.0%
Telligen	4,408,150	5,211,100	(802,950)	(18.2)%
Total OHCA Medical Programs	**1,685,228,472**	**1,692,035,342**	**(6,806,871)**	**(0.4)%**
OHCA Non-Title XIX Medical Payments	89,382	-	89,382	0.0%
TOTAL OHCA	**$ 1,751,512,885**	**$ 1,754,125,540**	**$ (2,612,656)**	**(0.1)%**
REVENUES OVER/(UNDER) EXPENDITURES	**$ 32,075,311**	**$ 34,136,000**	**$ 2,060,688**	

OKLAHOMA HEALTH CARE AUTHORITY

Total Medicaid Program Expenditures
by Source of State Funds
SFY 2018, For the Five Month Period Ending November 30, 2017

Category of Service	Total	Health Care Authority	Quality of Care Fund	HEEIA	SHOPP Fund	BCC Revolving Fund	Other State Agencies
SoonerCare Choice	$ 18,292,892	$ 18,234,044	$ -	$ 53,628	$ -	$ 5,219	$ -
Inpatient Acute Care	513,499,791	249,801,635	202,786	1,402,405	194,360,989	309,986	67,421,991
Outpatient Acute Care	180,853,757	127,170,000	17,335	1,892,855	50,428,252	1,345,315	-
Behavioral Health - Inpatient	22,157,046	5,526,720	-	148,712	12,219,915	-	4,261,699
Behavioral Health - Psychiatrist	3,912,815	3,266,308	-	-	646,507	-	-
Behavioral Health - Outpatient	6,479,749	-	-	-	-	-	6,479,749
Behaviorial Health-Health Home	21,400,560	-	-	-	-	-	21,400,560
Behavioral Health Facility- Rehab	103,693,827	-	-	-	-	29,145	103,693,827
Behavioral Health - Case Management	4,318,040	-	-	-	-	-	4,318,040
Behavioral Health - PRTF	24,559,717	-	-	-	-	-	24,559,717
Behavioral Health - CCBHC	21,126,799	-					21,126,799
Residential Behavioral Management	6,384,912	-	-	-	-	-	6,384,912
Targeted Case Management	26,799,051	-	-	-	-	-	26,799,051
Therapeutic Foster Care	751	751	-	-	-	-	-
Physicians	193,541,618	163,232,203	24,209	2,102,748	-	1,762,587	26,419,872
Dentists	55,120,595	55,097,913	-	17,414	-	5,268	-
Mid Level Practitioners	1,032,977	1,026,039	-	6,477	-	461	-
Other Practitioners	22,082,854	21,639,997	185,985	204,882	-	51,990	-
Home Health Care	7,673,345	7,670,411	-	1,205	-	1,729	-
Lab & Radiology	12,010,163	11,585,813	-	336,899	-	87,451	-
Medical Supplies	21,316,776	20,013,493	1,129,805	163,853	-	9,625	-
Clinic Services	87,050,005	83,031,814	-	545,232	-	75,036	3,397,923
Ambulatory Surgery Centers	3,007,749	2,931,066	-	72,911	-	3,773	
Personal Care Services	4,833,811	-	-	-	-	-	4,833,811
Nursing Facilities	231,879,537	141,108,946	90,762,975	-	-	7,616	-
Transportation	27,247,768	26,170,988	977,769	49,185	-	49,827	-
GME/IME/DME	91,662,523	-	-	-	-	-	91,662,523
ICF/IID Private	25,681,487	20,945,646	4,735,841	-	-	-	-
ICF/IID Public	7,181,339	-	-	-	-	-	7,181,339
CMS Payments	117,735,313	117,440,765	294,548	-	-	-	-
Prescription Drugs	251,717,575	245,551,505	-	5,061,668	-	1,104,401	-
Miscellaneous Medical Payments	40,874	38,924	-	-	-	1,950	-
Home and Community Based Waiver	83,758,550	-	-	-	-	-	83,758,550
Homeward Bound Waiver	32,591,074	-	-	-	-	-	32,591,074
Money Follows the Person	119,190	119,190	-	-	-	-	-
In-Home Support Waiver	10,435,444	-	-	-	-	-	10,435,444
ADvantage Waiver	71,841,648	-	-	-	-	-	71,841,648
Family Planning/Family Planning Waiver	2,033,643	-	-	-	-	-	2,033,643
Premium Assistance*	23,969,285	-	-	23,969,285	-	-	-
Telligen	5,211,100	5,211,100	-	-	-	-	-
Electronic Health Records Incentive Payments	4,410,924	4,410,924	-	-	-	-	-
Total Medicaid Expenditures	**$ 2,348,666,873**	**$ 1,331,226,195**	**$ 98,331,252**	**$ 36,029,359**	**$ 257,655,663**	**$ 4,851,378**	**$ 620,602,171**

* Includes $23,803,688 paid out of Fund 245

OKLAHOMA HEALTH CARE AUTHORITY
Summary of Revenues & Expenditures:
Other State Agencies
SFY 2018, For the Five Month Period Ending November 30, 2017

		FY18 Actual YTD
REVENUE		
Revenues from Other State Agencies	$	270,627,514
Federal Funds		379,615,509
TOTAL REVENUES	**$**	**650,243,023**
EXPENDITURES		**Actual YTD**
Department of Human Services		
Home and Community Based Waiver	$	83,758,550
Money Follows the Person		-
Homeward Bound Waiver		32,591,074
In-Home Support Waivers		10,435,444
ADvantage Waiver		71,841,648
Intermediate Care Facilities for Individuals with Intellectual Disabilities Public		7,181,339
Personal Care		4,833,811
Residential Behavioral Management		3,645,838
Targeted Case Management		22,848,856
Total Department of Human Services		**237,136,560**
State Employees Physician Payment		
Physician Payments		26,419,872
Total State Employees Physician Payment		**26,419,872**
Education Payments		
Graduate Medical Education		50,325,348
Graduate Medical Education - Physicians Manpower Training Commission		4,171,737
Indirect Medical Education		34,013,202
Direct Medical Education		3,152,236
Total Education Payments		**91,662,523**
Office of Juvenile Affairs		
Targeted Case Management		961,202
Residential Behavioral Management		2,739,074
Total Office of Juvenile Affairs		**3,700,276**
Department of Mental Health		
Case Management		4,318,040
Inpatient Psychiatric Free-standing		4,261,699
Outpatient		6,479,749
Health Homes		21,400,560
Psychiatric Residential Treatment Facility		24,559,717
Certified Community Behavioral Health Clinics		21,126,799
Rehabilitation Centers		103,693,827
Total Department of Mental Health		**185,840,392**
State Department of Health		
Children's First		559,142
Sooner Start		1,935,911
Early Intervention		2,382,928
Early and Periodic Screening, Diagnosis, and Treatment Clinic		624,428
Family Planning		77,942
Family Planning Waiver		1,947,225
Maternity Clinic		2,226
Total Department of Health		**7,529,803**
County Health Departments		
EPSDT Clinic		319,355
Family Planning Waiver		8,476
Total County Health Departments		**327,831**
State Department of Education		**28**
Public Schools		**46,894**
Medicare DRG Limit		**65,000,000**
Native American Tribal Agreements		**516,003**
Department of Corrections		**320,177**
JD McCarty		**2,101,814**
Total OSA Medicaid Programs	**$**	**620,602,171**
OSA Non-Medicaid Programs	**$**	**37,167,361**
Accounts Receivable from OSA	**$**	**7,526,510**

OKLAHOMA HEALTH CARE AUTHORITY

SUMMARY OF REVENUES & EXPENDITURES:

Fund 205: Supplemental Hospital Offset Payment Program Fund

SFY 2018, For the Five Month Period Ending November 30, 2017

REVENUES		FY 18 Revenue
SHOPP Assessment Fee	$	120,717,805
Federal Draws		152,721,588
Interest		69,038
Penalties		8,643
State Appropriations		(15,100,000)
TOTAL REVENUES	$	258,417,074

EXPENDITURES	Quarter	Quarter		FY 18 Expenditures
Program Costs:	7/1/17 - 9/30/17	10/1/17 - 12/31/17		
Hospital - Inpatient Care	98,870,820	95,490,169	$	194,360,989
Hospital -Outpatient Care	25,537,046	24,891,206		50,428,252
Psychiatric Facilities-Inpatient	7,574,695	4,645,220		12,219,915
Rehabilitation Facilities-Inpatient	328,886	317,622		646,507
Total OHCA Program Costs	132,311,447	125,344,216	$	257,655,663
Total Expenditures			$	257,655,663

CASH BALANCE		761,412

OKLAHOMA HEALTH CARE AUTHORITY
SUMMARY OF REVENUES & EXPENDITURES:
Fund 230: Nursing Facility Quality of Care Fund
SFY 2018, For the Five Month Period Ending November 30, 2017

REVENUES	Total Revenue	State Share
Quality of Care Assessment	**$ 32,702,044**	**$ 32,702,044**
Interest Earned	**14,383**	**14,383**
TOTAL REVENUES	**$ 32,716,427**	**$ 32,716,427**

EXPENDITURES	FY 18 Total $ YTD	FY 18 State $ YTD	Total State $ Cost
Program Costs			
Nursing Facility Rate Adjustment	$ 89,219,978	$ 36,232,233	
Eyeglasses and Dentures	114,117	46,343	
Personal Allowance Increase	1,428,880	580,268	
Coverage for Durable Medical Equipment and Supplies	1,129,805	458,814	
Coverage of Qualified Medicare Beneficiary	430,315	174,751	
Part D Phase-In	294,548	119,616	
ICF/IID Rate Adjustment	2,223,653	903,025	
Acute Services ICF/IID	2,512,188	1,020,200	
Non-emergency Transportation - Soonerride	977,769	397,072	
Total Program Costs	**$ 98,331,252**	**$ 39,932,321**	**$ 39,932,321**
Administration			
OHCA Administration Costs	$ 220,604	$ 110,302	
DHS-Ombudsmen	-	-	
OSDH-Nursing Facility Inspectors	211,508	211,508	
Mike Fine, CPA	-	-	
Total Administration Costs	**$ 432,112**	**$ 321,810**	**$ 321,810**
Total Quality of Care Fee Costs	**$ 98,763,363**	**$ 40,254,131**	
TOTAL STATE SHARE OF COSTS			**$ 40,254,131**

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

OKLAHOMA HEALTH CARE AUTHORITY

SUMMARY OF REVENUES & EXPENDITURES:

Fund 245: Health Employee and Economy Improvement Act Revolving Fund

SFY 2018, For the Five Month Period Ending November 30, 2017

REVENUES	FY 17 Carryover	FY 18 Revenue	Total Revenue
Prior Year Balance	$ 7,673,082	$ -	$ 4,811,312
State Appropriations	(3,000,000)	-	-
Tobacco Tax Collections	-	19,088,249	19,088,249
Interest Income	-	65,797	65,797
Federal Draws	307,956	14,664,875	14,664,875
TOTAL REVENUES	**$ 4,981,038**	**$ 33,818,920**	**$ 38,630,232**

EXPENDITURES		FY 17 Expenditures	FY 18 Expenditures	Total $ YTD
Program Costs:				
	Employer Sponsored Insurance		$ 23,803,688	$ 23,803,688
	College Students/ESI Dental		165,597	67,249
Individual Plan				
	SoonerCare Choice		$ 51,840	$ 21,052
	Inpatient Hospital		1,373,918	557,948
	Outpatient Hospital		1,869,068	759,029
	BH - Inpatient Services-DRG		145,566	59,114
	BH -Psychiatrist		-	-
	Physicians		2,091,577	849,389
	Dentists		16,279	6,611
	Mid Level Practitioner		6,309	2,562
	Other Practitioners		202,015	82,038
	Home Health		1,205	489
	Lab and Radiology		329,610	133,855
	Medical Supplies		160,913	65,347
	Clinic Services		532,729	216,341
	Ambulatory Surgery Center		72,911	29,609
	Prescription Drugs		4,986,836	2,025,154
	Transportation		48,835	19,832
	Premiums Collected		-	(272,048)
Total Individual Plan			**$ 11,889,611**	**$ 4,556,323**
	College Students-Service Costs		**$ 170,463**	**$ 69,225**
Total OHCA Program Costs			**$ 36,029,359**	**$ 28,496,485**
Administrative Costs				
	Salaries	$ 40,359	$ 910,323	$ 950,682
	Operating Costs	25,578	58,570	84,148
	Health Dept-Postponing	-	-	-
	Contract - HP	103,788	399,334	503,123
Total Administrative Costs		**$ 169,725**	**$ 1,368,227**	**$ 1,537,952**
Total Expenditures				**$ 30,034,438**
NET CASH BALANCE		**$ 4,811,312**		**$ 8,595,794**

OKLAHOMA HEALTH CARE AUTHORITY

SUMMARY OF REVENUES & EXPENDITURES:

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

SFY 2018, For the Five Month Period Ending November 30, 2017

REVENUES	FY 18 Revenue	State Share
Tobacco Tax Collections	$ 380,909	$ 380,909
TOTAL REVENUES	**$ 380,909**	**$ 380,909**

EXPENDITURES	FY 18 Total $ YTD	FY 18 State $ YTD	Total State $ Cost
Program Costs			
SoonerCare Choice	$ 5,219	$ 1,483	
Inpatient Hospital	309,986	$ 88,098	
Outpatient Hospital	1,345,315	$ 382,339	
Inpatient Services-DRG	-	$ -	
Psychiatrist	-	$ -	
TFC-OHCA	-	$ -	
Nursing Facility	7,616	$ 2,164	
Physicians	1,762,587	$ 500,927	
Dentists	5,268	$ 1,497	
Mid-level Practitioner	461	$ 131	
Other Practitioners	51,990	$ 14,775	
Home Health	1,729	$ 491	
Lab & Radiology	87,451	$ 24,854	
Medical Supplies	9,625	$ 2,735	
Clinic Services	75,036	$ 21,325	
Ambulatory Surgery Center	3,773	$ 1,072	
Prescription Drugs	1,104,401	$ 313,871	
Transportation	49,827	$ 14,161	
Miscellaneous Medical	1,950	$ 554	
Total OHCA Program Costs	**$ 4,822,233**	**$ 1,370,479**	
OSA DMHSAS Rehab	$ 29,145	$ 8,242	
Total Medicaid Program Costs	**$ 4,851,378**	**$ 1,378,721**	
TOTAL STATE SHARE OF COSTS			**$ 1,378,721**

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.

January MAC
Proposed Rule Amendment Summaries

Face-to-face tribal consultations regarding the following proposed changes were held on Tuesday, September 5, 2017, Tuesday, November 3, 2017 and Tuesday, January 2, 2018 in the Board Room of the Oklahoma Health Care Authority (OHCA).

APA work folder 17-15 was posted on the OHCA public website for a comment period from December 18, 2017 through January 17, 2018. APA work folders 17-17, 17-19, 17-20, 17-23, 17-24 A&B, and 17-25 A&B, were posted on the OHCA public website for a comment period from December 15, 2017 through January 16, 2018. APA work folder 17-28 was posted on the OHCA public website for a comment period from December 12, 2017 through January 11, 2018. APA work folders 17-33 A&B will be posted on the OHCA public website for a comment period through January 25, 2018.

17–15 Student Earned Income Exclusion for Aged, Blind and Disabled (ABD) Applicants — The proposed ABD countable income policy revisions will remove specific amounts for the income disregard of a student's earned income and will refer to the Oklahoma Department of Human Services (OKDHS) Appendix C-1. These amounts are used by OKDHS when determining countable income and eligibility for the ABD category. The Social Security Administration revises the student earned income exclusion yearly. Additionally, the proposed revisions will clarify the definition of student status to ensure that an unintended barrier is not created for the access of SoonerCare services.
Budget Impact: Budget neutral

17–17 Indian Health Services, Tribal Program and Urban Indian Clinics (I/T/U) Current Procedural Terminology (CPT) Language Removal — The proposed I/T/U policy revisions will remove the restriction to billing with only a CPT procedure code for outpatient behavioral health encounters. Proposed revisions will clarify and allow more flexibility when billing for these types of encounters. Additionally, revisions require that services are billed on an appropriate claim form using the appropriate procedure code and guidelines.
Budget Impact: Services provided to the Native American population are 100% federally funded; therefore, no impact on state revenue is expected.

17–19 Inpatient Behavioral Health Revisions — The proposed inpatient behavioral health policy will revise definitions and align them with federal regulations. Definitions will be incorporated throughout policy in the Sections in which they are used. In addition, the term "American Osteopathic Accreditation" will be removed as an accrediting body for Psychiatric Residential Treatment Facilities (PRTFs), as it is no longer an accreditation option for this kind of facility. The term "Licensed independent practitioner" will be removed from the rules, and the rules will now specifically explain which types of practitioners can order restraint or seclusion, or perform face-to-face assessments of patients.

Additionally, revisions will align policy with federal regulations regarding the standards of restraint or seclusion for members under the age of 21 receiving inpatient psychiatric services. Rules are revised to assure all general and psychiatric hospitals and PRTFs comply with the condition of participation for restraint or seclusion, as is established federal regulations.
Budget Impact: Budget neutral

17–20 Grandfathered Children's Health Insurance Program (CHIP) Children — The proposed revisions will amend the Qualifying Categorical Relationship policy by removing the

subsection "Grandfathered CHIP children." The current rule identifies that this eligibility group terminated December 31, 2015 necessitating the removal of this subsection from policy to eliminate any confusion.
Budget Impact: Budget neutral

17–23 Breast and Cervical Cancer (BCC) Benefit Update — The proposed BCC benefit revisions will comply with federal regulation, which addresses optional eligibility for individuals needing treatment for breast and cervical cancer. In order to align revisions with federal regulation requirements, the references to "women" will be replaced with the terms that are inclusive of both males and females for eligibility purposes. Revisions also include removal of old references to the Oklahoma Department of Human Services (OKDHS) and outdated language regarding creditable coverage in order to reflect current business practices. In addition, the proposed revisions replace the term "OKDHS worker" with the term "eligibility coordinator."
Budget Impact: **Agency staff has determined that the impact to expand the scope of BCC benefits will result in an approximately 1.7 percent increase in enrollment equaling an estimated total 12 month cost of $205,898 total dollars, $85,304 state dollars using FFY 2018 FMAP.**

17–24A ADvantage Waiver Revisions — The proposed ADvantage Waiver policy revisions will replace references to the Interactive Voice Response Authentication system with references to the Electronic Visit Verification (EVV) system. The EVV system is the current industry standard for electronic billing and verification software systems. Proposed revisions will provide clarification of the EVV system billing process, which is currently in place for billing of personal care and nursing services in both the ADvantage and State Plan Personal Care programs. Finally, revisions will ensure that the technological terms used in this policy accurately reflect the advances in electronic billing and verification software systems.
Budget Impact: Budget neutral

17–24B ADvantage Waiver Revisions — The proposed ADvantage Waiver policy revisions will provide information regarding the certification and recertification periods of medical eligibility determination and systems that are used by the nurses in communicating with the Department of Human Services county offices. In addition, proposed revisions will add new language outlining the rules and processes for the Ethics of Care Committee for the ADvantage and State Plan Personal Care programs. Finally, proposed revisions will update obsolete acronyms that are used in existing policy.
Budget Impact: Budget neutral

17–25A Developmental Disabilities Services (DDS) Revisions — The proposed DDS revisions will remove treatment extensions for Habilitation Services authorized by DDS area managers. New qualifications for psychological technicians will be added, which allow for services to be provided under the supervision of a licensed psychologist. Additional revisions will require psychologists to implement the Protective Intervention Protocol (PIP) for the member's individual plan. New billing requirements will not allow psychologists to bill for no more than 12 hours (48 units) for PIP preparation. The proposed revisions also request that the authorization period for psychological services be changed from 6 to 12 months. Lastly, revisions will provide a detailed description and new documentation requirements for prevocational services.
Budget Impact: Budget neutral

17–25B Developmental Disabilities Services (DDS) Revisions — The proposed DDS revisions will affirm a member's rights to have visitors of his/her choosing and allow eligible members, 16 years of age or older, access to waiver employment services through the Home and Community-Based Services waiver. Finally, revisions add new language to clarify state-funded employment services are available to members of the Homeward Bound class who are not eligible for DDS waiver services.
Budget Impact: Budget neutral

17–28 Federally Qualified Health Center Services (FQHC) Alternative Payment Methodology (APM) — The proposed policy revisions will introduce a new optional payment methodology for Federally Qualified Health Centers (FQHCs). FQHCs are currently reimbursed through a Prospective Payment System (PPS) methodology; the proposed revision will add the Alternative Payment Methodology (APM) as an optional reimbursement method for FQHCs. In order to align with the methodology change, the FQHC policy will also be updated to reflect the term and definition for APM.
Budget Impact: Budget neutral

17–33 A&B Nursing Home Supplemental Payment Program — The proposed revisions will update and revise the nursing home supplemental payment program for nursing facilities by changing the methodology for computing the Upper Payment Limit (UPL). Additionally, the proposed revisions will update the care criteria section and eligibility requirements that a nursing facility will be required to meet to participate in the UPL program and receive the UPL payments. Finally, revisions will update some acronyms, definitions and references to other legal authorities.
Budget Impact: There is no cost to the OHCA as the state share will be financed by the NSGO and will be transferred to the state by way of an intergovernmental transfer for claiming of federal financial participation.

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

SUBCHAPTER 5. ELIGIBILITY AND COUNTABLE INCOME
PART 5. COUNTABLE INCOME AND RESOURCES

317:35-5-42. Determination of countable income for individuals categorically related to aged, blind and disabled

(a) **General.** The term income is defined as that gross gain or gross recurrent benefit which is derived from labor, business, property, retirement and other benefits, and many other forms which can be counted on as currently available for use on a regular basis. When an individual's income is reduced due to recoupment of an overpayment or garnishment, the gross amount before the recoupment or garnishment is counted as income. Verification of the member's countable income or resources held in bank accounts or at other financial institutions can be established through an ~~AVS~~Asset Verification System (AVS).

(1) If it appears the applicant or SoonerCare member is eligible for any type of income (excluding SSI) or resources, he/she must be notified in writing by the Agency of his/her potential eligibility. The notice must contain the information that failure to file for and take all appropriate steps to obtain such benefit within 30 days from the date of the notice will result in a determination of ineligibility.

(2) If a husband and wife are living in their own home, the couple's total income and/or resource is divided equally between the two cases. If they both enter a nursing facility, their income and resources are considered separately.

(3) If only one spouse in a couple is eligible and the couple ceases to live together, only the income and resources of the ineligible spouse that are actually contributed to the eligible spouse beginning with the month after the month which they ceased to live together are considered.

(4) In calculating monthly income, cents are included in the computation until the monthly amount of each individual's source of income has been established. When the monthly amount of each income source has been established, cents are rounded to the nearest dollar (1 - 49 cents is rounded down, and 50 - 99 cents is rounded up). For example, an individual's weekly earnings of $99.90 are multiplied by 4.3 and the cents rounded to the nearest dollar ($99.90 x 4.3 = $429.57 rounds to $430). See rounding procedures in OAC 340:65-3-4 when using BENDEX to verify OASDI benefits.

