Oklahoma Health Care Authority
MEDICAL ADVISORY COMMITTEE

AGENDA

January 9, 2020
1:00 PM – 3:30 PM

Charles Ed McFall Board Room

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

II. Action Item: Approval of Minutes of the November 7th, 2019: **Medical Advisory Committee Meeting**

III. Public Comments (2 minute limit)

IV. MAC Member Comments/Discussion

V. Financial Report: **Tasha Black, Senior Director of Financial Services**

VI. SoonerCare Operations Update: **Melinda Thomason, Senior Director for Stakeholder Engagement**

VII. Proposed Rule Changes: Presentation, Discussion, and Vote: **Sandra Puebla, Director of Federal & State Authorities**

- **A. 19-21 Claim Inquiry Policy**
- **B. 19-22 Expedited Appeals**
- **C. 19-23 Free-Standing Birthing Centers**
- **D. 19-30 The Oklahoma Office of Juvenile Affairs (OJA) Targeted Case Management (TCM) Services**
- **E. 19-31 Nursing Licensure Revisions**
- **F. 19-33 Indian Health Services, Tribal Programs, and Urban Indian Clinics (I/T/Us) Obstetrical (OB) Care**
- **G. 19-36 Programs of All-Inclusive Care for the Elderly (PACE)**
- **H. 19-38 Title XXI Parity Compliance**
- **I. 19-39A&B Nursing Home Supplemental Payment Program Revocation**
- **J. 19-40 Defunding Statutory Rape Cover-Up Act**

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

IX. Future Meeting:
March 12, 2020
May 14, 2020
July 9, 2020
September 10, 2020

X. Adjourn

Oklahoma Health Care Authority
MEDICAL ADVISORY COMMITTEE
MINUTES of the November 7th, 2019 Meeting
4345 N. Lincoln Blvd., Oklahoma City, OK 73105

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

Chairman, Dr. Steven Crawford called the meeting to order at 1:00 PM.

***Delegates present were*:** Ms. Sarah Baker, Ms. Debra Billingsly, Dr. Erin Balzer, Dr. Joe Catalano, Dr. Steven Crawford, Ms. Wanda Felty, Dr. Arlen Foulks, Ms. Terrie Fritz, Ms. Allison Garrison, Ms. Annette Mays, Mr. James Patterson, Dr. Daniel Post, Ms. Toni Pratt-Reid, Ms. Kristi Balckburn, Dr. Edd Rhoades, Dr. Jason Rhynes, Dr. Dwight Sublett, Mr. Rick Snyder, Mr. William Whited, Dr. Paul Wright, and Dr. Whitney Yeates.

Alternates present were: Ms. Lois Baer and Ms. Katie Roberts providing a quorum.

***Delegates absent without an alternate were*:** Ms. Mary Brinkley, Mr. Victor Clay, Mr. Brett Coble, Mr. Steve Goforth, Dr. Lori Holmquist-Day, Mr. Mark Jones, Ms. Carrie Slatton-Hodges, Dr. Raymond Smith, and Mr. Jeff Tallent.

II. Approval of the September 5th, 2019 Minutes

Medical Advisory Committee

The motion to approve the minutes was by Dr. Catalano and seconded by Dr. Dwight Sublett with an abstention from Ms. Kristi Blackburn and passed unanimously.

III. Public Comments (2 minute limit):

There were no public comments made at this meeting.

IV. MAC Member Comments/Discussion:

There were no MAC Member comments.

V. SoonerCare Operations Update:

Melinda Thomason, Senior Director for Stakeholder Engagement

Ms. Thomason presented the SoonerCare Operations update to the committee. Information is based on data for September 2019. Patient Centered Medical Home enrollment is at 523,924 which is down by 9,675. Sooner Care Traditional has a current enrollment of 238,835 which is 5,349 more than the previous month. SoonerPlan is down by 255, giving a total number of 28,444. Insure Oklahoma has a total enrollment of 18,278, of which 13,066 are in the Employee Sponsored Plan, and 5,212 are in the individual plan. In total, SoonerCare enrollment is at 809,481. Total in state providers is up 5,577, giving a total of 43,614.

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VI. Proposed Rule Changes: Presentation, Discussion, and Vote:

Sandra Puebla, Director of Federal & State Authorities

Face-to-face tribal consultations regarding the following proposed changes were held on Tuesday, June 18, 2019, Tuesday, July 2, 2019 and Tuesday, November 5, 2019 in the Charles Ed McFall boardroom of the Oklahoma Health Care Authority (OHCA).

APA work folder 19-03 will be posted for public comment through November 18, 2019. APA work folders 19-09 and 19-18 will be posted for public comment through November 19, 2019. APA work folders 19-19 A&B will be posted for public comment through November 17, 2019. APA work folder 19-20 will be posted for public comment through November 18, 2019.

19-03 Registered Behavior Technicians (RBTs) — The proposed revisions will add RBTs as a new SoonerCare provider. The proposed revisions will also outline provider qualifications and other requirements for provision of applied behavior analysis (ABA) services. Other revisions will be made to clarify current provider and reimbursement requirements.
Budget Impact: The proposed rule change will not result in any additional costs and/or savings to the agency. Budget allocation to establish coverage of and reimbursement for ABA services, including services rendered by RBTs, was approved during promulgation of the emergency rule on July 1, 2019.
The rule change motion to approve was by Dr. Joe Catalano and seconded by Ms. Sarah Baker and passed unanimously.

19-09 SUPPORT Act — The proposed revisions are in response to recent changes in federal law which require that individuals under the age of twenty-one, or individuals in the former foster care eligibility group under the age of twenty-six, who become incarcerated, shall not have their Medicaid eligibility terminated. Eligibility for the aforementioned populations will instead be suspended for the duration of the incarceration. Additional revisions outline that a redetermination of eligibility, based on information known to the OHCA, will be conducted prior to the inmate's release without requiring a new SoonerCare application. Eligibility will be restored to the date the inmate is released from custody, if the individual meets all other eligibility requirements. The process of restoring eligibility to the date the individual is released from incarceration will involve collaboration between the OHCA, Oklahoma Department of Human Services (DHS), Oklahoma Office of Juvenile Affairs (OJA), and the Oklahoma Department of Corrections (DOC). Of note, coverage and reimbursement of inpatient services while an individual is incarcerated, will not change through these proposed changes.
Budget Impact: The estimated budget impact for State Fiscal Year (SFY) 2020 will be an increase in the total amount of $227,512; with $77,309 in state share. The estimated budget impact for future years, beginning in SFY 2021, will be an increase in the total amount of $341,268; with $115,963 in state share.
The rule change motion to approve was by Mr. William Whited and seconded by Dr. Joe Catalano and passed unanimously.

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19-18 HR6 Opioid Standards and Drug Utilization Review (DUR) Requirements — The proposed rule changes will comply with 42 USC § 1396a(oo), which requires state Medicaid agencies to implement newly-required DUR activities to better monitor opioid prescribing and dispensing patterns. Opioid safety edits will be implemented to alert pharmacists when potential concerns regarding medications prescribed to members exist; concerns must be resolved before medications can be dispensed to the member. Additionally, a claims review automated process will be in place to identify refills in excess of state limits and monitor concurrent prescribing of opioids, benzodiazepines, and/or antipsychotics. The OHCA will also implement a program to monitor the use of antipsychotic medications by members age eighteen (18) and younger, including children in foster care. Lastly, the OHCA will implement a process to identify potential fraud and abuse of controlled substances by members, health care professionals prescribing drugs to members, and pharmacies dispensing drugs to members.
Budget Impact: Budget neutral.
The rule change motion to approve was by Dr. Joe Catalano and seconded by Dr. Daniel Post and passed unanimously.

19-19A&B Step Therapy Exception Process — The proposed revisions will comply with Oklahoma Senate Bill (SB) 509, which directs the OHCA to revise current step therapy protocols for medications approved by the Drug Utilization Review (DUR) Board and provide an exception process to the drug step therapy protocol. The exception applies to cases when: the required prescribed drug will likely cause an adverse reaction or harm; the prescription drug will likely be ineffective; the patient has already tried the prescription drug and discontinued use; the prescription drug is not in the best interest of the patient; or the patient is stable on another prescription drug. Revisions will also establish an appeals process for step therapy exception requests that have been denied. Other revisions will correct outdated language.
Budget Impact: The estimated budget impact for the remainder of SFY20 (6-month impact) will be an increase in the total amount of $15,000,000; with $2,548,500 in state share. The estimated budget impact for SFY21 will be an increase in the total amount of $30,000,000; with $4,875,000 in state share.
The rule change motion to approve was by Dr. Edd Rhoades and seconded by Dr. Joe Catalano and passed unanimously.

19-20 Pharmacy Revisions and American Indians/Alaska Natives (AI/AN) Cost Sharing Exemptions — The proposed revisions will remove prescription limits of certain frequently monitored prescription drugs and medication-assisted treatment (MAT) drugs for opioid use disorder. The proposed revisions will also remove co-payments for MAT drugs. Additional rule revisions will amend prescription quantity limits when a product is on the maintenance drug list. Finally, revisions will align policy regarding cost sharing exemptions for AI/AN members with Oklahoma's Medicaid State Plan language and federal regulation at 42 CFR § 447.56(a)(x). Other revisions will align policy with current practice and correct grammatical errors.
Budget Impact: The estimated budget impact to remove prescription limits and co-payment requirements for MAT drugs in SFY20 will be an increase in the total amount of $2,951,666; with

$514,918 in state share. The estimated budget impact for SFY21 will be an increase in the total amount of $1,161,000; with $188,662 in state share.

The estimated budget impact to increase prescription quantity limits when a product is on the maintenance drug list will potentially result in an estimated total savings of $414,251; with $140,762 in state savings for SFY20 (6-month savings) and an estimated annual savings for SFY21 of 828,502; with $269,263 in state savings.

The proposed rule change to align SoonerCare rules with the Medicaid State Plan's cost sharing exemptions for AI/AN members is budget neutral for SFY 2020 and 2021. The budget impact for this rule change was observed in SFY 2015.
The rule change motion to approve was by Dr. Paul Wright and seconded by Dr. Arlen Foulks and passed unanimously.

VII. 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 2020. Dr. Jason Rhynes was nominated for Chair by Dr. Edd Rhoades, and seconded by Ms. Wanda Felty and passed unanimously. Dr. Dwight Sublett was nominated for Co-Chairman by Dr. Edd Rhoads and seconded by Ms. Wanda Felty and passed unanimously.

Dr. Steven Crawford was nominated for Chair Emeritus by Dr. Dwight Sublett and seconded by Dr. Jason Rhynes and passed unanimously.

VIII. Future Meeting

January 9, 2020
March 12, 2020
May 14, 2020
July 9, 2020
September 10, 2020
November 12, 2020

IX. Adjournment

There was no dissent and the meeting was adjourned at 1:50p.m.

