OKLAHOMA HEALTH CARE AUTHORITY
REGULARLY SCHEDULED BOARD MEETING
June 10, 2010 at 1:00 P.M.
Oklahoma Health Care Authority
4545 N. Lincoln Blvd, Suite 124
Oklahoma City, Oklahoma

A G E N D A

Items to be presented by Lyle Roggow, Chairman

1. Call To Order/Determination of Quorum
2. Action Item – Approval of May 13, 2010 OHCA Board Minutes

Item to be presented by Mike Fogarty, Chief Executive Officer

3. Discussion Item – Chief Executive Officer's Report

    a) Financial Update – Carrie Evans, Chief Financial Officer
    b) Medicaid Director's Update – Becky Pasternik-Ikard
    c) Legislative Update – Nico Gomez, Deputy Chief Executive Officer
    d) Update on Member Satisfaction Survey – Becky Pasternik-Ikard
    e) Update on Building Flood Damage – Mike Fogarty

Item to be presented by Chairman Roggow

4. Discussion Item – Reports to the Board by Board Committees

    a) Audit/Finance Committee – Member Miller
    b) Legislative Committee – Member McFall
    c) Rules Committee – Member Langenkamp

Item to be presented by Howard Pallotta, Director of Legal Services

5. Announcement of Conflicts of Interest Panel Recommendations for all action items regarding this board meeting.

Items to be presented by Cindy Roberts, Deputy Chief Executive Officer

6. Action Item – Consideration and Vote of agency recommended rulemaking pursuant to Article I of the Administrative Procedures Act.

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

    b) Consideration and Vote Upon promulgation of ***Emergency Rules*** as follows:

    6.b-1 ADDING Agency rules at OAC 317:50-1-1 through 50-1-16 to implement a new Home and Community Based Waiver Program to accommodate the "medically fragile" population whose medical needs require services in excess of those offered by current HCBW programs. This Program will finance non-institutional long-term

care services for individuals requiring skilled nursing or hospital level of care. Individuals must be at least 19 years of age, have a chronic medical condition which results in prolonged dependency on medical care for which daily skilled intervention is necessary and is characterized by one or more of the following: (1) a life threatening condition characterized by reasonably frequent periods of acute exacerbation which requires frequent medical supervision and/or physician consultation and which, in the absence of such supervision or consultation, would require hospitalization; (2) the individual requires frequent time consuming administration of specialized treatments which are medically necessary; (3) the individual is dependent on medical technology such that without the technology, a reasonable level of health could not be maintained.
(Reference APA WF # 10-13)

6.b-2 AMENDING Agency rules at OAC 317:30-5-700 through 30-5-700.1 to add clarity to Dental Program rules regarding eligibility requirements for orthodontic services, documentation required in order to receive prior authorization, limits on the types of orthodontic therapy allowed, and progress reporting requirements.
(Reference APA WF # 10-17)

6.b-3 REVOKING Agency rules at OAC 317:30-5-586.1 and 30-5-589, and AMENDING Agency rules at OAC 317:30-5-595 through 30-5-596 to remove language that allows reimbursement for behavioral health case managers' travel time to and from meetings for the purpose of development or implementation of the individual plan of care. Current policy conflicts with the Agency's State Plan reimbursement methodology which includes travel time as a component of the case management rate. Additionally, rules are revised to revoke sections that were previously combined with other areas of policy.
(Reference APA WF # 10-19)

6.b-4 AMENDING Agency rules at OAC 317:30-3-2.1 to allow providers the option of requesting OHCA to perform a full-scope audit or utilize an extrapolation method to determine overpayments, if during a review a sample indicates an error rate greater than 10 percent of paid claims. If the full-scope audit produces an error rate less than the initial error rate, OHCA will bear the cost of the full-scope audit. However, if it produces an error rate equal to or greater than that of the initial audit, the provider will be responsible for the cost of the full-scope audit and repayment of the identified overpayment resulting from the review method chosen.
(Reference APA WF # 10-26)

6.b-5 AMENDING Agency rules at OAC 317:30-3-24 and 35-5-43 to reflect changes in third party liability recovery procedures necessitated by the Agency's implementation of Online Enrollment. In 2007, the OHCA received a Transformation Grant through the Centers for Medicare and Medicaid Services (CMS) to develop a web based online application and eligibility determination system in order to improve the ease and efficiency of enrollment. The Online Enrollment process allows potential members to apply for

SoonerCare electronically. Because OHCA will assume responsibility for determining eligibility for certain groups of individuals under SoonerCare through this process, rules regarding Third Party Liability are in need of revision to update procedures to be followed by both OKDHS and OHCA employees.
(Reference APA WF # 10-28A and 10-28B)

6.b-6 AMENDING Agency rules at OAC 317:30-5-240 through 30-5-241, 30-5-241.2, 30-5-241.3, 30-5-241.5, and 30-5-248 to clarify the definition and credential requirements of a Behavioral Health Rehabilitation Specialists (BHRS).Current policy conflicts with Oklahoma Department of Mental Health Substance Abuse Services (ODMHSAS) definition and credential requirements. Additionally, rules are revised to clean up discrepancies between OHCA and ODMHSAS policy for consistency.
(Reference APA WF # 10-29)

6.b-7 AMENDING Agency rules at OAC 317:30-5-95, 30-5-95.4 through 30-5-95.6, 30-5-95.8 through 30-5-95.10, 30-5-95.13 through 30-5-95.16, 30-5-95.18 through 30-5-95.20, 30-5-95.22 through 30-5-95.40, 30-5-95.42, 30-5-96.2 through 30-5-96.4, and 30-5-96.7 to modify Residential Treatment Center (RTC) requirements for Community Based transitional level of care. Modifications allow the requirements to be less restrictive as a step-down from standard RTC. By reducing the treatment requirements for the Community Based Transitional level of care, this allows facilities to step down that member to a lower level of RTC care and focus on transitioning the member back to the community, which supports RTC diversion. Additionally, rules are revised to add the Child and Adolescent Level of Care Utilization System (CALOCUS) to be used when determining level of care. Other revisions include removing medical necessity from policy and directing providers to reference the OHCA Behavioral Health Provider Manual.
(Reference APA WF # 10-30)

6.b-8 AMENDING Agency rules at OAC 317:2-1-2 and 2-1-6, and ADDING Agency rules at OAC 317:2-1-14 to provide for an appeals process for purchasing decisions made internally at OHCA, pursuant to 74 Okla. Stat., §85.5(T). Further revisions are made to clean up simple terminology within the existing language. These revisions are needed to provide immediate consistency and clarity within agency purchasing rules.
(Reference APA WF # 10-31)

Item to be presented by Cindy Roberts, Chairperson of State Plan Amendment Rate Committee

7. Action Item – Consideration and Vote Upon the recommendations of the State Plan Amendment Rate Committee

   a) Consideration and Vote Upon rate proposal for ADvantage Incontinence Supplies
   b) Consideration and Vote Upon rate proposal to implement a weekly rate for Developmental Disabilities Services Division Targeted Case Management(DDSDTCM) services

c) Consideration and Vote Upon rate proposal to implement a weekly rate for Child Welfare Targeted Case Management(CWTCM) services
d) Consideration and Vote Upon rate proposal to implement a weekly rate for Targeted Case Management services for children under age 18 who are involved in or at serious risk of involvement with the juvenile justice system(excludes those who are involuntarily in secure custody of law enforcement of judicial systems)OJATCM
e) Consideration and Vote Upon rate proposal to reduce expenditures in the dental program with a change in reimbursement for posterior restorations and an overall decrease in dental rates

Item to be presented by Beth VanHorn, Director of Legal Operations

8. a) Action Item - Consideration and Vote to authorize expenditure of funds for State Fiscal Year 2011 renewal of the Hewlett-Packard contract for the current MMIS

b) Action Item - Consideration and Vote to authorize expenditure of funds for State Fiscal Year 2011 renewal and amendment of the Fox Systems contract

c) Action Item – Consideration and Vote to authorize expenditure of funds for Reprocurement of the Third Party Liability (TPL) collection services

Item to be presented by Nancy Nesser, PharmD. JD, Pharmacy Director

9. Action Item - Consideration and Vote Regarding Recommendations Made by the Drug Utilization Review Board Under 63 Oklahoma Statutes § 5030.3.

a) Consideration and Vote to add Mozobil® (plerixafor), Nplate® (romiplostim), and Arcalyst® (rilonocept) to the utilization and scope prior authorization program under OAC 317:30-5-77.2(e)

Item to be presented by Chairman Roggow

10. Discussion Item - Proposed Executive Session as Recommended by the Director of Legal Services and Authorized by the Open Meetings Act, 25 Okla. Stat. § 307(B)(1),(4)&(7)

Status of pending suits and claims

1. PharmCare v. OHCA CJ-03-830(Oklahoma County)
2. Morehead v. OKDHS CJ-07-1110-L(Cleveland County)
3. Covalt v. OKDHS CJ-08-85(Grant County)
4. Webb v. OKDHS 09-CV-438(USDC, Northern District)
5. Morris v. OKDHS CIV-09-1357-C(USDC, Western District)
6. Woodlawn v. OHCA 107,408(Okla. Supreme Court)
7. Daily v. OKDHS 09-1095(US Supreme Court)
8. Moss v. Wittmer 108,355 (Okla. Supreme Court)
9. Water Damage Claim by Agency from Recent Flooding
10. Castro v. Oklahoma Health Care Authority CV-2010-690(Oklahoma County)

11. Action Item – Election of Oklahoma Health Care Authority 2011 Board Officers

12. New Business

13. Adjournment

NEXT BOARD MEETING

July 8, 2010
Oklahoma Health Care Authority
Oklahoma City, OK

MINUTES OF A REGULARLY SCHEDULED BOARD MEETING OF THE OKLAHOMA HEALTH CARE AUTHORITY BOARD
May 13, 2010 at 1:00 P.M.
Held at Oklahoma Health Care Authority
4545 N. Lincoln Blvd., Suite 124
Oklahoma City, OK

Manner and Time of Notice of Meeting: A public notice was placed on the front door of the Oklahoma Health Care Authority on May 11, 2010.

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

BOARD MEMBERS PRESENT:	Vice Chairman Armstrong, Member Bryant, Member Miller, Member Langenkamp, Member McFall, and Chairman Roggow
ABSENT:	Member McVay

OTHERS PRESENT:	OTHERS PRESENT:
James Baughman, MH Assn./Tulsa	Mary Brinkley, OKAHA
Debbie Williams, SA&I	Anne Anthony, Willow Crest Hospital
Steve Goodman, Willow Crest H.	Scott Anthony,Willow Crest Hospital
Lori Henderson	Samantha Bradshaw, SA&I
Kerri Bourman, American Legion	Rich Edwards, OSF
Rebecca Moore, OAHCP	Nola Harrison
Monte Akridge, Integris H.	Rick Snyder, OHA
Walter Gerow	Tracy Jones, Chickasaw Nation
Becky Moore, OAHCP	Tom Dunning, OKDHS
Rhonda Booker	Jim Igo, Integris
Bryan Day	Sandra Harrison, OKDHS
Nancy Kachel, PPAEO	Holly Turner, Merck
Walt Gerron, 12&12 BH	Valerie Anderson, 12&12 BH

DISCUSSION AND POSSIBLE VOTE ON APPROVAL OF BOARD MINUTES OF THE REGULARLY SCHEDULED BOARD MEETING HELD APRIL 8, 2010

The Board routinely reviews and approves a synopsis of all its meetings. The full-length recordings of the meetings of the Board are retained at the Board Offices and may be reviewed upon written request.