(b) **Income disregards.** In determining need, the following are not considered as income:

(1) The value of Supplemental Nutrition Assistance Program (food stamps) received;

(2) Any payment received under Title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970;

(3) Educational grants (excluding work study), scholarships, etc., that are contingent upon the student regularly attending school. The student's classification (graduate or undergraduate) is not a factor;
(4) Loans (regardless of use) if a bona fide debt or obligation to pay can be established. Criteria to establish a loan as bona fide includes:
(A) An acknowledgment of obligation to repay or evidence that the loan was from an individual or financial institution in the loan business. If the loan agreement is not written, an OKDHS Form 08AD103E, Loan Verification, should be completed by the borrower attesting that the loan is bona fide and signed by the lender verifying the date and amount of loan. When copies of written agreements or OKDHS Form 08AD103E are not available, detailed case documentation must include information that the loan is bona fide and how the debt amount and date of receipt was verified.
(B) If the loan was from a person(s) not in the loan business, the borrower's acknowledgment of obligation to repay (with or without interest) and the lender's verification of the loan are required to indicate that the loan is bona fide.
(C) Proceeds of a loan secured by an exempt asset are not an asset;
(5) One-third of child support payments received on behalf of the disabled minor child;
(6) Indian payments (including judgment funds or funds held in trust) distributed by the Secretary of the Interior (BIA) or distributed by the tribe subject to approval by the Secretary of the Interior. Also, any interest or investment income accrued on such funds while held in trust or any purchases made with judgment funds, trust funds, interest or investment income accrued on such funds. Any income from mineral leases, from tribal business investments, etc. However, any interest or income derived from the principal or produced by purchases made with funds after distribution is considered as any other income;
(7) Special allowance for school expenses made available upon petition (in writing) for funds held in trust for the student;
(8) Title III benefits from State and Community Programs on Aging;
(9) Payment for supportive services or reimbursement of out-of-pocket expenses made to individual volunteers serving as foster grandparents, senior health aides, or senior companions, and to persons serving in the Service Corps of Retired Executives (SCORE) and Active Corps of Executives (ACE);
(10) Payments to volunteers under the Domestic Volunteer Services Act of 1973 (VISTA), unless the gross amount of VISTA payments equals or exceeds the state or federal minimum wage, whichever is greater;
(11) The value of supplemental food assistance received under the Child Nutrition Act or the special food service program for children under the ~~national~~National School Lunch Act;
(12) Any portion of payments made under the Alaska Native Claims Settlement Act to an Alaska Native which are exempt from taxation

under the Settlement Act;
(13) Reimbursements from an employer for out-of-pocket expenditures and allowances for travel or training to the extent the funds are used for expenses directly related to such travel or training and uniform allowance if the uniform is uniquely identified with company names or logo;
(14) Assistance or services from the Vocational Rehabilitation program such as transportation expenses to a rehabilitation center, extra clothing, lunches, grooming needed for a training program and any other such complementary payments;
(15) Experimental Housing Allowance Program (EHAP) payments made under Annual Contributions Contracts entered into prior to January 1, 1975, under Section 23 of the U.S. Housing Act of 1937, as amended;
(16) Payments made by a public or private non-profit child care agency for a child placed in foster care or subsidized adoption;
(17) Governmental rental or housing subsidies by governmental agencies, e.g., HUD (received in-kind or in cash) for rent, mortgage payments, or utilities;
(18) LIHEAP payments for energy assistance and payments for emergency situations under Emergency Assistance to Needy Families with Children;
(19) Payments made from the Agent Orange Settlement Fund or any other fund established pursuant to the settlement in the In Re Agent Orange product liability litigation, M.D.L. No. 381 (E.D.N.Y.);
(20) Payments made from the Radiation Exposure Compensation Trust Fund as compensation for injuries or deaths resulting from the exposure to radiation from nuclear testing and uranium mining;
(21) Federal major disaster and emergency assistance provided under the Disaster Relief Act of 1974, and comparable disaster assistance provided by States, local governments, and disaster assistance organizations;
(22) Income of a sponsor to the sponsored eligible alien;
(23) Income that is set aside under an approved Plan for Achieving Self-Support for Blind or Disabled People (PASS). The Social Security Administration approves the plan, the amount of income excluded and the period of time approved. A plan can be approved for an initial period of 18 months. The plan may be extended for an additional 18 months if needed, and an additional 12 months (total 48 months) when the objective involves a lengthy educational or training program;
(24) Payments made to individuals because of their status as victims of Nazi persecution (PL 103-286);
(25) Payments received under the Civil Liberties Act of 1988. These payments are to be made to individuals of Japanese ancestry who were detained in internment camps during World War II;
(26) Payments received as a result of participation in a class action lawsuit entitled "Factor VIII or IX Concentrate Blood Products Litigation". These payments are made to hemophilia patients who are infected with HIV. However, if the payments are placed in an interest-bearing account, or some other investment medium that

produces income, the income generated by the account may be countable as income to the individual;
(27) Payments made to certain Vietnam veterans' children with spina bifida (PL 104-204);
(28) Payments made to certain Korea service veterans' children with spina bifida (PL 108-183);
(29) Payments made to the children of women Vietnam veterans who suffer from certain birth defects (PL 106-419);
(30) Additional payments of regular unemployment compensation in the amount of $25 per week ending June 30, 2010, and any amount of emergency unemployment compensation paid through May 31, 2010, as authorized under the American Recovery and Reinvestment Tax Act of 2009;
(31) Wages paid by the Census Bureau for temporary employment related to Census activities;
(32) Income tax refunds;
(33) Home energy assistance;
(34) Food or shelter based on need provided by nonprofit agencies;
(35) Money someone else spends to pay your expenses for items other than food or shelter (e.g., someone pays for your telephone or medical bills);
(36) ~~Earnings up to $1,750 per month to a maximum of $7,060 per year (effective January 2014) for a student under age 22~~Earned income for working students younger than 22 years of age when they regularly attend a school, college, university or a course of vocational or technical training. Refer to Appendix C-1, Schedule VIII.E; Maximum Income, Resource and Payment Standards for the maximum monthly and yearly exclusion amounts;
(37) The cost of impairment-related work expenses for items or services that a disabled person needs in order to work; and
(38) The first $2,000 of compensation received per calendar year for participating in certain clinical trials~~;~~.

(c) **Determination of income.** The member is responsible for reporting information regarding all sources of available income. This information is verified and used by the worker in determining eligibility.

(1) Gross income is listed for purposes of determining eligibility. It may be derived from many sources, and some items may be automatically disregarded by the computer when so provided by state or federal law.
(2) If a member is determined to be categorically needy and is also an SSI recipient, any change in countable income (see OAC 317:35-5-42(d)(3) to determine countable income) will not affect receipt of SoonerCare and amount of State Supplemental Payment (SSP) as long as the amount does not cause SSI ineligibility. Income which will be considered by SSI in the retrospective cycle is documented in the case with computer update at the time that SSI makes the change (in order not to penalize the member twice). If the SSI change is not timely, the worker updates the computer using the appropriate date as if it had been timely. If the receipt of the income causes SSI ineligibility, the income is considered

immediately with proper action taken to reduce or close the SoonerCare benefit and SSP case. Any SSI overpayment caused by SSA not making timely changes will result in recovery by SSI in the future. When the worker becomes aware of income changes which will affect SSI eligibility or payment amount, the information is to be shared with the SSA office.

(3) Some of the more common income sources to be considered in determining eligibility are as follows:

(A) **Retirement and disability benefits.** These include but are not limited to OASDI, VA, Railroad Retirement, SSI, and unemployment benefits. Federal and State benefits are considered for the month they are intended when determining eligibility.

(i) Verifying and documenting the receipt of the benefit and the current benefit amount are achieved by:

(I) seeing the member's award letter or warrant;

(II) obtaining a signed statement from the individual who cashed the warrant; or

(III) by using BENDEX and SDX.

(ii) Determination of OASDI benefits to be considered (disregarding COLA's) for former State Supplemental recipients who are reapplying for medical benefits under the Pickle Amendment must be computed according to OKDHS Form 08AX011E.

(iii) The Veterans Administration allows their recipients the opportunity to request a reimbursement for medical expenses not covered by SoonerCare. If a recipient is eligible for the readjustment payment, it is paid in a lump sum for the entire past year. This reimbursement is disregarded as income and a resource in the month it is received; however, any amount retained in the month following receipt is considered a resource.

(iv) Government financial assistance in the form of VA Aid and Attendance or Champus payments is considered as follows:

(I) **Nursing facility care.** VA Aid and Attendance or Champus payment whether paid directly to the member or to the facility, are considered as third party resources and do not affect the income eligibility or the vendor payment of the member.

(II) **Own home care.** The actual amount of VA Aid and Attendance payment paid for an attendant in the home is disregarded as income. In all instances, the amount of VA Aid and Attendance is shown on the computer form.

(v) Veterans or their surviving spouse who receive a VA pension may have their pension reduced to $90 by the VA if the veteran does not have dependents, is SoonerCare eligible, and is residing in a nursing facility that is approved under SoonerCare. Section 8003 of Public Law 101-508 allows these veterans' pensions to be reduced to $90 per month. None of the $90 may be used in computing any vendor payment or spenddown. In these instances, the nursing home resident is entitled to the $90 reduced VA pension as well as the regular

nursing facility maintenance standard. Any vendor payment or spenddown will be computed by using other income minus the monthly nursing facility maintenance standard minus any applicable medical deduction(s). Veterans or their surviving spouse who meet these conditions will have their VA benefits reduced the month following the month of admission to a SoonerCare approved nursing facility.

(B) **SSI benefits.** SSI benefits may be continued up to three months for a recipient who enters a public medical or psychiatric institution, a SoonerCare approved hospital, extended care facility, intermediate care facility for the mentally retarded or nursing facility. To be eligible for the continuation of benefits, the SSI recipient must have a physician's certification that the institutionalization is not expected to exceed three months and there must be a need to maintain and provide expenses for the home. These continued payments are intended for the use of the recipient and do not affect the vendor payment.

(C) **Lump sum payments.**

(i) Any income received in a lump sum (with the exception of SSI lump sum) covering a period of more than one month, whether received on a recurring or nonrecurring basis, is considered as income in the month it is received. Any amount from any lump sum source, including SSI (with the exception of dedicated bank accounts for disabled/blind children under age 18), retained on the first day of the next month is considered as a resource. Such lump sum payments may include, but are not limited to, accumulation of wages, retroactive OASDI, VA benefits, Workers' Compensation, bonus lease payments and annual rentals from land and/or minerals.

(ii) Lump sum payments used to establish dedicated bank accounts by representative payees in order to receive and maintain retroactive SSI benefits for disabled/blind children under age 18 are excluded as income. The interest income generated from dedicated bank accounts is also excluded. The dedicated bank account consisting of the retroactive SSI lump sum payment and accumulated interest is excluded as a resource in both the month received and any subsequent months.

(iii) A life insurance death benefit received by an individual while living is considered as income in the month received and as a resource in the following months to the extent it is available.

(iv) Changing a resource from one form to another, such as converting personal property to cash, is not considered a lump sum payment.

(D) **Income from capital resources and rental property.** Income from capital resources can be derived from rental of a house, rental from land (cash or crop rent), leasing of minerals, life estate, homestead rights or interest.

(i) If royalty income is received monthly but in irregular amounts, an average based on the previous six months' royalty income is computed and used to determine income eligibility. When the difference between the gross and net income represents a production or severance tax (e.g., most oil royalties are reduced by this tax), the OHCA only uses the net figure when determining income eligibility. The production or severance tax is the cost of producing the income, and, therefore, is deducted from the gross income. Exception: At any time that the county becomes aware of and can establish a trend showing a dramatic increase or decrease in royalty income, the previous two months' royalty income is averaged to compute countable monthly income.

(ii) Rental income may be treated as earned income when the individual participates in the management of a trade or business or invests his/her own labor in producing the income. The individual's federal income tax return will verify whether or not the income is from self-employment. Otherwise, income received from rental property is treated as unearned income.

(iii) When rental property is handled by a leasing agent who collects the rent and deducts a management fee, only the rent actually received by the member is considered as income.

(E) **Earned income/self-employment.** The term "earned income" includes income in cash earned by an individual through the receipt of wages, salary, commission, or profit from activities in which he/she is engaged as a self-employed individual or as an employee. See subparagraph (G) of this paragraph for earnings received in fluctuating amounts. "Earned Income" is also defined to include in-kind benefits received by an employee from an employer in lieu of wages or in conjunction with wages. Such benefits received in-kind are considered as earned income only when the employee/employer relationship has been established. The cash value of the in-kind benefits must be verified by the employer. Income from self-employment also includes in-kind benefits for a work activity or service for which the self-employed person ordinarily receives payment in his/her business enterprise. An exchange of labor or services, e.g., barter, is considered as an in-kind benefit. Medical insurance secured through the employer, whether purchased or as a benefit, is not considered in-kind but is recorded on the case computer input document for coordination with SoonerCare benefits.

(i) Work study received by an individual who is attending school is considered as earned income with appropriate earned income disregards applied.

(ii) Money from the sale of whole blood or blood plasma is considered as self-employment income subject to necessary business expenses and appropriate earned income

disregards.

(iii) Self-employment income is determined as follows:

(I) Generally, the federal or state income tax form for the most recent year is used for calculating the self-employment income to project income on a monthly basis for the certification period. The gross income amount, as well as the allowable deductions, are the same as can be claimed under the Internal Revenue code for tax purposes.

(II) Self-employment income which represents a household's annual support is prorated over a 12- month period, even if the income is received in a short period of time. For example, self-employment income received by crop farmers is averaged over a 12-month period if the income represents the farmer's annual support.

(III) If the household's self-employment enterprise has been in existence for less than a year, the income from that self-employment enterprise is averaged over the period of time the business has been in operation to establish the monthly income amount.

(IV) If a tax return is not available because one has not been filed due to recent establishment of the self-employment enterprise, a profit and loss statement must be seen to establish the monthly income amount.

(V) The purchase price and/or payment(s) on the principal of loans for capital assets, equipment, machinery, and other durable goods is not considered as a cost of producing self-employed income. Also not considered are net losses from previous periods, depreciation of capital assets, equipment, machinery, and other durable goods; and federal, state and local income taxes, FICA, money set aside for retirement purposes, and other work related personal expenses, such as meals and necessary transportation (these expenses are accounted for by the work related expense deduction given in OAC 340:10-3-33(1)).

(iv) Countable self-employment income is determined by deducting allowable business expenses to determine the adjusted gross income. The earned income deductions are then applied to establish countable earned income.

(F) **Infrequent or irregular income.**

(i) Income is considered to be infrequent if the individual receives it only once during a calendar quarter from a single source and the individual did not receive that type of income in the month preceding or following the month the income was received.

(ii) Income is considered to be irregular if the individual cannot reasonably expect to receive it.

(iii) OHCA excludes the following amount of infrequent or irregular income:

(I) the first $30 per calendar quarter of earned income; and

(II) the first $60 per calendar quarter of unearned income.

(iv) Infrequent or irregular income, whether earned or unearned, that exceeds these amounts is considered countable income in the month it is received.

(G) **Monthly income received in fluctuating amounts.** Income which is received monthly but in irregular amounts is averaged using two months' income, if possible, to determine income eligibility. Less than two months' income may be used when circumstances (e.g., new employment, unpaid sick leave, etc.) would indicate that previous income amounts would not be appropriate to use in determining future income amounts. Income received more often than monthly is converted to monthly amounts as follows:

(i) **Daily.** Income received on a daily basis is converted to a weekly amount then multiplied by 4.3.

(ii) **Weekly.** Income received weekly is multiplied by 4.3.

(iii) **Twice a month.** Income received twice a month is multiplied by 2.

(iv) **Biweekly.** Income received every two weeks is multiplied by 2.15.

(H) **Non-negotiable notes and mortgages.** Installment payments received on a note, mortgage, etc., are considered as monthly income.

(I) **Income from the Job Training and Partnership Act (JTPA).** Unearned income received by an adult, such as a needs based payment, cash assistance, compensation in lieu of wages, allowances, etc., from a program funded by JTPA is considered as any other unearned income. JTPA earned income received as wages is considered as any other earned income.

(J) **Other income.** Any other monies or payments which are available for current living expenses must be considered.

(d) **Computation of income.**

(1) **Earned income or unearned income.** The general income exclusion of $20 per month is allowed for earned or unearned income, unless the unearned income is SSP, on the combined income of the eligible individual and eligible or ineligible spouse. See paragraph (5) of this subsection if there are ineligible minor children. After the $20 exclusion, deduct $65 and one-half of the remaining combined earned income. The total gross amount of unearned income of the eligible individual and eligible or ineligible spouse is considered.

(2) **Countable income.** The countable income is the sum of the earned income and the total gross unearned income after exclusions.

(3) **Deeming computation for disabled or blind minor child(ren).** An automated calculation is available for computing the income amount to be deemed from parent(s) and the

spouse of the parent to eligible disabled or blind minor child(ren) by use of transaction CID. The ineligible minor child in the computation regarding allocation for ineligible child(ren) is defined as: a dependent child under age 18.

(A) An intellectually disabled child living in the home who is ineligible for SSP due to the deeming process may be approved for SoonerCare under the Home and Community Based Services Waiver (HCBS) Program as outlined in OAC 317:35-9- 5.

(B) For TEFRA, the income of child's parent(s) is not deemed to him/her.

(4) **Premature infants.** Premature infants (i.e., 37 weeks or less) whose birth weight is less than 1200 grams (approximately 2 pounds 10 ounces) will be considered disabled by SSA even if no other medical impairment(s) exist. In this event, the parents' income is not deemed to the child until the month following the month in which the child leaves the hospital and begins living with his/her parents.

(5) **Procedures for deducting ineligible minor child allocation.** When an eligible individual has an ineligible spouse and ineligible minor children (not receiving TANF), the computation is as follows:

(A) Each ineligible child's allocation (OKDHS Form 08AX001E, Schedule VII. C.) minus each child's gross countable income is deducted from the ineligible spouse's income. Deeming of income is not done from child to parent.

(B) The deduction in subparagraph (A) of this paragraph is prior to deduction of the general income exclusion and work expense.

(C) After computations in subparagraphs (A) and (B) of this paragraph, the remaining amount is the ineligible spouse's countable income considered available to the eligible spouse.

(6) **Special exclusions for blind individuals.** Any blind individual who is employed may deduct the general income exclusion and the work exclusion from the gross amount of earned income. After the application of these exclusions, one-half of the remaining income is excluded. The actual work expense is then deducted from the remaining half to arrive at the amount of countable income. If this blind individual has a spouse who is also eligible due to blindness and both are working, the amount of ordinary and necessary expenses attributable to the earning of income for each of the blind individuals may be deducted. Expenses are deductible as paid but may not exceed the amount of earned income. To be deductible, an expense need not relate directly to the blindness of the individual, it need only be an ordinary and necessary work expense of the blind individual. Such expenses fall into three broad categories:

(A) transportation to and from work;

(B) job performance; and

(C) job improvement.

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)

317:30-5-1094. 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 and/or Substance Use Assessment/Evaluation And Testing;
(2) Service 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 use disorder(s). Behavioral health services must be billed on an appropriate claim form using the appropriate ~~Current Procedural Terminology (CPT)~~ procedure code and guidelines. The time indicated on the claim form must be the time actually spent with the member.

(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 (LCSW), licensed marital and family therapists (LMFT), licensed professional counselors (LPC), licensed behavioral practitioners (LBP), 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 317:30-5-241.6, 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 must meet the requirements found at OAC 317:30-5-241.3, 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.

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. General provisions and eligible providers

~~(a) Inpatient psychiatric hospitals or psychiatric units provide treatment in a hospital setting 24 hours a day. Psychiatric Residential Treatment Facilities (PRTF) provide non-acute inpatient facility care for members who have a behavioral health disorder and need 24-hour supervision and specialized interventions. Payment for psychiatric and/or chemical dependency/detoxification services for adults between the ages of 21 and 64 are limited to acute inpatient hospital settings.~~

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

~~(1) **"AOA"** means American Osteopathic Accreditation.~~

~~(2) **"CARF"** means the Commission on Accreditation of Rehabilitation Facilities.~~

~~(3) **"Licensed independent practitioner (LIP)"** means any individual permitted by law and by the licensed hospital to provide care and services, without supervision, within the scope of the individual's license and consistent with clinical privileges individually granted by the licensed hospital. Licensed independent practitioners may include Advanced Practice Nurses (APN) with prescriptive authority and Physician Assistants.~~

~~(4) **"Psychiatric Residential Treatment Facility (PRTF)"** means a facility other than a hospital.~~

~~(5) **"Restraint"** means any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a member to move his or her arms, legs, body, or head freely, or drug or medication when it is used as a restriction to manage the member's behavior or restrict the member's freedom of movement and is not the standard treatment or dosage for the member's condition. Restraint does not include devices such as orthopedically prescribed devices, surgical dressings or bandages, protective helmets, or other methods that involve the physical holding of a member for the purpose of conducting routine physical examinations or tests, or to protect the member from falling out of bed, or to permit the member to participate in activities without the risk of physical harm (this does not include physical escort).~~

~~(6) **"Seclusion"** means the involuntary confinement of a member alone in a room or area from which the member is physically prevented from leaving and may only be used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the member, a staff member, or~~

~~others.~~

~~(7) **"TJC"** means The Joint Commission.~~

~~(c) **Hospitals and freestanding psychiatric facilities.** To be eligible for payment under this Section, inpatient psychiatric programs must be provided to eligible SoonerCare members in a hospital that is:~~

~~(1) appropriately licensed and surveyed by the state survey agency;~~

~~(2) accredited by TJC; and~~

~~(3) contracted with the Oklahoma Health Care Authority (OHCA).~~

~~(d) **Psychiatric Residential Treatment Facility (PRTF).** A PRTF is any non-hospital facility contracted with the OHCA to provide inpatient services to SoonerCare eligible members under the age of 21. To enroll as a hospital-based or freestanding PRTF, the provider must be appropriately state licensed pursuant to Title 10 O.S. Section 402 accredited by TJC, CARF, COA or AOA and approved by the OHCA to provide services to individuals under age 21. Distinct PRTF units of state operated psychiatric hospitals serving individuals ages 18-22 are exempt from licensure pursuant to Title 63 O.S. Section 1-702. Out-of-state PRTFs should be appropriately licensed in the state in which they do business. In addition, the following requirements must be met:~~

~~(1) **Restraint and seclusion reporting requirements.** In accordance with Federal Regulations at 42 CFR 483.350, the OHCA requires a PRTF that provides SoonerCare inpatient psychiatric services to members under age 21 to attest, in writing, that the facility is in compliance with all of the standards governing the use of restraint and seclusion. The attestation letter must be signed by an individual who has the legal authority to obligate the facility. OAC 317:30-5-95.39 describes the documentation required by the OHCA.~~

~~(2) **Attestation letter.** The attestation letter at a minimum must include:~~

~~(A) the name and address, telephone number of the facility, and a provider identification number;~~

~~(B) the signature and title of the individual who has the legal authority to obligate the facility;~~

~~(C) the date the attestation is signed;~~

~~(D) a statement certifying that the facility currently meets all of the requirements governing the use of restraint and seclusion;~~

~~(E) a statement acknowledging the right of the State Survey Agency (or its agents) and, if necessary, Center for Medicare and Medicaid Services (CMS) to conduct an on-site survey at any time to validate the facility's compliance with the requirements of the rule, to investigate complaints lodged against the facility, or to investigate serious occurrences;~~

~~(F) a statement that the facility will notify the OHCA and the State Health Department if it no longer complies with the requirements; and~~

~~(G) a statement that the facility will submit a new attestation of compliance in the event the individual who has the legal authority to obligate the facility is no longer in such position.~~

~~(3) **Reporting of serious injuries or deaths.** Each PRTF is required to report a resident's death, serious injury, and a resident's suicide attempt to the OHCA, and unless prohibited by state law, to the state-designated Protection and Advocacy System (P and As). In addition to reporting requirements contained in this section, facilities must report the death of any resident to the CMS regional office no later than close of business the next business day after the resident's death. Staff must document in the resident's record that the death was reported to the CMS Regional Office.~~

~~(c) **Required documents.** The required documents for enrollment for each participating provider can be downloaded from the OHCA's website.~~

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

(1) **"C.F.R."** means Code of Federal Regulations.

(2) **"General Hospital"** means a general medical surgical hospital, as defined by 63 Oklahoma Statutes, Sec. 1-701(2).

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

(4) **"OHCA"** means Oklahoma Health Care Authority.

(5) **"O.S."** means Oklahoma Statutes.

(6) **"Psychiatric Hospital"** means an institution which is primarily engaged in providing, by or under the supervision of a physician, psychiatric services for the diagnosis and treatment of mentally ill persons, as defined by 42 of the United States Code, Sec. 1395x(f).

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

(8) **"U.S.C."** means United States Code.

(b) **Eligible settings for inpatient psychiatric services.** The following individuals may receive SoonerCare-reimbursable inpatient psychiatric services in the following eligible settings:

(1) Individuals twenty-one (21) to sixty-four (64) years of age may receive SoonerCare-reimbursable inpatient psychiatric and/or chemical dependency/substance use/detoxification services in a psychiatric unit of a general hospital.

(2) Individuals sixty-five (65) years of age or older may receive SoonerCare-reimbursable inpatient psychiatric services

in a psychiatric unit of a general hospital, or in a psychiatric hospital.

(3) Individuals under twenty-one (21) years of age, in accordance with OAC 317:30-5-95.23, may receive SoonerCare-reimbursable inpatient psychiatric services in a psychiatric unit of a general hospital, a psychiatric hospital, or a PRTF.

(c) **Psychiatric hospitals and psychiatric units of general hospitals.** To be eligible for payment under this Part, inpatient psychiatric programs must be provided to eligible SoonerCare members in a hospital that:

(1) is licensed and surveyed by the appropriate State survey agency, except for those hospitals exempted by 63 O.S. § 1-702(A);

(2) meets all applicable federal regulations, including, but not limited to:

(A) Medicare Conditions of Participation for Hospitals (42 C.F.R. Part 482), including special provisions applying to psychiatric hospitals (42 C.F.R. §§ 482.60-.62);

(B) Medicaid for Individuals Age 65 or over in Institutions for Mental Diseases (42 C.F.R. 441 Subpart C);

(C) Inpatient Psychiatric Services for Individuals under Age 21 in Psychiatric Facilities or Programs (42 C.F.R. 441 Subpart D); and/or

(D) Utilization Control [42 C.F.R. Part 456, Subpart C (Utilization Control: Hospitals) or Subpart D (Utilization Control: Mental Hospitals)];

(3) is accredited by The Joint Commission (TJC) or certified as a Medicare and/or Medicaid hospital provider;

(4) is contracted with the OHCA; and

(5) if located within Oklahoma and serving members under eighteen (18) years of age, is appropriately licensed by the Oklahoma Department of Human Services (DHS) as a residential child care facility (10 O.S. §§ 401 to 402) that is providing services as a residential treatment facility in accordance with OAC 340:110-3-168.