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FINANCIAL REPORT

For the Three Month Period Ended September 30, 2019
Submitted to the CEO & Board

- Revenues for OHCA through September, accounting for receivables, were **$1,099,983,269** or **1.3% under** budget.
- Expenditures for OHCA, accounting for encumbrances, were **$1,049,522,684** or **1.8% under** budget.
- The state dollar budget variance through September is a positive **$4,732,196.**
- The budget variance is primarily attributable to the following (in millions):

Expenditures:		
Medicaid Program Variance		5.1
Administration		0.5
Revenues:		
Drug Rebate		(2.4)
Medical Refunds		0.3
Taxes and Fees		1.2
Total FY 20 Variance	**$**	**4.7**

ATTACHMENTS

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

OKLAHOMA HEALTH CARE AUTHORITY
Summary of Revenues & Expenditures: OHCA
SFY 2020, For the Three Month Period Ending September 30, 2019

REVENUES	FY20 Budget YTD	FY20 Actual YTD	Variance	% Over/ (Under)
State Appropriations	$ 282,874,694	$ 282,874,694	$ -	0.0%
Federal Funds	613,499,148	603,876,815	(9,622,333)	(1.6)%
Tobacco Tax Collections	11,027,876	12,413,783	1,385,907	12.6%
Quality of Care Collections	20,461,269	20,222,871	(238,398)	(1.2)%
Prior Year Carryover	20,110,285	20,110,285	-	0.0%
Federal Deferral - Interest	87,891	87,891	-	0.0%
Rate Preservation Fund	7,340,187	7,340,187	-	0.0%
Drug Rebates	93,466,058	86,991,693	(6,474,365)	(6.9)%
Medical Refunds	9,704,858	10,411,849	706,991	7.3%
Supplemental Hospital Offset Payment Program	53,594,722	53,594,722	-	0.0%
Other Revenues	1,957,270	2,058,480	101,210	5.2%
TOTAL REVENUES	**$ 1,114,124,258**	**$ 1,099,983,269**	**$ (14,140,989)**	**(1.3)%**

EXPENDITURES	FY20 Budget YTD	FY20 Actual YTD	Variance	% (Over)/ Under
ADMINISTRATION - OPERATING	**$ 14,822,738**	**$ 13,536,969**	**$ 1,285,769**	**8.7%**
ADMINISTRATION - CONTRACTS	**$ 27,887,029**	**$ 26,544,161**	**$ 1,342,867**	**4.8%**
MEDICAID PROGRAMS				
Managed Care:				
SoonerCare Choice	10,580,847	10,161,880	418,967	4.0%
Acute Fee for Service Payments:				
Hospital Services	242,007,216	239,813,898	2,193,318	0.9%
Behavioral Health	4,540,070	4,385,565	154,506	3.4%
Physicians	96,691,567	92,847,660	3,843,906	4.0%
Dentists	34,251,911	34,162,105	89,805	0.3%
Other Practitioners	16,798,754	11,023,934	5,774,820	34.4%
Home Health Care	6,523,382	6,744,468	(221,086)	(3.4)%
Lab & Radiology	6,512,797	5,457,314	1,055,482	16.2%
Medical Supplies	13,166,307	13,199,450	(33,143)	(0.3)%
Ambulatory/Clinics	64,993,988	61,648,215	3,345,774	5.1%
Prescription Drugs	162,813,203	162,148,371	664,831	0.4%
OHCA Therapeutic Foster Care	4,854	-	4,854	100.0%
Other Payments:				
Nursing Facilities	144,347,790	144,112,653	235,137	0.2%
Intermediate Care Facilities for Individuals with Intellectual Disabilities Private	16,258,790	18,587,566	(2,328,776)	(14.3)%
Medicare Buy-In	44,036,841	44,701,479	(664,638)	(1.5)%
Transportation	18,627,686	17,950,682	677,004	3.6%
Money Follows the Person-OHCA	80,652	65,418	15,234	18.9%
Electronic Health Records-Incentive Payments	109,744	109,744	-	0.0%
Part D Phase-In Contribution	26,457,167	26,528,920	(71,753)	(0.3)%
Supplemental Hospital Offset Payment Program	114,012,161	114,012,161	-	0.0%
Telligen	2,780,995	1,780,069	1,000,925	36.0%
Total OHCA Medical Programs	**1,025,596,720**	**1,009,441,553**	**16,155,167**	**1.6%**
OHCA Non-Title XIX Medical Payments	89,382	-	89,382	0.0%
TOTAL OHCA	**$ 1,068,395,869**	**$ 1,049,522,684**	**$ 18,873,185**	**1.8%**
REVENUES OVER/(UNDER) EXPENDITURES	**$ 45,728,390**	**$ 50,460,586**	**$ 4,732,196**	

OKLAHOMA HEALTH CARE AUTHORITY
Total Medicaid Program Expenditures
by Source of State Funds
SFY 2020, For the Three Month Period Ending September 30, 2019

Category of Service	Total		Health Care Authority	Quality of Care Fund	HEEIA	SHOPP Fund	BCC Revolving Fund	Other State Agencies
SoonerCare Choice	$ 10,186,273		$ 10,159,461	$ -	$ 24,393	$ -	$ 2,419	$ -
Inpatient Acute Care	312,642,079		151,723,821	121,672	696,159	85,252,282	319,028	74,529,117
Outpatient Acute Care	112,926,627		86,326,308	10,401	1,503,024	23,774,225	1,312,669	-
Behavioral Health - Inpatient	19,645,189		2,444,409	-	114,277	4,602,238	-	12,484,264
Behavioral Health - Psychiatrist	2,324,571		1,939,174	-	-	383,416	1,981	-
Behavioral Health - Outpatient	4,550,285		-	-	-	-	-	4,550,285
Behaviorial Health-Health Home	6,749,794		-	-	-	-	-	6,749,794
Behavioral Health Facility- Rehab	59,180,569		-	-	-	-	32,218	59,180,569
Behavioral Health - Case Management	708,304		-	-	-	-	-	708,304
Behavioral Health - PRTF	2,966,999		-	-	-	-	-	2,966,999
Behavioral Health - CCBHC	19,296,936		-					19,296,936
Residential Behavioral Management	2,513,347		-	-	-	-	-	2,513,347
Targeted Case Management	11,627,965		-	-	-	-	-	11,627,965
Therapeutic Foster Care	-		-	-	-	-	-	-
Physicians	109,520,999		91,980,026	14,525	1,654,235	-	853,109	15,019,103
Dentists	34,167,710		34,160,056	-	5,605	-	2,049	-
Mid Level Practitioners	587,287		583,027	-	3,137	-	1,123	-
Other Practitioners	10,579,763		10,306,604	111,591	139,979	-	21,588	-
Home Health Care	6,745,886		6,744,236	-	1,418	-	232	-
Lab & Radiology	5,610,999		5,407,548	-	153,685	-	49,767	-
Medical Supplies	13,251,098		12,515,857	677,883	51,647	-	5,710	-
Clinic Services	62,271,145		59,878,458	-	501,163	-	63,358	1,828,167
Ambulatory Surgery Centers	1,750,672		1,701,742	-	44,272	-	4,657	-
Personal Care Services	2,650,458		-	-	-	-	-	2,650,458
Nursing Facilities	144,112,653		87,645,384	56,467,269	-	-	-	-
Transportation	17,950,412		17,198,987	682,388	27,872	-	41,166	-
IME/DME/GME	68,910,370		-	-	-	-	-	68,910,370
ICF/IID Private	18,587,566		15,606,902	2,980,664	-	-	-	-
ICF/IID Public	2,487,667		-	-	-	-	-	2,487,667
CMS Payments	71,230,399		71,121,261	109,138	-	-	-	-
Prescription Drugs	166,061,100		161,504,791	-	3,912,729	-	643,580	-
Miscellaneous Medical Payments	28,141		26,556	-	-	-	1,585	-
Home and Community Based Waiver	53,502,255		-	-	-	-	-	53,502,255
Homeward Bound Waiver	19,632,967		-	-	-	-	-	19,632,967
Money Follows the Person	65,418		65,418	-	-	-	-	-
In-Home Support Waiver	6,474,580		-	-	-	-	-	6,474,580
ADvantage Waiver	39,900,377		-	-	-	-	-	39,900,377
Family Planning/Family Planning Waiver	947,426		-	-	-	-	-	947,426
Premium Assistance*	13,824,509		-	-	13,824,509.24	-	-	-
Telligen	1,780,069		1,780,069	-	-	-	-	-
Electronic Health Records Incentive Payments	109,744		109,744	-	-	-	-	-
Total Medicaid Expenditures	**$ 1,438,060,609**	**$ -**	**$ 830,929,840**	**$ 61,175,530**	**$ 22,658,104**	**$ 114,012,161**	**$ 3,356,240**	**$ 405,960,951**

* Includes $13,703,597.01 paid out of Fund 245

OKLAHOMA HEALTH CARE AUTHORITY

Summary of Revenues & Expenditures:
Other State Agencies
SFY 2020, For the Three Month Period Ending September 30, 2019

REVENUE	FY20 Actual YTD
Revenues from Other State Agencies	$ 161,172,803
Federal Funds	259,781,854
TOTAL REVENUES	**$ 420,954,657**

EXPENDITURES	Actual YTD
Department of Human Services	
Home and Community Based Waiver	53,502,255
Money Follows the Person	-
Homeward Bound Waiver	19,632,967
In-Home Support Waivers	6,474,580
ADvantage Waiver	39,900,377
Intermediate Care Facilities for Individuals with Intellectual Disabilities Public	2,487,667
Personal Care	2,650,458
Residential Behavioral Management	1,314,094
Targeted Case Management	9,877,670
Total Department of Human Services	**135,840,069**
State Employees Physician Payment	
Physician Payments	15,019,103
Total State Employees Physician Payment	**15,019,103**
Education Payments	
Graduate Medical Education	31,622,608
Indirect Medical Education	35,874,676
Direct Medical Education	1,413,086
Total Education Payments	**68,910,370**
Office of Juvenile Affairs	
Targeted Case Management	538,693
Residential Behavioral Management	1,199,253
Total Office of Juvenile Affairs	**1,737,945**
Department of Mental Health	
Case Management	708,304
Inpatient Psychiatric Free-standing	12,484,264
Outpatient	4,550,285
Health Homes	6,749,794
Psychiatric Residential Treatment Facility	2,966,999
Certified Community Behavioral Health Clinics	19,296,936
Rehabilitation Centers	59,180,569
Total Department of Mental Health	**105,937,152**
State Department of Health	
Children's First	200,014
Sooner Start	659,694
Early Intervention	932,854
Early and Periodic Screening, Diagnosis, and Treatment Clinic	453,403
Family Planning	79,711
Family Planning Waiver	862,635
Maternity Clinic	-
Total Department of Health	**3,188,310**
County Health Departments	
EPSDT Clinic	182,016
Family Planning Waiver	5,080
Total County Health Departments	**187,096**
State Department of Education	**45,743**
Public Schools	**32,991**
Medicare DRG Limit	**72,267,584**
Native American Tribal Agreements	**533,054**
Department of Corrections	**943,141**
JD McCarty	**1,318,392**
Total OSA Medicaid Programs	**$ 405,960,951**
OSA Non-Medicaid Programs	**$ 19,972,490**
Accounts Receivable from OSA	**$ 4,978,784**

OKLAHOMA HEALTH CARE AUTHORITY
SUMMARY OF REVENUES & EXPENDITURES:
Fund 205: Supplemental Hospital Offset Payment Program Fund
SFY 2020, For the Three Month Period Ending September 30, 2019

REVENUES		FY 20 Revenue
SHOPP Assessment Fee		53,550,147
Federal Draws	$	71,120,786
Interest		44,575
Penalties		-
State Appropriations		(7,550,000)
TOTAL REVENUES	$	117,165,508