MOTION:	Vice Chairman moved for approval of the April 8, 2010 board minutes as presented. Member Miller.
FOR THE MOTION:	Vice Chairman Armstrong, Member Miller, Member Langenkamp, Member McFall, and Chairman Roggow
ABSENT:	Member McVay
ABSTAIN:	Member Bryant

ITEM 3.a/FINANCIAL UPDATE
Carrie Evans, Chief Financial Officer

Ms. Evans reported that revenues for OHCA through March, accounting for receivables, were **$2,682,969,277** or **.8% over** budget. The expenditures, accounting for encumbrances, were **$2,546,182,306** or **.5% over** budget. The state dollar budget variance through March is **$183,325 positive.** The state dollar budget variance due to Medicare Part D Stimulus allocation is **$10,021,700 positive.** Ms. Evans stated that the budget variance is primarily attributable to the following (in millions):

Expenditures:		
Medicaid Program Variance		(14.5)
Medicare Part D		10.0
Administration		3.4
Unbudgeted Carryover		3.4
Revenues:		
Taxes and Fees		2.6
Drug Rebate		1.5
Overpayments/Settlements		3.8
Total FY 10 Variance	**$**	**10.2**

ITEM 3.b/MEDICAID DIRECTOR'S UPDATE
Lynn Mitchell, M.D.

Dr. Mitchell reported that the enrollment numbers for SoonerCare plus Insure Oklahoma stand at 720,607. She said that the employer-sponsored insurance in Insure Oklahoma has dropped for the first time. Although the number of employers leaving the program did not change dramatically over the past few months Dr. Mitchell said less people are starting the program to compensate for those who do drop. She stated that it can partially be contributed to the current economic situation and less people willing to make a financial commitment at this time. Dr. Mitchell discussed the OHCA article in the Center for Health Strategies, the Provider Update and the SoonerCare Companion update. For details, see board packet handouts.

Dr. Mitchell then reported on the Psychiatric Residential Treatment Facilities update stating there has been more communication on things that can be done. In looking at the numbers we noticed the trend of length of stays going down, and are seeing more members utilizing those services at the same time. We are staying aware of the issues that the providers are facing and giving as much input as possible. Finally, she highlighted the quality report "Minding our P's and Q's" for SFY 2009. The report is now on the website for the public to view.

Dr. Mitchell spoke briefly about her time of 16 years with the agency as State Medicaid Director and said that she appreciated the opportunity to work for an agency that has the goal of improving the health care for Oklahomans. She said she was proud of SoonerCare, Insure Oklahoma and the staff who work hard and care so much.

Chairman Roggow presented Dr. Mitchell with a Governor's Commendation for her 16 years of service to the Oklahoma Health Care Authority and her 23 years of state service.

Mr. Fogarty stated that even in the midst of financial difficulty, we are doing fine as a state agency. "That's the bottom line".

ITEM 3.c/LEGISLATIVE UPDATE
Nico Gomez, Deputy Chief Executive Officer

OHCA REQUEST BILLS:

- SB 1349 – Obesity Treatment Pilot Program for Medicaid (Failed 4/8/10 deadline)
- SB 1836 - Health Information Infrastructure Advisory Board to Assist OHCA In Developing Electronic Health Record Incentive Payments

After the April 22nd committee deadline, and as of noon, Wednesday, May 5, 2010, the Oklahoma Legislature is currently tracking a total of 1,106 active bills. OHCA is currently tracking 63 bills. They are broken down as follows:

- OHCA Request 01
- Direct Impact 21
- Agency Interest 07
- Appropriations 10
- Employee Interest 09
- Carry Over 04
- Governor Signed 11

April 29, 2010 was the internal House deadline for rejecting Senate Amendments to House measures and requesting conference. Tuesday, May 4th was the internal House deadline for members to request House conferees for House bills. Monday, May 10th will be the deadline for filing first Conference Committee Reports other than CCRS referred to the General Conference Committee on Appropriations (GCCA).

Sine Die adjournment is set for May 28th.

Mr. Fogarty asked Ms. Zinn of Human Resources to present letters received in the last 2 weeks regarding some of the outstanding work of the OHCA staff. Ms. Zinn read 3 letters of appreciation.

ITEM 3.d/OHCA TEAM DAY REPORT
Cindy Roberts, Deputy Chief Executive Officer

Ms. Roberts presented the Quality Team Day 2010 awards. She stated that Team Day happens once a year. This year there were 79 teams representing 15 state agencies. OHCA presented 10 projects and 4 booth only displays and won 6 teams awarded Governor's Commendation for Excellence and one booth for best booth award for the second year. They are as follows: Program of All Inclusive Care for the Elderly (PACE) received the Governor's Commendation for Excellence; Developmental Screening Initiative - Integrating Developmental Screens

in the Medical Home received the Governor's Commendation for Excellence; OB(Pregnancy) Outreach Project received the Governor's Commendation for Excellence; OHCA Medical Authorization Unit for Risk and High Risk Obstetrics received the Best Booth Award; OHCA and Riverside Indian Boarding School received the Governor's Commendation for Excellence; SoonerPlan – Oklahoma's Free Family Planning Program received the Governor's Commendation for Excellence; and Electronic Provider Enrollment received the Governor's Commendation for Excellence. Ms. Roberts thanked all staff involved for their participation and hard work.

ITEM 4 – PRESENTATION OF THE 2009 AUDIT FINDINGS OF THE OKLAHOMA HEALTH CARE AUTHORITY BY THE STATE AUDITOR AND INSPECTORS OFFICE

Cindy Roberts, Deputy Chief Executive Officer

Ms. Roberts introduced Ms. Debbie Williams, Audit Manager, State Auditor and Inspectors Office. Ms. Roberts stated that every year we have an Audit called the Single Audit, or otherwise known as that OMB Circular A133 Audit. This is a regular organizational wide audit or examination for any agency that spends $500,000 in federal funds. It is performed annually. The objective is to assure the federal government that we manage our funds appropriately. It is both a financial and a compliance audit. Ms. Williams thanked the Provider Services unit for housing the Auditors for the last few months, also Program Integrity and Finance division for their daily interaction with the auditors. She stated that they conducted a statewide single audit; the audit was conducted in accordance with generally accepted auditing standards and circular A133. She explained the purpose of the audit was to determine the Oklahoma Health Care Authority's compliance with material laws and regulations and to determine whether the internal controls over these programs are adequate to insure compliance. Ms. Williams stated that they audited Medicaid and SCHIP programs during fiscal year 09. He said that the following are requirements that are generally applicable to each audited program: activities allowed allowable costs, cash management, eligibility, matching, and level of effort, period of availability, reporting and special tests. She stated that for each of these requirements they document and test internal controls. Another part of the audit is cost allocation and the purpose is to allocate and direct administrative costs that are in the agency. For detailed information see the 2009 single audit by the State Auditor's Office.

ITEM 5/BOARD COMMITTEE REPORTS

5.a)Audit/Finance Committee

Member Miller

Member Miller stated that the Committee met and discussed being able to finish the fiscal year in the black. Our overwhelming issue will arrive with the outcome of the SFY 2011 authorization and at this moment, we just do not know. The really bad news is that SFY 2012 can be even worse without stimulus funds available.

5.b) Legislative Committee
Member McFall

Member McFall stated the Legislative Committee did meet and discussed the tracking lists of bills and will have a complete report in June.

5.c) Legislative Committee
Member Langenkamp

Member Langenkamp stated that the Rules Committee met and reviewed rules.

Chairman Roggow presented Ms. Branstetter with her 20 year certificate for state service.

ITEM 6 - ANNOUNCEMENTS OF CONFLICTS OF INEREST PANEL RECOMMENDATIONS FOR ALL ACTION ITEMS REGARDING THIS BOARD MEETING
Howard Pallotta, Director of Legal Services

Mr. Pallotta stated that the Conflicts of Interest Panel had met and there were no conflicts regarding Items 7.b-1 thru 7.b-4

ITEM 7.a) CONSIDERATION AND VOTE UPON A DECLARATION OF A COMPELLING PUBLIC INTEREST FOR THE PROMULGATION OF ALL EMERGENCY RULES IN ACCORDANCE WITH 75 OKLA. STAT. § 253
Cindy Roberts, Deputy Chief Executive Officer

MOTION:	Member McFall moved for declaration of emergency as presented. Member Bryant seconded.
FOR THE MOTION:	Vice Chairman Armstrong, Member Bryant, Member Miller, Member Langenkamp, Member McFall, and Chairman Roggow
ABSENT:	Member McVay

ITEM 7.b) CONSIDERATION AND VOTE UPON PROMULGATION OF EMERGENCY RULES AS FOLLOWS:
Cindy Roberts, Deputy Chief Executive Officer

7.b-1 through 7.b-4 as published in meeting agenda.

MOTION:	Member Langenkamp moved for approval of rules 7.b-1 through 7.b-4 as published in meeting agenda. Member McFall seconded.
FOR THE MOTION:	Vice Chairman Armstrong, Member Bryant, Member Miller, Member Langenkamp, Member McFall, and Chairman Roggow
ABSENT:	Member McVay

ITEM 8 - DISCUSSION ITEM – PROPOSED EXECUTIVE SESSION AS RECOMMENDED BY THE DIRECTOR OF LEGAL SERVICES AND AUTHORIZED BY THE OPEN MEETINGS ACT, 25 OKLA. STATE. §307(B)(1),(4)&(7)

Nicole Nantois, Deputy General Counsel

MOTION:	Member Langenkamp moved for an executive session. Member McFall seconded.
FOR THE MOTION:	Vice Chairman Armstrong, Member Bryant, Member Miller, Member Langenkamp, Member McFall, and Chairman Roggow
ABSENT:	Member McVay

ITEM 9/NEW BUSINESS

NONE

ITEM 12/ADJOURNMENT

MOTION:	Vice Chairman Armstrong moved for adjournment. Member McFall seconded.
FOR THE MOTION:	Vice Chairman Armstrong, Member Bryant, Member Miller, Member Langenkamp, Member McFall, and Chairman Roggow
ABSENT:	Member McVay

FINANCIAL REPORT

For the Ten Months Ended April 30, 2010
Submitted to the CEO & Board
June 10, 2010

- Revenues for OHCA through April, accounting for receivables, were **$2,890,676,122** or **.6% over** budget.
- Expenditures for OHCA, accounting for encumbrances, were **$2,790,045,527** or **.0% over** budget.
- The state dollar budget variance through April is **$2,256,758 positive.**
- The state dollar budget variance due to Medicare Part D Stimulus allocation is **$15,568,845 positive.**
- The budget variance is primarily attributable to the following (in millions):

Expenditures:		
Medicaid Program Variance		(14.5)
Medicare Part D		15.6
Administration		3.7
Unbudgeted Carryover		3.4
Revenues:		
Taxes and Fees		3.8
Drug Rebate		1.9
Overpayments/Settlements		3.9
Total FY 10 Variance	**$**	**17.8**

ATTACHMENTS

OKLAHOMA HEALTH CARE AUTHORITY
Summary of Revenues & Expenditures: OHCA
Fiscal Year 2010, for the Ten Months Ended April 30, 2010