(d) **PRTF.** Every PRTF must:

(1) be individually contracted with OHCA as a PRTF;

(2) meet all of the state and federal participation requirements for SoonerCare reimbursement, including, but not limited to, 42 C.F.R. § 483.354, as well as all requirements in 42 C.F.R. Part 483, Subpart G governing the use of restraint and seclusion;

(3) be appropriately licensed by DHS as a residential child care facility (10 O.S. §§ 401 to 402) that is providing services as a residential treatment facility in accordance with OAC 340:110-3-168; and

(4) be accredited by TJC, the Council on Accreditation of Rehabilitation Facilities (CARF), or the Council on Accreditation (COA).

(e) **Out-of-state PRTF.** Any out-of-state PRTF must be appropriately licensed and/or certified in the state in which it does business, and must provide an attestation to OHCA that the PRTF is in

compliance with the condition of participation for restraint and seclusion, as is required by federal law. Any out-of-state PRTF must also be accredited in conformance with OAC 317:30-5-95(d)(4).

(f) **Required documents.** The required documents for enrollment for each participating provider can be downloaded from the OHCA's website.

317:30-5-95.39. ~~Seclusion, restraint~~ Restraint, seclusion, and serious ~~incident~~ occurrence reporting requirements for ~~children~~members under the age of twenty-one (21)

~~(a) Restraint or seclusion may only be used when less restrictive interventions have been determined to be ineffective to protect the member, a staff member or others from harm and may only be imposed to ensure the immediate physical safety of the member, a staff member or others. The use of restraint or seclusion must be in accordance with a written modification to the member's individual plan of care. The type or technique of restraint or seclusion used must be the least restrictive intervention that will be effective to protect the member or others from harm. Restraint or seclusion must be discontinued at the earliest possible time, regardless of the length of time identified in the order. Mechanical restraints will not be used on children under age 18.~~

~~(1) Each facility must have policies and procedure to describe the conditions, in which seclusion and restraint would be utilized, the behavioral/management intervention program followed by the facility and the documentation required. Each order by a physician or Licensed Independent Practitioner (LIP) may authorize the RN to continue or terminate the restraint or seclusion based on the member's face to face evaluation. Each order for restraint or seclusion may only be renewed in accordance with the following limits for up to a total of 24 hours:~~

~~(A) four hours for children 18 to 20 years of age;~~

~~(B) two hours for children and adolescents nine to 17 years of age; or~~

~~(C) one hour for children under nine years of age.~~

~~(2) The documentation required to ensure that seclusion and restraint was appropriately implemented and monitored will include at a minimum:~~

~~(A) documentation of events leading to intervention used to manage the violent or self-destructive behaviors that jeopardize the immediate physical safety of the member or others;~~

~~(B) documentation of alternatives or less restrictive interventions attempted;~~

~~(C) an order for seclusion/restraint including the name of the LIP, date and time of order;~~

~~(D) orders for the use of seclusion/restraint must never be written as a standing order or on an as needed basis;~~

~~(E) documentation that the member continually was monitored face to face by an assigned, trained staff member, or~~

~~continually monitored by trained staff using both video and audio equipment during the seclusion/restraint;~~

~~(F) the results of a face to face assessment completed within one hour by a LIP or RN who has been trained in accordance with the requirements specified at OAC 317:30-5-95.35 to include the:~~

~~(i) member's immediate situation;~~

~~(ii) member's reaction to intervention;~~

~~(iii) member's medical and behavioral conditions; and~~

~~(iv) need to continue or terminate the restraint or seclusion.~~

~~(G) in events the face to face was completed by a trained RN, documentation that the trained RN consulted the attending physician or other LIP responsible for the care of the member as soon as possible after the completion of the one-hour face to face evaluation;~~

~~(H) debriefing of the child within 24 hours by an LBHP or licensure candidate;~~

~~(I) debriefing of staff within 48 hours; and~~

~~(J) notification of the parent/guardian.~~

~~(b) Staff must be trained and able to demonstrate competency in the application of restraints, implementation of seclusion, monitoring, assessment, and providing care for a member in restraint or seclusion before performing any of these actions and subsequently on an annual basis. The PRTF must require appropriate staff to have education, training, and demonstrated knowledge based on the specific needs of the member population in at least the following:~~

~~(1) techniques to identify staff and member behaviors, events, and environmental factors that may trigger circumstances that require the use of restraint or seclusion;~~

~~(2) the use of nonphysical intervention skills;~~

~~(3) choosing the least restrictive intervention based on an individualized assessment of the member's medical behavior status or condition;~~

~~(4) the safe application and use of all types of restraint or seclusion used in the PRTF, including training in how to recognize and respond to signs of physical and psychological distress;~~

~~(5) clinical identification of specific behavioral changes that indicate that restraint or seclusion is no longer necessary;~~

~~(6) monitoring the physical and psychological well-being of the member who is restrained or secluded, including but not limited to, respiratory and circulatory status, skin integrity, vital signs, and any special requirements specified by the policy of the PRTF associated with the one hour face to face evaluation; and~~

~~(7) the use of first aid techniques and certification in the use of cardiopulmonary resuscitation, including annual re-certification.~~

~~(c) Individuals providing staff training must be qualified as evidence by education, training and experience in techniques used to address members' behaviors. The PRTF must document in staff~~

~~personnel records that the training and demonstration of competency were successfully completed.~~

~~(d) The process by which a facility is required to inform the OHCA of a death, serious injury, or suicide attempt is as follows:~~

~~(1) The hospital administrator, executive director, or designee is required to contact the OHCA Behavioral Health Unit by phone no later than 5:00 p.m. on the business day following the incident.~~

~~(2) Information regarding the SoonerCare member involved, the basic facts of the incident, and follow-up to date must be reported. The agency will be asked to supply, at a minimum, follow-up information with regard to member outcome, staff debriefing and programmatic changes implemented (if applicable).~~

~~(3) Within three days, the OHCA Behavioral Health Unit must receive the above information in writing (example: Facility Critical Incident Report).~~

~~(4) Member death must be reported to the OHCA Behavioral Health Services Unit as well as to the Centers for Medicare and Medicaid Regional office in Dallas, Texas.~~

~~(5) Compliance with seclusion and restraint reporting requirements will be verified during the onsite inspection of care see OAC 317:30-5-95.42, or using other methodologies.~~

(a) All PRTFs must comply with the condition of participation for restraint or seclusion, as is established by 42 C.F.R. §§ 483.350 through 483.376, which is hereby incorporated by reference in its entirety. All general and psychiatric hospitals must comply with the standard for restraint or seclusion, as is established by 42 C.F.R. § 482.13(e) – (g), which is hereby incorporated by reference in its entirety. In the case of any inconsistency or duplication between these federal regulations and OAC 317:30-5-95.39, the federal regulations shall prevail, except where OAC 317:30-5-95.39 and/or other Oklahoma law is more protective of a member's health, safety, or well-being.

(b) Restraint or seclusion may only be used when less restrictive interventions have been determined to be ineffective to protect the member, a staff member, or others from harm and may only be imposed to ensure the immediate physical safety of the member, a staff member, or others. The use of restraint or seclusion must be in accordance with a written modification to the member's individual plan of care. The type or technique of restraint or seclusion used must be the least restrictive intervention that will be effective to protect the member or others from harm. Restraint or seclusion must be discontinued at the earliest possible time, regardless of the length of time identified in the order. Mechanical restraints will not be used on children under age eighteen (18).

(1) Each facility must have policies and procedure to describe the conditions in which restraint or seclusion would be utilized, the behavioral/management intervention program followed by the facility, and the documentation required. Restraint or seclusion may only be ordered by the following individuals trained in the use of emergency safety interventions: a Physician; a Physician Assistant (PA); or an

Advanced Practice Registered Nurse (APRN) with prescriptive authority. If, however, the member's treatment team physician is available, then only he or she can order restraint or seclusion. Each order for restraint or seclusion may only be renewed in accordance with the following limits for up to a total of twenty-four (24) hours:

(A) four (4) hours for adults eighteen (18) to twenty-one (21) years of age;

(B) two (2) hours for children and adolescents nine (9) to seventeen (17) years of age; or

(C) one (1) hour for children under nine (9) years of age.

(2) An order for the use of restraint/seclusion must never be written as a standing order or on an as-needed basis.

(3) The documentation required to ensure that restraint or seclusion was appropriately implemented and monitored will include, at a minimum:

(A) documentation of events leading to intervention used to manage the violent or self-destructive behaviors that jeopardize the immediate physical safety of the member or others;

(B) documentation of alternatives or less restrictive interventions attempted;

(C) a signed order for restraint/seclusion that includes the name of the individual ordering the restraint/seclusion, the date and time the order was obtained, and the length of time for which the order was authorized;

(D) the time the restraint/seclusion actually began and ended;

(E) the name of staff involved in the restraint/seclusion;

(F) documentation sufficient to show the member was monitored in accordance with 42 C.F.R. § 482.13(e) (for general and psychiatric hospitals) or 42 C.F.R. §§ 483.362 and 483.364 (for PRTFs), as applicable;

(G) the time and results of a face-to-face assessment completed within one (1) hour after initiation of the restraint/seclusion by a Physician, PA, APRN with prescriptive authority, or Registered Nurse, who has been trained in the use of emergency safety interventions. The assessment must evaluate the member's well-being, including those criteria set forth in 42 C.F.R. § 482.13(e) (for general and psychiatric hospitals) or 42 C.F.R. § 483.358(f) (for PRTFs), as applicable;

(H) in the event the face-to-face assessment was completed by anyone other than the member's treatment team physician, documentation that he or she consulted the member's treatment team physician as soon as possible after completion of the face-to-face assessment;

(I) debriefing of the child and staff involved in the emergency safety intervention within twenty-four (24) hours, in accordance with 42 C.F.R. § 483.370, as applicable;

(J) debriefing of all staff involved in the emergency safety intervention and appropriate supervisory and administrative

staff within twenty-four (24) hours, in accordance with 42 C.F.R. § 483.370, as applicable; and

(K) for minors, notification of the parent(s)/guardian(s).

(c) Serious occurrences, including death, serious injury, or suicide attempt, must be reported as follows:

(1) In accordance with 42 C.F.R. § 483.374, PRTFs must notify the OHCA Behavioral Health Unit and Oklahoma Department of Human Services (DHS) by phone no later than 5:00 p.m. on the business day following a serious occurrence and disclose, at a minimum: the name of the member involved in the serious occurrence; a description of the occurrence; and the name, street address, and telephone number of the facility.

(A) Within three (3) days of the serious occurrence, a PRTF must also submit a written Facility Critical Incident Report to the OHCA Behavioral Health Unit containing: the information in OAC 317:30-5-95.39(c)(1), above; and any available follow-up information regarding the member's condition, debriefings, and programmatic changes implemented (if applicable). A copy of this report must be maintained in the member's record, along with the names of the persons at OHCA and DHS to whom the occurrence was reported. A copy of the report must also be maintained in the incident and accident report logs kept by the facility.

(B) In the case of a minor, the PRTF must also notify the member's parent(s) or legal guardian(s) as soon as possible, and in no case later than twenty-four (24) hours after the serious occurrence.

(2) In addition to the requirements in paragraph (1), above, the death of any member must be reported in accordance with 42 C.F.R. § 482.13(g) (hospital reporting requirements for deaths associated with the use of seclusion or restraint) or 42 C.F.R. § 483.374(c) (PRTF reporting requirements for deaths), as applicable.

(d) In accordance with 42 C.F.R. § 483.374(a), OHCA requires all PRTFs that provide SoonerCare inpatient psychiatric services to members under age twenty-one (21) to attest in writing at the time of contracting, that the facility is in compliance with all federal standards governing the use of restraint and seclusion. The attestation letter must be signed by the facility director, and must include, at a minimum:

(1) the name, address, and telephone number of the facility, and its provider identification number;

(2) the name and signature of the facility director;

(3) the date the attestation is signed;

(4) a statement certifying that the facility currently meets all of the federal requirements governing the use of restraint and seclusion;

(5) a statement acknowledging the right of OHCA, the Center for Medicare and Medicaid Services (CMS), and/or any other entity authorized by law, to conduct an on-site survey at any time to validate the facility's compliance with 42 C.F.R. §§ 483.350 through 483.376, to investigate complaints lodged against the

facility, and to investigate serious occurrences;
(6) a statement that the facility will notify the OHCA if it is out of compliance with 42 C.F.R. §§ 483.350 through 483.376; and
(7) a statement that the facility will submit a new attestation of compliance in the event the facility director changes, for any reason.

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. General provisions and eligible providers

~~(a) Inpatient psychiatric hospitals or psychiatric units provide treatment in a hospital setting 24 hours a day. Psychiatric Residential Treatment Facilities (PRTF) provide non-acute inpatient facility care for members who have a behavioral health disorder and need 24-hour supervision and specialized interventions. Payment for psychiatric and/or chemical dependency/detoxification services for adults between the ages of 21 and 64 are limited to acute inpatient hospital settings.~~

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

~~(1) **"AOA"** means American Osteopathic Accreditation.~~

~~(2) **"CARF"** means the Commission on Accreditation of Rehabilitation Facilities.~~

~~(3) **"Licensed independent practitioner (LIP)"** means any individual permitted by law and by the licensed hospital to provide care and services, without supervision, within the scope of the individual's license and consistent with clinical privileges individually granted by the licensed hospital. Licensed independent practitioners may include Advanced Practice Nurses (APN) with prescriptive authority and Physician Assistants.~~

~~(4) **"Psychiatric Residential Treatment Facility (PRTF)"** means a facility other than a hospital.~~

~~(5) **"Restraint"** means any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a member to move his or her arms, legs, body, or head freely, or drug or medication when it is used as a restriction to manage the member's behavior or restrict the member's freedom of movement and is not the standard treatment or dosage for the member's condition. Restraint does not include devices such as orthopedically prescribed devices, surgical dressings or bandages, protective helmets, or other methods that involve the physical holding of a member for the purpose of conducting routine physical examinations or tests, or to protect the member from falling out of bed, or to permit the member to participate in activities without the risk of physical harm (this does not include physical escort).~~

~~(6) **"Seclusion"** means the involuntary confinement of a member alone in a room or area from which the member is physically prevented from leaving and may only be used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the member, a staff member, or~~

~~others.~~

~~(7) **"TJC"** means The Joint Commission.~~

~~(c) **Hospitals and freestanding psychiatric facilities.** To be eligible for payment under this Section, inpatient psychiatric programs must be provided to eligible SoonerCare members in a hospital that is:~~

~~(1) appropriately licensed and surveyed by the state survey agency;~~

~~(2) accredited by TJC; and~~

~~(3) contracted with the Oklahoma Health Care Authority (OHCA).~~

~~(d) **Psychiatric Residential Treatment Facility (PRTF).** A PRTF is any non-hospital facility contracted with the OHCA to provide inpatient services to SoonerCare eligible members under the age of 21. To enroll as a hospital-based or freestanding PRTF, the provider must be appropriately state licensed pursuant to Title 10 O.S. Section 402 accredited by TJC, CARF, COA or AOA and approved by the OHCA to provide services to individuals under age 21. Distinct PRTF units of state operated psychiatric hospitals serving individuals ages 18-22 are exempt from licensure pursuant to Title 63 O.S. Section 1-702. Out-of-state PRTFs should be appropriately licensed in the state in which they do business. In addition, the following requirements must be met:~~

~~(1) **Restraint and seclusion reporting requirements.** In accordance with Federal Regulations at 42 CFR 483.350, the OHCA requires a PRTF that provides SoonerCare inpatient psychiatric services to members under age 21 to attest, in writing, that the facility is in compliance with all of the standards governing the use of restraint and seclusion. The attestation letter must be signed by an individual who has the legal authority to obligate the facility. OAC 317:30-5-95.39 describes the documentation required by the OHCA.~~

~~(2) **Attestation letter.** The attestation letter at a minimum must include:~~

~~(A) the name and address, telephone number of the facility, and a provider identification number;~~

~~(B) the signature and title of the individual who has the legal authority to obligate the facility;~~

~~(C) the date the attestation is signed;~~

~~(D) a statement certifying that the facility currently meets all of the requirements governing the use of restraint and seclusion;~~

~~(E) a statement acknowledging the right of the State Survey Agency (or its agents) and, if necessary, Center for Medicare and Medicaid Services (CMS) to conduct an on-site survey at any time to validate the facility's compliance with the requirements of the rule, to investigate complaints lodged against the facility, or to investigate serious occurrences;~~

~~(F) a statement that the facility will notify the OHCA and the State Health Department if it no longer complies with the requirements; and~~

~~(G) a statement that the facility will submit a new attestation of compliance in the event the individual who has the legal authority to obligate the facility is no longer in such position.~~

~~(3) **Reporting of serious injuries or deaths.** Each PRTF is required to report a resident's death, serious injury, and a resident's suicide attempt to the OHCA, and unless prohibited by state law, to the state-designated Protection and Advocacy System (P and As). In addition to reporting requirements contained in this section, facilities must report the death of any resident to the CMS regional office no later than close of business the next business day after the resident's death. Staff must document in the resident's record that the death was reported to the CMS Regional Office.~~

~~(c) **Required documents.** The required documents for enrollment for each participating provider can be downloaded from the OHCA's website.~~

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

(1) **"C.F.R."** means Code of Federal Regulations.

(2) **"General Hospital"** means a general medical surgical hospital, as defined by 63 Oklahoma Statutes, Sec. 1-701(2).

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

(4) **"OHCA"** means Oklahoma Health Care Authority.

(5) **"O.S."** means Oklahoma Statutes.

(6) **"Psychiatric Hospital"** means an institution which is primarily engaged in providing, by or under the supervision of a physician, psychiatric services for the diagnosis and treatment of mentally ill persons, as defined by 42 of the United States Code, Sec. 1395x(f).

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

(8) **"U.S.C."** means United States Code.

(b) **Eligible settings for inpatient psychiatric services.** The following individuals may receive SoonerCare-reimbursable inpatient psychiatric services in the following eligible settings:

(1) Individuals twenty-one (21) to sixty-four (64) years of age may receive SoonerCare-reimbursable inpatient psychiatric and/or chemical dependency/substance use/detoxification services in a psychiatric unit of a general hospital.

(2) Individuals sixty-five (65) years of age or older may receive SoonerCare-reimbursable inpatient psychiatric services

in a psychiatric unit of a general hospital, or in a psychiatric hospital.

(3) Individuals under twenty-one (21) years of age, in accordance with OAC 317:30-5-95.23, may receive SoonerCare-reimbursable inpatient psychiatric services in a psychiatric unit of a general hospital, a psychiatric hospital, or a PRTF.

(c) **Psychiatric hospitals and psychiatric units of general hospitals.** To be eligible for payment under this Part, inpatient psychiatric programs must be provided to eligible SoonerCare members in a hospital that:

(1) is licensed and surveyed by the appropriate State survey agency, except for those hospitals exempted by 63 O.S. § 1-702(A);

(2) meets all applicable federal regulations, including, but not limited to:

(A) Medicare Conditions of Participation for Hospitals (42 C.F.R. Part 482), including special provisions applying to psychiatric hospitals (42 C.F.R. §§ 482.60-.62);

(B) Medicaid for Individuals Age 65 or over in Institutions for Mental Diseases (42 C.F.R. 441 Subpart C);

(C) Inpatient Psychiatric Services for Individuals under Age 21 in Psychiatric Facilities or Programs (42 C.F.R. 441 Subpart D); and/or

(D) Utilization Control [42 C.F.R. Part 456, Subpart C (Utilization Control: Hospitals) or Subpart D (Utilization Control: Mental Hospitals)];

(3) is accredited by The Joint Commission (TJC) or certified as a Medicare and/or Medicaid hospital provider;

(4) is contracted with the OHCA; and

(5) if located within Oklahoma and serving members under eighteen (18) years of age, is appropriately licensed by the Oklahoma Department of Human Services (DHS) as a residential child care facility (10 O.S. §§ 401 to 402) that is providing services as a residential treatment facility in accordance with OAC 340:110-3-168.

(d) **PRTF.** Every PRTF must:

(1) be individually contracted with OHCA as a PRTF;

(2) meet all of the state and federal participation requirements for SoonerCare reimbursement, including, but not limited to, 42 C.F.R. § 483.354, as well as all requirements in 42 C.F.R. Part 483, Subpart G governing the use of restraint and seclusion;

(3) be appropriately licensed by DHS as a residential child care facility (10 O.S. §§ 401 to 402) that is providing services as a residential treatment facility in accordance with OAC 340:110-3-168; and

(4) be accredited by TJC, the Council on Accreditation of Rehabilitation Facilities (CARF), or the Council on Accreditation (COA).

(e) **Out-of-state PRTF.** Any out-of-state PRTF must be appropriately licensed and/or certified in the state in which it does business, and must provide an attestation to OHCA that the PRTF is in

compliance with the condition of participation for restraint and seclusion, as is required by federal law. Any out-of-state PRTF must also be accredited in conformance with OAC 317:30-5-95(d)(4).

(f) **Required documents.** The required documents for enrollment for each participating provider can be downloaded from the OHCA's website.

317:30-5-95.39. ~~Seclusion, restraint~~ Restraint, seclusion, and serious ~~incident~~ occurrence reporting requirements for ~~children~~members under the age of twenty-one (21)

~~(a) Restraint or seclusion may only be used when less restrictive interventions have been determined to be ineffective to protect the member, a staff member or others from harm and may only be imposed to ensure the immediate physical safety of the member, a staff member or others. The use of restraint or seclusion must be in accordance with a written modification to the member's individual plan of care. The type or technique of restraint or seclusion used must be the least restrictive intervention that will be effective to protect the member or others from harm. Restraint or seclusion must be discontinued at the earliest possible time, regardless of the length of time identified in the order. Mechanical restraints will not be used on children under age 18.~~

~~(1) Each facility must have policies and procedure to describe the conditions, in which seclusion and restraint would be utilized, the behavioral/management intervention program followed by the facility and the documentation required. Each order by a physician or Licensed Independent Practitioner (LIP) may authorize the RN to continue or terminate the restraint or seclusion based on the member's face to face evaluation. Each order for restraint or seclusion may only be renewed in accordance with the following limits for up to a total of 24 hours:~~

~~(A) four hours for children 18 to 20 years of age;~~

~~(B) two hours for children and adolescents nine to 17 years of age; or~~

~~(C) one hour for children under nine years of age.~~

~~(2) The documentation required to ensure that seclusion and restraint was appropriately implemented and monitored will include at a minimum:~~

~~(A) documentation of events leading to intervention used to manage the violent or self-destructive behaviors that jeopardize the immediate physical safety of the member or others;~~

~~(B) documentation of alternatives or less restrictive interventions attempted;~~

~~(C) an order for seclusion/restraint including the name of the LIP, date and time of order;~~

~~(D) orders for the use of seclusion/restraint must never be written as a standing order or on an as needed basis;~~

~~(E) documentation that the member continually was monitored face to face by an assigned, trained staff member, or~~

~~continually monitored by trained staff using both video and audio equipment during the seclusion/restraint;~~

~~(F) the results of a face to face assessment completed within one hour by a LIP or RN who has been trained in accordance with the requirements specified at OAC 317:30-5-95.35 to include the:~~

~~(i) member's immediate situation;~~

~~(ii) member's reaction to intervention;~~

~~(iii) member's medical and behavioral conditions; and~~

~~(iv) need to continue or terminate the restraint or seclusion.~~

~~(G) in events the face to face was completed by a trained RN, documentation that the trained RN consulted the attending physician or other LIP responsible for the care of the member as soon as possible after the completion of the one-hour face to face evaluation;~~

~~(H) debriefing of the child within 24 hours by an LBHP or licensure candidate;~~

~~(I) debriefing of staff within 48 hours; and~~

~~(J) notification of the parent/guardian.~~

~~(b) Staff must be trained and able to demonstrate competency in the application of restraints, implementation of seclusion, monitoring, assessment, and providing care for a member in restraint or seclusion before performing any of these actions and subsequently on an annual basis. The PRTF must require appropriate staff to have education, training, and demonstrated knowledge based on the specific needs of the member population in at least the following:~~

~~(1) techniques to identify staff and member behaviors, events, and environmental factors that may trigger circumstances that require the use of restraint or seclusion;~~

~~(2) the use of nonphysical intervention skills;~~

~~(3) choosing the least restrictive intervention based on an individualized assessment of the member's medical behavior status or condition;~~

~~(4) the safe application and use of all types of restraint or seclusion used in the PRTF, including training in how to recognize and respond to signs of physical and psychological distress;~~

~~(5) clinical identification of specific behavioral changes that indicate that restraint or seclusion is no longer necessary;~~

~~(6) monitoring the physical and psychological well-being of the member who is restrained or secluded, including but not limited to, respiratory and circulatory status, skin integrity, vital signs, and any special requirements specified by the policy of the PRTF associated with the one hour face to face evaluation; and~~

~~(7) the use of first aid techniques and certification in the use of cardiopulmonary resuscitation, including annual re-certification.~~

~~(c) Individuals providing staff training must be qualified as evidence by education, training and experience in techniques used to address members' behaviors. The PRTF must document in staff~~

~~personnel records that the training and demonstration of competency were successfully completed.~~

~~(d) The process by which a facility is required to inform the OHCA of a death, serious injury, or suicide attempt is as follows:~~

~~(1) The hospital administrator, executive director, or designee is required to contact the OHCA Behavioral Health Unit by phone no later than 5:00 p.m. on the business day following the incident.~~

~~(2) Information regarding the SoonerCare member involved, the basic facts of the incident, and follow-up to date must be reported. The agency will be asked to supply, at a minimum, follow-up information with regard to member outcome, staff debriefing and programmatic changes implemented (if applicable).~~

~~(3) Within three days, the OHCA Behavioral Health Unit must receive the above information in writing (example: Facility Critical Incident Report).~~

~~(4) Member death must be reported to the OHCA Behavioral Health Services Unit as well as to the Centers for Medicare and Medicaid Regional office in Dallas, Texas.~~

~~(5) Compliance with seclusion and restraint reporting requirements will be verified during the onsite inspection of care see OAC 317:30-5-95.42, or using other methodologies.~~

(a) All PRTFs must comply with the condition of participation for restraint or seclusion, as is established by 42 C.F.R. §§ 483.350 through 483.376, which is hereby incorporated by reference in its entirety. All general and psychiatric hospitals must comply with the standard for restraint or seclusion, as is established by 42 C.F.R. § 482.13(e) – (g), which is hereby incorporated by reference in its entirety. In the case of any inconsistency or duplication between these federal regulations and OAC 317:30-5-95.39, the federal regulations shall prevail, except where OAC 317:30-5-95.39 and/or other Oklahoma law is more protective of a member's health, safety, or well-being.