EXPENDITURES	Quarter	Quarter	Quarter	Quarter		FY 20 Expenditures
Program Costs:	7/1/19 - 9/30/19	10/1/19 - 12/31/19	1/1/20 - 3/31/20	4/1/20 - 6/30/20		
Hospital - Inpatient Care	85,252,282				$	85,252,282
Hospital -Outpatient Care	23,774,225					23,774,225
Psychiatric Facilities-Inpatient	4,602,238					4,602,238
Rehabilitation Facilities-Inpatient	383,416					383,416
Total OHCA Program Costs	114,012,161	-	-	-	$	114,012,161
Total Expenditures					$	114,012,161
CASH BALANCE					$	3,153,347

*** Expenditures and Federal Revenue processed through Fund 340

OKLAHOMA HEALTH CARE AUTHORITY
SUMMARY OF REVENUES & EXPENDITURES:
Fund 230: Nursing Facility Quality of Care Fund
SFY 2020, For the Three Month Period Ending September 30, 2019

REVENUES	Total Revenue	State Share
Quality of Care Assessment	**$ 20,208,030**	**$ 20,208,030**
Interest Earned	**14,840**	**14,840**
TOTAL REVENUES	**$ 20,222,871**	**$ 20,222,871**

EXPENDITURES	FY 20 Total $ YTD	FY 20 State $ YTD	Total State $ Cost
Program Costs			
Nursing Facility Rate Adjustment	$ 55,537,847	$ 20,893,338	
Eyeglasses and Dentures	69,482	26,139	
Personal Allowance Increase	859,940	323,509	
Coverage for Durable Medical Equipment and Supplies	677,883	255,020	
Coverage of Qualified Medicare Beneficiary	258,189	97,131	
Part D Phase-In	109,138	109,138	
ICF/IID Rate Adjustment	1,330,925	500,694	
Acute Services ICF/IID	1,649,739	620,632	
Non-emergency Transportation - Soonerride	682,388	256,714	
Total Program Costs	**$ 61,175,530**	**$ 23,082,314**	**$ 23,082,314**
Administration			
OHCA Administration Costs	$ 140,042	$ 70,021	
DHS-Ombudsmen	-	-	
OSDH-Nursing Facility Inspectors	-	-	
Mike Fine, CPA	-	-	
Total Administration Costs	**$ 140,042**	**$ 70,021**	**$ 70,021**
Total Quality of Care Fee Costs	**$ 61,315,572**	**$ 23,152,336**	
TOTAL STATE SHARE OF COSTS			**$ 23,152,336**

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 2020, For the Three Month Period Ending September 30, 2019

REVENUES	FY 19 Carryover	FY 20 Revenue	Total Revenue
Prior Year Balance	**$ 8,433,128**	**$ -**	**$ -**
State Appropriations	**-**	**-**	**-**
Federal Draws - Prior Year	**256,769**		
Total Prior Year Revenue			**8,689,897**
Tobacco Tax Collections	**-**	**10,209,943**	**10,209,943**
Interest Income	**-**	**63,672**	**63,672**
Federal Draws	**-**	**8,778,691**	**8,778,691**
TOTAL REVENUES	**$ 8,689,897**	**$ 19,052,305**	**$ 27,742,202**

EXPENDITURES		FY 19 Expenditures	FY 20 Expenditures	Total State $ YTD
Program Costs:				
	Employer Sponsored Insurance		**$ 13,703,597**	**$ 13,703,597**
	College Students/ESI Dental		**120,912**	**45,487**
Individual Plan				
	SoonerCare Choice		$ 23,724	$ 8,925
	Inpatient Hospital		687,277	258,554
	Outpatient Hospital		1,483,143	557,958
	BH - Inpatient Services-DRG		110,925	41,730
	BH -Psychiatrist		-	-
	Physicians		1,632,430	614,120
	Dentists		5,554	2,089
	Mid Level Practitioner		2,831	1,065
	Other Practitioners		138,349	52,047
	Home Health		1,418	533
	Lab and Radiology		149,659	56,302
	Medical Supplies		50,908	19,152
	Clinic Services		490,458	184,510
	Ambulatory Surgery Center		44,272	16,655
	Prescription Drugs		3,858,907	1,451,721
	Transportation		27,872	10,485
	Premiums Collected		-	(132,833)
Total Individual Plan			**$ 8,707,727**	**$ 3,143,014**
	College Students-Service Costs		**$ 125,868**	**$ 47,352**
Total OHCA Program Costs			**$ 22,658,104**	**$ 16,939,450**
Administrative Costs				
	Salaries	$ 43,006	$ 540,319	$ 583,325
	Operating Costs	1,501	2,568	4,069
	Health Dept-Postponing	-	-	-
	Contract - HP	79,002	69,603	148,605
Total Administrative Costs		**$ 123,509**	**$ 612,490**	**$ 735,999**
Total Expenditures				**$ 17,675,449**
NET CASH BALANCE		**$ 8,566,388**	**$ 1,500,365.25**	**$ 10,066,753**

OKLAHOMA HEALTH CARE AUTHORITY

SUMMARY OF REVENUES & EXPENDITURES:

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

SFY 2020, For the Three Month Period Ending September 30, 2019

REVENUES	FY 20 Revenue	State Share
Tobacco Tax Collections	$ 203,760	$ 203,760
TOTAL REVENUES	**$ 203,760**	**$ 203,760**

EXPENDITURES	FY 20 Total $ YTD	FY 20 State $ YTD	Total State $ Cost
Program Costs			
SoonerCare Choice	$ 2,419	$ 637	
Inpatient Hospital	319,028	84,000	
Outpatient Hospital	1,312,669	345,626	
Inpatient Services-DRG	-	-	
Psychiatrist	1,981	522	
TFC-OHCA	-	-	
Nursing Facility	-	-	
Physicians	853,109	224,624	
Dentists	2,049	540	
Mid-level Practitioner	1,123	296	
Other Practitioners	21,588	5,684	
Home Health	232	61	
Lab & Radiology	49,767	13,104	
Medical Supplies	5,710	1,504	
Clinic Services	63,358	16,682	
Ambulatory Surgery Center	4,657	1,226	
Prescription Drugs	643,580	169,455	
Transportation	41,166	10,839	
Miscellaneous Medical	1,585	417	
Total OHCA Program Costs	**$ 3,324,022**	**$ 875,215**	
OSA DMHSAS Rehab	$ 32,218	8,483	
Total Medicaid Program Costs	**$ 3,356,240**	**$ 883,698**	
TOTAL STATE SHARE OF COSTS			**$ 883,698**

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.

All things SoonerCare (in 10 minutes or less)

Melinda Thomason
Senior Director for Stakeholder Engagement

January 9, 2020

Oklahoma Health Care Authority

OHCA was established by the legislature in 1993 under House Bill 1573. The agency administers the Medicaid (SoonerCare) and Insure Oklahoma programs.

Medicaid is a state and federal partnership that provides coverage for basic health and long-term care services based on income and resources.

Oklahoma's current Medicaid program

- State plan amendment gives OHCA federal authority to administer the state Medicaid program.
- The 1115 demonstration waiver allows us to modify the federal Medicaid requirements to address coverage issues unique to Oklahoma.
  - SoonerCare Choice (patient-centered medical home delivery model).
  - SoonerCare Health Management Program.
  - SoonerCare Health Access Networks.
  - SoonerPlan.
  - Insure Oklahoma program.

Oklahoma's current Medicaid program

- OHCA facilitates state plan amendments for sister agencies. OHCA keeps administrative authority while the sister agency is responsible for the operations component.
- The same applies to 1915(c) home and community-based waivers that allow the Department of Human Services to have the operational authority for the five waiver programs while OHCA keeps the administrative authority.

SoonerCare programs

- Fee for service.
- Managed care.
  - SoonerCare Choice – patient-centered medical home.
    - Care coordination.
    - Increased physician visit limit for adults.
    - SoonerExcel pay for performance.
  - SoonerCare Choice – Indian Health Service, tribal and urban Indian health programs.
  - Insure Oklahoma premium assistance.
  - Program of All-Inclusive Care for the Elderly.

Partial benefit programs

- Pregnancy only.
  - Women residing in Oklahoma who are pregnant but do not qualify for full scope SoonerCare pregnancy benefits.
- Family planning.
  - Limited coverage for men and women. A joint venture with the Oklahoma State Department of Health.

Agency program areas

- Pharmacy.
- Population care management.
- Chronic care unit.

Behavioral health programs

- OHCA reviews and determines medical necessity for prior authorizations related to inpatient services.
- OHCA works with DHS on placement of children in foster care.
- Department of Mental Health and Substance Abuse Services is responsible for all outpatient behavioral health services.
- DMH developed health homes.
- DMH developed certified community behavioral health clinics.

OHCA and external partner shared programs

- Health access networks:
  - OU.
  - OSU.
  - Canadian County.
- Health Management/pain management program:
  - Telligen.
- Pharmacy management consultants:
  - Arine medication management program.
- Oklahoma Cares breast and cervical cancer treatment program:
  - Cherokee Nation, Kaw Nation and Oklahoma State Department of Health.
- Transportation:
  - Logisticare/SoonerRide.

Quality of care in SoonerCare programs

- Adult and child core set measures.
- Consumer Assessment of Healthcare Providers and Systems and other member satisfaction surveys.
- External quality review.
- Performance improvement projects.
- SoonerCare Choice evaluation.
- Health access network evaluation.
- Health Management Program evaluation.
- Chronic care unit evaluation.
- Focus on Excellence.

Health services initiatives

- Long-acting reversible contraceptive education for members.
- LARC education for providers, device promotions.
- Naloxone rescue kits.
- Psychotropic medication use for children in foster care.
- Evidence-based prescribing attention deficit hyperactivity disorder, meds, atypical antipsychotic meds for children under 18.

Health services initiatives

- Sickle cell kits for children ages 6-18.
- Safe Sleep
- LARC for health department locations statewide.
- Reach out and Read program.
  - Developmental screening for first three years of life.

Questions

Melinda Thomason

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405-522-7125

January MAC
Proposed Rule Amendment Summaries

A face-to-face tribal consultation regarding the following proposed changes was held on Tuesday, November 5, 2019 in the Charles Ed McFall Boardroom of the Oklahoma Health Care Authority (OHCA).

The following work folders will be posted on the OHCA public website for a comment period through January 15, 2020.