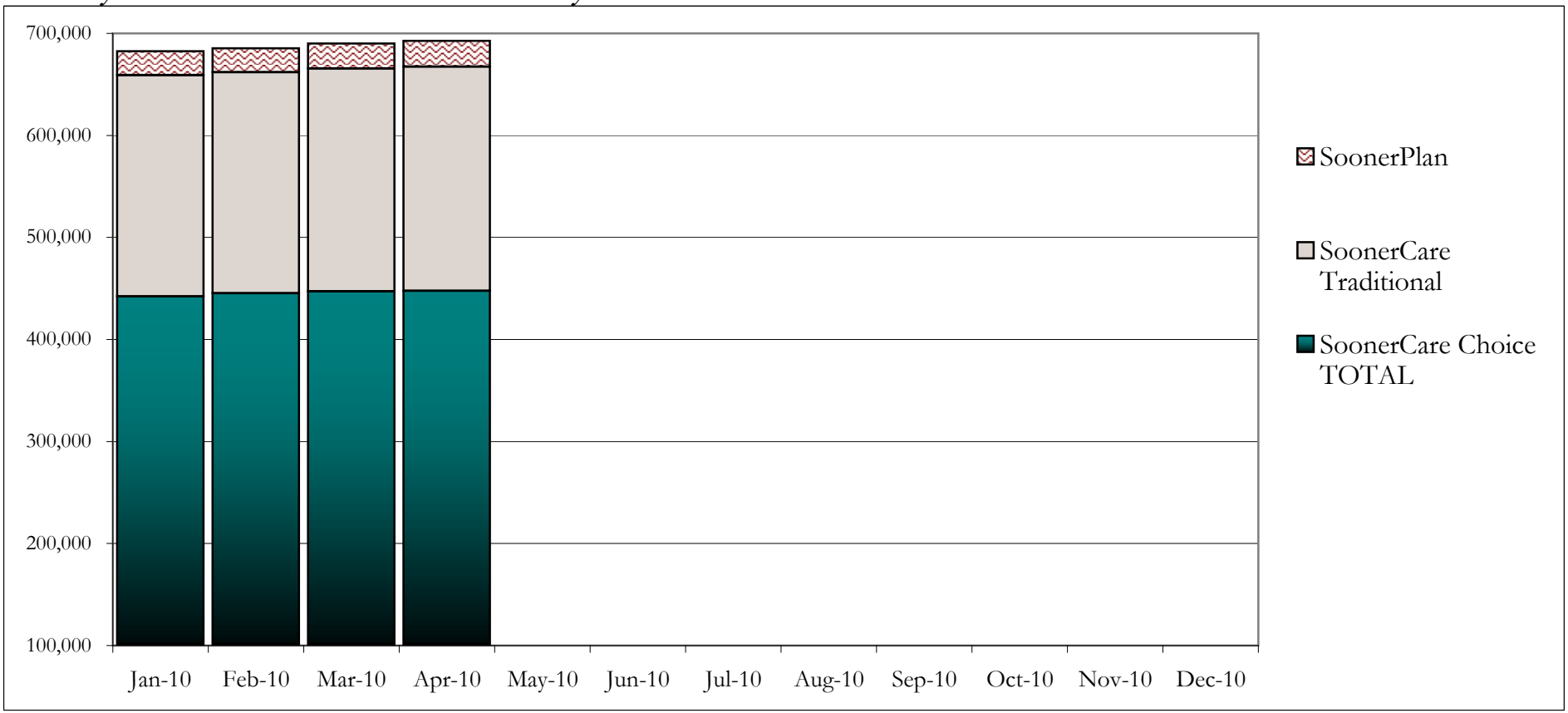
REVENUES	FY10 Budget YTD	FY10 Actual YTD	Variance	% Over/ (Under)
State Appropriations	$ 496,047,641	$ 496,047,641	$ -	0.0%
Federal Funds	1,708,748,878	1,703,384,681	(5,364,197)	(0.3)%
Tobacco Tax Collections	41,296,975	45,097,789	3,800,814	9.2%
Quality of Care Collections	42,734,912	42,772,365	37,453	0.1%
Prior Year Carryover	24,714,277	28,114,277	3,400,000	13.8%
Drug Rebates	121,721,222	127,046,063	5,324,841	4.4%
Medical Refunds	33,860,246	45,217,984	11,357,738	33.5%
Other Revenues	15,588,893	15,187,850	(401,042)	(2.6)%
Stimulus Funds Appropriated	341,662,709	341,662,709	-	0.0%
Stimulus Funds Drawn	46,144,764	46,144,764	-	0.0%
TOTAL REVENUES	**$ 2,872,520,517**	**$ 2,890,676,122**	**$ 18,155,606**	**0.6%**

EXPENDITURES	FY10 Budget YTD	FY10 Actual YTD	Variance	% (Over)/ Under
ADMINISTRATION - OPERATING	**$ 32,286,165**	**$ 30,602,294**	**$ 1,683,871**	**5.2%**
ADMINISTRATION - CONTRACTS	**$ 88,699,323**	**$ 68,334,052**	**$ 20,365,271**	**23.0%**
MEDICAID PROGRAMS				
Managed Care:				
SoonerCare Choice	24,110,657	22,759,934	1,350,724	5.6%
Acute Fee for Service Payments:				
Hospital Services	782,888,632	759,444,682	23,443,951	3.0%
Behavioral Health	216,154,746	235,650,154	(19,495,408)	(9.0)%
Physicians	371,150,100	350,364,629	20,785,471	5.6%
Dentists	123,292,689	135,699,680	(12,406,991)	(10.1)%
Other Practitioners	36,133,954	41,746,730	(5,612,776)	(15.5)%
Home Health Care	15,709,015	16,715,774	(1,006,759)	(6.4)%
Lab & Radiology	20,060,631	30,069,302	(10,008,671)	(49.9)%
Medical Supplies	47,027,022	45,867,012	1,160,011	2.5%
Ambulatory Clinics	50,600,887	73,052,443	(22,451,556)	(44.4)%
Prescription Drugs	305,747,584	316,280,209	(10,532,625)	(3.4)%
Miscellaneous Medical Payments	25,082,761	23,509,598	1,573,163	6.3%
Other Payments:				
Nursing Facilities	429,242,693	429,884,701	(642,007)	(0.1)%
ICF-MR Private	46,551,549	46,848,585	(297,035)	(0.6)%
Medicare Buy-In	97,997,218	101,768,342	(3,771,124)	(3.8)%
Transportation	21,663,644	21,740,129	(76,484)	(0.4)%
Part D Phase-In Contribution	55,276,123	39,707,278	15,568,845	28.2%
Total OHCA Medical Programs	**2,668,689,909**	**2,691,109,181**	**(22,419,273)**	**(0.8)%**
OHCA Non-Title XIX Medical Payments	40,128	-	40,128	0.0%
TOTAL OHCA	**$ 2,789,715,525**	**$ 2,790,045,527**	**$ (330,003)**	**(0.0)%**
REVENUES OVER/(UNDER) EXPENDITURES	**$ 82,804,992**	**$ 100,630,595**	**$ 17,825,603**	

SOONERCARE ENROLLMENT CY-2010

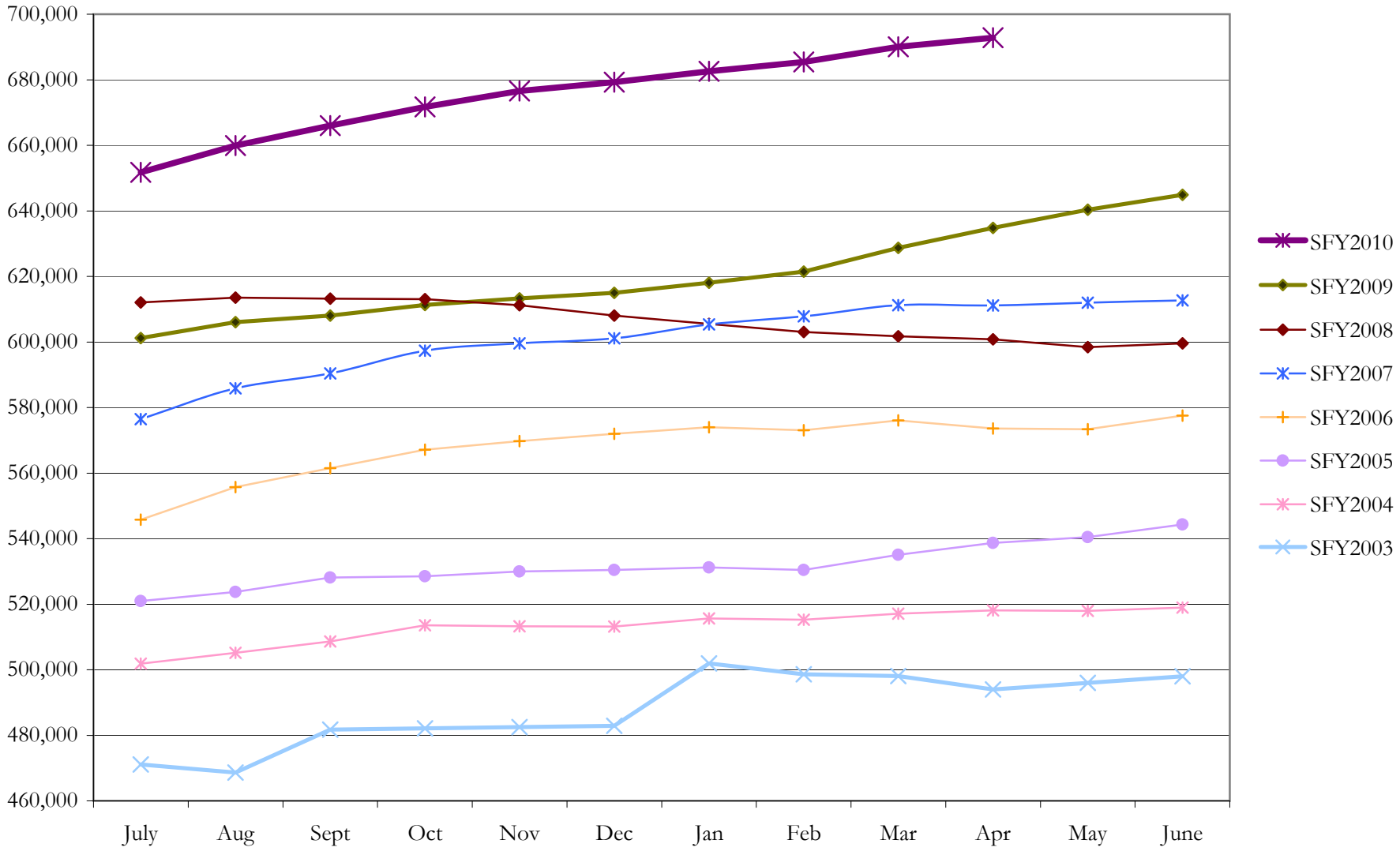
	Jan-10	Feb-10	Mar-10	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10	Total MMs
ENROLLEES													
SoonerCare Choice													
Choice Total	428,704	431,677	433,447	433,771									1,727,599
IHS/Urban/Tribal Total	13,503	13,619	13,780	14,000									54,902
SoonerCare Choice TOTAL	442,207	445,296	447,227	447,771									1,782,501
SoonerCare Traditional	216,989	216,542	218,449	219,772									
SoonerPlan	23,420	23,607	24,379	25,257									96,663
TOTAL ENROLLEES	682,616	685,445	690,055	692,800									2,750,916
Average Monthly Enrollment													687,729

Monthly Actual SoonerCare Enrollment Trends by Benefit Plan



MMs = Member Months

OHCA SoonerCare Enrollment Figures



SoonerCare Programs

April 2010

Choice PCMH	APRIL	
	2009	2010
Total Enrolled	400,744	447,771
American Indian Enrollment	11,571	14,000
Choice Enrollees (PCMH)	389,173	433,771

Traditional	APRIL	
	2009	2010
Total Enrolled	215,889	219,772
SoonerCare Programs Total (Unduplicated)	634,789	692,800

Oklahoma Cares	APRIL	
	2009	2010
Total Women Enrolled	2,653	2,369
SoonerCare Traditional	1,998	1,658
SoonerCare Choice	655	711
Total Women Ever-enrolled	19,462	23,125

SoonerPlan	APRIL	
	2009	2010
Total Enrolled	18,156	25,257
Male Enrollees	505	771
Female Enrollees	17,651	24,486
Total Ever-enrolled	66,504	82,617

TEFRA	APRIL	
	2009	2010
Total Children Enrolled	268	329
Male Enrollees	163	194
Female Enrollees	105	135
Total Ever-enrolled	347	444

Insure Oklahoma	APRIL	
	2009	2010
IO Total Enrollees	18,643	30,943
IO Enrollees Males	8,208	13,407
IO Enrollees Females	10,435	17,536
ESI Enrollees	12,161	18,946
IP Enrollees	6,482	11,997

Program	NOVEMBER 2009	DECEMBER 2009	JANUARY 2010	FEBRUARY 2010	MARCH 2010	APRIL 2010
Choice PCMH	432,068	438,276	442,207	445,296	447,227	447,771
Traditional	221,734	217,945	216,989	216,542	218,449	219,772
Oklahoma Cares	2,481	2,373	2,307	2,396	2,368	2,369
TEFRA	313	320	325	326	323	329
SoonerPlan	22,788	23,073	23,420	23,607	24,379	25,257
Soon-to-be Sooners	3,041	2,979	2,955	2,993	3,051	3,034
SoonerCare Programs Total (Unduplicated)	**676,590**	**679,294**	**682,616**	**685,445**	**690,055**	**692,800**
Insure Oklahoma ESI	17,882	18,133	18,521	18,877	18,774	18,946
Insure Oklahoma IP	10,146	10,825	11,100	11,437	11,778	11,997
Insure Oklahoma Programs Total (Unduplicated)	**28,028**	**28,958**	**29,621**	**30,314**	**30,552**	**30,943**
Programs Total	704,618	708,252	712,237	715,759	720,607	723,743

June 1, 2010

SoonerCare Fast Facts

April 2010

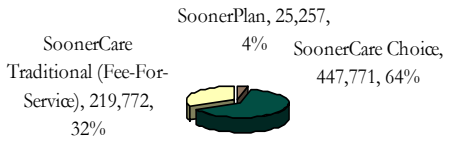
TOTAL ENROLLMENT —
OKLAHOMA SOONERCARE (MEDICAID)

Qualifying Group	Age Group	Enrollment	% of Total
Aged/Blind/Disabled	Child	18,530	2.67%
Aged/Blind/Disabled	Adult	125,734	18.15%
Children/Parents	Child	456,384	65.88%
Children/Parents	Adult	46,291	6.68%
Other	Child	68	0.01%
Other	Adult	17,838	2.57%
Oklahoma Cares (Breast & Cervical Cancer)		2,369	0.34%
SoonerPlan (Family Planning)		25,257	3.65%
TEFRA		329	0.05%
Total Enrollment	**692,800**	Adults	214,060 31%
		Children	478,740 69%

OTHER Group includes—DDSD State-PKU-Q1-Q2-Refugee--SLMB-Soon to be Sooners (STBS) and TB patients. Child custody was moved to Children/Parents effective April 2010.
For more information go to www.okhca.org under Individuals then to Programs. Insure Oklahoma members are NOT included in the figures above.