(b) Restraint or seclusion may only be used when less restrictive interventions have been determined to be ineffective to protect the member, a staff member, or others from harm and may only be imposed to ensure the immediate physical safety of the member, a staff member, or others. The use of restraint or seclusion must be in accordance with a written modification to the member's individual plan of care. The type or technique of restraint or seclusion used must be the least restrictive intervention that will be effective to protect the member or others from harm. Restraint or seclusion must be discontinued at the earliest possible time, regardless of the length of time identified in the order. Mechanical restraints will not be used on children under age eighteen (18).

(1) Each facility must have policies and procedure to describe the conditions in which restraint or seclusion would be utilized, the behavioral/management intervention program followed by the facility, and the documentation required. Restraint or seclusion may only be ordered by the following individuals trained in the use of emergency safety interventions: a Physician; a Physician Assistant (PA); or an

Advanced Practice Registered Nurse (APRN) with prescriptive authority. If, however, the member's treatment team physician is available, then only he or she can order restraint or seclusion. Each order for restraint or seclusion may only be renewed in accordance with the following limits for up to a total of twenty-four (24) hours:

(A) four (4) hours for adults eighteen (18) to twenty-one (21) years of age;

(B) two (2) hours for children and adolescents nine (9) to seventeen (17) years of age; or

(C) one (1) hour for children under nine (9) years of age.

(2) An order for the use of restraint/seclusion must never be written as a standing order or on an as-needed basis.

(3) The documentation required to ensure that restraint or seclusion was appropriately implemented and monitored will include, at a minimum:

(A) documentation of events leading to intervention used to manage the violent or self-destructive behaviors that jeopardize the immediate physical safety of the member or others;

(B) documentation of alternatives or less restrictive interventions attempted;

(C) a signed order for restraint/seclusion that includes the name of the individual ordering the restraint/seclusion, the date and time the order was obtained, and the length of time for which the order was authorized;

(D) the time the restraint/seclusion actually began and ended;

(E) the name of staff involved in the restraint/seclusion;

(F) documentation sufficient to show the member was monitored in accordance with 42 C.F.R. § 482.13(e) (for general and psychiatric hospitals) or 42 C.F.R. §§ 483.362 and 483.364 (for PRTFs), as applicable;

(G) the time and results of a face-to-face assessment completed within one (1) hour after initiation of the restraint/seclusion by a Physician, PA, APRN with prescriptive authority, or Registered Nurse, who has been trained in the use of emergency safety interventions. The assessment must evaluate the member's well-being, including those criteria set forth in 42 C.F.R. § 482.13(e) (for general and psychiatric hospitals) or 42 C.F.R. § 483.358(f) (for PRTFs), as applicable;

(H) in the event the face-to-face assessment was completed by anyone other than the member's treatment team physician, documentation that he or she consulted the member's treatment team physician as soon as possible after completion of the face-to-face assessment;

(I) debriefing of the child and staff involved in the emergency safety intervention within twenty-four (24) hours, in accordance with 42 C.F.R. § 483.370, as applicable;

(J) debriefing of all staff involved in the emergency safety intervention and appropriate supervisory and administrative

staff within twenty-four (24) hours, in accordance with 42 C.F.R. § 483.370, as applicable; and

(K) for minors, notification of the parent(s)/guardian(s).

(c) Serious occurrences, including death, serious injury, or suicide attempt, must be reported as follows:

(1) In accordance with 42 C.F.R. § 483.374, PRTFs must notify the OHCA Behavioral Health Unit and Oklahoma Department of Human Services (DHS) by phone no later than 5:00 p.m. on the business day following a serious occurrence and disclose, at a minimum: the name of the member involved in the serious occurrence; a description of the occurrence; and the name, street address, and telephone number of the facility.

(A) Within three (3) days of the serious occurrence, a PRTF must also submit a written Facility Critical Incident Report to the OHCA Behavioral Health Unit containing: the information in OAC 317:30-5-95.39(c)(1), above; and any available follow-up information regarding the member's condition, debriefings, and programmatic changes implemented (if applicable). A copy of this report must be maintained in the member's record, along with the names of the persons at OHCA and DHS to whom the occurrence was reported. A copy of the report must also be maintained in the incident and accident report logs kept by the facility.

(B) In the case of a minor, the PRTF must also notify the member's parent(s) or legal guardian(s) as soon as possible, and in no case later than twenty-four (24) hours after the serious occurrence.

(2) In addition to the requirements in paragraph (1), above, the death of any member must be reported in accordance with 42 C.F.R. § 482.13(g) (hospital reporting requirements for deaths associated with the use of seclusion or restraint) or 42 C.F.R. § 483.374(c) (PRTF reporting requirements for deaths), as applicable.

(d) In accordance with 42 C.F.R. § 483.374(a), OHCA requires all PRTFs that provide SoonerCare inpatient psychiatric services to members under age twenty-one (21) to attest in writing at the time of contracting, that the facility is in compliance with all federal standards governing the use of restraint and seclusion. The attestation letter must be signed by the facility director, and must include, at a minimum:

(1) the name, address, and telephone number of the facility, and its provider identification number;

(2) the name and signature of the facility director;

(3) the date the attestation is signed;

(4) a statement certifying that the facility currently meets all of the federal requirements governing the use of restraint and seclusion;

(5) a statement acknowledging the right of OHCA, the Center for Medicare and Medicaid Services (CMS), and/or any other entity authorized by law, to conduct an on-site survey at any time to validate the facility's compliance with 42 C.F.R. §§ 483.350 through 483.376, to investigate complaints lodged against the

facility, and to investigate serious occurrences;
(6) a statement that the facility will notify the OHCA if it is out of compliance with 42 C.F.R. §§ 483.350 through 483.376; and
(7) a statement that the facility will submit a new attestation of compliance in the event the facility director changes, for any reason.

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 RELATIONSHIP

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 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:

(1) Aged
(2) Disabled
(3) Blind
(4) Pregnancy
(5) Children, also including newborns deemed eligible
~~(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.

317:35-5-7. Determining categorical relationship to the children and parent and caretaker relative groups

(a) **Categorical relationship.** All individuals under age 19 are automatically related to the children's group and further determination is not required. Adults age 19 or older are related to the parent and caretaker relative group when there is a minor dependent child(ren) in the home and the individual is the parent, or is the caretaker relative other than the parent who meets the proper degree of relationship. A minor dependent

child is any child who meets the AFDC eligibility requirements of age and relationship.

~~(b) **Grandfathered CHIP children.** As provided in OAC 317:35-6-1, the MAGI methodology is not applied to determine eligibility for children who are enrolled in SoonerCare on December 31, 2013 until March 31, 2014 or the child's next regularly scheduled renewal, whichever is later.~~

~~(1) The MAGI methodology eliminates the following income disregards, which are subtracted from gross income under the TANF methodology prior to October 1, 2013:~~

~~(A) The $240 work related expense deduction from earned income per employed household member;~~

~~(B) The disregard of the first $50 of child support received by a household; and~~

~~(C) The deduction for child support expenses paid by an employed parent or caretaker who needs child care in order to work, in the amount of the actual expense paid up to a maximum of $200 per month for children under 2 years of age and up to a maximum of $175 per month for children 2 years of age or older.~~

~~(2) If the elimination of the disregards listed in (1) when the MAGI methodology is applied to a child who was enrolled in SoonerCare on December 31, 2013 makes the child financially ineligible, the child is related to the Grandfathered CHIP children group.~~

~~(3) The following children are not eligible for the Grandfathered CHIP Children group:~~

~~(A) Children who are eligible for SoonerCare through another eligibility group;~~

~~(B) Children who have other creditable health insurance coverage;~~

~~(C) Children who are inmates of public institutions or are patients in institutions for mental disease; or~~

~~(D) Children who are eligible for coverage under a health plan offered to employees of the State of Oklahoma.~~

~~(4) If a child's eligibility in this group is redetermined during his/her certification period and the child is financially ineligible without regard to elimination of the disregards in (1), the child's benefits are closed using normal procedures.~~

~~(5) Eligibility for children in this group expires on the date of the child's next regularly scheduled recertification after the recertification for which the MAGI methodology was first used. This eligibility group terminates for all children December 31, 2015.~~

~~(c)~~(b) **Requirement for referral to the Oklahoma Child Support Services Division (OCSS).** As a condition of eligibility, when both the parent or caretaker and minor child(ren) are receiving

SoonerCare and a parent is absent from the home, the parent or caretaker relative must agree to cooperate with OCSS. However, federal regulations provide for a waiver of this requirement when cooperation with OCSS is not in the best interest of the child. OCSS is responsible for making the good cause determination. If the parent or caretaker relative is claiming good cause, he/she cannot be certified for SoonerCare in the parent and caretaker relative group unless OCSS has determined good cause exists. There is no requirement of cooperation with OCSS for child(ren) or pregnant women to receive SoonerCare.

PART 7. APPLICATION AND ELIGIBILITY DETERMINATION PROCEDURES

317:35-5-63. Agency responsible for determination of eligibility

(a) **Determination of eligibility by OHCA.** OHCA is responsible for determining eligibility for the following eligibility groups:

(1) children
(2) newborns deemed eligible
~~(3) grandfathered CHIP children~~
~~(4)~~ (3) pregnant women
~~(5)~~ (4) pregnancy-related services under Title XXI
~~(6)~~ (5) parents and caretaker relatives
~~(7)~~ (6) former foster care children
~~(8)~~ (7) Oklahoma Cares Breast and Cervical Cancer program
~~(9)~~ (8) SoonerPlan Family Planning program.

(b) **Determination of eligibility by OKDHS.** OKDHS is responsible for determining eligibility for the following eligibility groups:

(1) TANF recipients
(2) recipients of adoption assistance or kinship guardianship assistance
(3) state custody
(4) Refugee Medical Assistance
(5) aged
(6) blind
(7) disabled
(8) Tuberculosis
(9) QMBP
(10) QDWI
(11) SLMB
(12) QI-1
(13) Long term care services
(14) alien emergency services.

(c) **Determination of eligibility for programs offered through the Health Insurance Exchange.** Effective October 1, 2013, OHCA

assesses applicants who are found to be ineligible for SoonerCare for potential eligibility for affordable insurance programs offered through the Health Insurance Exchange. OHCA does not determine eligibility or ineligibility for those programs. OHCA facilitates the determination for those affordable insurance programs by forwarding applicants' electronic applications to the Health Insurance Exchange.

SUBCHAPTER 6. SOONERCARE FOR PREGNANT WOMEN AND FAMILIES WITH CHILDREN

PART 1. GENERAL

317:35-6-1. Scope and applicability

(a) The rules in this Subchapter apply when determining financial eligibility for SoonerCare Health Benefits for groups whose eligibility is determined using Modified Adjusted Gross Income (MAGI). These rules apply to the following groups:

(1) Children,

~~(2) Grandfathered CHIP children,~~

~~(3)~~ (2) Pregnant women,

~~(4)~~ (3) Pregnancy-related services under Title XXI,

~~(5)~~ (4) Parents and caretaker relatives,

~~(6)~~ (5) SoonerPlan Family Planning program,

~~(7)~~ (6) Independent foster care adolescents,

~~(8)~~ (7) Inpatients in public psychiatric facilities under 21, and

~~(9)~~ (8) Tuberculosis.

(b) See 42 ~~CFR~~Code of Federal Regulation, Sec. 435.603 to determine whether MAGI applies to a group not specifically listed in this Section.

(c) MAGI rules take effect on October 1, 2013.

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

SUBCHAPTER 21. OKLAHOMA CARES BREAST AND CERVICAL CANCER TREATMENT PROGRAM

317:35-21-1. Oklahoma Cares Breast and Cervical Cancer Treatment program

(a) The Breast and Cervical Cancer Prevention and Treatment Act of 2000~~ (BCCPTA)~~ allows states to provide Medicaid to uninsured ~~women~~individuals under age 65 who are in need of treatment for breast and/or cervical cancer. A medical eligibility evaluation is performed through the Centers for Disease Control and Prevention's (CDC) National Breast and Cervical Cancer Early Detection Program~~ (NBCCEDP)~~. If the evaluation determines the ~~woman~~individual is in need of treatment for breast and/or cervical cancer, including pre-cancerous conditions and early stage, recurrent or metastatic cancer the case is forwarded to OHCA for final medical eligibility determination.

(b) To receive Breast and Cervical Cancer (BCC) Treatment services, the ~~woman~~individual must meet all of the following conditions.

(1) The ~~woman~~individual must have been screened for BCC under the CDC Breast and Cervical Cancer Early Detection Program (see OAC 317:35-21-3) established under Title XV of the Public Health Service~~ (PHS)~~ Act, and upon screening examination found to be in need of treatment, including an abnormal finding that is potentially indicative of a cancerous or precancerous condition or found to have an early stage, recurrent or metastatic cancer of the breast or cervix. (see OAC 317:35-21-5).

(2) The ~~woman~~individual must:

(A) not have creditable insurance coverage that covers the treatment of breast or cervical cancer (see OAC 317:35-21-4),

(B) not be eligible for any other categorically needy SoonerCare eligibility group,

(C) be under 65 years of age,

(D) be a US citizen or qualified alien (see OAC 317:35-5-25 for citizenship/alien status and identity verification requirements),

(E) be a resident of Oklahoma,

(F) declare ~~her~~his/her Social Security number,

(G) assign ~~her~~his/her rights to Third Party Liability if ~~she~~he/she has insurance that is not creditable, and

(H) declare ~~her~~his/her household income for the purpose of determining eligibility for services under the SoonerCare

program.

317:35-21-3. ~~CDC~~Centers for Disease Control and Prevention (CDC) screening

(a) To be eligible for the Oklahoma Cares Breast and Cervical Cancer (BCC) Treatment program, ~~a woman~~an individual must be screened under the CDC Breast and Cervical Cancer Early Detection Program. ~~A woman~~An individual is considered screened under the CDC program if ~~her~~his/her screening was provided all or in part by CDC Title XV funds, or the service was rendered by a provider funded at least in part by CDC Title XV funds, and/or if ~~she~~he/she is screened by another provider whose screening activities are pursuant to CDC Title XV of the Public Health Service ~~(PHS)~~ Act.

(b) Prior to certification of the BCC application an OHCA Care Management nurse must review the application and clinical data to verify the BCC applicant meets medical eligibility criteria for the BCC program.

(c) Upon verification by OHCA Care Management, the application is forwarded to the ~~OKDHS worker~~eligibility coordinator to verify ~~that~~ the BCC applicant was screened by a CDC provider and meets criteria for the program as outlined in OAC 317:35-21-1.

317:35-21-4. Creditable coverage

(a) Creditable coverage when used in this subchapter means any insurance that pays for medical bills incurred for the diagnosis and/or treatment of breast or cervical cancer. ~~A woman~~An individual having any one of the following types of coverage is considered to have creditable coverage and would normally be ineligible for the Breast and Cervical Cancer Treatment (BCC) program:

(1) Coverage under a group health plan;

(2) Health insurance coverage, i.e., benefits consisting of medical care under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract offered by a health insurance issuer;

(3) Medicare Part A and/or B;

(4) SoonerCare;

(5) Armed Forces insurance; and/or

(6) A state health risk pool.

(b) If ~~a woman~~an individual has limited coverage, such as limited drug coverage or limits on the number of outpatient visits, or high deductibles, ~~she~~he/she is still considered to have creditable coverage. However, if ~~she~~he/she has a policy with limited scope coverage such as those that only cover dental, vision, or long term care, or a policy that covers only a specific disease or illness, ~~she~~he/she is not considered to have creditable coverage, unless the policy provides coverage

for breast or cervical cancer.
(c) There may be some circumstances when ~~a woman~~an individual has creditable coverage but that coverage does not actually cover treatment of breast or cervical cancer. In instances such as pre-existing condition exclusions, or when the annual or lifetime limit on benefits has been exhausted, ~~a woman~~an individual is not considered to have creditable coverage for this treatment. In these types of circumstances the ~~woman~~individual may be eligible for ~~Breast and Cervical Cancer~~BCC services if ~~she~~he/she meets all other eligibility criteria.
(d) There is no requirement that ~~a woman~~an individual be uninsured for any specific length of time before ~~she~~he/she is found eligible for SoonerCare under this program. If ~~a woman~~an individual loses creditable coverage for any reason and satisfies all other eligibility requirements for the BCC program it is possible for ~~her~~him/her to become immediately eligible for coverage in this program.
(e) ~~The CDC screener evaluates whether or not the woman has creditable coverage. All health insurance, creditable or not, is listed on the OKDHS computer system in order for OHCA Third Party Liability Unit to verify insurance coverage. Questionable insurance coverage is noted in the application by the CDC screener. Applications with questionable insurance coverage are forwarded to the OHCA Third Party Liability Unit for further verification.~~ The existence of creditable coverage will be verified by the OHCA eligibility coordinator.

317:35-21-5. In need of treatment

In need of treatment, when used in this subchapter, means an abnormal screen determined as a result of a screening for ~~BCC~~Breast and Cervical Cancer (BCC) under the ~~CDC~~Centers for Disease Control and Prevention BCC Early Detection Program established under Title XV of the Public Health Service Act, indicating pre-cancerous conditions and early stage, recurrent or metastatic cancer. Services include diagnostic services for an abnormal finding that may be necessary to determine the extent and proper course of treatment, as well as definitive cancer treatment itself. ~~Women~~Individuals who are determined to require only routine monitoring services for precancerous breast or cervical condition (e.g., breast examinations, mammograms, pelvic exams and pap smears) are not considered to be "in need of treatment".

317:35-21-6. Age requirements

To be eligible for the Oklahoma Cares Breast and Cervical Cancer Treatment program, ~~a woman~~an individual must be under 65 years of age. If ~~a woman~~an individual turns 65 during the certification period, eligibility ends effective the last day of

~~her~~his/her birth month. The ~~OKDHS worker~~eligibility coordinator assists the ~~woman~~individual in determining if eligibility may continue in another SoonerCare category.

317:35-21-8. Social security number

Federal regulations require ~~a woman~~an individual furnish ~~her~~his/her Social Security number at the time of application for the Oklahoma Cares Breast and Cervical Cancer Treatment program.

317:35-21-9. Income

(a) There is no income limit imposed by ~~state or federal law~~State or Federal law for the Breast and Cervical Cancer Treatment program. However, the ~~CDC~~Centers for Disease Control and Prevention Breast and Cervical Cancer Early Detection Program established under Title XV of the Public Health Service ~~(PHS)~~ Act does allow CDC program grantees to set maximum income limits.

(b) Income limits are established for ~~women~~individuals receiving Breast and Cervical Cancer Treatment program services through SoonerCare. The ~~woman~~individual is required to declare ~~her~~his/her household income so that the ~~OKDHS worker~~eligibility coordinator may determine if ~~she~~he/she qualifies for the program or is otherwise SoonerCare eligible.

317:35-21-11. Certification for ~~BCC~~Breast and Cervical Cancer (BCC)

(a) In order for ~~a woman~~an individual to receive BCC treatment services ~~she~~he/she must first be screened for BCC ~~cancer~~ under the ~~CDC~~Centers for Disease Control and Prevention Breast and Cervical Cancer Early Detection Program established under Title XV of the Public Health Service Act and found to be in need of treatment. Once determined to be in need of treatment the CDC screener determines that the ~~woman:~~individual:

(1) does not have creditable health insurance coverage,
(2) is under age 65,
(3) is a US citizen or qualified alien (see OAC 317:35-5-25),
(4) is a ~~self declared~~self-declared Oklahoma resident,
(5) has provided ~~her~~his/her social security number,
(6) is willing to assign medical rights to ~~TPL,~~Third Party Liability, and
(7) has declared all household income.

(b) If all of the conditions in subchapter (a) are met, the CDC screener assists the ~~woman~~individual in completing the ~~BCC~~OHCA BCC-1 application ~~(OHCA BCC-1).~~(BCC-1) The completed BCC-1 along with the documentation of clinical findings, (i.e., history and physical findings, pathology reports, radiology reports and other pertinent data) is forwarded to the OHCA Care Management Unit.

(c) The OHCA Care Management nurse verifies that the member

meets the medical eligibility criteria described in OAC 317:35-21-1 (a) and meets the "in need of treatment" criteria set forth in OAC 317:35-21-1(b)1 and 317:35-21-5. If this criteria is not met or the appropriate clinical documentation is not included, the application will be denied and the OHCA will send a notice of ineligibility to the applicant. Abnormal findings do not include ~~women~~individuals who are at high risk or who could appropriately receive risk reduction therapy, but have no evidence of cancer or a precancerous condition. If it is determined that the ~~woman~~individual does not have cancer or a precancerous condition, a future application for the BCC program must be based on a different finding of abnormality than the previous application data.

(d) If all medical eligibility criteria are met the application will be forwarded to ~~OKDHS~~the eligibility coordinator for further determination of eligibility.

(e) The ~~OKDHS worker~~eligibility coordinator verifies that the screener is a CDC screener. The ~~worker~~eligibility coordinator also establishes whether or not the ~~woman~~individual is otherwise eligible for SoonerCare. If the ~~woman~~individual is not otherwise eligible for SoonerCare, ~~she~~he/she is certified for the BCC program. If the ~~woman~~individual is eligible under another SoonerCare category, the application is certified in the other Medicaid category.

(f) If ~~a woman~~an individual does not cooperate in determining ~~her~~his/her eligibility for other SoonerCare programs, ~~her~~his/her BCC application is denied and the appropriate notice is computer generated. For example, ~~a woman~~an individual otherwise eligible for SoonerCare, related to the low income families with children category, refuses to cooperate with child support enforcement without good cause would not be eligible for the BCC program.

(g) If ~~a woman~~an individual in treatment for breast or cervical cancer contacts the ~~OKDHS office~~OHCA and has not been through the CDC screening process, ~~she~~he/she is referred to the Oklahoma Cares toll free number (866-550-5585) for assistance.

(h) An individual determined eligible for the Oklahoma Cares Breast and Cervical Cancer Treatment program may be certified the first day of the month of application. If the individual had a medical service prior to the application date, certification will occur the first day of the first, second or third month prior to the month of application, in accordance with the date of the medical service, provided the date of certification is not prior to the CDC Screen.

317:35-21-12. Changes after certification/continued need for treatment

(a) ~~A woman~~An individual found to be in need of treatment as the result of an abnormal ~~BCC screen~~Breast and Cervical Cancer screening has 60 days from the date of the application to

complete the initial appointment for a diagnostic procedure and an additional 60 days to complete any additional diagnostic testing required or to initiate compensable treatment for a cancerous or pre-cancerous condition. The exception to the time limit is evidence of a lack of appointment availability. Upon completion of the diagnostic testing, OHCA is provided a medical report of the findings.

(1) If the ~~woman~~individual is found not to have breast or cervical cancer including pre-cancerous conditions and early stage, recurrent or metastatic cancer for which ~~she~~he/she is in need of treatment or fails to have diagnostic testing or begin treatment within the time frames described in OAC 317:35-21-12(a), the case is closed by ~~OKDHS~~OHCA and appropriate notification is computer generated.

(2) If a medical report necessary to determine continued treatment is not received from a provider within ten working days after a request is made by OHCA, the report is considered negative and the case is closed by ~~OKDHS~~OHCA and appropriate notification is computer generated.