19-21 Claim Inquiry Policy — The proposed policy revisions are necessary due to a new streamlined electronic process developed by OHCA for providers. The revisions will outline how providers can request a review of submitted claims and how to submit supporting documentation for their request through the OHCA provider portal. The electronic review process will replace the previous manual process of submitting paper forms and documentation to a post office box.
Budget Impact: Budget neutral

19-22 Expedited Appeals — The proposed revisions will add language to specify that requests for expedited appeal hearings should be sent to the Administrative Law Judge (ALJ) with a copy sent to the OHCA. Additionally, the appeal hearing request shall specify the services denied and the specific reason(s) why a regular 30-day appeal will seriously jeopardize the life or health of the member requesting an expedited appeal hearing.
Budget Impact: Budget neutral

19-23 Free-Standing Birthing Centers — The policy for free-standing birthing centers is being revoked as this type of provider no longer exists in Oklahoma.
Budget Impact: Budget neutral

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

19-31 Nursing Licensure Revisions — The proposed revisions will comply with Oklahoma House Bill (HB) 2351, which allows Oklahoma to enter into the enhanced Nurse Licensure Compact (eNLC). The eNLC is an agreement between states that allows a nurse's licensure to be portable to other member-states of the Compact. These revisions amend references that narrowly tie a nurse's license to the Oklahoma Board of Nursing and align SoonerCare rules with the eNLC.
Budget Impact: Budget neutral

19-33 Indian Health Services, Tribal Programs, and Urban Indian Clinics (I/T/Us) Obstetrical (OB) Care — The proposed revisions will clarify how I/T/U OB providers should bill for OB care. I/T/Us have the option of either billing for OB encounters or a bundled rate for total

OB care. The clarification will require I/T/Us to be specific when choosing a billing method as they are only allowed to choose one of the billing methods.
Budget Impact: Budget neutral

19-36 Programs of All-Inclusive Care for the Elderly (PACE) — The proposed revisions will bring the OHCA into compliance with Senate Bill (SB) 888 and federal regulations by adding language to clarify PACE participant enrollment and voluntary disenrollment process and criteria. Revisions will also add language to allow PACE providers to either be a non-profit or for-profit entity to align with the Social Security Act sections 1894(a)(3)(B) and 1934(a)(3)(B).
Budget Impact: Budget neutral

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

19-39A&B Nursing Home Supplemental Payment Program Revocation — The proposed revisions will remove rule sections that were created for the nursing home supplemental payment program, a program that was never implemented; the Centers for Medicare and Medicaid Services (CMS) did not ultimately approve the proposal.
Budget Impact: Budget neutral

19-40 Defunding Statutory Rape Cover-Up Act — The proposed new rule is needed to comply with House Bill (HB) 2591 which creates the Defunding Statutory Rape Cover-Up Act. The new law requires the OHCA to deny an application for a new or renewed provider agreement, or terminate an existing agreement, if a provider is investigated and found by a court to have failed to report statutory rape. The new rule outlines how an individual can report a complaint or a provider and the actions OHCA can take if the complaint has been found valid.
Budget Impact: Budget neutral

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

SUBCHAPTER 3. GENERAL PROVIDER POLICIES

PART 1. GENERAL SCOPE AND ADMINISTRATION

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

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

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TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY

CHAPTER 2. GRIEVANCE PROCEDURES AND PROCESS

317:2-1-2.5. Expedited appeals

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

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

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

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

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

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

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

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 87. BIRTHING CENTERS

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

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

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

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

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

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

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

317:30-5-890.1 Definitions [REVOKED]

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

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

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

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

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

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

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

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

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

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

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

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

~~(1) Urban areas:~~
~~(A) Canadian~~
~~(B) Cleveland~~
~~(C) Comanche~~
~~(D) Creek~~
~~(E) Garfield~~
~~(F) Logan~~
~~(G) McClain~~
~~(H) Oklahoma~~
~~(I) Osage~~
~~(J) Pottawatomie~~
~~(K) Rogers~~
~~(L) Sequoyah~~
~~(M) Tulsa~~
~~(N) Wagoner~~

~~(2) Rural areas:~~
~~(A) Adair~~
~~(B) Alfalfa~~
~~(C) Atoka~~

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

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

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

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

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

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

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

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

317:30-5-970. Eligible providers

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

~~(1) experience working with the target population.~~

~~(2) a minimum of five years experience in providing all core elements of case management services including:~~

~~(A) individualized strengths and needs assessment;~~

~~(B) needs-based service planning;~~

~~(C) service coordination and monitoring; and~~

~~(D) on-going assessment and treatment plan revision.~~

~~(3) adequate administrative capacity to fulfill State and federal requirements.~~

~~(4) a financial management capacity and system that provides documentation of services and costs.~~

~~(5) a capacity to document and maintain individual case records in accordance with State and federal requirements.~~

~~(6) ability to meet all State and federal laws governing the participation of providers in the State Medicaid program including, but not limited to, the ability to meet federal and State requirements for documentation, billing and audits.~~

~~(7) statutory authority to care for, supervise and provide services to the targeted population on a statewide basis.~~

~~(8) a minimum of five years experience in providing case management services that coordinate and link the community resources required by the target population.~~

~~(9) a minimum of five years experience in meeting the case management and service needs of the target population, including the statewide contract management/oversight and administration of services funded through the Oklahoma Children's Initiative.~~

~~(10) responsibility for planning and coordinating statewide~~

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

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

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

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

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

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

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

~~(B) community resources;~~

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

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

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

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

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

~~(4) possess skill in:~~

~~(A) crisis intervention;~~

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

~~(C) casework management;~~

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

~~(E) effective communication;~~

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

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

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

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

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

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

(1) Be available to all eligible members;

(2) Be delivered on a statewide basis with procedures that

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

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

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

social work theory and practices;
(D) Adverse childhood experiences and the impact of trauma on the developing adolescent brain;
(E) The risk and protective factors of child delinquency;
(F) Solution-focused practices and the critical role protective factors play in intervention planning;
(G) Sensitivity of cultural diversity; and
(H) Clinical and counseling techniques and treatment of juvenile delinquency;

(4) Possess skills in:
(A) Crisis intervention;
(B) Gathering necessary information to determine the needs of the child;
(C) Casework management;
(D) Courtroom testimony, terminology, and procedures;
(E) Effective communication;
(F) Developing, evaluating, and modifying, as appropriate, intervention planning on an ongoing basis;
(G) Establishing and maintaining supportive relationships with children and their families;
(H) Assisting children and families to access needed resources and supports; and
(I) Working with courts and law enforcement entities; and

(5) Have the ability to access multi-disciplinary staff, when needed. This includes, at a minimum, medical professionals and a child protective services social worker.

317:30-5-971. Coverage by category

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

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

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

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

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

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

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

~~(II) Monitoring financial goals;~~

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(i) Taking member history;

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

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

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

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

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

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

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

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

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address identified needs and achieve goals specified in the treatment service plan.

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

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

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

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

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

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

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

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

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

(2) Monitoring financial goals;

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

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

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

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

317:30-5-972. Reimbursement

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

(a) Targeted case management (TCM) services will be reimbursed

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pursuant to the methodology described in the Oklahoma Medicaid State Plan.

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

317:30-5-973. Billing

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

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

317:30-5-974. Documentation of records

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

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

(1) The name of the member;

(2) The dates of the case management services;

(3) The name of the OJA as the provider agency (if applicable) and the person providing the case management service;

(4) The nature, content, units of the case management services received, and whether goals specified in the treatment service plan have been achieved;

(5) Whether the member has declined services in the treatment service plan;

(6) The need for, and occurrences of, coordination with other case managers;

(7) A timeline for obtaining needed services; and

(8) A timeline for reevaluation of the plan.

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

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 21. OUTPATIENT BEHAVIORAL HEALTH AGENCY SERVICES

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

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

(1) ~~Allopathic or Osteopathic Physicians~~ An allopathic or osteopathic physician with a current license and board certification in psychiatry or board eligible in the state in which services are provided, or a current resident in psychiatry practicing as described in OAC 317:30-5-2.

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

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

(3) ~~Advanced Practice Nurse (certified in a psychiatric mental health specialty),~~An advanced practice registered nurse (APRN) certified in a psychiatric mental health specialty, and licensed as a registered nurse (RN) with a current certification of recognition from the board of nursing in the state in which services are provided.

(4) A ~~Physician Assistant~~physician assistant who is licensed and in good standing in ~~this~~the state in which services are provided and has received specific training for and is experienced in performing mental health therapeutic, diagnostic, or counseling functions.

(b) **Licensure ~~Candidates~~candidates.** Licensure candidates are practitioners actively and regularly receiving ~~board approved~~board-approved supervision, and extended supervision by a fully licensed clinician if board's supervision requirement is met but the individual is not yet licensed, to become licensed by one

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(1) of the ~~licensing boards~~areas of practice listed in (2)(A) through (F) above. The supervising LBHP responsible for the member's care must:

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

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

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

(4) ~~confirm~~Confirm that the service provided by the candidate was appropriate; and

(5) The member's medical record must show that the requirements for reimbursement were met and the LBHP responsible for the member's care has reviewed, countersigned, and dated the service plan and any updates thereto so that it is documented that the licensed professional is responsible for the member's care.

(c) **Certified ~~Alcohol and Drug Counselors~~alcohol and drug counselors (CADCs).** CADCs are defined as having a current certification as a CADC in the state in which services are provided.

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

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

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

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

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

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

~~(4) pass background checks;~~

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

~~(6) must function under the general direction of an LBHP, or Licensure Candidate or systems of care team, with an LBHP or Licensure Candidate available at all times to provide back up, support, and/or consultation.~~**Family support and training provider (FSP)**. FSPs must:

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(1) Have a high school diploma or equivalent;

(2) Be twenty-one (21) years of age and have a successful experience as a family member of a child/adolescent with serious emotional disturbance, or a minimum of have lived experience as the primary caregiver of a child/adolescent who has received services for substance use disorder and/or co-occurring substance use and mental health, or have lived experience being the caregiver for a child/adolescent with Child Welfare/Child Protective Services involvement;

(3) Successfully complete family support training according to a curriculum approved by ODMHSAS and pass the examination with a score of eighty percent (80%) or better;

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

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

(6) Function under the general direction of an LBHP, licensure candidate or systems of care team, with an LBHP or licensure candidate available at all times to provide back up, support, and/or consultation.

(g) ~~**Behavioral Health Aide (BHA).** BHAs are defined as follows:~~

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

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

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

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

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

~~(6) must function under the general direction of an LBHP, or Licensure Candidate and/or systems of care team, with an LBHP or Licensure Candidate available at all times to provide back up, support, and/or consultation.~~**Qualified behavioral health aide (QBHA).** QBHAs must:

(1) Have completed sixty (60) hours or equivalent of college credit; or may substitute one (1) year of relevant employment and/or responsibility in the care of children with complex emotional needs for up to two (2) years of college experience; and

(2) Have successfully completed the specialized training and education curriculum provided by the ODMHSAS; and

(3) Be supervised by a bachelor's level individual with a

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minimum of two (2) years case management or care coordination experience; and
(4) Have service plans be overseen and approved by an LBHP or licensure candidate; and
(5) Function under the general direction of an LBHP, or licensure candidate and/or systems of care team, with an LBHP or licensure candidate available at all times to provide back up, support, and/or consultation.

(h) **Behavioral ~~Health Case Manager~~health case manager**. For behavioral health case management services to be compensable by SoonerCare, the provider performing the services must be an LBHP, ~~Licensure Candidate~~licensure candidate, CADC or have and maintain a current certification as a ~~Case Manager~~case manager II (CM II) or ~~Case Manager~~case manager I (CM I) from ODMHSAS. The requirements for obtaining these certifications are as follows:

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

(A) Possess a ~~Bachelor's or Master's~~bachelor's or master's degree in a behavioral health related field earned from a regionally accredited college or university recognized by the United States Department of Education (USDE) or a ~~Bachelor's or Master's~~bachelor's or master's degree in education; and complete web-based training for behavioral health case management and behavioral health rehabilitation as specified by ODMHSAS; and complete one (1) day of face-to-face behavioral health case management training and two (2) days of face-to-face behavioral health rehabilitation training as specified by ODMHSAS; and pass web-based competency exams in behavioral health case management and behavioral health rehabilitation.

(B) ~~Possess a current license as a registered nurse in the State of Oklahoma~~Be licensed and in good standing as a registered nurse in the state in which services are provided, with experience in behavioral health care; complete web-based training for behavioral health case management and behavioral health rehabilitation as specified by ODMHSAS; complete one (1) day of face-to-face behavioral health case management training and two (2) days of face-to-face behavioral health rehabilitation training as specified by ODMHSAS; and pass web-based competency exams for behavioral health case management and behavioral health rehabilitation.