Note that all subsequent figures are groups within the above total enrollment numbers (except Insure Oklahoma). SoonerPlan (Family Planning) members are not entitled to the full scope of benefits only family planning services are covered.

Delivery System Breakdown of Total Enrollment



Other Enrollment Facts

Unduplicated enrollees State Fiscal Year-to-Date (July through report month including Insure Oklahoma) — **854,477**

Other Breakdowns of Total Enrollment

Oklahoma SoonerCare (Medicaid) members residing in a long-term care facility — 15,822

Oklahoma persons enrolled in both Medicare and Medicaid (dual eligibles) — 101,399

The Insure Oklahoma (Oklahoma Employer/Employee Partnership for Insurance Coverage—O-EPIC) is a program to assist qualifying small business owners, employees & their spouses (Employer Sponsored Insurance—**ESI**) and some individual Oklahomans (Individual Plan—**IP**) with health insurance premiums. www.insureoklahoma.org

Small Businesses Enrolled in ESI	Employees w/ ESI	Individual Plan (IP) Members
5,596	18,946	11,997

New Enrollees

Oklahoma SoonerCare members that have not been enrolled in the past 6 months.

Adults	6,657
Children	8,422
Total	**15,079**

Race Breakdown of Total Enrollment

	Children	Adults	Percent	Pregnant Women
American Indian	60,759	20,093	12%	2,811
Asian or Pacific Islander	6,990	2,850	1%	639
Black or African American	69,682	29,776	14%	2,441
Caucasian	326,719	158,832	70%	19,191
Multiple Races	14,590	2,509	2%	694
Hispanic Ethnicity	75,584	10,935	12%	5,331

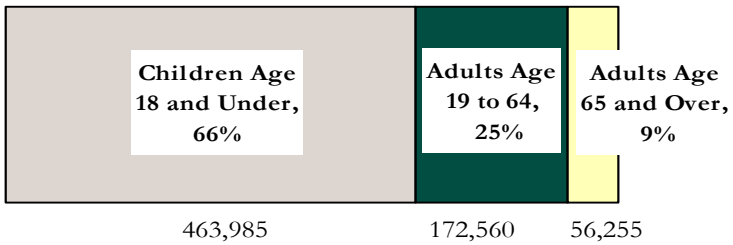
Race is self-reported by members at the time of enrollment. The multiple race members have selected two or more races. Hispanic is an ethnicity not a race. Hispanics can be of any race and are accounted for in a race category above.

CHIP Breakdown of Total Enrollment

Members qualifying for SoonerCare (Medicaid) eligibility under the CHIP program are under age 19 and have income between the maximum for standard eligibility and the expanded 185% of Federal Poverty Level (FPL) income guidelines.

Age Breakdown	% of FPL	CHIP Enrollees
PRENATAL		3,034
INFANT	150% to 185%	1,453
01-05	133% to 185%	11,566
06-12	100% to 185%	33,047
13-18	100% to 185%	20,635
Total		**69,735**

Age Breakdown of Total Enrollment

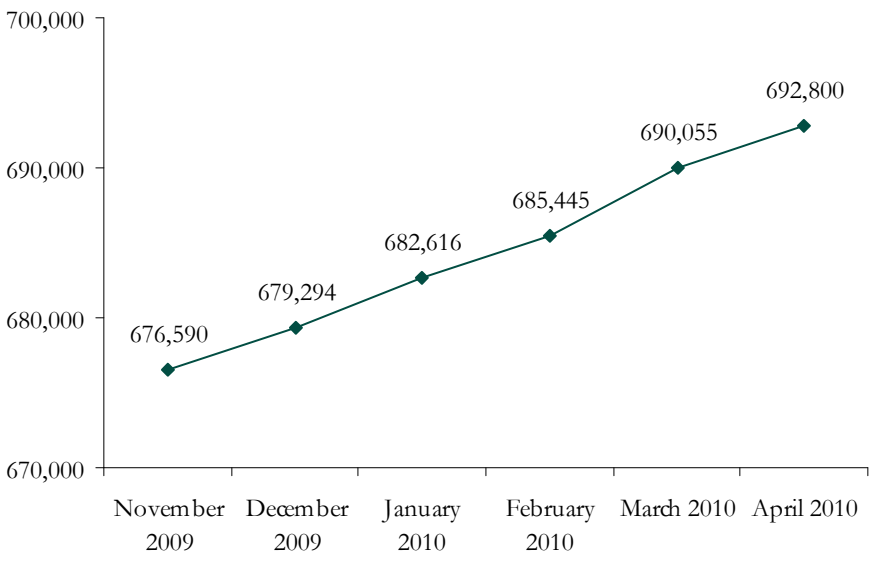


Data was compiled on 4/12/2010. Numbers frequently change due to certifications occurring after the data is extracted and other factors. This report is based on data within the system prior to 4/12/2010. A majority of the data is a "point in time" representation of the specific report month and is not cumulative. Unless stated otherwise, CHILD is defined as an individual under the age of 21.

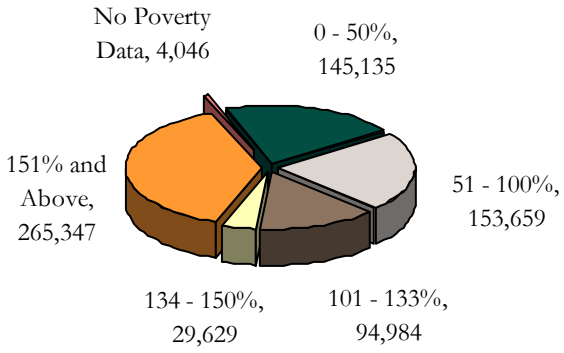
SoonerCare Fast Facts

April 2010

Total Enrollment Trend



Percent of Federal Poverty Level Totals



The "No Poverty Data" group consists of members with no poverty data and members enrolled with an aid category of U- DDSD State, R2 - OJA not Incarcerated, or R4 - OJA Incarcerated. These aid categories do not require poverty data or do not use the poverty data.

April 19, 2010

OHCA Contact: Jo Kilgore, Public Information Manager, (405) 522-7474.

Grant Aims to Reduce Tobacco Use Among Pregnant SoonerCare Members

OKLAHOMA CITY – The Oklahoma Tobacco Settlement Endowment Trust (TSET) and the Oklahoma Health Care Authority (OHCA) have joined forces to combat tobacco use by pregnant SoonerCare (Oklahoma Medicaid) members.

The campaign will have its official kickoff simultaneously in the Oklahoma City and Tulsa metro areas. Beginning April 5, practice facilitators will begin working with SoonerCare obstetric providers who serve the largest number of pregnant women in those areas. Practice facilitators will help providers adopt best practices to address tobacco use in pregnancy among their patients. They also will help providers learn how to get reimbursed for tobacco cessation counseling and encourage them to routinely use the benefit with their patients who use tobacco. For providers that serve smaller numbers of pregnant SoonerCare members or those outside the metro locations, a tobacco cessation outreach specialist will provide outreach and education.

The efforts will be funded through a grant from TSET. OHCA will receive a grant of $695,178 over three years. OHCA will be able to draw a 50 percent administrative match from federal Medicaid funds to match the TSET grant. Services will be provided by the Iowa Foundation for Medical Care, a nationally recognized quality improvement organization.

According to data from the Oklahoma State Department of Health, as recently as 2006 more than 30 percent of Oklahoma's new mothers smoked during the three months prior to their pregnancies. Nearly one in five pregnant Oklahomans continued to smoke into her third trimester, and 59 percent of women resumed smoking after their babies were born.

In state fiscal year 2008, SoonerCare paid for more than 32,000 Oklahoma births. More than 17 percent of these were births with complications. The average SoonerCare reimbursement for a complicated birth is nearly one and a half times that of the average cost for an uncomplicated delivery. Neonatal conditions caused by tobacco use during pregnancy have been estimated at $5.7 million annually in Oklahoma.

For more information about TSET, please visit their Web site at www.tset.ok.gov. To learn more about the SoonerCare program, please visit www.okhca.org.

Oklahoma Health Care Authority

Provider Fast Facts

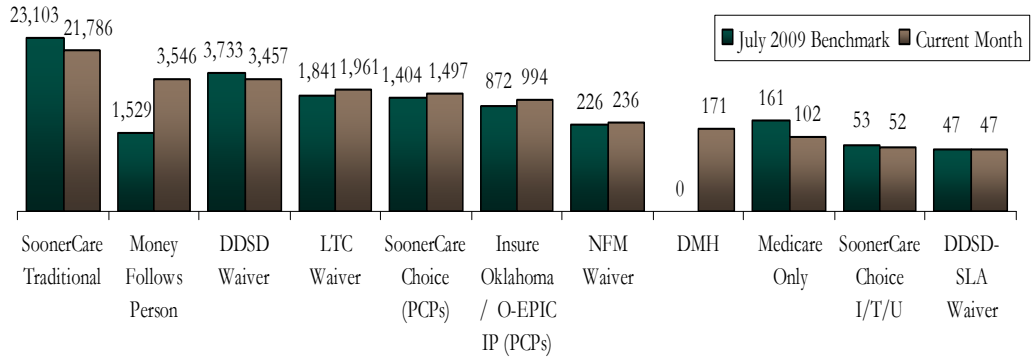
April 2010

OHCA is currently in a provider contract renewal period. Some of the totals below may indicate a decrease in the provider counts due to this process. This occurrence is typical during all renewal periods.

Total Unduplicated Provider Count
27,795

All subsequent provider counts were derived from the total unduplicated provider count. Some providers may be counted in multiple programs.

Total Unduplicated Provider Count by Program



A group provider is a corporation that houses multiple individual providers. In order to provide a more accurate count, the group's individual providers were counted instead of the group provider.

Total Unduplicated Newly Enrolled Provider Count
305

Total unduplicated newly enrolled provider count was determined by the number of newly unduplicated provider IDs added during the month of this report.

Primary Care Provider (PCP) Capacities

SoonerCare Program Description	Total Capacity	% of Capacity Used
SoonerCare Choice	1,030,499	41.85%
SoonerCare Choice I/T/U	116,150	12.20%
Insure Oklahoma/O-EPIC IP	329,145	3.83%

Total Capacity represents the maximum number of members that PCPs request to have assigned within OHCA's limit.