(b) If the ~~woman~~individual in need of treatment refuses SoonerCare compensable treatment or diagnostic services and does not plan to pursue the care in the time frames described in OAC 317:35-21-12(a), the case is closed by ~~OKDHS~~OHCA and appropriate notification is computer generated.

(c) In the event ~~a woman~~an individual is unable to initiate or complete diagnostic services due to a catastrophic illness or injury occurring after certification, SoonerCare will remain open with the approval of a SoonerCare Medical Director or his/her designee.

(d) If it is determined at any time during the certification period by either the ~~woman's~~individual's treating physician or by a SoonerCare Medical Director or his or her designee that the ~~woman~~individual is no longer in need of treatment for breast or cervical cancer or a precancerous condition, ~~OHCA will notify OKDHS and the OKDHS worker~~the eligibility coordinator closes the case and appropriate notification is computer generated.

(e) If it is determined at any time during the certification period that the ~~woman~~individual has creditable health insurance coverage, the ~~OKDHS worker~~eligibility coordinator closes the case and appropriate notification is computer generated.

(f) If the ~~OKDHS worker~~eligibility coordinator later determines that the ~~woman~~individual is otherwise eligible for SoonerCare, the worker takes necessary actions to certify ~~her~~his/her for the appropriate category of SoonerCare coverage.

317:35-21-13. Redetermination

A periodic redetermination of eligibility is required every 12 months. The computer generated redetermination form is mailed to the ~~woman~~individual during ~~her~~his/her 11th month of

eligibility. The ~~woman~~individual is responsible for having ~~her~~his/her SoonerCare provider complete the statement certifying that ~~she~~he/she continues to be in need of treatment and for providing any other information necessary to redetermine eligibility.

(1) If the completed forms are not returned, the case is closed and appropriate notice is computer generated.

(2) When the completed forms are returned timely and the ~~woman~~individual remains eligible for the BCC program, the computer is updated to show ~~her~~the individual's continued eligibility.

317:35-21-14. Appeals and reconsiderations

(a) Applicants who wish to appeal a denial decision made by the OHCA ~~or OKDHS~~ may submit form LD-1 to the OHCA within 20 days of receipt of the decision notification. If the form is not received at the OHCA within the required time frame, the appeal will not be heard. More information on the appeals process is provided at OAC 317:2-1-2(a).

(b) Reconsiderations to the OHCA may be requested by a ~~CDC~~Centers for Disease Control and Prevention screener if missing documentation, that could potentially result in a determination of eligibility, has been obtained. The missing documentation must be presented within 30 days of the date of the notice of denial.

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 51. HABILITATION SERVICES

317:30-5-482. Description of services

Habilitation services include the services identified in (1) through (15) of this ~~section. Providers of habilitation services~~ Section. Habilitation services providers must have an applicable agreement with the Oklahoma Health Care Authority (OHCA) to provide Developmental Disabilities Services (DDS) Home and ~~Community Based~~Community-Based Services (HCBS).

(1) **Dental services.** Dental services are provided per Oklahoma Administrative Code (OAC) 317:40-5-112.

(A) **Minimum qualifications.** ~~Providers of dental services~~Dental services providers must have non-restrictive licensure by the ~~Board of Governors of Registered Dentists of Oklahoma~~Oklahoma State Board of Dentistry to practice dentistry in Oklahoma.

(B) **Description of services.** Dental services include services for maintenance or improvement of dental health as well as relief of pain and infection. These services may include:

(i) an oral examination;
(ii) bite-wing ~~x-rays;~~X-rays;
(iii) ~~a prophylaxis;~~dental cleaning;
(iv) ~~topical fluoride~~topical-fluoride treatment;
(v) development of a sequenced treatment plan that prioritizes:
(I) elimination of pain;
(II) adequate oral hygiene; and
(III) restoration or an improved ability to chew;
(vi) routine training of member or primary caregiver regarding oral hygiene; and
(vii) preventive, restorative, replacement, and repair services to achieve or restore functionality~~, that are~~ provided after appropriate review when applicable, per OAC 317:40-5-112.

(C) **Coverage limitations.** Coverage of dental services is specified in the member's Individual Plan (IP)~~,~~ in accordance with applicable Waiver limits. Dental services are not authorized when recommended for cosmetic purposes.

(2) **Nutrition services.** Nutrition Services are provided per OAC 317:40-5-102.

(3) **Occupational therapy services.**

(A) **Minimum qualifications.** Occupational therapists and occupational therapy assistants must have current, non-

restrictive licensure by the Oklahoma ~~State~~ Board of Medical Licensure and Supervision. Occupational therapy assistants must be employed by ~~the~~ occupational ~~therapist.~~therapists.

(B) **Description of services.** Occupational therapy services include evaluation, treatment, and consultation in leisure management, daily living skills, sensory motor, perceptual motor, and mealtime assistance. Occupational therapy services may include the use of occupational therapy assistants, within the limits of the occupational therapist's practice.

(i) Services are:

(I) intended to help the member achieve greater independence to reside and participate in the community; and

(II) rendered in any community setting as specified in the member's ~~individual plan (IP).~~IP. The IP must include a practitioner's prescription.

(ii) For purposes of this Section, a practitioner is defined as medical and osteopathic physicians, physician assistants, and other licensed health care professionals with prescriptive authority to order occupational therapy services in accordance with the rules and regulations governing the SoonerCare program.

(iii) The provision of services includes a written report or record documentation in the member's record, as required.

(C) **Coverage limitations.** Payment is made for compensable services to the individual occupational therapist for direct services or for services provided by a qualified occupational therapist assistant, within the occupational therapist's employment. Payment is made in 15-minute units, with a limit of 480 units per Plan of Care year. Payment is not allowed solely for written reports or record documentation.

(4) **Physical therapy services.**

(A) **Minimum qualifications.** Physical therapists and physical therapist assistants must have current, non-restrictive licensure with the Oklahoma ~~State~~ Board of Medical Licensure and Supervision. The physical therapist must employ the physical therapist assistant.

(B) **Description of services.** Physical therapy services include evaluation, treatment, and consultation in locomotion or mobility and skeletal and muscular conditioning to maximize the member's mobility and skeletal/muscular well-being. Physical therapy services may include the use of physical therapist assistants, within the limits of the physical therapist's practice.

(i) Services are intended to help the member achieve

greater independence to reside and participate in the community. Services are provided in any community setting as specified in the member's IP. The IP must include a practitioner's prescription.

(ii) For purposes of this Section, a practitioner is defined as a licensed medical and osteopathic physicians, and physician assistants in accordance with the rules and regulations covering the OHCA SoonerCare program.

(iii) The provision of services includes a written report or record documentation in the member's record, as required.

(C) **Coverage limitations.** Payment is made for compensable services to individual physical therapists for direct services or for services provided by a qualified physical therapist assistant within the physical therapist's employment. Payment is made in 15-minute units with a limit of 480 units per Plan of Care year. Payment is not allowed solely for written reports or record documentation.

(5) **Psychological services.**

(A) **Minimum qualifications.** Qualification as a provider of psychological services requires current, non-restrictive licensure as a psychologist by the Oklahoma ~~Psychologist~~State Board of Examiners~~,~~ of Psychologists or licensing board in the state in which service is provided. Psychological technicians who have completed all board certification and training requirements may provide services under a licensed psychologist's supervision.

(B) **Description of services.** Psychological services include evaluation, psychotherapy, consultation, and behavioral treatment. Service is provided in any community setting as specified in the member's IP. The provider must develop, implement, evaluate and revise the Protective Intervention Protocol (PIP) corresponding to the relevant outcomes identified in the member's IP.

(i) Services are:

(I) intended to maximize a member's psychological and behavioral well-being; and

(II) provided in individual and group formats, with a ~~six person~~six-person maximum.

(ii) ~~A minimum of 15 minutes for each individual encounter, 15 minutes for each group encounter, and record documentation of each treatment session is included and required.~~Approval of services is based upon assessed needs per OAC 340:100-5-51.

(C) **Coverage limitations.**

(i) ~~Limitations for psychological services are:~~

~~(I) description: psycho therapy services and behavior treatment services, individual: unit: 15 minutes; and~~

~~(II) description: cognitive/behavioral treatment, group: unit: 15 minutes.~~Payment is made in 15 minute units. A minimum of 15 minutes for each individual and group encounter is required.

(ii) Psychological services are authorized for a period, not to exceed ~~six~~twelve (12) months.

(I) Initial authorization ~~is obtained through the Developmental Disabilities Services (DDS) case manager, with review and approval by the DDS case management supervisor.~~must not exceed 192 units, 48 hours of service.

(II) ~~Initial authorization must not exceed 192 units, 48 hours of service.~~Authorizations may not exceed 288 units per plan of care year unless an exception is made by the DDS director of Behavior Support Services or his or her designee.

(III) ~~Quarterly progress notes must include a statement of hours and types of services provided, and an empirical measure of member status as it relates to each objective in the member's IP.~~No more than 12 hours of services, 48 units, may be billed for PIP preparation. Any clinical document must be prepared within sixty (60) calendar days of the request. Further, if the document is not prepared, payments are suspended until the requested document is provided.

(IV) When ~~progress notes for each quarter of service provision are not submitted to the DDS case manager, authorization for payment must be withdrawn until such time as progress notes are submitted.~~revising a PIP to accommodate recommendations of a required committee review, the provider may bill for only one revision. The time for preparing the revision must be clearly documented and must not exceed four hours.

~~(iii) Treatment extensions may be authorized by the DDS area manager, based upon evidence of continued need and effectiveness of treatment.~~

~~(I) Evidence of continued need of treatment, treatment effectiveness, or both, is submitted by the provider to the DDS case manager and must include, at a minimum, completion of the Service Utilization and Evaluation protocol.~~

~~(II) When revising a protective intervention plan (PIP) to accommodate recommendations of a required~~

committee review or an Oklahoma Department of Human (DHS) audit, the provider may bill for only one revision. The time for preparing the revision must be clearly documented and must not exceed four hours.

(III) Treatment extensions must not exceed 24 hours, 96 units, of service, per request.

(iv) The provider must develop, implement, evaluate, and revise the PIP corresponding to the relevant goals and objectives identified in the member's IP.

(v) No more than 12 hours, 48 units, may be billed for the preparation of a PIP. Any clinical document must be prepared within 45 calendar days of the request. Further, if the document is not prepared, payments are suspended until the requested document is provided.

(vi) Psychological technicians may provide up to 140 billable hours, 560 units, of service per month to members.

(vii) The psychologist must maintain a record of all billable services provided by a psychological technician.

(6) **Psychiatric services.**

(A) **Minimum qualifications.** Qualification as a ~~provider of~~ psychiatric services provider requires a current, non-restrictive license to practice medicine in Oklahoma. Certification by the American Board of Psychiatry and Neurology or satisfactory completion of an approved residency program in psychiatry is required.

(B) **Description of services.** Psychiatric services include outpatient evaluation, psychotherapy, medication and prescription management and consultation, and are provided to eligible members. Services are provided in community setting specified in the member's IP.

(i) Services are intended to contribute to the member's psychological well-being.

(ii) A minimum of 30 minutes for encounter and record documentation is required.

(C) **Coverage limitations.** A unit is 30 minutes, with a limit of 200 units, per Plan of Care year.

(7) **Speech/language services.**

(A) **Minimum qualifications.** Qualification as a ~~provider of~~ speech and/or language services provider requires current, non-restrictive licensure as a speech and/or language pathologist by the ~~State~~Oklahoma Board of Examiners for Speech Pathology and Audiology.

(B) **Description of services.** Speech therapy includes evaluation, treatment, and consultation in communication and oral motor and/or feeding activities provided to eligible members. Services are intended to maximize the

member's community living skills and may be provided in the community setting specified in the member's IP. The IP must include a practitioner's prescription.

(i) For purposes of this Section, practitioners are defined as licensed medical and osteopathic physicians, physician assistants, and other licensed professionals with prescriptive authority to order speech and/or language services in accordance with rules and regulations covering the OHCA SoonerCare program.

(ii) A minimum of 15 minutes for encounter and record documentation is required.

(C) **Coverage limitations.** A unit is 15 minutes, with a limit of 288 units, per Plan of Care year.

(8) **Habilitation training specialist (HTS) services.**

(A) **Minimum qualifications.** Providers must complete the ~~DHS DDS sanctioned~~Oklahoma Department of Human Services (DHS) DDS-sanctioned training curriculum. Residential habilitation providers:

(i) are at least 18 years of age;

(ii) are specifically trained to meet ~~the~~members' unique needs~~ of members~~;

(iii) ~~have~~were not~~ been~~ convicted of, pled guilty to, or pled nolo contendere to misdemeanor assault and battery, or a felony, per Section 1025.2 of Title 56 of the Oklahoma Statutes (56 O.S. § 1025.2)~~,~~; unless a waiver is granted, per 56 O.S. § 1025.2; and

(iv) receive supervision and oversight from ~~a contracted agency~~contracted-agency staff with a minimum of four years of any combination of ~~college level~~college-level education or full-time equivalent experience in serving persons with disabilities.

(B) **Description of services.** HTS services include services to support the member's self-care, daily living, and adaptive and leisure skills needed to reside successfully in the community. Services are provided in community-based settings in a manner that contributes to the member's independence, self-sufficiency, community inclusion, and well-being.

(i) Payment ~~will~~is not~~ be~~ made for:

(I) routine care and supervision normally provided by family; or

(II) services furnished to a member by a person who is legally responsible per OAC 340:100-3-33.2.

(ii) Family members who provide HTS services must meet the same standards as providers who are unrelated to the member. HTS staff residing in the same household as the member may not provide services in excess of 40 hours per week. Members ~~who require~~requiring more than 40 hours per week of HTS services, must use staff

members, who do not reside in the household and are employed by the member's chosen provider agency to deliver the balance of necessary support staff hours. Exceptions may be authorized, when needed, for members who receive services through the Homeward Bound Waiver.

(iii) Payment does not include room and board or maintenance, upkeep, ~~and~~or improvement of the member's or family's residence.

(iv) For members who also receive intensive personal supports (IPS), the member's IP must clearly specify the role of the HTS and person providing IPS to ensure there is no duplication of services.

(v) ~~DDS case management supervisor review~~Review and approval by the DDS plan of care reviewer is required.

(vi) Pre-authorized HTS services accomplish the same objectives as other HTS services, but are limited to situations where the HTS provider is unable to obtain required professional and administrative oversight from an ~~OHCA approved~~OHCA-approved oversight agency. For pre-authorized HTS services, the service:

(I) provider receives DDS area staff oversight; and

(II) must be pre-approved by the DDS director or his or her designee.

(C) **Coverage limitations.** HTS services are authorized per OAC 317:40-5-110, 317:40-5-111, ~~and~~ 317:40-7-13, and 340:100-3-33.1.

(i) A unit is 15 minutes.

(ii) Individual HTS services providers are limited to a maximum of 40 hours per week regardless of the number of members served.

(iii) More than one HTS may provide care to a member on the same day.

(iv) Payment cannot be made for services provided by two or more HTSs to the same member during the same hours of a day.

(v) A HTS may receive reimbursement for providing services to only one member at any given time. This does not preclude services from being provided in a group setting where services are shared among members of the group.

(vi) HTS providers may not perform any job duties associated with other employment~~,~~ including on-call duties, at the same time they are providing HTS services.

(9) **Self Directed HTS (SD HTS).** SD HTS are provided per OAC 317:40-9-1.

(10) **Self Directed Goods and Services (SD GS).** SD GS are provided per OAC 317:40-9-1.

(11) **Audiology services.**

(A) **Minimum qualifications.** Audiologists must have licensure as an audiologist by the ~~State~~Oklahoma Board of Examiners for Speech Pathology and Audiology.

(B) **Description of services.** Audiology services include individual evaluation, treatment, and consultation in hearing to eligible members. Services are intended to maximize the member's auditory receptive abilities. The member's IP must include a practitioner's prescription.

(i) For purposes of this Section, practitioners are defined as licensed medical and osteopathic physicians, and physician assistants in accordance with rules and regulations covering the OHCA SoonerCare program.

(ii) A minimum of 15 minutes for encounter and record documentation is required.

(C) **Coverage limitations.** Audiology services are provided in accordance with the member's IP.

(12) **Prevocational services.**

(A) **Minimum qualifications.** Prevocational services providers:

(i) are at least 18 years of age;

(ii) complete the DHS ~~DDS sanctioned~~DDS-sanctioned training curriculum;

(iii) ~~have~~were not ~~been~~ convicted of, pled guilty to, or pled nolo contendere to misdemeanor assault and battery, or a felony per 56 O.S. §1025.2, unless a waiver is granted per 56 O.S. §1025.2; and

(iv) receive supervision and oversight by a person with a minimum of four years of any combination of ~~college level~~college-level education or full-time equivalent experience in serving persons with disabilities.

(B) **Description of services.** Prevocational services are not available to persons who can be served under a program funded per Section 110 of the Rehabilitation Act of 1973 or ~~Section 602(16) and (17) of~~ the Individuals with Disabilities Education Act (IDEA)~~. Services are aimed at preparing a member for employment, but are not job-task oriented. Services include teaching concepts, such as compliance, attendance, task completion, problem solving, and safety.~~ per Section 1401 et seq. of Title 20 of the United States Code.

(i) Prevocational services are ~~provided to members who are not expected to:~~learning and work experiences where the individual can develop general, non-job, task-specific strengths that contribute to employability in paid employment in integrated community settings.

~~(I) join the general work force; or~~

~~(II) participate in a transitional sheltered workshop within one year, excluding supported employment programs.~~

(ii) ~~When compensated, members are paid at less than 50 percent of the minimum wage. Activities included in this service are not primarily directed at teaching specific job skills, but at underlying, habilitative goals, such as attention span and motor skills.~~Activities include teaching concepts, such as communicating effectively with supervisors, co-workers, and customers, attendance, task completion, problem solving, and safety. These activities are associated with building skills necessary to perform work.

(iii) Pre-vocational services are delivered for the purpose of furthering habilitation goals that lead to greater opportunities for competitive, integrated employment. All prevocational services are reflected in the member's IP~~ as habilitative, rather than explicit employment objectives~~. Documentation must be maintained in the record of each member receiving this service, noting the service is not otherwise available through a program funded under the Rehabilitation Act of 1973 or IDEA.

(iv) ~~Documentation must be maintained in the record of each member receiving this service, noting the service is not otherwise available through a program funded under the Rehabilitation Act of 1973 or IDEA.~~

~~(v)~~Services include:

(I) center-based prevocational services, per OAC 317:40-7-6;

(II) community-based prevocational services per, OAC 317:40-7-5;

(III) enhanced community-based prevocational services per, OAC 317:40-7-12; and

(IV) supplemental supports, as specified in OAC 317:40-7-13.

(C) **Coverage limitations.** A unit of center-based or community-based prevocational services is one hour and payment is based ~~upon~~on the number of hours the member participates in the service. All prevocational services and ~~supported employment~~supported-employment services combined may not exceed $27,000, per Plan of Care year. The~~ following~~ services that may not be provided to the same member at the same time as prevocational services~~:~~ are:

(i) HTS;

(ii) Intensive Personal Supports;

(iii) Adult Day Services;

(iv) Daily Living Supports;

(v) Homemaker; or

(vi) therapy services, such as occupational therapy~~,~~; physical therapy~~,~~; nutrition, speech, or psychological

services~~,~~; family counseling~~,~~; or family training, except to allow the therapist to assess the individual's needs at the workplace or to provide staff training, ~~and as allowed~~ per OAC 317:40-7-6.

(13) **Supported employment.**

(A) **Minimum qualifications.** Supported employment providers:

(i) are at least 18 years of age;

(ii) complete the DHS ~~DDS sanctioned~~DDS-sanctioned training curriculum;

(iii) ~~have~~were not ~~been~~ convicted of, pled guilty to, or pled nolo contendere to misdemeanor assault and battery, or a felony, per ~~56 O.S. §1025.2,~~Section 1025.2 of Title 56 of the Oklahoma Statutes (O.S. 56 § 1025.2) unless a waiver is granted, per 56 O.S. ~~§1025.2;~~§ 1025.5; and

(iv) receive supervision and oversight by a person with a minimum of four years of any combination of ~~college level~~college-level education or full-time equivalent experience in serving persons with disabilities.

(B) **Description of services.** Supported employment is conducted in a variety of settings, particularly ~~work sites~~worksites in which persons without disabilities are employed, and includes activities that are outcome based and needed to sustain paid work by members receiving services through HCBS Waivers, including supervision and training. The outcome of supported employment is sustained paid employment at or above minimum wage, but not less than the customary wage and benefit level paid by the employer for the same or similar work performed by individuals without disabilities. The paid employment occurs in an integrated setting in the general workforce in a job that meets personal and career goals.

(i) When ~~supported employment~~supported-employment services are provided at a ~~work site~~worksite in which persons without disabilities are employed, payment:

(I) is made for the adaptations, supervision, and training required by members as a result of their disabilities; and

(II) does not include payment for the supervisory activities rendered as a normal part of the business setting.

(ii) Services include:

(I) job coaching per OAC 317:40-7-7;

(II) enhanced job coaching per OAC 317:40-7-12;

(III) employment training specialist services per OAC 317:40-7-8; and

(IV) stabilization per OAC 317:40-7-11.

(iii) ~~Supported employment~~Supported-employment services

furnished under HCBS Waivers are not available under a program funded by the Rehabilitation Act of 1973 or ~~IDEA.~~Individuals with Disabilities Education Act (IDEA).

(iv) Documentation that the service is not otherwise available under a program funded by the Rehabilitation Act of 1973 or IDEA must be maintained in the record of each member receiving ~~this~~the service.

(v) Federal financial participation (FFP) may not be claimed for incentive payment subsidies or unrelated vocational training expenses, such as:

(I) incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program;

(II) payments passed through to users of ~~supported employment~~supported-employment programs; or

(III) payments for vocational training not directly related to a member's ~~supported employment~~supported-employment program.

(C) **Coverage limitations.** A unit is 15 minutes and payment is made per OAC 317:40-7-1 through 317:40-7-21. All prevocational services and ~~supported employment~~supported-employment services combined cannot exceed $27,000, per Plan of Care year. The DDS case manager assists the member to identify other alternatives to meet identified needs above the limit. The~~ following~~ services that may not be provided to the same member, at the same time~~,~~ as ~~supported employment services:~~supported-employment services are:

(i) HTS;

(ii) Intensive Personal Supports;

(iii) Adult Day Services;

(iv) Daily Living Supports;

(v) Homemaker; or

(vi) ~~Therapy~~therapy services, such as occupational therapy~~,~~; physical therapy~~,~~; nutrition, speech, or psychological services, family counseling, or family training, except to allow the therapist to assess the individual's needs at the workplace or to provide staff training.

(14) **Intensive personal supports (IPS).**

(A) **Minimum qualifications.** IPS provider agencies must have a current provider agreement with OHCA and DHS DDS. Providers:

(i) are at least 18 years of age;

(ii) complete the DHS ~~DDS-sanctioned~~DDS-sanctioned training curriculum;

(iii) ~~have~~were not ~~been~~ convicted of, pled guilty to, or pled nolo contendere to misdemeanor assault and

battery, or a felony, per ~~56 O.S. §1025.2,~~Section 1025.2 of Title 56 of the Oklahoma Statutes (O.S. 56 § 1025.2) unless a waiver is granted, per 56 O.S. ~~§1025.2;~~§ 1025.2;

(iv) receive supervision and oversight by a person with a minimum of four years of any combination of ~~college level~~college-level education or full-time equivalent experience in serving persons with disabilities; and

(v) receive oversight regarding specific methods to be used with the member to meet the member's complex behavioral or health support needs.

(B) **Description of services.**

(i) IPS:

(I) are support services provided to members who need an enhanced level of direct support in order to successfully reside in a community-based setting; and

(II) build upon the level of support provided by a HTS or daily living supports (DLS) staff by utilizing a second staff person on duty to provide assistance and training in self-care, daily living, and recreational~~,~~ and habilitation activities.

(ii) The member's ~~IP~~Individual Plan (IP) must clearly specify the role of HTS and the person providing IPS to ensure there is no duplication of services.

(iii) ~~DDS case management supervisor review~~Review and approval by the DDS plan of care reviewer is required.

(C) **Coverage limitations.** IPS are limited to 24 hours per day and must be included in the member's IP, per OAC 317:40-5-151 and 317:40-5-153.

(15) **Adult day services.**

(A) **Minimum qualifications.** Adult day services provider agencies must:

(i) meet the licensing requirements, per 63 O.S. ~~§§1-873~~§ 1-873 *et seq.* and comply with OAC 310:605; and

(ii) be approved by the DHS DDS director and have a valid OHCA contract for adult day services.

(B) **Description of services.** Adult day services provide assistance with the retention or improvement of self-help, adaptive~~,~~ and socialization skills, including the opportunity to interact with peers in order to promote a maximum level of independence and function. Services are provided in a non-residential setting ~~separate~~away from the home or facility where the member resides.