(C) Possess a ~~Bachelor's or Master's~~bachelor's or master's degree in any field earned from a regionally accredited college or university recognized by the USDE and a current certification or Children's Certificate in Psychiatric Rehabilitation from the US Psychiatric Rehabilitation Association (USPRA); complete the behavioral health case

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management web-based training as specified by ODMHSAS; complete one (1) day of face-to-face behavioral health case management training; and pass web-based competency exams for behavioral health case management. Applicants who have not received a certificate in children's psychiatric rehabilitation from the ~~US Psychiatric Association (USPRA)~~USPRA must also complete the behavioral health rehabilitation web-based training as specified by ODMHSAS.

(D) Possess a ~~Bachelor's or Master's~~bachelor's or master's degree in any field and proof of active progression toward obtaining a clinical licensure ~~Master's or Doctoral~~master's or doctoral degree at a regionally accredited college or university recognized by the USDE and complete web-based training for behavioral health case management and behavioral health rehabilitation as specified by ODMHSAS; complete one (1) day of face-to-face behavioral health case management training and two (2) days of face-to-face behavioral health rehabilitation training as specified by ODMHSAS; and pass web-based competency exams in behavioral health case management and behavioral health rehabilitation.

(2) ~~Certified Behavioral Health Case Manager~~The CM I meets the requirements in either (A) or (B) and (C):

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

(B) ~~has~~Possesses a high school diploma with ~~36~~thirty-six (36) total months of experience working with persons who have a mental illness and/or substance abuse. Documentation of experience on file with ODMHSAS; and

(C) ~~completes~~Completes two (2) days of ODMHSAS specified behavioral health case management training and passes a web-based competency exam for behavioral health case management.

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

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

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

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

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

(4) Intensive ~~Case Manager~~case manager is ~~a~~an LBHP, ~~Licensure~~

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~~Candidate~~licensure candidate, or CADC that meets the provider qualifications of a ~~Case Manager~~CM II and has the following:

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

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

PART 37. ADVANCED PRACTICE REGISTERED NURSE

317:30-5-375. Eligible providers

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

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

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

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

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

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

317:30-5-376. Coverage by category

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

(1) **Adults.** Payment for adults is made for primary care health

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services, within the scope of practice of ~~Advanced Practice Nurse~~an APRN and within the scope of the Oklahoma Health Care Authority (OHCA) medical programs.

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

(A) Payment is made to eligible providers for ~~Early and Periodic Screening, Diagnosis and Treatment of individuals under age 21~~EPSDT services to members under twenty-one (21) years of age. Specific guidelines for the EPSDT program including the periodicity schedule are found in ~~OAC~~Oklahoma Administrative Code (OAC) 317:30-3-65 through ~~317:30-3-65.11~~317:30-3-65.12.

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

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

PART 39. SKILLED NURSING SERVICES

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

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

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

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

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

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

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

(E) ~~medication~~Medication administration;

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

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

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

(2) The first ~~36~~thirty-six (36) visits provided by the home

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health care agency are covered by the Oklahoma Medicaid State Plan.

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

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

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

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

(2) Agency providers must:

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

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

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

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

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

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

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

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

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

PART 85. ADVANTAGE PROGRAM WAIVER SERVICES

317:30-5-763. Description of services

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

(1) **Case management.**

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

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

(ii) ~~develop~~Develop the member's comprehensive person-centered service plan, listing only the services necessary to prevent institutionalization of the member, as determined through the assessments;

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

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

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

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

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

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

(B) Providers of ADvantage services for the member or for those who have an interest in or are employed by an ADvantage provider for the member must not provide case management or develop the person-centered service plan, except when the ADvantage Administration (AA) demonstrates the only willing

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and qualified entity to provide case management and/or develop person-centered service plans in a geographic area, also provides other ADvantage services. Prior to providing services to members receiving Consumer-Directed Personal Assistance Services and Supports (CD-PASS), case manager supervisors, and case managers are required to receive training and demonstrate knowledge regarding the CD-PASS service delivery model, "Independent Living Philosophy," and demonstrate competency person-centered planning.

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

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

(ii) ~~ancillary~~Ancillary activities, such as clerical tasks, including, but not limited to, mailing, copying, filing, faxing, driving time, or supervisory and administrative activities are not billable case management activities. The administrative cost of these activities and other normal and customary business overhead costs are included in the reimbursement rate for billable activities.

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

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

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

(iii) The latest United States Census, Oklahoma counties population data is the source for determination of whether a member resides in a county with a population

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density equal to, or less than twenty-five (25) persons per square mile, or resides in a county with a population density greater than twenty-five (25) persons per square mile.

(2) **Respite.**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(I) ~~daily~~Daily activities;

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

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

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

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

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

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

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

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

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

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

(H) When the ADH is presumed not HCBS, according to 42 ~~CFR~~C.F.R. § 441.301(c)(5)(v), it may be subject to heightened scrutiny by AA, ~~OHCA~~the Oklahoma Health Care Authority (OHCA), and the Centers for Medicare and Medicaid Services (CMS). The ADH must provide evidence that the ADH portion of the facility has clear administrative, financial, programmatic, and environmental distinctions from the institution and comply with additional monitoring by the AA.

(4) **Environmental modifications.**

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

(B) All services require prior authorization.

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

(A) Specialized medical equipment and supplies are devices, controls, or appliances specified in the person-centered service plan that enable members to increase their abilities to perform ADLs, or to perceive, control, or communicate with the environment in which they live. Necessary items for

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life support, ancillary supplies, and equipment necessary for the proper functioning of such items, and durable and non-durable medical equipment not available under the Oklahoma Medicaid State Plan are also included. This service excludes any equipment and/or supply items not of direct medical or remedial benefit to the waiver member and necessary to prevent institutionalization.

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

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

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

(B) Advanced supportive/restorative assistance service is billed per ~~fifteen-minute (15-minute)~~fifteen (15) minute unit of service. The number of units of service a member may receive is limited to the number of units approved on the person-centered service plan.

(7) **Nursing.**

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

(B) Nursing services are services of a maintenance or preventative nature provided to members with stable, chronic conditions. These services are not intended to treat an acute

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

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

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

(II) ~~adequacy~~Adequacy of personal care and/or advanced supportive/restorative assistance services to meet the member's needs, including providing on-the-job training and competency testing for personal care or advanced supportive/restorative care aides per rules and regulations for the delegation of nursing tasks established by the ~~Oklahoma Board of Nursing~~board of nursing in the state in which services are provided.

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

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

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

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

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

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

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

(8) **Skilled nursing services.**

(A) Skilled nursing services listed in the person-centered service plan that are within the scope of the state's Nurse Practice Act and are ordered by a licensed physician, osteopathic physician, physician assistant, or an advanced practice nurse and are provided by an RN, LPN, or LVN under the supervision of an RN, licensed to practice and in good standing in the state in which services are provided. Skilled nursing services provided in the member's home or other community setting are services requiring the specialized

skills of a licensed nurse. The scope and nature of these services are intended for treatment of a disease or a medical condition and are beyond the scope of ADvantage nursing services. These intermittent nursing services are targeted toward a prescribed treatment or procedure that must be performed at a specific time or other predictable rate of occurrence. The RN contacts the member's physician to obtain necessary information or orders pertaining to the member's care. When the member has an ongoing need for service activities requiring more or less units than authorized, the RN must recommend, in writing, that the service plan be revised.

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

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

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

(B) Home-delivered meals are billed per meal, with one (1) meal equaling one (1) unit of service. The limit of the number of units a member is allowed to receive is in accordance with the member's person-centered service plan. The provider must obtain a signature from the member or the member's representative at the time the meal is delivered. In the event the member is temporarily unavailable, such as at a doctor's appointment and the meal is left at the member's home, the provider must document the reason a signature was not obtained. The signature logs must be available for review.

(10) **Occupational therapy services.**

(A) Occupational therapy services are services that increase functional independence by enhancing the development of adaptive skills and performance capacities of members with physical disabilities and related psychological and cognitive impairments. Services are provided in the member's

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

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

(11) **Physical therapy services.**

(A) Physical therapy services are those services that maintain or improve physical disability through the evaluation and rehabilitation of members disabled by pain, disease, or injury. Services are provided in the member's home and are intended to help the member achieve greater independence to reside and participate in the community. Treatment involves the use of physical therapeutic means, such as massage, manipulation, therapeutic exercise, cold and/or heat therapy, hydrotherapy, electrical stimulation, and light therapy. Under a physician's order, a licensed physical therapist evaluates the member's rehabilitation potential and develops an appropriate, written, therapeutic regimen. Under the Oklahoma Physical Therapy Practice Act, a physical therapist may evaluate a member's rehabilitation potential and develop and implement an appropriate, written, therapeutic regimen without a referral from a licensed health care practitioner for a period not to exceed ~~thirty-calendar (30-calendar)~~thirty (30) calendar days. Any treatment required after the ~~thirty-calendar (30-calendar)~~thirty (30) calendar day period requires a prescription from a physician or the physician's assistant of the licensee. The regimen utilizes paraprofessional physical therapy assistant services, within the limitations

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of his or her practice, working under the supervision of the licensed physical therapist. The regimen includes education and training for informal caregivers to assist with and/or maintain services when appropriate. The licensed physical therapist ensures monitoring and documentation of the member's rehabilitative progress and reports to the member's case manager and physician to coordinate the necessary addition or deletion of services, based on the member's condition and ongoing rehabilitation potential.

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

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

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

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

(13) **Hospice services.**

(A) Hospice services are palliative and comfort care provided to the member and his or her family when a physician certifies the member has a terminal illness, with a life

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

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

(C) A hospice person-centered service plan must be developed by the hospice team in conjunction with the member's ADvantage case manager before hospice services are provided. The hospice services must be related to the palliation or management of the member's terminal illness, symptom control, or to enable the member to maintain ADL and basic functional skills. A member who is eligible for Medicare hospice provided as a Medicare Part A benefit, is not eligible to receive ADvantage hospice services.

(D) Hospice services are billed per diem of service for days covered by a hospice person-centered service plan and while the hospice provider is responsible for providing hospice services as needed by the member or member's family. The

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maximum total annual reimbursement for a member's hospice care within a ~~twelve-month (12-month)~~twelve (12) month period is limited to an amount equivalent to ~~eighty-five (85) percent~~eighty-five percent (85%) of the Medicare hospice cap payment, and must be authorized on the member's person-centered service plan.

(14) **ADvantage personal care.**

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

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

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

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

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

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

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

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

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

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

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

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

(16) **CD-PASS.**

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

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

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

(iii) ~~determines~~Determines where and how the PSA or APSA works, hours of work, what is to be accomplished and,

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within individual budget allocation limits, wages to be paid for the work;

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

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

(B) The services the PSA may provide include:

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

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

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

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

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

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

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

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

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

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(ii) ~~removing~~Removing external catheters, inspecting skin, and reapplication of same;
(iii) ~~administering~~Administering prescribed bowel program, including use of suppositories and sphincter stimulation, and enemas pre-packaged only without contraindicating rectal or intestinal conditions;
(iv) ~~applying~~Applying medicated prescription lotions or ointments and dry, non-sterile dressings to unbroken skin;
(v) ~~using~~Using a lift for transfers;
(vi) ~~manually~~Manually assisting with oral medications;
(vii) ~~providing~~Providing passive range of motion (non-resistive flexion of joint) therapy, delivered in accordance with the person-centered service plan unless contraindicated by underlying joint pathology;
(viii) ~~applying~~Applying non-sterile dressings to superficial skin breaks or abrasions; and
(ix) ~~using~~Using universal precautions as defined by the Centers for Disease Control and Prevention.