Acronyms

DDSD - Developmental Disabilities Services Division

DDSD-SLA - Developmental Disabilities Services Division-Supported Living Arrangement

DME - Durable Medical Equipment

DMH - Department of Mental Health

I/T/U - Indian Health Service/Tribal/Urban Indian

LTC - Long-Term Care

NET - Non-Emergency Transportation

NFM - Non-Federal Medical

NPI - National Provider Identifier

O-EPIC IP - Oklahoma Employer/Employee Partnership for Insurance Coverage Individual Plan

PCMH - Patient-Centered Medical Home

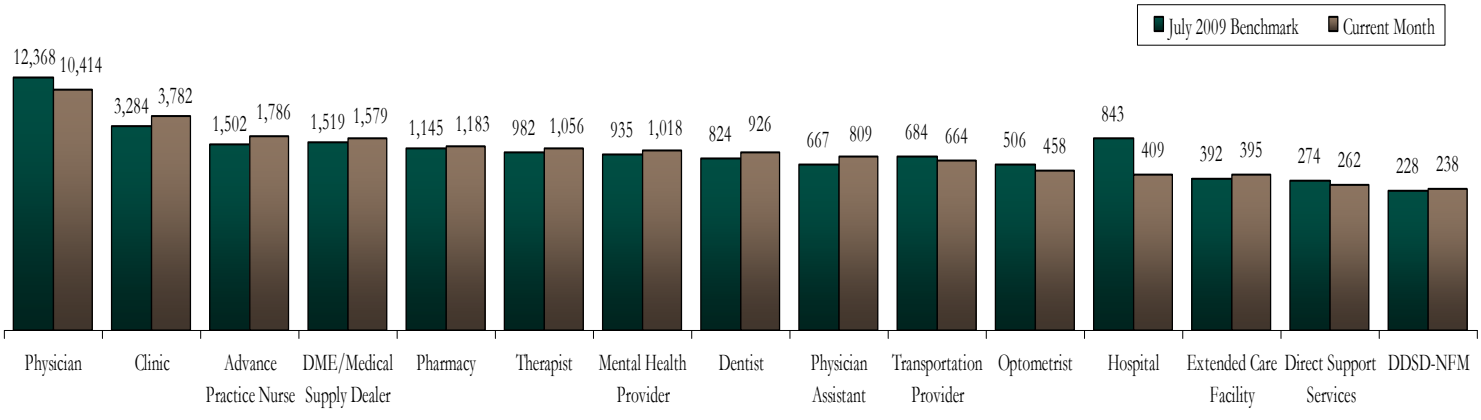
PCP - Primary Care Provider

PCMH Enrollment by Tier

Payment Tier Code	Count
Tier 1	488
Tier 2	234
Tier 3	46

These counts were computed using a different method than indicated elsewhere on the report and are not comparable to any other figures.

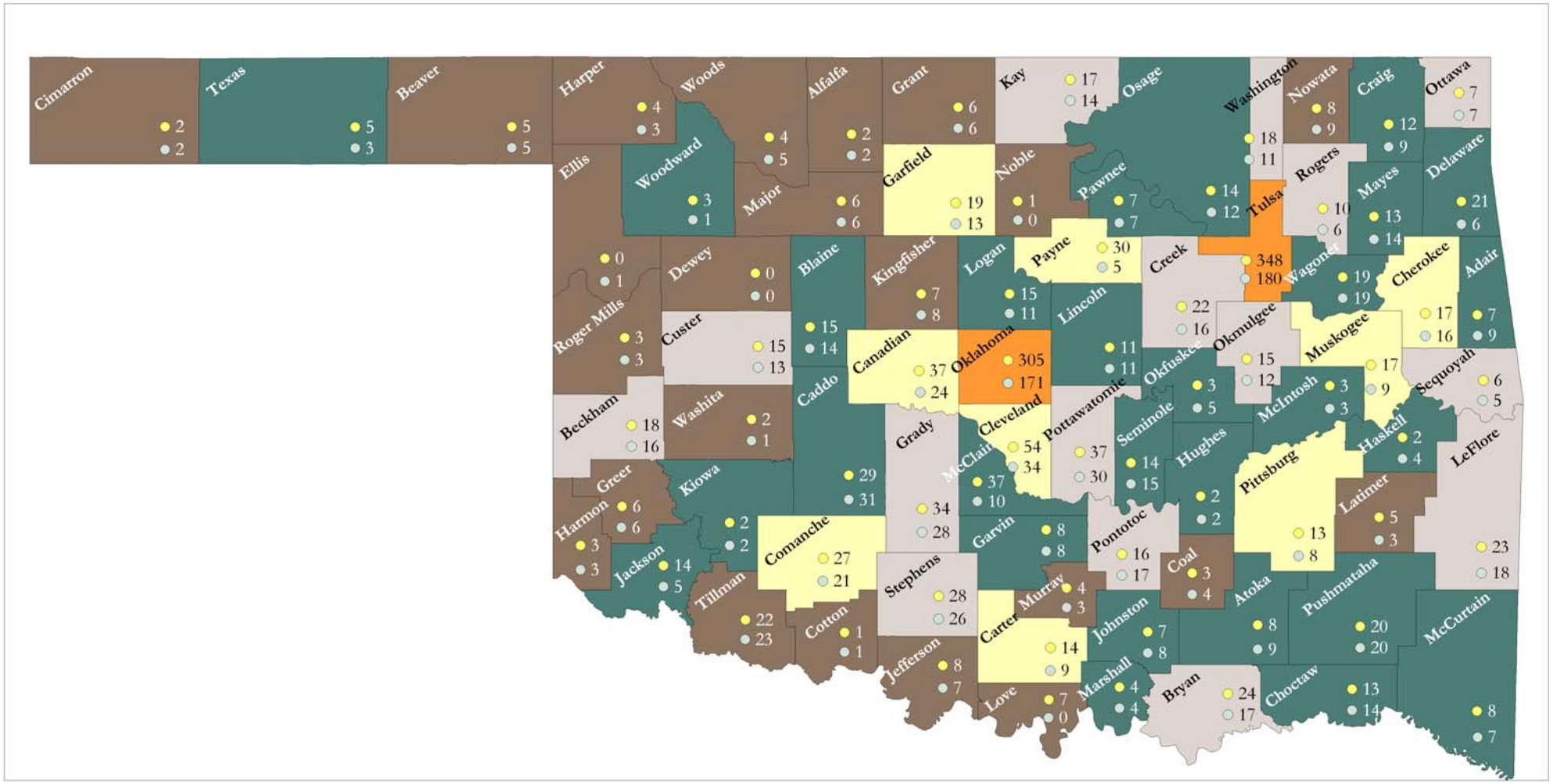
Top 15 Provider Types



The top 15 provider types consists of the 15 provider types with the highest number of contracted providers.

Provider Fast Facts
April 2010

oklahoma health care authority



Total Provider Count

- 4,000 to 5,330 (2)
- 300 to 1,000 (9)
- 150 to 300 (15)
- 50 to 150 (28)
- 0 to 50 (23)

Primary Care Providers (PCPs)

- SoonerCare Choice PCPs
- Insure Oklahoma IP PCPs

05/11/2010

Insure Oklahoma
Fast Facts
June 2010

Business, insurance, state government and you Working Together to ***Insure Oklahoma!***

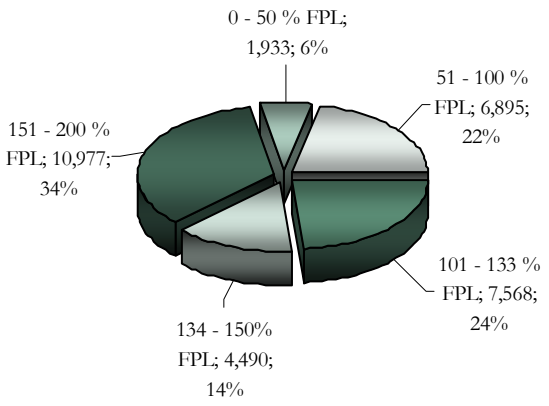
Insure Oklahoma is an innovative program Oklahoma has created to bridge the gap in the health care coverage for low-income working adults. Under the Employer-Sponsored Insurance (ESI) program, premium costs are shared by the state (60 percent), the employer (25 percent) and the employee (15 percent). The Individual Plan (IP) allows people who can't access the benefits through their employer, including those who are self-employed or may be temporarily unemployed, to buy health insurance directly through the state. Find out more information by visiting **www.insureoklahoma.org** or by calling 1-888-365-3742.

Insure Oklahoma Total Enrollment

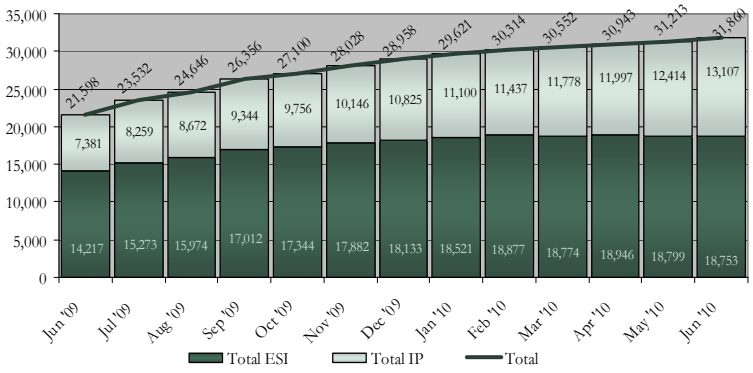
Qualifying Enrollment		Enrollment	% of Total
Employer Sponsored Insurance (ESI)	Employee	15,641	49.09%
Employer Sponsored Insurance (ESI)	Spouse	3,055	9.59%
Individual Plan (IP)	Employee	9,904	31.09%
Individual Plan (IP)	Spouse	3,004	9.43%
Student (ESI)	---	57	0.18%
Student (IP)	---	199	0.62%
Businesses	---	5,496	---
Carriers / HealthPlans	---	20 / 476	---
Primary Care Physician	---	1,028	---

Total Enrollment	**31,860**	ESI	18,753	59%
		IP	13,107	41%

Federal Poverty Level Breakdown of Total Enrollment



Total Insure Oklahoma Member Monthly Enrollment



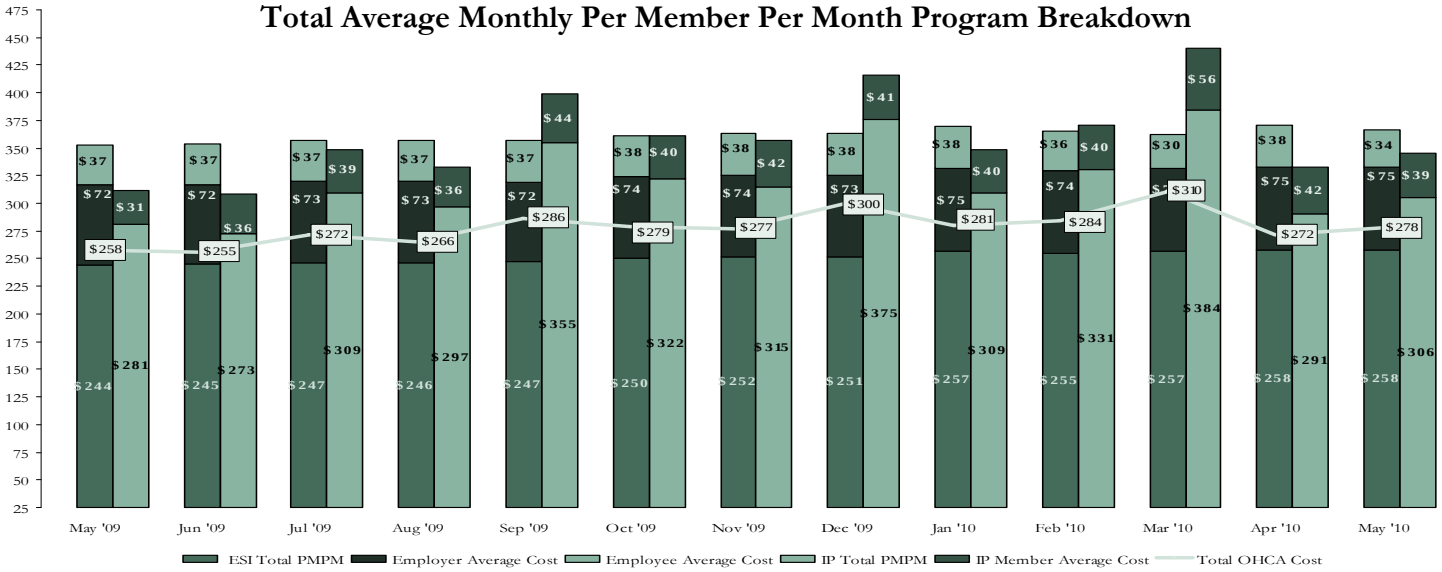
Currently Enrolled		Up from Previous Year
Businesses	5,496	16%
ESI Enrollees	18,753	32%
IP Enrollees	13,107	78%

ESI & IP Enrollee totals include Students.