(C) **Coverage limitations.** Adult day services are ~~typically~~ furnished four or more hours per day on a regularly scheduled basis, for one or more days per week. A unit is 15 minutes for up to a maximum of six hours daily, at which point a unit is one day. All services must

be authorized in the member's IP.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 40. DEVELOPMENTAL DISABILITIES SERVICES

SUBCHAPTER 1. GENERAL PROVISIONS

317:40-1-3. Requirements for Home and Community-Based settings

(a) The Oklahoma Department of Human Services Developmental Disabilities Services Home and Community-Based Services (HCBS) Waiver settings have the following qualities defined in federal regulation per ~~42 CFR § 441.301(c)(4)~~Section 441.301(c)(4) of Title 42 of the Code of Federal Regulations [42 CFR § 441.301(c)(4)] based on the needs of the individual defined in his or her Individual Plan (Plan).

(1) The setting is integrated and supports full access of individuals receiving HCBS Waivers to the greater community, including opportunities to:

(A) seek employment and work in competitive, integrated settings;

(B) engage in community life;

(C) control personal resources; and

(D) receive services in the community, to the same degree as individuals not receiving Medicaid HBCS Waiver Services.

(2) The setting is selected by the member from options including non-disability settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and based on individual needs and preferences.

(3) For residential settings, the member must have income available for room and board.

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

(5) The setting optimizes individual initiative, autonomy, and independence in making life choices including, but not limited to:

(A) daily activities;

(B) the physical environment; and

(C) with whom to interact.

(6) The setting facilitates individual choice regarding services and supports, including who provides them.

(b) In a provider-owned or controlled residential setting, in addition to the attributes specified above, the additional conditions listed in (1) through (8) of this subsection must be met.

(1) The unit or dwelling is a specific, physical place, owned, rented, or occupied under a ~~legally enforceable~~legally-enforceable agreement by the member receiving services.

(2) The member has the same responsibilities and protections from eviction, that tenants have per the Residential Landlord and Tenant Act, ~~41 O.S. § 101, et seq.~~Section 101 et. seq. of Title 41 of the Oklahoma Statutes (41 O.S. § 101, et. seq.)

(3) In settings where landlord tenant laws do not apply, the provider agency completes a lease, residency agreement, or other form of written agreement for each member. The document provides protections that address eviction processes and appeals comparable to those provided in the Residential Landlord and Tenant Act, 41 O.S. § 101, et seq.

(4) Each member has privacy in his or her sleeping or living unit, where:

(A) units have entrance doors lockable by the member, with only appropriate staff having keys to doors;

(B) members sharing units have a choice of roommates; and

(C) members have freedom to furnish and decorate ~~his or her~~ sleeping or living units within the lease or other agreement.

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

(6) ~~Each member may have visitors whenever he or she chooses.~~Members are able to have visitors of his or her choosing, at any time.

(7) The setting is physically accessible to the member.

(8) Any modifications of the additional conditions specified in this subsection, must be supported by a specific, assessed need, ~~and~~ justified in the person-centered ~~Plan~~plan and includes:

(A) an identified individualized assessed need;

(B) documentation of the positive interventions and supports used prior to any modifications to the person-centered plan;

(C) documentation of less intrusive methods tried, including those that did not work;

(D) a clear description of the condition, proportionate to the specific assessed need;

(E) regular collection and review of data to measure the ongoing effectiveness of the modification;

(F) established time limits for periodic reviews to determine if the modification continues to be necessary or can be terminated;

(G) the informed consent of the member; and

(H) an assurance the interventions and supports will cause no harm to the member.

(c) Any setting that isolates members from the broader community of individuals not receiving HCBS is not considered an HCBS.

(1) Settings that are not HCBS per 42 CFR § 441.301(c)(5)(v) include:

(A) a nursing facility;
(B) an institution for mental diseases;
(C) an intermediate care facility for individuals with intellectual disabilities;
(D) a hospital; or
(E) any other locations with qualities of an institutional setting per 42 CFR § 441.301(c)(5)(v).

SUBCHAPTER 7. EMPLOYMENT SERVICES THROUGH HOME AND COMMUNITY-BASED SERVICES WAIVERS

317:40-7-3. Eligibility for Waiver Employment Services

(a) Individuals served through Waiver Employment Services must be:

(1) 16 years of age ~~or~~and older for persons receiving services through the Community Waiver, ~~or 18 years of age or older for persons receiving services through the~~ In Home Supports Waiver, or the Homeward Bound Waiver; and

(2) approved for waiver services ~~in accordance with OAC~~, per Oklahoma Administrative Code (OAC) 317:40-1-1.

(b) Services available to the ~~service recipient~~member through the Oklahoma Department of Rehabilitation Services (DRS) or through the state or local education agency are not funded under Waiver Employment Services.

(1) ~~Service recipients~~Members may utilize waiver employment services during times when school is not in session, ~~unless an IEP approved program through the school system is in place.~~and/or the member is not participating in an Individual Education Program that includes extended school year services through the school system.

(2) All ~~service recipients~~members seeking ~~supported~~ competitive, integrated employment make application to DRS. Prior to the authorization of Waiver Employment Services, the case manager ~~completes OKDHS Form DDS-55, Documentation of Application for DRS Supported Employment Services, to be maintained as a permanent entry in the local case record.~~documents the application for DRS services. The documentation is permanently maintained in the Client Contact Manager record.

(3) Since services provided by DRS are time-limited by federal law, ~~DDSD~~Developmental Disabilities Services provides ~~long term,~~long-term, on-going supports for individuals who need long-term supports, ~~as described in~~per OAC 317:40-7-11.

317:40-7-4. Services provided through Waiver Employment Services

(a) Waiver Employment Services are offered under the ~~Medicaid~~ Home and Community-Based Waiver for persons with intellectual disabilities at rates prescribed by the Oklahoma Health Care

Authority.

(b) ~~Types of~~ Waiver Employment Services ~~offered~~ include:

(1) Vocational Habilitation Training Specialist ~~(VHTS)~~, Supplemental Support;

(2) Employment Training Specialist ~~(ETS)~~;

(3) Center-Based Services;

(4) Community-Based Services;

(5) Enhanced Community-Based Services;

(6) Job Coaching;

(7) Enhanced Job Coaching; and

(8) Stabilization Services.

(c) ~~State-funded services described in OAC 340:100-17-30 may supplement Employment Services funded through the Community Waiver.~~State-funded employment services are available to members of the Homeward Bound class who are not eligible for Developmental Disabilities Services Waiver services.

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 51. HABILITATION SERVICES

317:30-5-482. Description of services

Habilitation services include the services identified in (1) through (15) of this ~~section. Providers of habilitation services~~ Section. Habilitation services providers must have an applicable agreement with the Oklahoma Health Care Authority (OHCA) to provide Developmental Disabilities Services (DDS) Home and ~~Community Based~~Community-Based Services (HCBS).

(1) **Dental services.** Dental services are provided per Oklahoma Administrative Code (OAC) 317:40-5-112.

(A) **Minimum qualifications.** ~~Providers of dental services~~Dental services providers must have non-restrictive licensure by the ~~Board of Governors of Registered Dentists of Oklahoma~~Oklahoma State Board of Dentistry to practice dentistry in Oklahoma.

(B) **Description of services.** Dental services include services for maintenance or improvement of dental health as well as relief of pain and infection. These services may include:

(i) an oral examination;
(ii) bite-wing ~~x-rays;~~X-rays;
(iii) ~~a prophylaxis;~~dental cleaning;
(iv) ~~topical fluoride~~topical-fluoride treatment;
(v) development of a sequenced treatment plan that prioritizes:
(I) elimination of pain;
(II) adequate oral hygiene; and
(III) restoration or an improved ability to chew;
(vi) routine training of member or primary caregiver regarding oral hygiene; and
(vii) preventive, restorative, replacement, and repair services to achieve or restore functionality~~, that are~~ provided after appropriate review when applicable, per OAC 317:40-5-112.

(C) **Coverage limitations.** Coverage of dental services is specified in the member's Individual Plan (IP)~~,~~ in accordance with applicable Waiver limits. Dental services are not authorized when recommended for cosmetic purposes.

(2) **Nutrition services.** Nutrition Services are provided per OAC 317:40-5-102.

(3) **Occupational therapy services.**

(A) **Minimum qualifications.** Occupational therapists and occupational therapy assistants must have current, non-

restrictive licensure by the Oklahoma ~~State~~ Board of Medical Licensure and Supervision. Occupational therapy assistants must be employed by ~~the~~ occupational ~~therapist.~~therapists.

(B) **Description of services.** Occupational therapy services include evaluation, treatment, and consultation in leisure management, daily living skills, sensory motor, perceptual motor, and mealtime assistance. Occupational therapy services may include the use of occupational therapy assistants, within the limits of the occupational therapist's practice.

(i) Services are:

(I) intended to help the member achieve greater independence to reside and participate in the community; and

(II) rendered in any community setting as specified in the member's ~~individual plan (IP).~~IP. The IP must include a practitioner's prescription.

(ii) For purposes of this Section, a practitioner is defined as medical and osteopathic physicians, physician assistants, and other licensed health care professionals with prescriptive authority to order occupational therapy services in accordance with the rules and regulations governing the SoonerCare program.

(iii) The provision of services includes a written report or record documentation in the member's record, as required.

(C) **Coverage limitations.** Payment is made for compensable services to the individual occupational therapist for direct services or for services provided by a qualified occupational therapist assistant, within the occupational therapist's employment. Payment is made in 15-minute units, with a limit of 480 units per Plan of Care year. Payment is not allowed solely for written reports or record documentation.

(4) **Physical therapy services.**

(A) **Minimum qualifications.** Physical therapists and physical therapist assistants must have current, non-restrictive licensure with the Oklahoma ~~State~~ Board of Medical Licensure and Supervision. The physical therapist must employ the physical therapist assistant.

(B) **Description of services.** Physical therapy services include evaluation, treatment, and consultation in locomotion or mobility and skeletal and muscular conditioning to maximize the member's mobility and skeletal/muscular well-being. Physical therapy services may include the use of physical therapist assistants, within the limits of the physical therapist's practice.

(i) Services are intended to help the member achieve

greater independence to reside and participate in the community. Services are provided in any community setting as specified in the member's IP. The IP must include a practitioner's prescription.

(ii) For purposes of this Section, a practitioner is defined as a licensed medical and osteopathic physicians, and physician assistants in accordance with the rules and regulations covering the OHCA SoonerCare program.

(iii) The provision of services includes a written report or record documentation in the member's record, as required.

(C) **Coverage limitations.** Payment is made for compensable services to individual physical therapists for direct services or for services provided by a qualified physical therapist assistant within the physical therapist's employment. Payment is made in 15-minute units with a limit of 480 units per Plan of Care year. Payment is not allowed solely for written reports or record documentation.

(5) **Psychological services.**

(A) **Minimum qualifications.** Qualification as a provider of psychological services requires current, non-restrictive licensure as a psychologist by the Oklahoma ~~Psychologist~~State Board of Examiners~~,~~ of Psychologists or licensing board in the state in which service is provided. Psychological technicians who have completed all board certification and training requirements may provide services under a licensed psychologist's supervision.

(B) **Description of services.** Psychological services include evaluation, psychotherapy, consultation, and behavioral treatment. Service is provided in any community setting as specified in the member's IP. The provider must develop, implement, evaluate and revise the Protective Intervention Protocol (PIP) corresponding to the relevant outcomes identified in the member's IP.

(i) Services are:

(I) intended to maximize a member's psychological and behavioral well-being; and

(II) provided in individual and group formats, with a ~~six person~~six-person maximum.

(ii) ~~A minimum of 15 minutes for each individual encounter, 15 minutes for each group encounter, and record documentation of each treatment session is included and required.~~Approval of services is based upon assessed needs per OAC 340:100-5-51.

(C) **Coverage limitations.**

(i) ~~Limitations for psychological services are:~~

~~(I) description: psycho therapy services and behavior treatment services, individual: unit: 15 minutes; and~~

~~(II) description: cognitive/behavioral treatment, group: unit: 15 minutes.~~Payment is made in 15 minute units. A minimum of 15 minutes for each individual and group encounter is required.

(ii) Psychological services are authorized for a period, not to exceed ~~six~~twelve (12) months.

(I) Initial authorization ~~is obtained through the Developmental Disabilities Services (DDS) case manager, with review and approval by the DDS case management supervisor.~~must not exceed 192 units, 48 hours of service.

(II) ~~Initial authorization must not exceed 192 units, 48 hours of service.~~Authorizations may not exceed 288 units per plan of care year unless an exception is made by the DDS director of Behavior Support Services or his or her designee.

(III) ~~Quarterly progress notes must include a statement of hours and types of services provided, and an empirical measure of member status as it relates to each objective in the member's IP.~~No more than 12 hours of services, 48 units, may be billed for PIP preparation. Any clinical document must be prepared within sixty (60) calendar days of the request. Further, if the document is not prepared, payments are suspended until the requested document is provided.

(IV) When ~~progress notes for each quarter of service provision are not submitted to the DDS case manager, authorization for payment must be withdrawn until such time as progress notes are submitted.~~revising a PIP to accommodate recommendations of a required committee review, the provider may bill for only one revision. The time for preparing the revision must be clearly documented and must not exceed four hours.

~~(iii) Treatment extensions may be authorized by the DDS area manager, based upon evidence of continued need and effectiveness of treatment.~~

~~(I) Evidence of continued need of treatment, treatment effectiveness, or both, is submitted by the provider to the DDS case manager and must include, at a minimum, completion of the Service Utilization and Evaluation protocol.~~

~~(II) When revising a protective intervention plan (PIP) to accommodate recommendations of a required~~

committee review or an Oklahoma Department of Human (DHS) audit, the provider may bill for only one revision. The time for preparing the revision must be clearly documented and must not exceed four hours.

(III) Treatment extensions must not exceed 24 hours, 96 units, of service, per request.

(iv) The provider must develop, implement, evaluate, and revise the PIP corresponding to the relevant goals and objectives identified in the member's IP.

(v) No more than 12 hours, 48 units, may be billed for the preparation of a PIP. Any clinical document must be prepared within 45 calendar days of the request. Further, if the document is not prepared, payments are suspended until the requested document is provided.

(vi) Psychological technicians may provide up to 140 billable hours, 560 units, of service per month to members.

(vii) The psychologist must maintain a record of all billable services provided by a psychological technician.

(6) **Psychiatric services.**

(A) **Minimum qualifications.** Qualification as a ~~provider of~~ psychiatric services provider requires a current, non-restrictive license to practice medicine in Oklahoma. Certification by the American Board of Psychiatry and Neurology or satisfactory completion of an approved residency program in psychiatry is required.

(B) **Description of services.** Psychiatric services include outpatient evaluation, psychotherapy, medication and prescription management and consultation, and are provided to eligible members. Services are provided in community setting specified in the member's IP.

(i) Services are intended to contribute to the member's psychological well-being.

(ii) A minimum of 30 minutes for encounter and record documentation is required.

(C) **Coverage limitations.** A unit is 30 minutes, with a limit of 200 units, per Plan of Care year.

(7) **Speech/language services.**

(A) **Minimum qualifications.** Qualification as a ~~provider of~~ speech and/or language services provider requires current, non-restrictive licensure as a speech and/or language pathologist by the ~~State~~Oklahoma Board of Examiners for Speech Pathology and Audiology.

(B) **Description of services.** Speech therapy includes evaluation, treatment, and consultation in communication and oral motor and/or feeding activities provided to eligible members. Services are intended to maximize the

member's community living skills and may be provided in the community setting specified in the member's IP. The IP must include a practitioner's prescription.

(i) For purposes of this Section, practitioners are defined as licensed medical and osteopathic physicians, physician assistants, and other licensed professionals with prescriptive authority to order speech and/or language services in accordance with rules and regulations covering the OHCA SoonerCare program.

(ii) A minimum of 15 minutes for encounter and record documentation is required.

(C) **Coverage limitations.** A unit is 15 minutes, with a limit of 288 units, per Plan of Care year.

(8) **Habilitation training specialist (HTS) services.**

(A) **Minimum qualifications.** Providers must complete the ~~DHS DDS sanctioned~~Oklahoma Department of Human Services (DHS) DDS-sanctioned training curriculum. Residential habilitation providers:

(i) are at least 18 years of age;

(ii) are specifically trained to meet ~~the~~members' unique needs~~ of members~~;

(iii) ~~have~~were not~~ been~~ convicted of, pled guilty to, or pled nolo contendere to misdemeanor assault and battery, or a felony, per Section 1025.2 of Title 56 of the Oklahoma Statutes (56 O.S. § 1025.2)~~,~~; unless a waiver is granted, per 56 O.S. § 1025.2; and

(iv) receive supervision and oversight from ~~a contracted agency~~contracted-agency staff with a minimum of four years of any combination of ~~college level~~college-level education or full-time equivalent experience in serving persons with disabilities.

(B) **Description of services.** HTS services include services to support the member's self-care, daily living, and adaptive and leisure skills needed to reside successfully in the community. Services are provided in community-based settings in a manner that contributes to the member's independence, self-sufficiency, community inclusion, and well-being.

(i) Payment ~~will~~is not~~ be~~ made for:

(I) routine care and supervision normally provided by family; or

(II) services furnished to a member by a person who is legally responsible per OAC 340:100-3-33.2.

(ii) Family members who provide HTS services must meet the same standards as providers who are unrelated to the member. HTS staff residing in the same household as the member may not provide services in excess of 40 hours per week. Members ~~who require~~requiring more than 40 hours per week of HTS services, must use staff

members, who do not reside in the household and are employed by the member's chosen provider agency to deliver the balance of necessary support staff hours. Exceptions may be authorized, when needed, for members who receive services through the Homeward Bound Waiver.

(iii) Payment does not include room and board or maintenance, upkeep, ~~and~~or improvement of the member's or family's residence.

(iv) For members who also receive intensive personal supports (IPS), the member's IP must clearly specify the role of the HTS and person providing IPS to ensure there is no duplication of services.

(v) ~~DDS case management supervisor review~~Review and approval by the DDS plan of care reviewer is required.

(vi) Pre-authorized HTS services accomplish the same objectives as other HTS services, but are limited to situations where the HTS provider is unable to obtain required professional and administrative oversight from an ~~OHCA approved~~OHCA-approved oversight agency. For pre-authorized HTS services, the service:

(I) provider receives DDS area staff oversight; and

(II) must be pre-approved by the DDS director or his or her designee.

(C) **Coverage limitations.** HTS services are authorized per OAC 317:40-5-110, 317:40-5-111, ~~and~~ 317:40-7-13, and 340:100-3-33.1.

(i) A unit is 15 minutes.

(ii) Individual HTS services providers are limited to a maximum of 40 hours per week regardless of the number of members served.

(iii) More than one HTS may provide care to a member on the same day.

(iv) Payment cannot be made for services provided by two or more HTSs to the same member during the same hours of a day.

(v) A HTS may receive reimbursement for providing services to only one member at any given time. This does not preclude services from being provided in a group setting where services are shared among members of the group.

(vi) HTS providers may not perform any job duties associated with other employment~~,~~ including on-call duties, at the same time they are providing HTS services.

(9) **Self Directed HTS (SD HTS).** SD HTS are provided per OAC 317:40-9-1.

(10) **Self Directed Goods and Services (SD GS).** SD GS are provided per OAC 317:40-9-1.

(11) **Audiology services.**

(A) **Minimum qualifications.** Audiologists must have licensure as an audiologist by the ~~State~~Oklahoma Board of Examiners for Speech Pathology and Audiology.

(B) **Description of services.** Audiology services include individual evaluation, treatment, and consultation in hearing to eligible members. Services are intended to maximize the member's auditory receptive abilities. The member's IP must include a practitioner's prescription.

(i) For purposes of this Section, practitioners are defined as licensed medical and osteopathic physicians, and physician assistants in accordance with rules and regulations covering the OHCA SoonerCare program.

(ii) A minimum of 15 minutes for encounter and record documentation is required.

(C) **Coverage limitations.** Audiology services are provided in accordance with the member's IP.

(12) **Prevocational services.**

(A) **Minimum qualifications.** Prevocational services providers:

(i) are at least 18 years of age;

(ii) complete the DHS ~~DDS sanctioned~~DDS-sanctioned training curriculum;

(iii) ~~have~~were not ~~been~~ convicted of, pled guilty to, or pled nolo contendere to misdemeanor assault and battery, or a felony per 56 O.S. §1025.2, unless a waiver is granted per 56 O.S. §1025.2; and

(iv) receive supervision and oversight by a person with a minimum of four years of any combination of ~~college level~~college-level education or full-time equivalent experience in serving persons with disabilities.

(B) **Description of services.** Prevocational services are not available to persons who can be served under a program funded per Section 110 of the Rehabilitation Act of 1973 or ~~Section 602(16) and (17) of~~ the Individuals with Disabilities Education Act (IDEA)~~. Services are aimed at preparing a member for employment, but are not job-task oriented. Services include teaching concepts, such as compliance, attendance, task completion, problem solving, and safety.~~ per Section 1401 et seq. of Title 20 of the United States Code.

(i) Prevocational services are ~~provided to members who are not expected to:~~learning and work experiences where the individual can develop general, non-job, task-specific strengths that contribute to employability in paid employment in integrated community settings.

~~(I) join the general work force; or~~

~~(II) participate in a transitional sheltered workshop within one year, excluding supported employment programs.~~

(ii) ~~When compensated, members are paid at less than 50 percent of the minimum wage. Activities included in this service are not primarily directed at teaching specific job skills, but at underlying, habilitative goals, such as attention span and motor skills.~~Activities include teaching concepts, such as communicating effectively with supervisors, co-workers, and customers, attendance, task completion, problem solving, and safety. These activities are associated with building skills necessary to perform work.

(iii) Pre-vocational services are delivered for the purpose of furthering habilitation goals that lead to greater opportunities for competitive, integrated employment. All prevocational services are reflected in the member's IP~~ as habilitative, rather than explicit employment objectives~~. Documentation must be maintained in the record of each member receiving this service, noting the service is not otherwise available through a program funded under the Rehabilitation Act of 1973 or IDEA.

(iv) ~~Documentation must be maintained in the record of each member receiving this service, noting the service is not otherwise available through a program funded under the Rehabilitation Act of 1973 or IDEA.~~

~~(v)~~Services include:

(I) center-based prevocational services, per OAC 317:40-7-6;

(II) community-based prevocational services per, OAC 317:40-7-5;

(III) enhanced community-based prevocational services per, OAC 317:40-7-12; and

(IV) supplemental supports, as specified in OAC 317:40-7-13.

(C) **Coverage limitations.** A unit of center-based or community-based prevocational services is one hour and payment is based ~~upon~~on the number of hours the member participates in the service. All prevocational services and ~~supported employment~~supported-employment services combined may not exceed $27,000, per Plan of Care year. The~~ following~~ services that may not be provided to the same member at the same time as prevocational services~~:~~ are:

(i) HTS;

(ii) Intensive Personal Supports;

(iii) Adult Day Services;

(iv) Daily Living Supports;

(v) Homemaker; or

(vi) therapy services, such as occupational therapy~~,~~; physical therapy~~,~~; nutrition, speech, or psychological

services~~,~~; family counseling~~,~~; or family training, except to allow the therapist to assess the individual's needs at the workplace or to provide staff training, ~~and as allowed~~ per OAC 317:40-7-6.

(13) **Supported employment.**

(A) **Minimum qualifications.** Supported employment providers:

(i) are at least 18 years of age;

(ii) complete the DHS ~~DDS sanctioned~~DDS-sanctioned training curriculum;

(iii) ~~have~~were not ~~been~~ convicted of, pled guilty to, or pled nolo contendere to misdemeanor assault and battery, or a felony, per ~~56 O.S. §1025.2,~~Section 1025.2 of Title 56 of the Oklahoma Statutes (O.S. 56 § 1025.2) unless a waiver is granted, per 56 O.S. ~~§1025.2;~~§ 1025.5; and

(iv) receive supervision and oversight by a person with a minimum of four years of any combination of ~~college level~~college-level education or full-time equivalent experience in serving persons with disabilities.

(B) **Description of services.** Supported employment is conducted in a variety of settings, particularly ~~work sites~~worksites in which persons without disabilities are employed, and includes activities that are outcome based and needed to sustain paid work by members receiving services through HCBS Waivers, including supervision and training. The outcome of supported employment is sustained paid employment at or above minimum wage, but not less than the customary wage and benefit level paid by the employer for the same or similar work performed by individuals without disabilities. The paid employment occurs in an integrated setting in the general workforce in a job that meets personal and career goals.

(i) When ~~supported employment~~supported-employment services are provided at a ~~work site~~worksite in which persons without disabilities are employed, payment:

(I) is made for the adaptations, supervision, and training required by members as a result of their disabilities; and

(II) does not include payment for the supervisory activities rendered as a normal part of the business setting.