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

(i) ~~processing~~Processing employer payroll, after the member/employer has verified and approved the employee timesheet, at a minimum of semi-monthly, and associated withholding for taxes, or for other payroll withholdings performed on behalf of the member as employer of the PSA or APSA;
(ii) ~~other employer related~~Other employer-related payment disbursements as agreed to with the member/employer and in accordance with the member/employer's individual budget allocation;
(iii) ~~responsibility~~Responsibility for obtaining criminal and abuse registry background checks on prospective hires for PSA or APSA on the member/employer's behalf;
(iv) ~~providing~~Providing orientation and training regarding employer responsibilities, as well as employer information and management guidelines, materials, tools, and staff consultant expertise to support and assist the member successfully perform employer-related functions; and
(v) ~~making~~Making Hepatitis B vaccine and vaccination series available to PSA and APSA employees in compliance with Occupational Safety and Health Administration (OSHA)

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standards.

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

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

(17) **Institutional transition services.**

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

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

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

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

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management services.

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

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

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

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

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

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

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

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

(B) The ADvantage ALS philosophy of service delivery promotes member choice, and to the greatest extent possible, member control. A member has control over his or her living space and his or her choice of personal amenities, furnishings, and activities in the residence. The ADvantage member must have the freedom to control his or her schedule and activities. The ALS provider's documented operating

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philosophy, including policies and procedures, must reflect and support the principles and values associated with the ADvantage assisted living philosophy and approach to service delivery emphasizing member dignity, privacy, individuality, and independence.

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

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

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

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

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

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

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

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

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

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State Department of Health (OSDH) regulations, per OAC 310:663-3-3, except for specialized services.

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

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

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

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

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

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

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

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personal needs" in this definition includes assistance with grooming and transferring. The term "assistance" is clarified to mean hands-on help, in addition to supervision.

(ix) The specific ALS assistance provided along with amount and duration of each type of assistance is based upon the member's assessed need for service assistance and is specified in the ALC's service plan that is incorporated as supplemental detail into the ADvantage comprehensive person-centered service plan. The ADvantage case manager in cooperation with ALC professional staff, develops the person-centered service plan to meet member needs. As member needs change, the person-centered service plan is amended consistent with the assessed, documented need for change in services.

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

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

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

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

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

(xi) Termination of residence when inappropriately placed. Once a determination is made that a member is inappropriately placed, the ALC must inform the member, the member's representative, ~~when~~if applicable, the AA, and the member's ADvantage case manager. The ALC must develop a discharge plan in consultation with the member, the member's representative, the ADvantage case manager, and the AA. The ALC and case manager must ensure the discharge plan includes strategies for providing increased services, when appropriate, to minimize risk

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and meet the higher care needs of members transitioning out of the ALC, when the reason for discharge is inability to meet member needs. When voluntary termination of residency is not arranged, the ALC must provide written notice to the member and to the member's representative, with a copy to the member's ADvantage case manager and the AA. The written notice provides intent to terminate the residency agreement and move the member to an appropriate care provider. The thirty (30) calendar-day requirement must not apply when emergency termination of the residency agreement is mandated by the member's immediate health needs or when the termination of the residency agreement is necessary for the physical safety of the member or other ALC residents. The written involuntary termination of residency notice for reasons of inappropriate placement must include:

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

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

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

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

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

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

(i) **Physical environment.**

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

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

(III) The ALC must provide each rental unit with a means for each member to control the temperature in the residential unit through the use of a damper,

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register, thermostat, or other reasonable means under the control of the member and that preserves privacy, independence, and safety, provided that the OSDH may approve an alternate means based on documentation that the design of the temperature control is appropriate to the special needs of each member who has an alternate temperature control.

(IV) For ALCs built prior to January 1, 2008, each ALC individual residential unit must have a minimum total living space, including closets and storage areas, of two-hundred and fifty (250) square feet; for ALCs built after December 31, 2007, each ALC individual residential unit must have a minimum total living space, including closets and storage areas, of three-hundred and sixty (360) square feet.

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

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

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

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

(IX) The ALC must ensure the design of common areas accommodates the special needs of the resident population and that the rental unit accommodates the special needs of the member in compliance with the Americans with Disabilities Act accessibility guidelines per ~~28 Code of Federal Regulations, Part 36, Appendix A~~Nondiscrimination on the Basis of Disability By Public Accommodations and in in

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Commercial Facilities, 28 Code of Federal Regulations, Appendix A, at no additional cost to the member.

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

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

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

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

(ii) **Sanitation.**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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(vi) **Staff supervision.**

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

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

(vii) **Resident rights.**

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

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

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

(viii) **Incident reporting.**

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

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

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

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

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

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

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

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

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any available provider qualified by licensure or certification to provide necessary health services in the ALC.

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

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

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

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

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

(ii) The notice of closure must include:

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

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

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

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

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

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

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

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

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

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

317:30-5-1043. Coverage by category

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

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

(1) **Description.** RBMS are provided by Organized Health Care Delivery Systems (OHCDS) for children in the care and custody of the State who have special psychological, behavioral, emotional and social needs that require more intensive care than can be provided in a family or foster home setting. The behavior management services are provided in the least restrictive environment and within a therapeutic milieu. The group setting is restorative in nature, allowing children with emotional and psychological problems to develop the necessary control to function in a less restrictive setting. RBMS are reimbursed in accordance with established rate methodology as described in the Oklahoma Medicaid State Plan. It is expected that RBMS in group settings are an all-inclusive array of treatment services provided in one (1) day. In the case of a child who needs additional specialized services, under the Rehabilitation Option or by a psychologist, prior authorization by the OHCA or designated agent is required. Only specialized rehabilitation or psychological treatment services to address unique, unusual or severe symptoms or disorders will be authorized. If additional services are approved, the OHCDS collaborates with the provider of such services as directed by the OHCA or its agent. Any additional specialized behavioral health services provided to children in state custody are funded in the normal manner. The OHCDS must provide concurrent documentation that these services are not duplicative. The OHCDS determines the need for RBMS.

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

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

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

(C) It has been determined by the OHCDS that the current disabling symptoms could not have been or have not been manageable in a less intensive treatment program.
(D) Documentation that the child's presenting emotional and/or behavioral problems prevent the child from living in a traditional family home. The child requires the availability of twenty-four (24) hour crisis response/behavior management and intensive clinical interventions from professional staff.
(E) The agency which has permanent or temporary custody of the child agrees to active participation in the child's treatment needs and planning.
(F) All of the medical necessity criteria must also be met for continued stay in residential group settings.

(3) **Treatment components.**

(A) **Individual plan of care development.** A comprehensive individualized plan of care for each resident shall be formulated by the provider agency staff within thirty (30) days of admission, for intensive treatment services (ITS) level within seventy-two (72) hours, with documented input from the agency which has permanent or temporary custody of the child and when possible, the parent. This plan must be revised and updated at least every three (3) months, every seven (7) days for ITS, with documented involvement of the agency which has permanent or temporary custody of the child. Documented involvement can be written approval of the individual plan of care by the agency which has permanent or temporary custody of the child and indicated by the signature of the agency case worker or liaison on the individual plan of care. It is acceptable in circumstances where it is necessary to fax a service plan to someone for review and then have him/her fax back his/her signature; however, the provider obtains the original signature for the clinical file within thirty (30) days. No stamped or Xeroxed signatures are allowed. An individual plan of care is considered inherent in the provision of therapy and is not covered as a separate item of behavior management services. The individual plan of care is individualized taking into account the child's age, history, diagnosis, functional levels, and culture. It includes appropriate goals and time limited and measurable objectives. Each member's individual plan of care must also address the provider agency's plans with regard to the provision of services in each of the following areas:

(i) Group therapy;
(ii) Individual therapy;
(iii) Family therapy;
(iv) Alcohol and other drug counseling;

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(v) Basic living skills redevelopment;
(vi) Social skills redevelopment;
(vii) Behavior redirection; and
(viii) The provider agency's plan to access appropriate educational placement services. (Any educational costs are excluded from calculation of the daily rate for behavior management services.)

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

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

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

(E) **Alcohol and other drug abuse treatment education, prevention, therapy.** The provider agency must provide alcohol and other drug abuse treatment for residents who have emotional or behavioral problems related to substance abuse/chemical dependency, to begin, maintain and enhance recovery from alcoholism, problem drinking, drug abuse, drug

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dependency addiction or nicotine use and addiction. This service is considered ancillary to any other formal treatment program in which the child participates for treatment and rehabilitation. For residents who have no identifiable alcohol or other drug use, abuse, or dependency, age appropriate education and prevention activities are appropriate. These may include self-esteem enhancement, violence alternatives, communication skills or other skill development curriculums.

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

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

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

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

(A) Be licensed in the state in which the services are delivered as a licensed psychologist, social worker (clinical specialty only), professional counselor, marriage

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

(B) Be licensed as an advanced practice registered nurse (APRN) certified in a psychiatric mental health specialty, and licensed as a registered nurse (RN) with a current certification of recognition from the Board of Nursing in the state in which services are provided~~, AND~~;and

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

(i) Case management, assessment and treatment planning;

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

(iii) Treatment of children with attachment disorders;

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

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

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

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

(viii) Anger management; and

(ix) Crisis intervention.

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

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

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

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

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

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

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

(i) Trauma-informed methodology;
(ii) Anger management;
(iii) Crisis intervention;
(iv) Normal child and adolescent development and the effect of abuse;
(v) Neglect and/or violence on such development;
(vi) Grief and loss issues for children in out of home placement;
(vii) Interventions with victims of physical, emotional and sexual abuse;
(viii) Care and treatment of children with attachment disorders;
(ix) Care and treatment of children with hyperactive, or attention deficit, or conduct disorders;
(x) Care and treatment of children, youth and families with substance abuse and chemical dependency disorders;
(xi) Passive physical restraint procedures; or
(xii) Procedures for working with delinquents or the Inpatient Mental Health and Substance Abuse Treatment of Minors Act.

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

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

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

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

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

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

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

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

(1) **Multiple encounters.** An I/T/U facility may bill for more than one encounter per ~~24~~twenty-four (24) hour period under certain conditions.
(2) **Behavioral Health services.** Behavioral Health Services are limited to those services furnished to members at or on behalf of the I/T/U facility.
(3) **Laboratory procedures.** Laboratory procedures performed by an I/T/U outpatient facility (not an independently certified enrolled laboratory) on the same date of service are considered part of the health care practitioner's service and are included in the I/T/U encounter.
(4) **Obstetrical services.** For OB services provided to a member before, during, and/or after the same pregnancy, ITUs may not bill for individual encounters and the package/bundled rate. Providers may only either:

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

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CHAPTER 35. MEDICAL ASSISTANCE FOR ADULTS AND CHILDREN-ELIGIBILITY

SUBCHAPTER 5. ELIGIBILITY AND COUNTABLE INCOME

PART 7. APPLICATION AND ELIGIBILITY DETERMINATION PROCEDURES

317:35-5-63. Agency responsible for determination of eligibility
(a) **Determination of eligibility by ~~OHCA.~~Oklahoma Health Care Authority (OHCA).** OHCA is responsible for determining eligibility for the following eligibility groups:
(1) children
(2) newborns deemed eligible
(3) pregnant women
(4) pregnancy-related services under Title XXI
(5) parents and caretaker relatives
(6) former foster care children
(7) Oklahoma Cares Breast and Cervical Cancer program
(8) SoonerPlan Family Planning program.
(9) Programs of All-Inclusive Care for the Elderly

(b) **Determination of eligibility by ~~OKDHS.~~DHS.** ~~OKDHS~~DHS is responsible for determining eligibility for the following eligibility groups:
(1) TANF recipients
(2) recipients of adoption assistance or kinship guardianship assistance
(3) state custody
(4) Refugee Medical Assistance
(5) aged
(6) blind
(7) disabled
(8) Tuberculosis
(9) QMBP
(10) QDWI
(11) SLMB
(12) QI-1
(13) Long term care services
(14) alien emergency services.