Latest Monthly Marketing Statistics	
Web Hits on InsureOklahoma.org	35,513
Call Center - Calls Answered	16,150

Call Center count now includes OHCA calls.
Unable to produce Call Center Counts for April.

Total Average Monthly Per Member Per Month Program Breakdown



All the state share of the Insure Oklahoma program costs are budgeted from the state's tobacco tax revenues. (All financial information is previous month activity.)

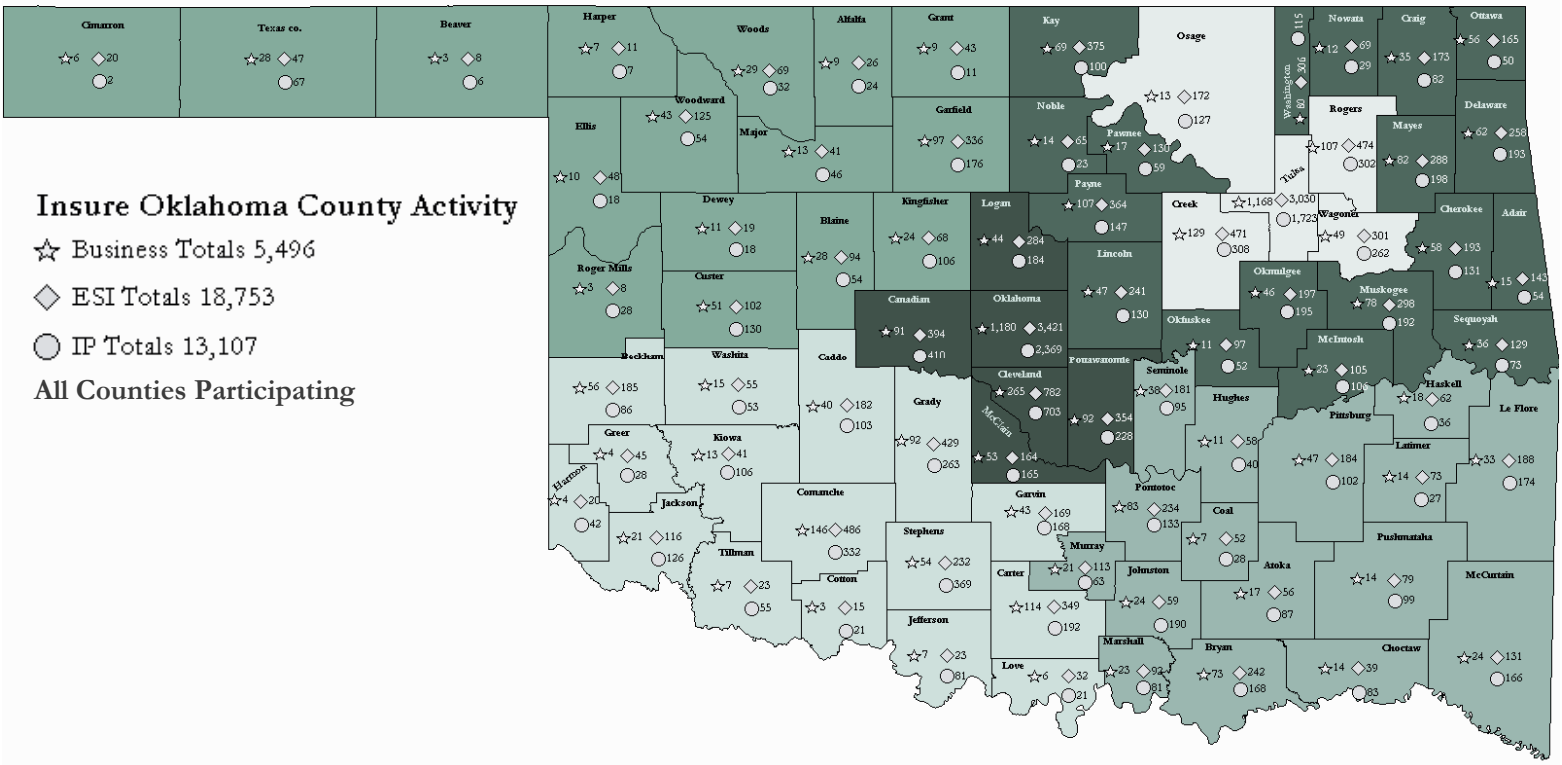
Data is valid as of the date of the report; any subsequent figures for this group for this time period may vary. www.insureoklahoma.org

6/8/2010

Insure Oklahoma
Fast Facts
June 2010

Business, insurance, state government and you Working Together to ***Insure Oklahoma!***

November 2005	Oklahoma implemented Insure Oklahoma Employer Sponsored Insurance (ESI), the premium assistance for health insurance coverage targeting some 50,000 low-wage working adults in Oklahoma.
January 2007	Insure Oklahoma implements the Individual Plan (IP) to assist sole proprieetors (self employed), certain unemployed individuals, and working individuals who do not have access to small group health coverage.
November 2007	Increased Insure Oklahoma ESI qualifying income guidelines from 185 to 200 percent of the federal poverty level.
	ESI available to businesses with 25 to 50 employees.
March 2009	Expanded IP to offer coverage for full-time Oklahoma college students within qualifying income guidelines age 19 through 22.
	ESI available to businesses with 50 to 99 employees.



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6/8/2010

Employer Sponsored Insurance (ESI)

Fast Facts

June 2010

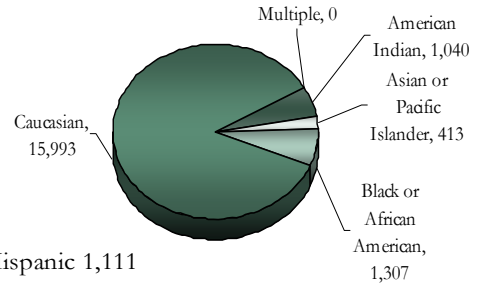
Business, insurance, state government and you Working Together to ***Insure Oklahoma!***

The Insure Oklahoma Employer Sponsored Insurance program is designed to assist small business owners, employees and their spouses with health insurance premiums. Find out more information by visiting **www.insureoklahoma.org**.

	Total Current Enrollment			Breakdown of Current Enrollment					
				New Enrollment this Month			Expanded 185 to 200% FPL*		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
Employee	7,652	7,989	**15,641**	343	331	**674**	892	778	**1,670**
Spouse	788	2,267	**3,055**	31	82	**113**	89	235	**324**
Student	30	27	**57**	2	0	**2**	2	0	**2**
Total	8,470	10,283	**18,753**	376	413	**789**	983	1,013	**1,996**

*Expanded income qualifications from 185 to 200% effective November 2007.

Race Breakdown of ESI Members

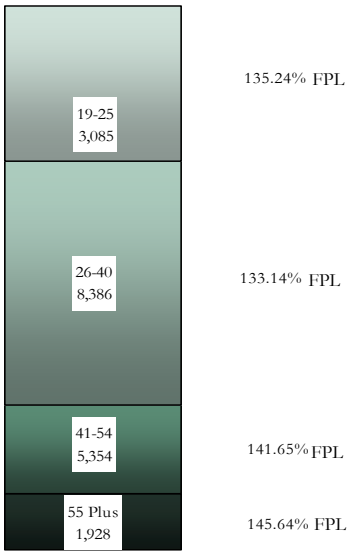


Race is self-reported by members at the time of enrollment. The multiple race members have selected two or more races. Hispanic is an ethnicity not a race. Hispanics can be of any race and are accounted for in a race category above.

Business Activity with Employee Participation Counts				
	0 to 25	26 to 50	51 to 100	Total
Current	4,552	539	297	**5,388**
New	83	15	10	**108**
Total	**4,635**	**554**	**307**	**5,496**

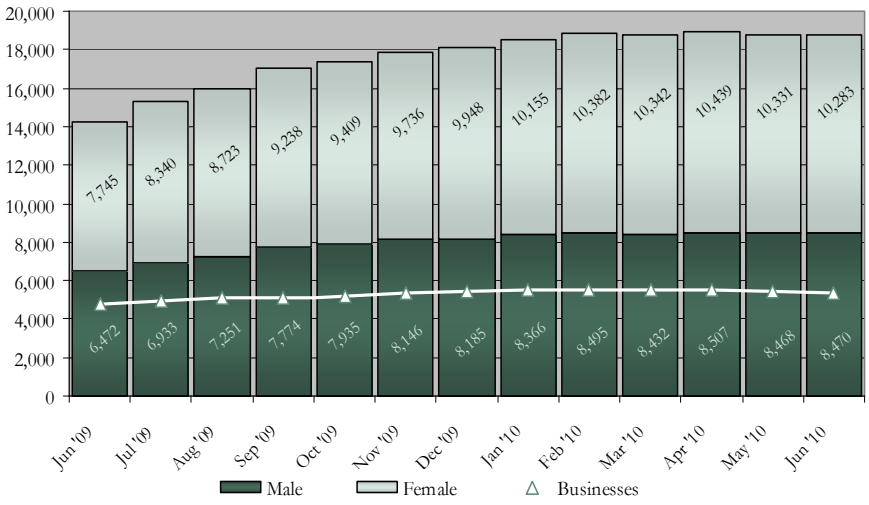
Some approved businesses may not have approved employees.

Age Breakdown with Average Federal Poverty Level of ESI Members

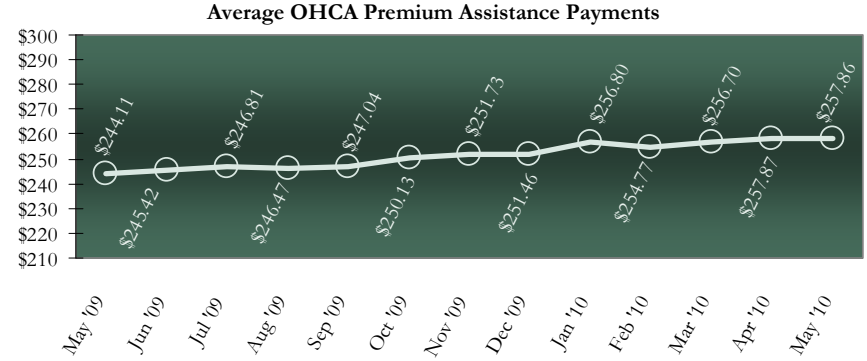


Federal Poverty Level is used to determine income qualification.

Member and Employer Monthly Enrollment



Average OHCA Premium Assistance Payments



Effective February 2007 OHCA Per Member Per Month reporting will be of the previous month due to semi-monthly payments verses monthly payments.

Insure Oklahoma/OEPIC ESI by Region			
	Employers	Employee/ Spouse	Participating Counties
Region 1	625	2,402	16 of 16
Region 2	371	1,065	16 of 16
Region 3	1,725	5,399	6 of 6
Region 4	1,466	4,448	5 of 5
Region 5	848	3,596	18 of 18
Region 6	461	1,843	16 of 16
Total	**5,496**	**18,753**	**77 of 77**

Regions identified on Insure Oklahoma/OEPIC Region map on next page.