(ii) Services include:

(I) job coaching per OAC 317:40-7-7;

(II) enhanced job coaching per OAC 317:40-7-12;

(III) employment training specialist services per OAC 317:40-7-8; and

(IV) stabilization per OAC 317:40-7-11.

(iii) ~~Supported employment~~Supported-employment services

furnished under HCBS Waivers are not available under a program funded by the Rehabilitation Act of 1973 or ~~IDEA.~~Individuals with Disabilities Education Act (IDEA).

(iv) Documentation that the service is not otherwise available under a program funded by the Rehabilitation Act of 1973 or IDEA must be maintained in the record of each member receiving ~~this~~the service.

(v) Federal financial participation (FFP) may not be claimed for incentive payment subsidies or unrelated vocational training expenses, such as:

(I) incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program;

(II) payments passed through to users of ~~supported employment~~supported-employment programs; or

(III) payments for vocational training not directly related to a member's ~~supported employment~~supported-employment program.

(C) **Coverage limitations.** A unit is 15 minutes and payment is made per OAC 317:40-7-1 through 317:40-7-21. All prevocational services and ~~supported employment~~supported-employment services combined cannot exceed $27,000, per Plan of Care year. The DDS case manager assists the member to identify other alternatives to meet identified needs above the limit. The~~ following~~ services that may not be provided to the same member, at the same time~~,~~ as ~~supported employment services:~~supported-employment services are:

(i) HTS;

(ii) Intensive Personal Supports;

(iii) Adult Day Services;

(iv) Daily Living Supports;

(v) Homemaker; or

(vi) ~~Therapy~~therapy services, such as occupational therapy~~,~~; physical therapy~~,~~; nutrition, speech, or psychological services, family counseling, or family training, except to allow the therapist to assess the individual's needs at the workplace or to provide staff training.

(14) **Intensive personal supports (IPS).**

(A) **Minimum qualifications.** IPS provider agencies must have a current provider agreement with OHCA and DHS DDS. Providers:

(i) are at least 18 years of age;

(ii) complete the DHS ~~DDS-sanctioned~~DDS-sanctioned training curriculum;

(iii) ~~have~~were not ~~been~~ convicted of, pled guilty to, or pled nolo contendere to misdemeanor assault and

battery, or a felony, per ~~56 O.S. §1025.2,~~Section 1025.2 of Title 56 of the Oklahoma Statutes (O.S. 56 § 1025.2) unless a waiver is granted, per 56 O.S. ~~§1025.2;~~§ 1025.2;

(iv) receive supervision and oversight by a person with a minimum of four years of any combination of ~~college level~~college-level education or full-time equivalent experience in serving persons with disabilities; and

(v) receive oversight regarding specific methods to be used with the member to meet the member's complex behavioral or health support needs.

(B) **Description of services.**

(i) IPS:

(I) are support services provided to members who need an enhanced level of direct support in order to successfully reside in a community-based setting; and

(II) build upon the level of support provided by a HTS or daily living supports (DLS) staff by utilizing a second staff person on duty to provide assistance and training in self-care, daily living, and recreational~~,~~ and habilitation activities.

(ii) The member's ~~IP~~Individual Plan (IP) must clearly specify the role of HTS and the person providing IPS to ensure there is no duplication of services.

(iii) ~~DDS case management supervisor review~~Review and approval by the DDS plan of care reviewer is required.

(C) **Coverage limitations.** IPS are limited to 24 hours per day and must be included in the member's IP, per OAC 317:40-5-151 and 317:40-5-153.

(15) **Adult day services.**

(A) **Minimum qualifications.** Adult day services provider agencies must:

(i) meet the licensing requirements, per 63 O.S. ~~§§1-873~~§ 1-873 *et seq.* and comply with OAC 310:605; and

(ii) be approved by the DHS DDS director and have a valid OHCA contract for adult day services.

(B) **Description of services.** Adult day services provide assistance with the retention or improvement of self-help, adaptive~~,~~ and socialization skills, including the opportunity to interact with peers in order to promote a maximum level of independence and function. Services are provided in a non-residential setting ~~separate~~away from the home or facility where the member resides.

(C) **Coverage limitations.** Adult day services are ~~typically~~ furnished four or more hours per day on a regularly scheduled basis, for one or more days per week. A unit is 15 minutes for up to a maximum of six hours daily, at which point a unit is one day. All services must

be authorized in the member's IP.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 40. DEVELOPMENTAL DISABILITIES SERVICES

SUBCHAPTER 1. GENERAL PROVISIONS

317:40-1-3. Requirements for Home and Community-Based settings

(a) The Oklahoma Department of Human Services Developmental Disabilities Services Home and Community-Based Services (HCBS) Waiver settings have the following qualities defined in federal regulation per ~~42 CFR § 441.301(c)(4)~~Section 441.301(c)(4) of Title 42 of the Code of Federal Regulations [42 CFR § 441.301(c)(4)] based on the needs of the individual defined in his or her Individual Plan (Plan).

(1) The setting is integrated and supports full access of individuals receiving HCBS Waivers to the greater community, including opportunities to:

(A) seek employment and work in competitive, integrated settings;

(B) engage in community life;

(C) control personal resources; and

(D) receive services in the community, to the same degree as individuals not receiving Medicaid HBCS Waiver Services.

(2) The setting is selected by the member from options including non-disability settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and based on individual needs and preferences.

(3) For residential settings, the member must have income available for room and board.

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

(5) The setting optimizes individual initiative, autonomy, and independence in making life choices including, but not limited to:

(A) daily activities;

(B) the physical environment; and

(C) with whom to interact.

(6) The setting facilitates individual choice regarding services and supports, including who provides them.

(b) In a provider-owned or controlled residential setting, in addition to the attributes specified above, the additional conditions listed in (1) through (8) of this subsection must be met.

(1) The unit or dwelling is a specific, physical place, owned, rented, or occupied under a ~~legally enforceable~~legally-enforceable agreement by the member receiving services.

(2) The member has the same responsibilities and protections from eviction, that tenants have per the Residential Landlord and Tenant Act, ~~41 O.S. § 101, et seq.~~Section 101 et. seq. of Title 41 of the Oklahoma Statutes (41 O.S. § 101, et. seq.)

(3) In settings where landlord tenant laws do not apply, the provider agency completes a lease, residency agreement, or other form of written agreement for each member. The document provides protections that address eviction processes and appeals comparable to those provided in the Residential Landlord and Tenant Act, 41 O.S. § 101, et seq.

(4) Each member has privacy in his or her sleeping or living unit, where:

(A) units have entrance doors lockable by the member, with only appropriate staff having keys to doors;

(B) members sharing units have a choice of roommates; and

(C) members have freedom to furnish and decorate ~~his or her~~ sleeping or living units within the lease or other agreement.

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

(6) ~~Each member may have visitors whenever he or she chooses.~~Members are able to have visitors of his or her choosing, at any time.

(7) The setting is physically accessible to the member.

(8) Any modifications of the additional conditions specified in this subsection, must be supported by a specific, assessed need, ~~and~~ justified in the person-centered ~~Plan~~plan and includes:

(A) an identified individualized assessed need;

(B) documentation of the positive interventions and supports used prior to any modifications to the person-centered plan;

(C) documentation of less intrusive methods tried, including those that did not work;

(D) a clear description of the condition, proportionate to the specific assessed need;

(E) regular collection and review of data to measure the ongoing effectiveness of the modification;

(F) established time limits for periodic reviews to determine if the modification continues to be necessary or can be terminated;

(G) the informed consent of the member; and

(H) an assurance the interventions and supports will cause no harm to the member.

(c) Any setting that isolates members from the broader community of individuals not receiving HCBS is not considered an HCBS.

(1) Settings that are not HCBS per 42 CFR § 441.301(c)(5)(v) include:

(A) a nursing facility;
(B) an institution for mental diseases;
(C) an intermediate care facility for individuals with intellectual disabilities;
(D) a hospital; or
(E) any other locations with qualities of an institutional setting per 42 CFR § 441.301(c)(5)(v).

SUBCHAPTER 7. EMPLOYMENT SERVICES THROUGH HOME AND COMMUNITY-BASED SERVICES WAIVERS

317:40-7-3. Eligibility for Waiver Employment Services

(a) Individuals served through Waiver Employment Services must be:

(1) 16 years of age ~~or~~and older for persons receiving services through the Community Waiver, ~~or 18 years of age or older for persons receiving services through the~~ In Home Supports Waiver, or the Homeward Bound Waiver; and

(2) approved for waiver services ~~in accordance with OAC~~, per Oklahoma Administrative Code (OAC) 317:40-1-1.

(b) Services available to the ~~service recipient~~member through the Oklahoma Department of Rehabilitation Services (DRS) or through the state or local education agency are not funded under Waiver Employment Services.

(1) ~~Service recipients~~Members may utilize waiver employment services during times when school is not in session, ~~unless an IEP approved program through the school system is in place.~~and/or the member is not participating in an Individual Education Program that includes extended school year services through the school system.

(2) All ~~service recipients~~members seeking ~~supported~~ competitive, integrated employment make application to DRS. Prior to the authorization of Waiver Employment Services, the case manager ~~completes OKDHS Form DDS-55, Documentation of Application for DRS Supported Employment Services, to be maintained as a permanent entry in the local case record.~~documents the application for DRS services. The documentation is permanently maintained in the Client Contact Manager record.

(3) Since services provided by DRS are time-limited by federal law, ~~DDSD~~Developmental Disabilities Services provides ~~long term,~~long-term, on-going supports for individuals who need long-term supports, ~~as described in~~per OAC 317:40-7-11.

317:40-7-4. Services provided through Waiver Employment Services

(a) Waiver Employment Services are offered under the ~~Medicaid~~ Home and Community-Based Waiver for persons with intellectual disabilities at rates prescribed by the Oklahoma Health Care

Authority.

(b) ~~Types of~~ Waiver Employment Services ~~offered~~ include:

(1) Vocational Habilitation Training Specialist ~~(VHTS)~~, Supplemental Support;

(2) Employment Training Specialist ~~(ETS)~~;

(3) Center-Based Services;

(4) Community-Based Services;

(5) Enhanced Community-Based Services;

(6) Job Coaching;

(7) Enhanced Job Coaching; and

(8) Stabilization Services.

(c) ~~State-funded services described in OAC 340:100-17-30 may supplement Employment Services funded through the Community Waiver.~~State-funded employment services are available to members of the Homeward Bound class who are not eligible for Developmental Disabilities Services Waiver services.

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 75. FEDERALLY QUALIFIED HEALTH CENTERS

317:30-5-660.1. Health Center multiple sites contracting

(a) Health Centers may contract as SoonerCare ~~Traditional~~fee-for-service providers and as a ~~PCP/CM~~Primary Care Provider or Case Manager under SoonerCare Choice (Refer to OAC 317:25-7-5).

(b) Health Centers are required to submit a list of all entities affiliated or owned by the Center including any programs that do not have Health Center status, along with all ~~OHCA~~Oklahoma Health Care Authority provider numbers.

(c) Payment for FQHC services is based on a Prospective Payment System (PPS)~~.~~ or an Alternative Payment Methodology (APM) (Refer to OAC 317:30-5-664.10) In order to be eligible for reimbursement under this method for covered services, in traditional primary care settings, each site must submit an approval copy of the Health Resource and Service Administration (HRSA) Notice of Grant Award Authorization for Public Health Services Funds under Section 330, (or a copy of the letter from CMS designating the facility as a "Look Alike" FQHC) at the time of enrollment.

317:30-5-660.5. Health Center service definitions

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

"Alternative Payment Methodology (APM)" as defined in the state plan.

"Core Services" means outpatient services that may be covered when furnished to a ~~patient~~member at the ~~Center~~center or other location, including the ~~patient's~~member's place of residence.

"Encounter or Visit" means a face-to-face contact between an approved health care professional as authorized in the FQHC state plan pages and an eligible SoonerCare member for the provision of defined services through a Health Center within a ~~24-hour~~twenty-four (24) hour period ending at midnight, as documented in the patient's medical record.

"Licensed Behavioral Health Professional (LBHP)" means licensed psychologists, licensed clinical social workers (LCSWs), licensed marital and family therapists (LMFTs), licensed professional counselors (LPCs), licensed behavioral practitioners (LBPs), and licensed alcohol and drug counselors (LADCs).

"Other ambulatory services" means other health services covered under the ~~State~~state plan other than core services.

"Physician" means:

(A) a doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which the function is performed or who is a licensed physician employed by the ~~Public Health Service;~~public health service;

(B) within limitations as to the specific services furnished, a doctor of dentistry or dental or oral surgery, a doctor of optometry, or a doctor of podiatry;

"Physicians' services" means professional services that are performed by a physician at the Health Center (or are performed away from the Center, excluding inpatient hospital services) whose agreement with the Center provides that he or she will be paid by the Health Center for such services.

~~**"PPS"**~~**"Prospective Payment System (PPS)"** means~~ prospective payment system~~ all-inclusive per visit rate method specified in the ~~State~~state plan.

317:30-5-661.4. Behavioral health professional services provided at Health Centers and other settings

(a) Medically necessary behavioral health services that are primary, preventive, and therapeutic and that would be covered if provided in another setting may be provided by Health Centers. Services provided by a Health Center (refer to OAC 317:30-5-241 for a description of services) must meet the same requirements as services provided by other behavioral health providers. Rendering providers must be eligible to individually enroll or meet the requirements as an agency/organization provider specified in OAC 317:30-5-240.2 and 317:30-5-280. Behavioral Health Services include:

(1) ~~Assessment/Evaluation;~~assessment/evaluation;

(2) ~~Crisis Intervention Services;~~crisis intervention services;

(3) ~~Individual/Interactive Psychotherapy;~~individual/interactive psychotherapy;

(4) ~~Group Psychotherapy;~~group psychotherapy;

(5) ~~Family Psychotherapy;~~family psychotherapy;

(6) ~~Psychological Testing; and~~psychological testing; and

(7) ~~Case Management~~case management (as an integral component of services 1-6 above).

(b) Medically necessary behavioral health professional therapy services are covered when provided in accordance with a documented individualized treatment plan, developed to treat the identified behavioral health disorder(s). A one-on-one standard clinical session must be completed by a health care professional authorized in the approved ~~FQHC State Plan~~Federally Qualified Health Center (FQHC) state plan pages in order to bill the PPS or APM encounter rate for the session. Services rendered by providers not authorized under the approved FQHC state plan

pages to bill the PPS or APM encounter rate will be reimbursed pursuant to the SoonerCare fee-for-service fee schedule and must comply with rules found at OAC 317:30-5-280 through 317:30-5-283. Behavioral health services must be billed on an appropriate claim form using the appropriate ~~Current Procedural Terminology (CPT)~~ procedure code and guidelines. The time indicated on the claim form must be the time actually spent with the member.
(c) Centers are reimbursed the PPS or APM encounter rate for services when rendered by approved health care professionals, as authorized under FQHC state plan pages, if the Health Center receives funding pursuant to Section 330 or is otherwise funded under Public Law to provide primary health care services at locations off-site (not including satellite or mobile locations) to Health Center patients on a temporary or intermittent basis, unless otherwise limited by Federal law.
(d) Health Centers that operate day treatment programs in school settings must meet the requirements found at OAC 317:30-5-240.2(b)(7).
(e) In order to support the member's access to behavioral health services, these services may take place in settings away from the Health Center. Off-site behavioral health services must take place in a confidential setting.

317:30-5-661.7. Allowable Places of services
(a) Services provided to members within the four walls of the Health Center and approved Health Center satellites including mobile health clinics operated by the Center are allowable for reimbursement under the PPS~~.~~ or APM encounter rate.
(b) Off-site services provided by employed practitioners of the Health Center to patients temporarily homebound or in any skilled nursing facility because of a medical condition that prevents the patient from going to the Health Center for health care are also allowable for reimbursement under the PPS or APM encounter rate if the service would be reimbursed the PPS or APM encounter rate at the Center. It is expected that services provided in off-site settings should be, in most cases, temporary and intermittent, i.e., when the member cannot come to the clinic due to health reasons.

317:30-5-664.1. Provision of other health services outside of the Health Center core services
(a) If the Center chooses to provide other SoonerCare ~~State Plan~~state plan covered health services which are not included in the Health Center core service definition in OAC 317:30-5-661.1, the practitioners of those services are subject to the same program coverage limitations, enrollment and billing procedures described by the ~~OHCA,~~Oklahoma Health Care Authority, and these services (e.g., home health services) are not included in the PPS settlement methodology or APM settlement methodology in OAC

317:30-5-664.12.
(b) Other health services include, but are not limited to:
(1) dental services (refer to OAC 317:30-5-696) except for primary preventive dental services;
(2) eyeglasses (OAC 317:30-5-430 and OAC 317:30-5-450);
(3) clinical lab tests performed in the Center lab (other than the specific laboratory tests set out for Health Centers' certification and covered as Health Center services);
(4) technical component of diagnostic tests such as x-rays and EKGs (interpretation of the test provided by the Center physician is included as physician professional services);
(5) durable medical equipment (refer to OAC 317:30-5-210);
(6) emergency ambulance transportation (refer to OAC 317:30-5-335);
(7) prescribed drugs (refer to OAC 317:30-5-70);
(8) 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;
(9) specialized laboratory services furnished away from the clinic;
(10) ~~Psychosocial Rehabilitation Services~~psychosocial rehabilitation services [refer to OAC 317:30-5-241.3]; and
(11) behavioral health related case management services(refer to OAC 317:30-5-241.6).

317:30-5-664.3. Health Center encounters
(a) Health Center encounters that are billed to the OHCA must meet the definition in this Section and are limited to services covered by OHCA. Only encounters provided by the authorized health care professional on the approved ~~FQHC~~Federally Qualified Health Center state plan pages within the scope of their licensure trigger a PPS or APM encounter rate.
(b) An encounter is defined as a face-to-face contact between a health care professional and a member for the provision of defined services through a Health Center within a ~~24-hour~~twenty-four (24) hour period ending at midnight, as documented in the member's medical record.
(c) A Health Center may bill for one medically necessary encounter per ~~24~~twenty-four (24) hour period. Medical review will be required for additional visits for children. Payment is limited to four (4) visits per member per month for adults.
(d) Services considered reimbursable encounters (including any related medical supplies provided during the course of the encounter) include:
(1) medical;
(2) diagnostic;
(3) dental, medical and behavioral health screenings;

(4) vision;
(5) physical therapy;
(6) occupational therapy;
(7) podiatry;
(8) behavioral health;
(9) speech;
(10) hearing;
(11) medically necessary Health Center encounters with a RN or LPN and related medical supplies (other than drugs and biologicals) furnished on a part-time or intermittent basis to home-bound members (refer to OAC 317:30-5-661.3);
(12) any other medically necessary health services (i.e. optometry and podiatry) are also reimbursable as permitted within the Health Center's scope of services when medically reasonable and necessary for the diagnosis or treatment of illness or injury, and must meet all applicable coverage requirements.

(e) Services and supplies incident to a physician's professional service are reimbursable within the encounter if the service or supply is:
(1) of a type commonly furnished in physicians' offices;
(2) of a type commonly rendered either without a charge or included in the health clinic's bill;
(3) furnished as an incidental, although integral, part of a physician's professional services;
(4) furnished under the direct, personal supervision of a physician; and
(5) in the case of a service, furnished by a member of the clinic's health care staff who is an employee of the clinic.

(f) Only drugs and biologicals which cannot be self-administered are included within the scope of this benefit.

317:30-5-664.10. Health Center reimbursement

(a) In accordance with Section 702 of the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000, reimbursement is provided for core services and other health services at a Health Center facility-specific Prospective Payment System (PPS) ~~rate per visit (encounter)~~ or an Alternative Payment Method (APM) encounter rate determined according to the methodology described in OAC 317:30-5-664.12.

(b) As claims/encounters are filed, reimbursement for SoonerCare Choice members is made for all medically necessary covered primary care and other approved health services at the PPS or APM encounter rate.

(c) Primary and preventive behavioral health services rendered by health care professionals authorized in the FQHC approved state plan pages will be reimbursed at the PPS or APM encounter rate.

(d) Vision services provided by Optometrists within the scope of their licensure for non-dual eligible members and allowed under the Medicaid ~~State Plan~~state plan are reimbursed pursuant to the SoonerCare fee-for-service fee schedule.

317:30-5-664.12. Determination of Health Center PPS or APM encounter rate

(a) **Methodology.** The methodology for establishing each facility's PPS rate is found in Attachment 4.19 B of the ~~OHCA's State Plan,~~Oklahoma Health Care Authority's state plan as amended effective January 1, 2001, and incorporated herein by reference. The methodology for establishing each facility's APM encounter rate is found in Attachment 4.19 B of OHCA's state plan as amended effective April 1, 2018 and incorporated herein by reference.

(b) **Scope of service adjustment.** If a Center significantly changes its scope of services, the Center may request in writing that new baseline encounter rates be determined. Adjustments to encounter rates are made if it is determined that a significant change in the scope-of-service has occurred which impacts the base rate, as indicated within the ~~State Plan.~~state plan. If there is a change in scope-of-service, it is the responsibility of the FQHC to request OHCA to review services that have had a change to the scope-of-service. The OHCA may initiate a rate adjustment in accordance with procedures in the ~~State Plan,~~state plan, based on audited financial statements or cost reports, if the scope of services has been modified or would otherwise result in a ~~changeto~~change to the Center's current rate. If a new rate is set, the rate will be effective on the date the change in scope-of-service was implemented.

ITLE 317: OKLAHOMA HEALTH CARE AUTHORITY

CHAPTER 2. GRIEVANCE PROCEDURES AND PROCESS

317:2-1-16. Nursing Facility Supplemental Payment Program appeals

In accordance with ~~OAC~~Oklahoma Administrative Code (OAC) 317:30-5-136, ~~OHCA~~the Oklahoma Health Care Authority (OHCA) is authorized to promulgate rules for appeals of the Nursing Facility Supplemental Payment Program (NFSPP). The rules in this ~~Section~~section describe those appeal rights.

(1) The following are appealable issues of the program: ~~program eligibility determination,~~ the assessed amount for each component of the ~~Intergovernmental transfer~~intergovernmental transfer (IGT), the Upper Payment Limit (UPL) payment, the ~~Upper Payment Limit~~UPL Gap payment, and penalties for the ~~providers~~non-state government-owned entity (NSGO). This is the final and only process for appeals regarding NFSPP. Suspensions or terminations from the program are not appealable in the administrative process.

(2) Appeals are heard by the OHCA Administrative Law Judge (ALJ).

(3) To file an appeal, the ~~provider (Appellant~~NSGO (appellant is the ~~provider~~NSGO who files an appeal) shall file an LD-2 form within twenty (20) days from the date of the OHCA letter which advises the ~~provider~~NSGO of ~~the program eligibility determination,~~ component of ~~intergovernmental transfer (IGT)~~IGT, UPL payment, UPL ~~GAP~~Gap payment and/or a penalty. An IGT that is not received by the date specified by OHCA, or that is not in the total amount indicated on the ~~NPR~~notice of program reimbursement (NPR) shall be subject to penalty and suspension from the program. Any applicable penalties must also be deducted from the UPL payment regardless of any appeal action requested by the facility. Any change in the payment amount resulting from an appeals decision in which a recoupment or additional allocation is necessary will be adjusted in the future from any ~~Medicaid~~SoonerCare payments.

(4) The LD-2 shall only be filed by the NSGO or the NSGO's attorney in accordance with (5) below.

~~(4)~~ (5) Consistent with Oklahoma rules of practice, the non-state ~~government owned~~government-owned (NSGO) 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 O.S. Art II, Sec. 5~~ Article II, Section (§) 5 of Title 5 of the Oklahoma Statutes (O.S.), and rules of the Oklahoma Bar Association.

~~(5)~~ (6) The hearing will be conducted in an informal manner,

without formal rules of evidence or procedure. However, parties who fail to appear at a hearing, after notification of said hearing date, ~~will~~shall have their cases dismissed for failure to prosecute.

~~(6)~~(7) The ~~provider~~appellant has the burden of proof by the preponderance of the evidence standard as defined by the Oklahoma Supreme Court.

~~(7)~~(8) The docket clerk will send the ~~Appellant~~appellant and any other necessary party a notice which states the hearing location, date, and time.

~~(8)~~(9) The ALJ may:

(A) Identify and rule on issues being appealed which will be determined at the administrative hearing;

(B) Require the parties to state their positions concerning appeal issue(s);

(C) Require the parties to produce for examination those relevant witnesses and documents under their control;

(D) Rule on whether witnesses have knowledge of the facts at issue;

(E) Establish time limits for the submission of motions or memoranda;

(F) Rule on relevant motions, requests, and other procedural items~~,~~; limiting all decisions to procedure matters and issues directly related to the contested determination resulting from ~~OAC~~Oklahoma Administrative Code 317:30-5-136;

(G) Rule on whether discovery requests are relevant;

(H) Strike or deny witnesses, documents, exhibits, discovery requests, and other requests or motions which are cumulative, not relevant, not material, or used as a means of harassment, unduly burdensome, or not timely filed;

(I) Schedule pre-hearing conferences to settle, simplify, or identify issues in a proceeding or to consider other matters that may end the appeal;

(J) Impose appropriate sanctions against any party failing to obey an order of the ALJ;

(K) Rule on any requests for extension of time;

(L) Dismiss an issue or appeal if:

(i) it is not timely filed or is not within the OHCA's jurisdiction or authority;

(ii) it is moot or there is insufficient evidence to support the allegations;

(iii) the appellant fails or refuses to appear for a scheduled meeting, conference or hearing; or

(iv) the appellant refuses to accept a settlement offer which affords the relief the party could reasonably expect if the party prevailed in the appeal;

(M) Set and/or limit the time frame for the hearing.