(c) **Determination of eligibility for programs offered through the Health Insurance Exchange.** Effective October 1, 2013, OHCA assesses applicants who are found to be ineligible for SoonerCare for potential eligibility for affordable insurance programs offered through the Health Insurance Exchange. OHCA does not determine eligibility or ineligibility for those programs. OHCA facilitates the determination for those affordable insurance

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programs by forwarding applicants' electronic applications to the Health Insurance Exchange.

SUBCHAPTER 18. PROGRAMS OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)

317:35-18-3. Definitions

The words and terms used in this Subchapter have the following meanings, unless the context clearly indicates otherwise:

(1) **"American Indian/Alaska Native (AI/AN)"** means an individual of Native American descent who has or is eligible for a Certificate of Degree of Indian Blood (CDIB) card;

(2) **"Capitation"** means the per member per month (pmpm) amount that the Oklahoma Health Care Authority pays PACE providers for PACE compensable services.

(3) **"Interdisciplinary Team (IDT)"** means the team of persons who interact and collaborate to assess PACE participants and plan for their care as set forth in 42 CFR 460.102. The IDT may also include the PACE participant's personal representative or advocate.

(4) **"Participant"** means an individual enrolled in a PACE program.

(5) **"Program agreement"** means the three-party agreement between the PACE provider, Centers for Medicare & Medicaid Services (CMS), and OHCA.

(6) **"Provider"** means the non-profit or for-profit entity that delivers required PACE services under an agreement with OHCA and CMS.

(7) **"Service area"** means the geographic area served by the provider agency, according to the program agreement.

(8) **"State Administering Agency (SAA)"** means the Oklahoma Health Care Authority.

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

SUBCHAPTER 22. PREGNANCY RELATED BENEFITS COVERED UNDER TITLE XXI

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

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

(b) ~~Only two~~Medical visits ~~per month~~ for other related services to evaluate and/or treat conditions that may adversely impact the pregnancy are covered. All visits shall require medical review to deem whether the medical visit is within the scope of coverage.

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TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY

CHAPTER 2. GRIEVANCE PROCEDURES AND PROCESS

317:2-1-16. Nursing Facility Supplemental Payment Program appeals [REVOKED]

~~In accordance with Oklahoma Administrative Code (OAC) 317:30-5-136, the Oklahoma Health Care Authority (OHCA) is authorized to promulgate rules for appeals of the Nursing Facility Supplemental Payment Program (NFSPP). The rules in this section describe those appeal rights.~~

~~(1) The following are appealable issues of the program: the assessed amount for each component of the intergovernmental transfer (IGT), the Upper Payment Limit (UPL) payment, the UPL Gap payment, and penalties for the non-state government-owned entity (NSGO). This is the final and only process for appeals regarding NFSPP. Suspensions or terminations from the program are not appealable in the administrative process.~~

~~(2) Appeals are heard by the OHCA Administrative Law Judge (ALJ).~~

~~(3) To file an appeal, the NSGO (appellant is the NSGO who files an appeal) shall file an LD-2 form within thirty (30) days from the date of the OHCA letter which advises the NSGO of component of IGT, UPL payment, UPL Gap payment and/or a penalty. An IGT that is not received by the date specified by OHCA, or that is not in the total amount indicated on the notice of program reimbursement (NPR) shall be subject to penalty and suspension from the program. Any applicable penalties shall also be deducted from the UPL payment regardless of any appeal action requested by the facility. Any change in the payment amount resulting from an appeals decision in which a recoupment or additional allocation is necessary will be adjusted in the future from any SoonerCare payments.~~

~~(4) The LD-2 shall only be filed by the NSGO or the NSGO's attorney in accordance with (5) below.~~

~~(5) Consistent with Oklahoma rules of practice, the non-state government-owned (NSGO) entity shall be represented by an attorney licensed to practice within the State of Oklahoma. Attorneys not licensed to practice in Oklahoma shall comply with Article II, Section 5 of Title 5 of the Oklahoma Statutes (O.S.), and rules of the Oklahoma Bar Association.~~

~~(6) The hearing will be conducted in an informal manner, without formal rules of evidence or procedure. However, parties who fail to appear at a hearing, after notification of said hearing date, will have their cases dismissed for failure to prosecute.~~

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~~(7) The appellant has the burden of proof by the preponderance of the evidence standard as defined by the Oklahoma Supreme Court.~~

~~(8) The docket clerk will send the appellant and any other necessary party a notice which states the hearing location, date, and time.~~

~~(9) The ALJ may:~~

~~(A) Identify and rule on issues being appealed which will be determined at the administrative hearing;~~

~~(B) Require the parties to state their positions concerning appeal issue(s);~~

~~(C) Require the parties to produce for examination those relevant witnesses and documents under their control;~~

~~(D) Rule on whether witnesses have knowledge of the facts at issue;~~

~~(E) Establish time limits for the submission of motions or memoranda;~~

~~(F) Rule on relevant motions, requests, and other procedural items; limiting all decisions to procedure matters and issues directly related to the contested determination resulting from OAC 317:30-5-136;~~

~~(G) Rule on whether discovery requests are relevant;~~

~~(H) Strike or deny witnesses, documents, exhibits, discovery requests, and other requests or motions which are cumulative, not relevant, not material, or used as a means of harassment, unduly burdensome, or not timely filed;~~

~~(I) Schedule pre-hearing conferences to settle, simplify, or identify issues in a proceeding or to consider other matters that may end the appeal;~~

~~(J) Impose appropriate sanctions against any party failing to obey an order of the ALJ;~~

~~(K) Rule on any requests for extension of time;~~

~~(L) Dismiss an issue or appeal if:~~

~~(i) it is not timely filed or is not within the OHCA's jurisdiction or authority;~~

~~(ii) it is moot or there is insufficient evidence to support the allegations;~~

~~(iii) the appellant fails or refuses to appear for a scheduled meeting, conference or hearing; or~~

~~(iv) the appellant refuses to accept a settlement offer which affords the relief the party could reasonably expect if the party prevailed in the appeal;~~

~~(M) Set and/or limit the time frame for the hearing.~~

~~(10) After the hearing:~~

~~(A) The ALJ should attempt to make the final hearing decision within ninety (90) days from the date of the hearing and send a copy of the ALJ's decision to both parties outlining~~

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~~their rights to appeal the decision. Any appeal of the final order pursuant to 12 O.S. ' 951 shall be filed with the District Court of Oklahoma County within thirty (30) days.~~

~~(B) It shall be the duty of the appellant in any District Court appeal to order a written transcript of proceedings to be used on appeal. The transcript must be ordered within thirty (30) days of the filing of an appeal in the District Court and any costs associated with the preparation of the transcript shall be borne by the appellant.~~

~~(11) All orders and settlements are non-precedential decisions.~~

~~(12) The hearing shall be digitally recorded and closed to the public.~~

~~(13) The case file and any audio recordings shall remain confidential.~~

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 9. LONG-TERM CARE FACILITIES

317:30-5-136. Nursing Facility Supplemental Payment Program [REVOKED]

~~(a) **Purpose.** The Nursing Facility Supplemental Payment Program (NFSPP) is a supplemental payment, up to the Medicare upper payment limit (UPL), made to a non-state government-owned entity that owns and as applicable has operating responsibility for a nursing facility(ies).~~

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

~~(1) **"Funds"** means a sum of money or other resources, as outlined in Public Funds as the State Share of Financial Participation, 42 Code of Federal Regulation (C.F.R.), Sec.433.51, appropriated directly to the State or local Medicaid agency, or funds that are transferred from other public agencies (including Indian tribes) to the State or local agency and under its administrative control, or funds certified by the contributing public agency as representing expenditures eligible for Federal Financial Participation (FFP).~~

~~(2) **"Intergovernmental transfer (IGT)"** means a transfer of state share funds from a non-state government-owned entity to the Oklahoma Health Care Authority (OHCA).~~

~~(3) **"Non-state government-owned (NSGO)"** means an entity owned and/or operated by a unit of government other than the state and the application packet is accepted and determined complete by OHCA as a qualified NSGO.~~

~~(4) **"Resource Utilization Groups (RUGs)"** means the system used to set Medicare per diem payments for skilled-nursing facilities, as the basis to demonstrate a Medicare payment estimate for use in the UPL calculation.~~

~~(5) **"Supplemental payment calculation period"** means the State Fiscal Year for which supplemental payment amounts are calculated based on Medicaid paid claims (less leave days) compiled from the state's Medicaid Management Information System (MMIS) at a minimum yearly to a maximum quarterly.~~

~~(6) **"Upper payment limit (UPL)"** means a reasonable estimate of the amount that would be paid for the services furnished by a facility under Medicare equivalent payment.~~

~~(c) **Eligible nursing facilities.** A nursing facility that is owned and as applicable under the operational responsibility of an NSGO,~~

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~~is eligible for participation when the following conditions are met:~~

~~(1) the nursing facility is licensed and certified by the Oklahoma State Department of Health;~~

~~(2) the participating NSGO has provided proof that it holds the facility's license and has complete operational responsibility for the facility;~~

~~(3) the participating NSGO has completed and submitted the Agreement of Participation application at minimum thirty (30) days prior to the start of the participation quarter and received the application packet is accepted and determined complete by OHCA;~~

~~(4) the facility is an active participant in the Focus on Excellence program and has earned at minimum one-hundred (100) points; does not receive an immediate jeopardy (IJ) scope and severity tag for abuse or neglect on three (3) separate surveys within a twelve (12) month period; and~~

~~(5) the facility and NSGO comply with care criteria requirements. All facilities shall provide supporting documentation (e.g., baselines, written plan, improvement summary, data sources) for the care criteria metrics.~~

~~(d) **NSGO participation requirements.** The following conditions are required of the NSGO:~~

~~(1) shall provide proof of ownership, if applicable (i.e. Change of Ownership) as licensed operator of the nursing facility;~~

~~(2) shall provide proof of proximity requirements of no greater than one hundred fifty (150) miles of NSGO. Exceptions may be made at the sole discretion of OHCA;~~

~~(3) shall execute a nursing facility provider contract as well as an agreement of participation with the OHCA;~~

~~(4) shall provide OHCA with an executed Management Agreement between the NSGO and the facility manager;~~

~~(5) shall provide and identify the state share dollars' source of the IGT;~~

~~(6) shall pay the calculated IGT to OHCA by the required deadline;~~

~~(7) shall utilize program dollars for health care related expenditures; and~~

~~(8) shall provide per facility, the per patient per Medicaid day (PPMD) IGT within specified timeframe of receipt of the Notice of Program Reimbursement (NPR) as indicated below:~~