Data is valid as of the date of the report; any subsequent figures for this group for this time period may vary. www.insureoklahoma.org

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6/8/2010

Individual Plan (IP)
Fast Facts

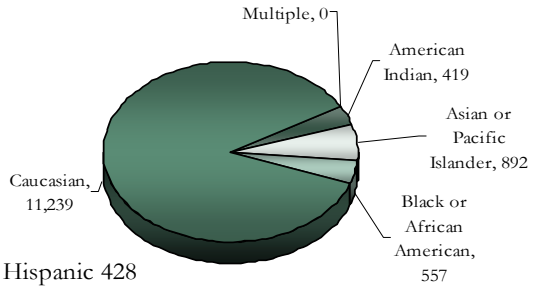
June 2010

Business, insurance, state government and you Working Together to ***Insure Oklahoma!***

The Insure Oklahoma Individual Plan program is designed to provide Oklahoma individuals with health insurance for themselves and their spouse if needed. It is available to Oklahomans who are not qualified for an employer-sponsored health plan and work for an Oklahoma small business with 99 or fewer full time employees; temporarily unemployed adults who are eligible to receive unemployment benefits through the Oklahoman Employment Security Commission; or working adults with a disability who work for any size employer and have a "ticket to work". Find out more information by visiting **www.insureoklahoma.org**.

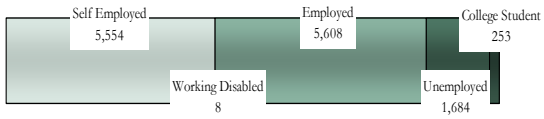
	Total Current Enrollment			Breakdown of Current Enrollment					
				New Enrollment this Month			Expanded 185 to 200% FPL*		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
Employee	4,562	5,342	**9,904**	229	322	**551**	351	344	**695**
Spouse	680	2,324	**3,004**	49	117	**166**	58	181	**239**
Student	84	115	**199**	5	7	**12**	9	6	**15**
Total	5,326	7,781	**13,107**	278	439	**729**	409	525	**949**

Race Breakdown of IP Members



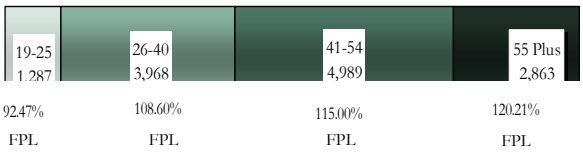
Race is self-reported by members at the time of enrollment. The multiple race members have selected two or more races. Hispanic is an ethnicity not a race. Hispanics can be of any race and are accounted for in a race category above.

IP Application Type Breakdown

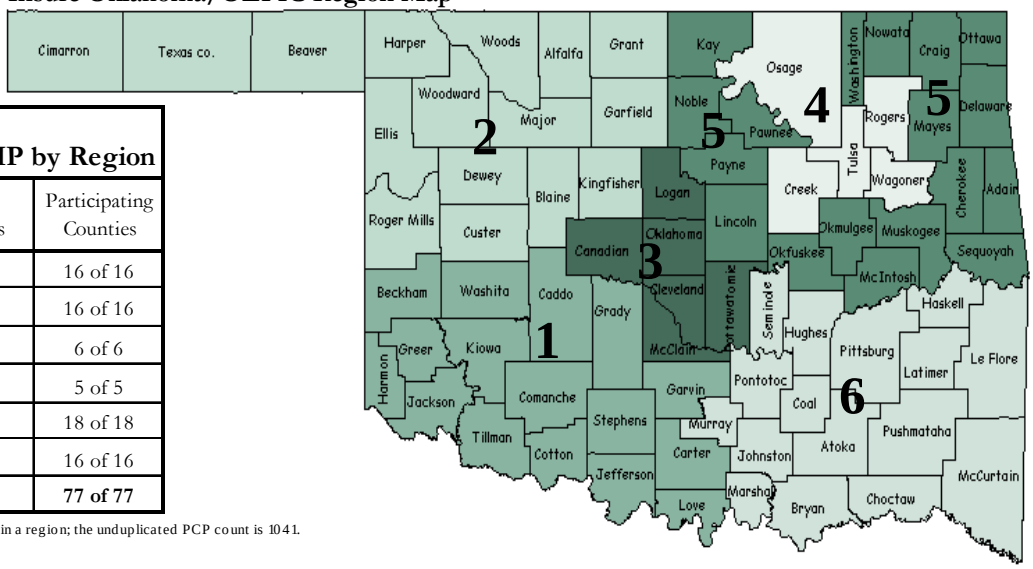


Unduplicated Counts	
IP Members SFY2010 (July 2009 - Current)	17,678
IP Members Since Program Inception March 2007	20,430
Miscellaneous	
Average IP Member Premium	$56.60
Average Federal Poverty Level of IP Members	111.99%
Federal Poverty Level is used to determine income qualification.	

IP Age Breakdown with Average Federal Poverty Level for each group.



Insure Oklahoma/OEPIC Region Map



Insure Oklahoma/OEPIC IP by Region

	PCP	Participating Counties	Members	Participating Counties
Region 1	145	15 of 16	2,046	16 of 16
Region 2	84	15 of 16	779	16 of 16
Region 3	274	6 of 6	4,059	6 of 6
Region 4	231	5 of 5	2,722	5 of 5
Region 5	156	17 of 18	1,929	18 of 18
Region 6	138	16 of 16	1,572	16 of 16
Total	**1,028**	**74 of 77**	**13,107**	**77 of 77**

PCPs maybe counted in multiple regions or out of state and not counted in a region; the unduplicated PCP count is 1041.

Data is valid as of the date of the report; any subsequent figures for this group for this time period may vary. www.insureoklahoma.org

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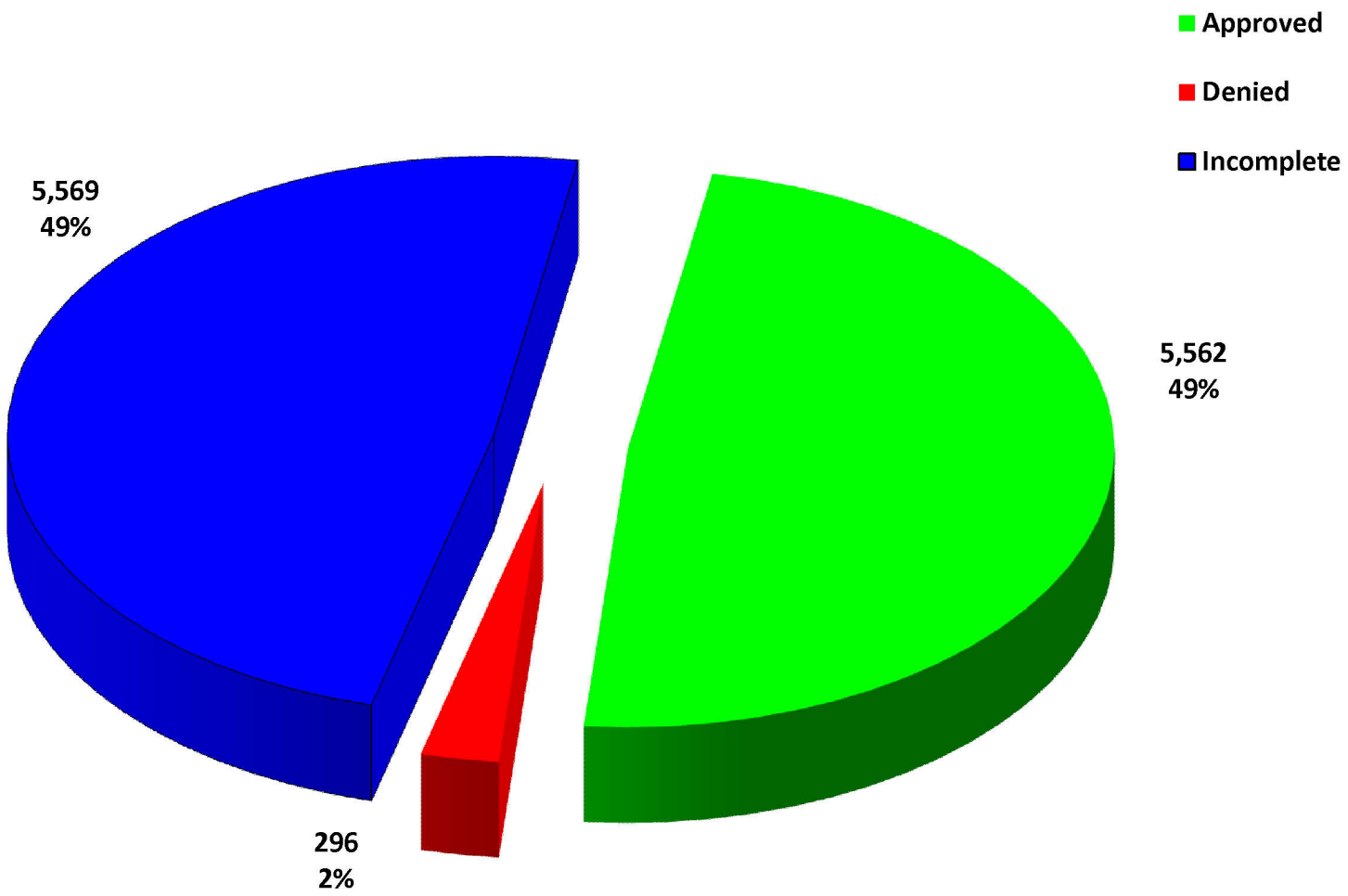
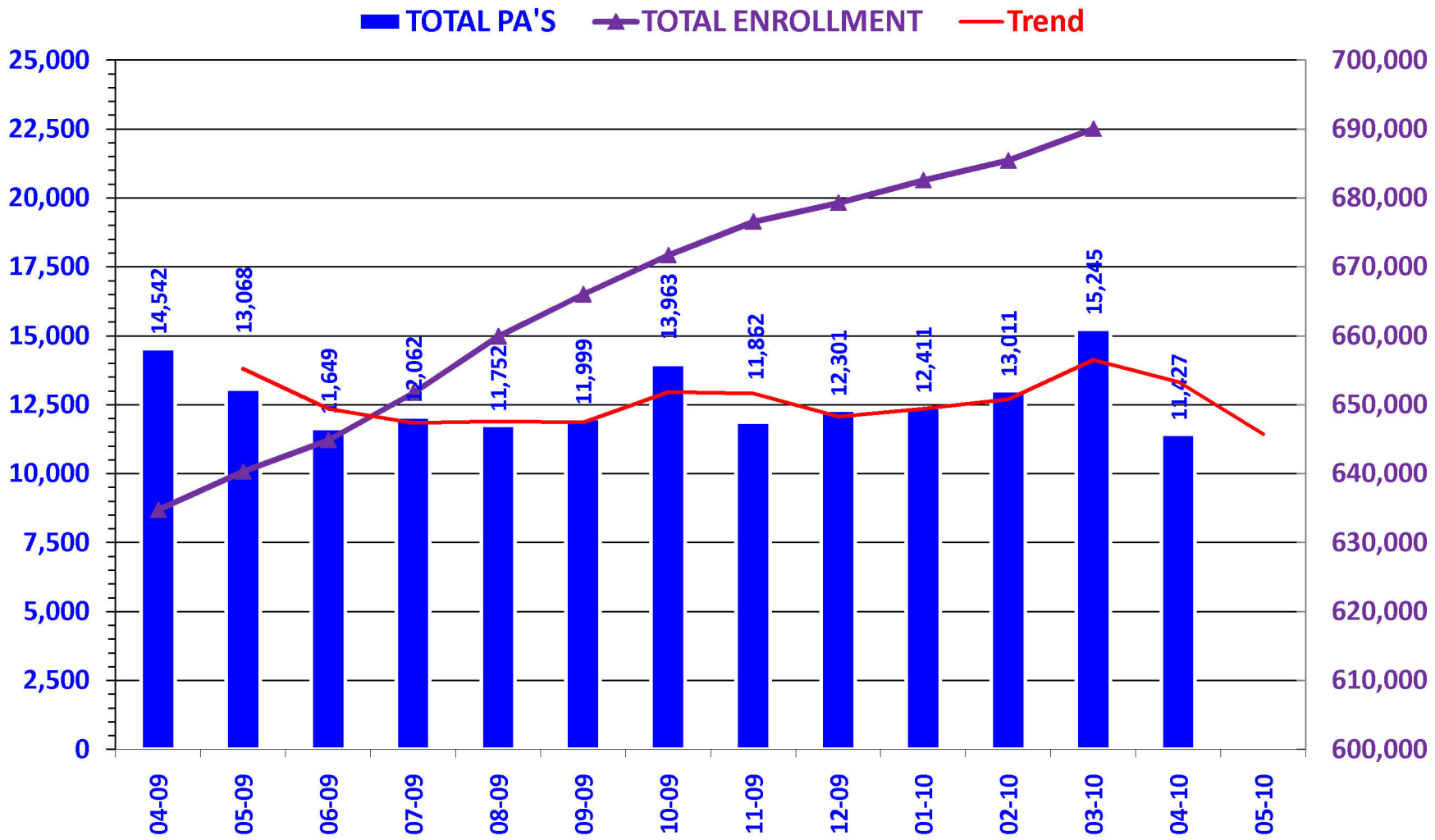
6/8/2010