~~(9)~~(10) After the hearing:

(A) The ALJ should attempt to make the final hearing decision within ninety (90) days from the date of the hearing and send a copy of the ALJ's decision to both parties outlining their rights to appeal the decision. Any appeal of the final order pursuant to 12 O.S. § 951 must be filed with the District Court of Oklahoma County within 30 days.

(B) It shall be the duty of the ~~Appellant~~appellant in any District Court appeal to order a written transcript of proceedings to be used on appeal. The transcript must be ordered within thirty (30) days of the filing of an appeal in the District Court and any costs associated with the preparation of the transcript shall be borne by the ~~Appellant~~appellant.

~~(10)~~(11) All orders and settlements are non-precedential decisions.

~~(11)~~(12) The hearing shall be digitally recorded and closed to the public.

~~(12)~~(13) The case file and any audio recordings shall remain confidential.

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 9. ~~LONG TERM~~LONG-TERM CARE FACILITIES

317:30-5-136. Nursing Facility Supplemental Payment Program

(a) **Purpose.** The Nursing Facility Supplemental Payment Program (NFSPP) is a supplemental payment, up to the Medicare upper payment limit (UPL), made to a non-state ~~government owned~~government-owned entity that owns and as applicable has operating responsibility for a nursing facility(ies).

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

(1) **"Funds"** means a sum of money or other resources, as outlined in ~~42 Code of Federal Regulations 433.51~~Public Funds as the State Share of Financial Participation, 42 Code of Federal Regulation, Sec.433.51, appropriated directly to the State or local Medicaid agency, or funds that are transferred from other public agencies (including Indian tribes) to the State or local agency and under its administrative control, or funds certified by the contributing public agency as representing expenditures eligible for Federal Financial Participation (FFP).

(2) **"Intergovernmental transfer (IGT)"** means a transfer of state share funds from a non-state ~~government owned~~government-owned entity to the Oklahoma Health Care Authority (OHCA).

(3) **"Non-state government-owned (NSGO)"** means an entity owned ~~and~~and/or ~~as applicable~~ operated by a unit of government other than the state and ~~approved~~the application packet is accepted and determined complete by OHCA as a qualified NSGO. ~~Pursuant to federal and OHCA approval an NSGO may include public trusts pursuant to the Trust Authorities established under Oklahoma Statute Title 60.~~

(4) **"Resource Utilization Groups (RUGs)"** means the system used to set Medicare per diem payments for ~~skilled nursing~~skilled-nursing facilities, as the basis to demonstrate a Medicare payment estimate for use in the ~~upper payment limit~~UPL calculation.

(5) **"Supplemental payment calculation period"** ~~means the calendar quarter for which supplemental payment amounts are calculated based on adjudicated claims for days of service provided in the qualifying quarter. Note, in the event there are no paid days in the quarter as a result of the time in~~

~~which the claims are adjudicated, the supplemental payment will be calculated on days billed in a subsequent quarter.~~ means the State Fiscal Year for which supplemental payment amounts are calculated based on Medicaid paid claims (less leave days) compiled from the state's Medicaid Management Information System (MMIS)from the most recent twelve (12) months.

(6) **"Upper payment limit (UPL)"** means a reasonable estimate of the amount that would be paid for the services furnished by a facility under Medicare ~~payment principles~~equivalent payment.

(c) **Eligible nursing facilities.** A nursing facility that is owned and as applicable under the operational responsibility of an NSGO, is eligible for participation when the following conditions are met:

(1) the nursing facility is licensed and certified by the Oklahoma State Department of Health;

(2) the participating NSGO has provided proof that it holds the facility's license and has complete operational responsibility for the facility;

(3) the participating NSGO has completed and submitted the Agreement of Participation application at minimum thirty (30) days prior to the start of the participation quarter and received ~~approval from OHCA for participation~~ the application packet is accepted and determined complete by OHCA;

~~(4) the NSGO has signed an attestation that a plan towards the reduction and mitigation of unnecessary Return to Acute Admissions (RTA) will be implemented within six (6) months of program participation start date;~~

~~(5)~~(4) the facility is an active participant in the Focus on Excellence program and has earned at minimum 100 points; does not receive an immediate jeopardy (IJ) scope and severity tag for abuse or neglect on three (3) separate surveys within a twelve (12) month period; and

~~(6)~~(5) the facility and NSGO comply with care criteria requirements. All facilities must provide supporting documentation (e.g., baselines, written plan, improvement summary, data sources) for the care criteria metrics.

~~(d) **NSGO participation requirements.** The following conditions are required of the NSGO:~~

~~(1) must execute a nursing facility provider contract as well as an agreement of participation with the OHCA;~~

~~(2) must provide and identify the state share dollars' source of the IGT;~~

~~(3) must pay the calculated IGT to OHCA by the required deadline;~~

(4) must provide proof of ownership, if applicable (i.e. Change of Ownership) as Licensed Operator of the nursing facility;

(5) must provide OHCA with an executed Management Agreement between the NSGO and the facility Manager;

(6) must provide proof of district authority for nursing facility participants which include proximity requirements of no greater than one hundred fifty (150) miles of NSGO. Exceptions may be made at the sole discretion of OHCA; and

(7) must provide per facility, the per patient per Medicaid day (PPMD) IGT within specified timeframe of receipt of the Notice of Program Reimbursement (NPR) as indicated below:

(A) For the first year-$6.50 PPMD.

(B) For the second year-$7.50 PPMD.

(C) For the third year-$8.50 PPMD, or the equivalent of ten percent (10%) of nursing facility budget of the current fiscal year, whichever is less. This amount excludes any IGT for actual administration cost associated with the nursing home UPL supplemental program. Any remaining IGT after administration cost will be distributed through the rate setting methodology process. Distribution will occur once escrowed funds reach an amount sufficient to distribute as determined by OHCA.

(c) **Care Criteria.**

(1)Each facility will be required to meet or exceed at minimum two (2) of the five (5) established care criteria metrics contained in paragraphs (A) through (E) of this section. The facility will be required to develop and implement a plan and identify the current baseline for each criterion. Each facility must demonstrate ongoing progress through baseline outcomes, performance summary and goals. Care criteria data and forms must be completed and submitted within five (5) business day after quarter end.

(A) Facilities must develop and implement a written plan for the mitigation of unnecessary Return to Acute Admissions (RTA) within six (6) months of participation. The plan will include the RTA for the trailing twelve (12) month period. The resulting outcome is to improve the efficiency and care avoidance cost to the overall SoonerCare program. A written plan must be developed and must include the following:

(i) the RTA management tool which identifies those residents at high risk for the potential return to acute;

(ii) the RTA management tools to support effective communications;

(iii) advance directive planning and implementation;

and

(iv) application of Quality Assurance/Program Integrity (QA/PI) methodology in review of RTAs for the root cause analysis and teaching needs.

(B) Facilities are required to implement a pro-active Pneumonia/Flu Vaccination program which will result in improved vaccination scores above the facility specific baseline at or above the national average, as measured using the CMS Quality Metrics. The resulting outcome is to improve efficiency and care avoidance costs to the overall SoonerCare program. A written plan must be developed and must include the following:

(i) the latest available three quarter average of CMS measure code 411 (% of long-stay residents assessed and appropriately given the seasonal influenza vaccine) and 415 (% of long-stay residents assessed and appropriately given the pneumococcal vaccine) to establish baseline;

(ii) the current measure code 411 and 415 score; and

(iii) the written plan for flu and pneumonia vaccination program to address new admissions and current residents.

(C) Facilities are required to participate in the Oklahoma Healthy Aging Initiative. The resulting outcome is to improve the quality of care and health of members. Facilities must attest to elevate healthy aging in Oklahoma by implementing a plan that accomplishes at least one of the following strategies:

(i) preventing and reducing of falls;

(ii) improving of nutrition;

(iii) increasing physical activity; or

(iv) reducing depression.

(D) Facilities are required to actively take part in an OHCA approved satisfaction survey. The resulting outcome is to improve the quality of care being delivered to members. A written plan must be developed and implemented and must include the following:

(i) the satisfaction survey results;

(ii) analysis of satisfaction survey with identification of, at minimum, one area for improvement; and

(iii) plan of action towards identified areas of improvement.

(E) Facilities are required to demonstrate improvement above the facility specific baseline in the five (5) Star Quality Measures Composite scoring. Metrics will be determined based upon CMS Nursing Home Compare composite

score over the trailing twelve (12) month period. Facilities with Quality Measures star rating of three (3) or better for the most recent quarter or showing improvement in composite scoring with no two (2) quarters consistently below three (3), will be recognized as meeting the care criteria. The resulting outcome is to improve the quality of care being provided.

(i) Facilities must provide the most recent three (3) quarter average of the CMS quality measure star rating to establish baseline.

(ii) Facilities are required to have a star rating of (3) or better or must demonstrate improvement over previous quarter with no two (2) quarters below three (3) stars.

(2) The care criteria measures may be evaluated at the discretion of OHCA on an annual basis after each fiscal year, following implementation of the program. However, OHCA reserves the right to conduct intermittent evaluations within any given year based on the quality, care and safety of SoonerCare members. The evaluation may be conducted by an independent evaluator. In addition, care criteria metrics may be internally evaluated after each fiscal year at the discretion of OHCA, in collaboration with an advisory committee composed of OHCA agency staff and provider representatives. The OHCA may make adjustments to the care criteria measures based on findings and recommendations as a result of the independent or internal evaluation.

(f) **Supplemental Payments.**

(1) The nursing facility supplemental payments to a NSGO under this program shall not exceed Medicare payment principles pursuant to 42 CFR 447.272. Payments are made in accordance with the following criteria:

(A) The methodology utilized to calculate the upper payment limit is the RUGs.

(B) The eligible supplemental amount is the difference/gap between the SoonerCare payment and the Medicare upper payment limit as determined based on compliance with the Care Criteria metrics.

(2) The amount of the eligible supplemental payment is associated with improvement of care of SoonerCare nursing facility residents as demonstrated through the care criteria. NSGO participants receive payment under the program based on earned percentages related to the care criteria. The NSGO must meet or exceed at least two (2) of the five (5) established care criteria metrics to be eligible for UPL payment for each quarter. After at least two (2) of the five (5) metrics have been met, the NSGO is eligible for eighty-

~~five percent (85%) of the total eligible UPL amount for participating nursing facilities. The NSGO may qualify for the remaining fifteen percent (15%) of the total UPL by attribution in five percent (5%) increments for each additional care criterion that is met resulting in the full one hundred percent (100%) of the eligible UPL amount.~~

(d) **NSGO participation requirements.** The following conditions are required of the NSGO:

(1) must provide proof of ownership, if applicable (i.e. Change of Ownership) as licensed operator of the nursing facility;

(2) must provide proof of proximity requirements of no greater than one hundred fifty (150) miles of NSGO. Exceptions may be made at the sole discretion of OHCA;

(3) must execute a nursing facility provider contract as well as an agreement of participation with the OHCA;

(4) must provide OHCA with an executed Management Agreement between the NSGO and the facility manager;

(5) must provide and identify the state share dollars' source of the IGT;

(6) must pay the calculated IGT to OHCA by the required deadline; and

(7) must provide per facility, the per patient per Medicaid day (PPMD) IGT within specified timeframe of receipt of the Notice of Program Reimbursement (NPR) as indicated below:

(A) For the first year-$6.50 PPMD.

(B) For the second year-$7.50 PPMD.

(C) For the third year-$8.50 PPMD, or the equivalent of ten percent (10%) of nursing facility budget of the current fiscal year, whichever is less. This amount excludes any IGT for actual administration cost associated with the nursing home UPL supplemental program. Any remaining IGT after administration cost shall be distributed through the rate setting methodology process. Distribution shall occur once escrowed funds reach an amount sufficient to distribute as determined by OHCA.

(e) **Change in ownership.**

(1) A nursing facility participating in the supplemental payment program shall notify the OHCA of changes in ownership (CHOW) that may affect the nursing facility's continued eligibility within thirty (30) days after such change.

(2) For a nursing facility that changes ownership on or after the first day of the SoonerCare supplemental payment limit calculation period, the data used for the calculations will include data from the facility for the entire upper payment limit calculation period relating to payments for days of service provided under the prior owner, pro-rated to reflect

only the number of calendar days during the calculation period that the facility is owned by the new owner.

(f) **Care Criteria.** Each facility shall be required to meet the set benchmarks below for a minimum of one (1) of the two (2) care criteria components to participate in the UPL financial reimbursement.

(1) **Component 1- Quality Improvement Plan.** A facility shall hold monthly Quality Improvement Plan meetings. The meetings shall be tailored to identify an improvement plan for quality enhancement focused on nursing facility safety, quality of resident life, personal rights, choice and respect. Consistent with 42 CFR 483.75. Quality indicators shall be identified during the meetings and include the following:

(A) A written plan to include but not limited to the development, implementation and evaluation of the quality enhancement indicator. The plan shall be reviewed monthly for ongoing quality indicator progress, completion of the quality indicator and/or routine updates on the sustainability of current and/or prior indicators achieved.

(B) The design and scope of the plan should include the specific system and service that will be utilized to monitor and track performance improvement, the staff included to improve the quality indicator, resident choice, subjective/objective evidence and ongoing measures taken to ensure stability and enhancement. This may include but not be limited to a written policy, a procedure manual, data collections systems, management practices, resident/staff interviews, and trainings.

(C) Outcomes shall include evidence of improvement, cost expenditures toward improvement goal, how the facility shall continue to monitor the effectiveness of its quality enhancement and how it shall have ongoing sustainability.

(D) Facility shall submit program documentation monthly. The information shall include A-D as well as OHCA required form LTC-19.

(E) The quality improvement plan shall be reviewed monthly by the OHCA quality review team. Payment shall be assessed in increments of 20 percent (20%) per month for a total of 60 percent (60%) per quarter if approved.

(2) **Component 2- Health Improvement Plan**

(A) A facility shall hold quarterly Health Improvement Plan meetings. The meetings shall be tailored to identify an improvement plan for the quality indicators of urinary tract infection, unintended weight loss, developing or worsening pressure ulcers, and received antipsychotic medication. Meetings include the following:

(i) A written plan to include but not limited to the development, implementation and evaluation of the quality enhancement indicator. The plan shall be reviewed quarterly for ongoing quality indicator progress, completion of the quality indicator and/or routine updates on the sustainability of current and/or prior indicators achieved.

(ii) The design and scope of the plan should include the specific system and service that shall be utilized to monitor and track performance improvement, the staff included to improve the quality indicator, resident choice, subjective/objective evidence and ongoing measures taken to ensure stability and enhancement. This may include but not be limited to a written policy, a procedure manual, data collections systems, management practices, resident/staff interviews, and trainings.

(iii) Outcomes shall include evidence of improvement, cost expenditures toward improvement, how the facility will continue to monitor the effectiveness of its quality enhancement and how it shall have ongoing sustainability.

(iv) Facility shall submit program documentation quarterly. The information will include i-iii as well as OHCA required form LTC-18.

(B) The health improvement plan shall be reviewed quarterly by the OHCA quality review team. Payment shall be assessed in increments of ten percent (10%) per each of the four (4) components quarterly for a total of forty percent (40%) per quarter if approved.

(3) The care criteria measures may be evaluated at the discretion of OHCA on an annual basis after each fiscal year, following implementation of the program. However, OHCA reserves the right to conduct intermittent evaluations within any given year based on the quality, care and safety of SoonerCare members. The evaluation may be conducted by an independent evaluator. In addition, care criteria metrics may be internally evaluated after each fiscal year at the discretion of OHCA. The OHCA may make adjustments to the care criteria measures based on findings and recommendations as a result of the independent or internal evaluation.

(g) **Supplemental Payments.**

(1) The nursing facility supplemental payments to a NSGO under this program shall not exceed Medicare payment principles pursuant to Inpatient Services: Application of Upper Payment Limits, 42 Code of Federal Regulation, Sec. 447.272. Payments are made in accordance with the following

criteria:

(A) The methodology utilized to calculate the upper payment limit is the RUGs.

(B) The eligible supplemental amount is the difference/gap between the SoonerCare payment and the Medicare equivalent payment as determined based on compliance with the care criteria metrics.

(2) The amount of the eligible supplemental payment is associated with improvement of care of SoonerCare nursing facility residents as demonstrated through the care criteria. The quality components are evaluated monthly with a quarterly payout. Component 1 is assessed at twenty percent (20%) per month with a possible total achievement of sixty percent (60%) per quarter. Component 2 is assessed at ten percent (10%) per each of the four (4) components with a possible total achievement of 40 percent (40%) per quarter. Facilities will be reimbursed accordingly based on the percentage of care criteria earned.

~~(g) **Change in ownership.**~~

~~(1) A nursing facility participating in the supplemental payment program must notify the OHCA of changes in ownership (CHOW) that may affect the nursing facility's continued eligibility within thirty (30) days after such change.~~

~~(2) For a nursing facility that changes ownership on or after the first day of the SoonerCare supplemental payment limit calculation period, the data used for the calculations will include data from the facility for the entire upper payment limit calculation period relating to payments for days of service provided under the prior owner, pro-rated to reflect only the number of calendar days during the calculation period that the facility is owned by the new owner.~~

(h) **Disbursement of payment ~~to facilities~~**. ~~Facilities must~~NSGOs must secure allowable ~~Intergovernmental Transfer funds (IGT)~~IGT funds from a NSGO to fund the non-federal share amount. The method is as follows:

(1) The OHCA or its designee will notify the NSGO of the non-federal share amount to be transferred by an IGT, via ~~a designated portal~~electronic communications and NPR, for purposes of seeking federal financial participation (FFP) for the UPL supplemental payment, within twenty-five (25) business days after the end of the quarter. This amount will take into account the percentage of metrics achieved under the care criteria requirement. The NSGO will have five (5) business days to sign the participant agreement and make payment of the state share in the form of an IGT either in person or via mail. ~~In addition, the NSGO will be responsible to also remit, upon receipt of the NPR, the applicable PPMD~~

~~IGT in full, pursuant to (d)(7) above~~The date the NPR is sent by OHCA or its designee to the provider (NSGO) is the official date the clock starts to measure the five (5) business days. In addition, the NSGO shall also be required to remit, upon receipt of the NPR, the applicable PPMD IGT in full, pursuant to (d) (7) above.

(2) ~~If the total transfer and PPMD IGT are received within five (5) business days, the UPL payment will then be disbursed to the NSGO by OHCA within ten (10) business days in accordance with established payment cycles. An IGT that is not received by the date specified by OHCA, or that is not the total indicated on the NPR shall be subject to penalty and suspension from the program.~~If the full IGT and the PPMD IGT are received within five (5) business days, the UPL payment will then be disbursed to the NSGO by OHCA within ten (10) business days in accordance with established payment cycles.

~~(i) **Penalties/Adjustments.** Failure by an NSGO to remit the full IGT indicated on the NPR by OHCA or its designee within the defined timeframes below indicates the NSGO has voluntarily elected to withdraw participation for that current quarter and may reapply for participation in the program in subsequent quarter(s).~~

~~(1) The total IGT must be received within five (5) business days from receipt of the NPR uploaded by OHCA or its designee in the program portal.~~

~~(A) Receipt of the total IGT within five (5) business days is not subject to penalty.~~

~~(B) The date the NPR is uploaded to the portal the official date the clock starts to measure the five (5) business days.~~

~~(2) Any IGT received after the fifth business day but with an OHCA date stamp or mailing postal mark on or prior to five (5) business days from the official date of the uploaded NPR in the portal will not be subject to penalty; however, payment will be disbursed during the next available OHCA payment cycle.~~

~~(3) Any IGT with an OHCA date stamp or mailing postal mark received with a date after five (5) business days of receipt of the NPR, but not exceeding eight (8) business days of receipt of the NPR will be deemed late and subject to a penalty in accordance with (3)(B) below.~~

~~(A) Any NSGO that remits payment of the total IGT under the above circumstances will receive payment during the next available OHCA payment cycle including an assessed penalty as described below.~~

~~(B) A five percent (5%) penalty will be assessed for total IGT payments received after five (5) business days but within eight business days of receipt of the NPR of assessed amount. The five percent (5%) penalty will be assessed on the total eligible supplemental payment for the quarter in which the IGT is late and assessed to the specific NSGO as applicable.~~

~~(C) The OHCA will notify the NSGO of the assessed penalty via invoice. If the provider fails to pay the OHCA the assessed penalty within the time frame noted on the invoice to the NSGO, the assessed penalty will be deducted from the nursing facility's Medicaid payment. The penalty must be paid regardless of any appeals action requested by the NSGO. Should an appeals decision result in a disallowance of a portion or the entire assessed penalty, reimbursement to the NSGO will be made to future nursing facility Medicaid payments.~~

~~(4) If a nursing facility fails to achieve at a minimum, two (2) of the care criteria metrics for two (2) consecutive quarters, the facility will be suspended for two (2) subsequent quarters and will not be eligible to participate in the program during suspended quarters. A facility that has been suspended for a total of four (4) quarters within a two (2) year period due to non-compliance with the Care Criteria will be terminated from the program, and if the facility wishes to participate again, it will be required to reapply. Reentry into the program is at the sole discretion of the OHCA, taking into consideration input from the advisory committee and/or stakeholders. If the facility is readmitted to the program, terms of participation may include a probationary period with defined requirements as it relates to care.~~

(i) **Penalties.**

(1) Receipt of the total IGT(s) within five (5) business days is not subject to any penalty.

(2) Any total IGT received after the fifth (5th) business day, but with an OHCA date stamp or mailing postal mark on or prior to five (5) business days from the official date of the receipt of the NPR will not be subject to penalty.

(3) Any total IGT with an OHCA date stamp or mailing postal mark received with a date after five (5) business days of receipt of the NPR, but not exceeding eight (8) business days of receipt of the NPR shall be deemed late and subject to a penalty in accordance with (3)(A) below.

(A) A five percent (5%) penalty will be assessed for the total IGT payments received after five (5) business days, but within eight (8) business days of receipt of the NPR. The five percent (5%) penalty will be assessed on the

total eligible supplemental payment for the quarter in which the IGT is late and assessed to the specific NSGO as applicable.

(B) OHCA will notify the NSGO of the assessed penalty via invoice. If the NSGO fails to pay OHCA the assessed penalty within the time frame noted on the invoice to the NSGO, the assessed penalty will be deducted from the nursing facility's Medicaid payment. The penalty shall be paid regardless of any appeals action requested by the NSGO. Should an appeals decision result in a disallowance of a portion or the entire assessed penalty, reimbursement to the NSGO will be made to future nursing facility Medicaid payments.

(C) An NSGO that remits payment of the total IGT under the circumstances listed in (i) (2) or (i) (3) above will receive payment during the next available OHCA payment cycle.

(4) The first violation by an NSGO to remit the full IGT as indicated on the NPR by OHCA or its designee within the defined timeframes shall subject the NSGO to a penalty. The second violation by an NSGO to remit the full IGT indicated on the NPR by OHCA or its designee within the defined timeframes shall subject the NSGO to a penalty and a suspension for two (2) consecutive quarters. The NSGO will not be eligible to participate in the program during suspended quarters. A third violation by an NSGO to remit the full IGT indicated on the NPR by OHCA or its designee within the defined timeframes shall subject the NSGO to termination from the NFSPP. If the NSGO desires to participate again, it will be required to reapply. Reentry into the program is at the sole discretion of the OHCA. If the NSGO is readmitted to the program, terms of participation may include a probationary period with defined requirements.

(5) If OHCA receives a partial IGT or receives a full IGT after eight (8) business days of the receipt of the NPR, the NSGO shall be deemed to have voluntarily elected to withdraw participation in the NFSPP.

(6) If a nursing facility fails to meet the benchmarks of component 1 and/or component 2 of the care criteria for two (2) consecutive quarters, the facility shall be suspended for two (2) subsequent quarters and will not be eligible to participate in the program during suspended quarters. A facility that has been suspended for a total of four (4) quarters within a two (2) year period due to non-compliance with the Care Criteria shall be terminated from the program, and if the facility wishes to participate again, it will be required to reapply. Reentry into the program is at the sole

discretion of the OHCA. If the facility is readmitted to the program, terms of participation may include a probationary period with defined requirements as it relates to care.

(j) **Appeals.** Applicant and participant appeals may be filed in accordance with grievance procedures found at ~~OAC~~Oklahoma Administrative Code 317:2-1-2(b) and 317:2-1-16.