~~(A) For the first year-$6.50 PPMD.~~

~~(B) For the second year-$7.50 PPMD.~~

~~(C) For the third year-$8.50 PPMD, or the equivalent of ten percent (10%) of nursing facility budget of the current fiscal year, whichever is less. This amount excludes any IGT for actual administration cost associated with the nursing~~

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~~home UPL supplemental program. Any remaining IGT after administration cost shall be distributed through the rate setting methodology process. Distribution shall occur once escrowed funds reach an amount sufficient to distribute as determined by OHCA.~~

~~(e) **Change in ownership.**~~

~~(1) A nursing facility participating in the supplemental payment program shall notify the OHCA of changes in ownership (CHOW) that may affect the nursing facility's continued eligibility within thirty (30) days after such change.~~

~~(2) For a nursing facility that changes ownership on or after the first day of the SoonerCare supplemental payment limit calculation period, the data used for the calculations will include data from the facility for the entire upper payment limit calculation period relating to payments for days of service provided under the prior owner, pro-rated to reflect only the number of calendar days during the calculation period that the facility is owned by the new owner.~~

~~(f) **Care Criteria.** Each facility shall be required to participate in the following care criteria components to receive UPL financial reimbursement.~~

~~(1) **Component 1- Quality Improvement Plan.** A facility shall hold monthly Quality Improvement Plan meetings. The meetings shall be tailored to identify an improvement plan for quality enhancement focused on nursing facility safety, quality of resident life, personal rights, choice and respect. Consistent with 42 CFR 483.75. Quality indicators shall be identified during the meetings and include the following:~~

~~(A) A written plan to include but not limited to the development, implementation and evaluation of the quality enhancement indicator. The plan shall be reviewed monthly for ongoing quality indicator progress, completion of the quality indicator and/or routine updates on the sustainability of current and/or prior indicators achieved.~~

~~(B) The design and scope of the plan should include the specific system and service that will be utilized to monitor and track performance improvement, the staff included to improve the quality indicator, resident choice, subjective/objective evidence and ongoing measures taken to ensure stability and enhancement. This may include but not be limited to a written policy, a procedure manual, data collections systems, management practices, resident/staff interviews, and trainings.~~

~~(C) Outcomes shall include evidence of improvement, cost expenditures toward improvement goal, how the facility shall continue to monitor the effectiveness of its quality enhancement and how it shall have ongoing sustainability.~~

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~~(D) Facility shall submit program documentation monthly. The information shall include A-D as well as OHCA required form LTC-19.~~

~~(E) The quality improvement plan shall be reviewed monthly by the OHCA quality review team. Payment shall be assessed in increments of 20 percent (20%) per month for a total of 60 percent (60%) per quarter if approved.~~

~~(2) **Component 2- Health Improvement Plan.**~~

~~(A) A facility shall hold quarterly Health Improvement Plan meetings. The meetings shall be tailored to identify an improvement plan for the quality indicators of urinary tract infection, unintended weight loss, developing or worsening pressure ulcers, and received antipsychotic medication. Meetings include the following:~~

~~(i) A written plan to include but not limited to the development, implementation and evaluation of the quality enhancement indicator. The plan shall be reviewed quarterly for ongoing quality indicator progress, completion of the quality indicator and/or routine updates on the sustainability of current and/or prior indicators achieved.~~

~~(ii) The design and scope of the plan should include the specific system and service that shall be utilized to monitor and track performance improvement, the staff included to improve the quality indicator, resident choice, subjective/objective evidence and ongoing measures taken to ensure stability and enhancement. This may include but not be limited to a written policy, a procedure manual, data collections systems, management practices, resident/staff interviews, and trainings.~~

~~(iii) Outcomes shall include evidence of improvement, cost expenditures toward improvement, how the facility will continue to monitor the effectiveness of its quality enhancement and how it shall have ongoing sustainability.~~

~~(iv) Facility shall submit program documentation quarterly. The information will include i-iii as well as OHCA required form LTC-18.~~

~~(B) The health improvement plan shall be reviewed quarterly by the OHCA quality review team. Payment shall be assessed in increments of ten percent (10%) by achieving five percent (5%) relative improvement or by achieving the national average benchmark per each of the four (4) components quarterly for a total of forty percent (40%) per quarter if approved.~~

~~(3) **Care Criteria Evaluation and Audit.** The care criteria measures may be evaluated at the discretion of OHCA on an annual basis after each fiscal year, following implementation of the~~

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~~program. However, OHCA reserves the right to conduct intermittent evaluations within any given year based on the quality, care and safety of SoonerCare members. The evaluation may be conducted by an independent evaluator. In addition, care criteria metrics may be internally evaluated after each fiscal year at the discretion of OHCA. The OHCA may make adjustments to the care criteria measures based on findings and recommendations as a result of the independent or internal evaluation.~~

~~(g) **Supplemental Payments.**~~

~~(1) The nursing facility supplemental payments to a NSGO under this program shall not exceed Medicare payment principles pursuant to Inpatient Services: Application of Upper Payment Limits, 42 C.F.R., Sec. 447.272. Payments are made in accordance with the following criteria:~~

~~(A) The methodology utilized to calculate the upper payment limit is the RUGs.~~

~~(B) The eligible supplemental amount is the difference/gap between the SoonerCare payment and the Medicare equivalent payment as determined based on compliance with the care criteria metrics.~~

~~(2) The amount of the eligible supplemental payment is associated with improvement of care of SoonerCare nursing facility residents as demonstrated through the care criteria. The quality components are evaluated monthly with a quarterly payout. Component 1 is assessed at twenty percent (20%) per month with a possible total achievement of sixty percent (60%) per quarter. Component 2 is assessed at ten percent (10%) per each of the four (4) components with a possible total achievement of 40 percent (40%) per quarter. Facilities will be reimbursed accordingly based on the percentage of care criteria earned.~~

~~(h) **Disbursement of payment.** NSGOs shall secure allowable IGT funds from a NSGO to fund the non-federal share amount. The method is as follows:~~

~~(1) The OHCA or its designee will notify the NSGO of the non-federal share amount to be transferred by an IGT, via electronic communications and NPR, for purposes of seeking federal financial participation (FFP) for the UPL supplemental payment, within twenty-five (25) business days after the end of the quarter. This amount will take into account the percentage of metrics achieved under the care criteria requirement. The NSGO will have five (5) business days to sign the participant agreement and make payment of the state share in the form of an IGT either in person or via mail. The date the NPR is sent by OHCA or its designee to the provider (NSGO) is the official date the clock starts to measure the five (5) business days. In~~

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~~addition, the NSGO shall also be required to remit, upon receipt of the NPR, the applicable PPMD IGT in full, pursuant to (d)(7) above.~~

~~(2) If the full IGT and the PPMD IGT are received within five (5) business days, the UPL payment will then be disbursed to the NSGO by OHCA within ten (10) business days in accordance with established payment cycles.~~

~~(i) **Penalties**.~~

~~(1) Receipt of the total IGT(s) within five (5) business days is not subject to any penalty.~~

~~(2) Any total IGT received after the fifth (5th) business day, but with an OHCA date stamp or mailing postal mark on or prior to five (5) business days from the official date of the receipt of the NPR will not be subject to penalty.~~

~~(3) Any total IGT with an OHCA date stamp or mailing postal mark received with a date after five (5) business days of receipt of the NPR, but not exceeding eight (8) business days of receipt of the NPR shall be deemed late and subject to a penalty in accordance with (3)(A) below.~~

~~(A) A five percent (5%) penalty will be assessed for the total IGT payments received after five (5) business days, but within eight (8) business days of receipt of the NPR. The five percent (5%) penalty will be assessed on the total eligible supplemental payment for the quarter in which the IGT is late and assessed to the specific NSGO as applicable.~~

~~(B) OHCA will notify the NSGO of the assessed penalty via invoice. If the NSGO fails to pay OHCA the assessed penalty within the time frame noted on the invoice to the NSGO, the assessed penalty will be deducted from the nursing facility's Medicaid payment. The penalty shall be paid regardless of any appeals action requested by the NSGO. Should an appeals decision result in a disallowance of a portion or the entire assessed penalty, reimbursement to the NSGO will be made to future nursing facility Medicaid payments.~~

~~(C) An NSGO that remits payment of the total IGT under the circumstances listed in (i) (2) or (i) (3) above will receive payment during the next available OHCA payment cycle.~~

~~(4) The first violation by an NSGO to remit the full IGT as indicated on the NPR by OHCA or its designee within the defined timeframes shall subject the NSGO to a penalty. The second violation by an NSGO to remit the full IGT indicated on the NPR by OHCA or its designee within the defined timeframes shall subject the NSGO to a penalty and a suspension for two (2) consecutive quarters. The NSGO will not be eligible to participate in the program during suspended quarters. A third violation by an NSGO to remit the full IGT indicated on the NPR~~

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~~by OHCA or its designee within the defined timeframes shall subject the NSGO to termination from the NFSPP. If the NSGO desires to participate again, it will be required to reapply. Reentry into the program is at the sole discretion of the OHCA. If the NSGO is readmitted to the program, terms of participation may include a probationary period with defined requirements.~~

~~(5) If OHCA receives a partial IGT or receives a full IGT after eight (8) business days of the receipt of the NPR, the NSGO shall be deemed to have voluntarily elected to withdraw participation in the NFSPP.~~

~~(6) If a nursing facility fails to meet the benchmarks of component 1 and/or component 2 of the care criteria for two (2) consecutive quarters, the facility shall be suspended for two (2) subsequent quarters and will not be eligible to participate in the program during suspended quarters. A facility that has been suspended for a total of four (4) quarters within a two (2) year period due to non-compliance with the Care Criteria shall be terminated from the program, and if the facility wishes to participate again, it will be required to reapply. Reentry into the program is at the sole discretion of the OHCA. If the facility is readmitted to the program, terms of participation may include a probationary period with defined requirements as it relates to care.~~

~~(j)~~ **Appeals.** ~~Applicant and participant appeals may be filed in accordance with grievance procedures found at Oklahoma Administrative Code 317:2-1-2(c) and 317:2-1-16.~~

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

SUBCHAPTER 3. GENERAL PROVIDER POLICIES

PART 1. GENERAL SCOPE AND ADMINISTRATION

317:30-3-19.6. Complaints related to the Defunding Statutory Rape Cover-up Act

(a) In accordance with Title 56 of the Oklahoma Statutes (O.S.) § 1007.4, the Oklahoma Health Care Authority (OHCA) shall investigate complaints made pursuant to the Defunding Statutory Rape Cover-up Act that are submitted in writing to OHCA's Legal Division, and that include:

(1) The name and contact information of the person submitting the complaint;

(2) The name of the health care provider and/or affiliate, as that term is defined by 56 O.S. § 1007.1, who is alleged:

(A) To have been found by a court of law to have failed to report statutory rape; or

(B) To have failed to report statutory rape where the statutory rape resulted in a conviction against the assailant;

(3) The name of the SoonerCare member who allegedly was the victim of statutory rape (if the member is an adult), or of the member's parent(s) or legal guardian (if the member is a minor); and

(4) A short summary of any other relevant information.

(b) A complaint made pursuant to the Defunding Statutory Rape Cover-up Act may result in a denial of an application for a new or renewed provider enrollment contract, pursuant to Oklahoma Administrative Code (OAC) 317:30-3-19.3, or termination of an existing provider agreement, pursuant to OAC 317:30-3-19.5.

(c) A complaint made pursuant to the Defunding Statutory Rape Cover-up Act may also result in a referral to local law enforcement authorities, where appropriate.

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