PRIOR AUTHORIZATION ACTIVITY REPORT: April 2010



PA totals include overrides

PRIOR AUTHORIZATION REPORT: April 2009 – April 2010



PA totals include overrides

Prior Authoriztion Activity

April 2010

	Total	Approved	Denied	Incomplete	Average Length of Approvals in Days
Advair/Symbicort	569	251	4	314	357
Amitiza	25	7	1	17	197
Antidepressant	455	145	5	305	340
Antihistamine	573	304	6	263	310
Antihypertensives	127	53	0	74	304
Antimigraine	121	20	5	96	253
Atypical Antipsychotics	527	249	1	277	340
Benzodiazepines	590	309	5	276	139
Bladder Control	96	11	5	80	313
Brovana (Arformoterol)	1	0	0	1	0
Byetta	4	1	0	3	360
Elidel/Protopic	46	26	1	19	94
ESA	207	157	0	50	57
Fibric Acid Derivatives	11	2	0	9	359
Fibromyalgia	173	51	4	118	347
Forteo	1	1	0	0	360
Glaucoma	24	8	0	16	324
Growth Hormones	60	47	0	13	168
HFA Rescue Inhalers	98	34	4	60	256
Insomnia	121	35	1	85	146
Misc Analgesics	51	5	17	29	270
Muscle Relaxant	206	84	63	59	67
Nasal Allergy	560	84	10	466	145
NSAIDS	193	38	12	143	315
Ocular Allergy	43	3	3	37	30
Ocular Antibiotics	76	20	0	56	17
Opioid Analgesic	199	88	5	106	172
Other	520	162	37	321	118
Otic Antibiotic	142	64	0	78	13
Pediculicides	162	82	3	77	13
Plavix	346	238	0	108	309
Proton Pump Inhibitors	570	101	17	452	101
Qualaquin (Quinine)	1	0	1	0	0
Singulair	1,074	571	11	492	258
Smoking Cessation	68	22	0	46	68
Statins	127	41	0	86	355
Stimulant	1,132	717	10	405	232
Symlin	8	4	1	3	360
Topical Antibiotics	21	4	0	17	16
Topical Antifungals	27	6	1	20	40
Ultram ER and ODT	14	1	0	13	30
Xolair	4	2	1	1	362
Xopenex Nebs	39	17	3	19	275
Zetia (Ezetimibe)	26	15	0	11	360
Emergency PAs	14	14	0	0	
Total	**9,452**	**4,094**	**237**	**5,121**	

Overrides					
Brand	68	42	2	24	259
Dosage Change	557	505	11	41	13
High Dose	6	5	0	1	87
IHS - Brand	28	23	0	5	143
Ingredient Duplication	7	5	1	1	15
Lost/Broken Rx	79	74	2	3	11
NDC vs Age	3	3	0	0	361
Nursing Home Issue	64	60	2	2	11
Other	40	29	1	10	49
Quantity vs. Days Supply	1,120	720	40	360	266
Stolen	5	5	0	0	81
Wrong D.S. on Previous Rx	1	0	0	1	0
Overrides Total	**1,975**	**1,468**	**59**	**448**	
Total Regular PA + Overrides	**11,427**	**5,562**	**296**	**5,569**	

Denial Reasons

Unable to verify required trials.	2,672
Lack required information to process request.	2,502
Does not meet established criteria.	266
Not an FDA approved indication/diagnosis.	157
Member has active PA for requested medication.	80
Considered duplicate therapy. Member has a prior authorization for similar medication.	66
Medication not covered as pharmacy benefit.	56
Requested dose exceeds maximum recommended FDA dose.	37
Drug Not Deemed Medically Necessary	5

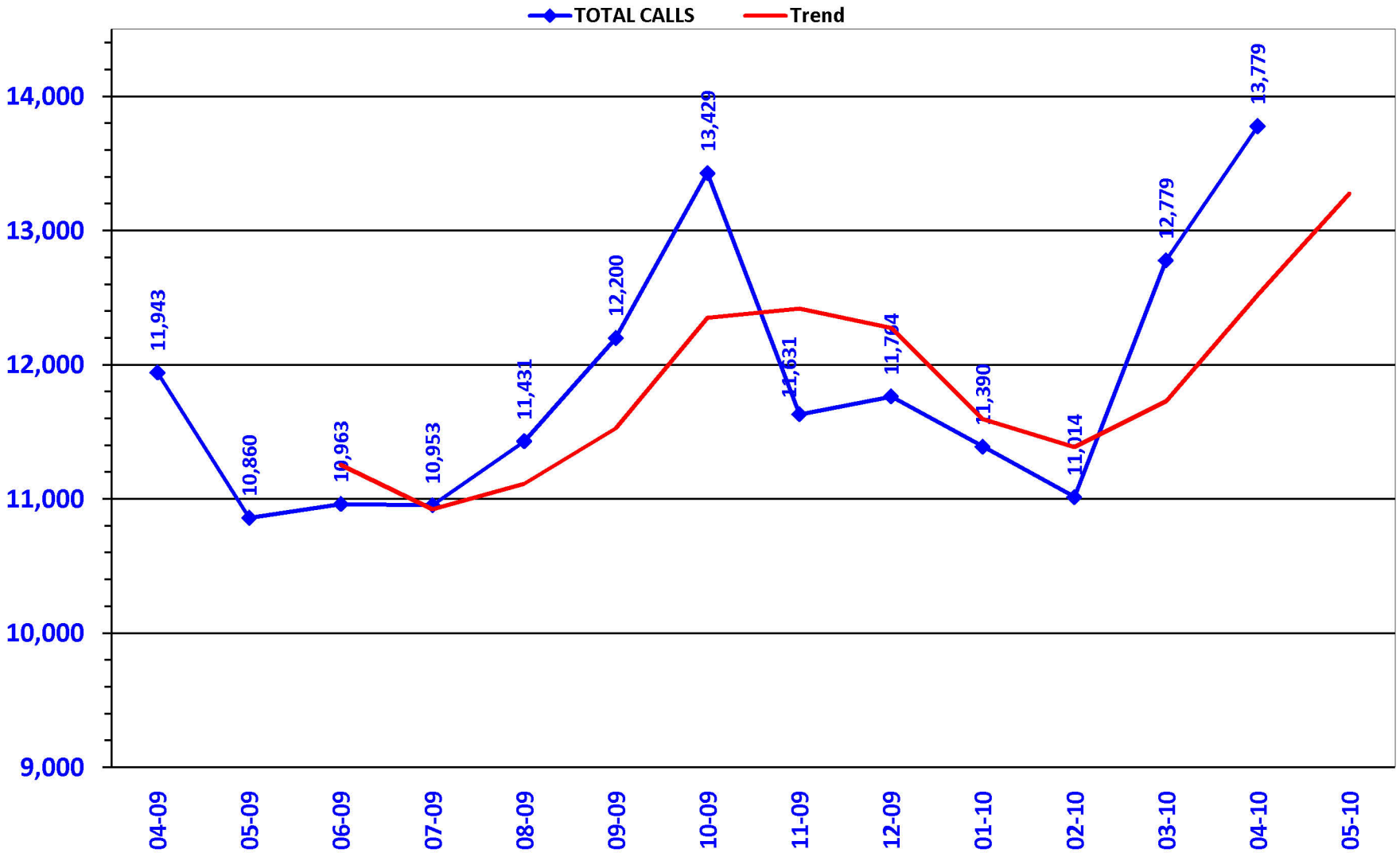
Duplicate Requests: 848

Letters: 1,420

No Process: 341

Changes to existing PAs: 650

CALL VOLUME MONTHLY REPORT:
April 2009 – April 2010



6.b-1 **CHAPTER 50. HOME AND COMMUNITY BASED WAIVERS**
Subchapter 1. Medically Fragile Waiver Services
OAC 317:50-1-1. through 317:50-5-16. [NEW]
(Reference APA WF # 10-13)

FINDING OF EMERGENCY: The Agency finds that a compelling public interest exists which necessitates promulgation of emergency rules and requests emergency approval of rule revisions to include provisions for a new home and community based waiver program providing non-institutional long-term care for individuals requiring skilled nursing or hospital level of care. These individuals' needs exceed the service capacity of the current ADvantage waiver and therefore require additional funding and waiver authority to be adequately served. Creation of the Medically Fragile Waiver will implement a more appropriate service delivery mechanism for this fragile population thereby increasing quality & continuity of care.

ANALYSIS: Rules are revised to implement a new Home and Community Based Waiver Program to accommodate the "medically fragile" population whose medical needs require services in excess of those offered by current HCBW programs. This Program will finance non-institutional long-term care services for individuals requiring skilled nursing or hospital level of care. Individuals must be at least 19 years of age, have a chronic medical condition which results in prolonged dependency on medical care for which daily skilled intervention is necessary and is characterized by one or more of the following: (1) a life threatening condition characterized by reasonably frequent periods of acute exacerbation which requires frequent medical supervision and/or physician consultation and which, in the absence of such supervision or consultation, would require hospitalization; (2) the individual requires frequent time consuming administration of specialized treatments which are medically necessary; (3) the individual is dependent on medical technology such that without the technology, a reasonable level of health could not be maintained.

BUDGET IMPACT: Agency staff has determined that implementation of the Medically Fragile Waiver Program will cost approximately $2,938,918 total annual dollars with a state share of $734,729.

MEDICAL ADVISORY COMMITTEE: The Medical Advisory Committee considered the proposed rule revisions on March 25, 2010, and recommended Board approval.

PROPOSED EFFECTIVE DATE: August 1, 2010

AUTHORITY: The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes

RESOLUTION:
Resolved, that the Oklahoma Health Care Authority Board does hereby approve the Administrative Rules, subject to the Administrative Procedure Act, as indicated:
Promulgating rules to implement a new Home and Community Based Waiver Program to accommodate the "medically fragile" population whose

medical needs require services in excess of those offered by current HCBW programs.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 50. HOME AND COMMUNITY BASED SERVICE WAIVERS
SUBCHAPTER 1. MEDICALLY FRAGILE WAIVER SERVICES

317-50-1-1. Purpose

The Medically Fragile Waiver Program is a Medicaid Home and Community Based Services (HCBS) Waiver used to finance non-institutional long-term care services through Oklahoma's SoonerCare program for medically fragile individuals. To receive Medically Fragile Program services, individuals must be at least 19 years of age, be SoonerCare eligible, and meet the OHCA skilled nursing facility (SNF) or hospital level of care (LOC) criteria. Eligibility does not guarantee placement in the program as Waiver membership is limited.

317:50-1-2. Definitions

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

(1) **"ADL"** means the activities of daily living. Activities of daily living are activities that reflect the member's ability to perform self-care tasks essential for sustaining health and safety such as:

(A) bathing,
(B) eating,
(C) dressing,
(D) grooming,
(E) transferring (includes getting in and out of a tub, bed to chair, etc.),
(F) mobility,
(G) toileting, and
(H) bowel/bladder control.

(2) **"Cognitive Impairment"** means that the person, as determined by the clinical judgment of the LTC Nurse or the AA, does not have the capability to think, reason, remember or learn required for self-care, communicating needs, directing care givers and/or using appropriate judgment for maintenance of their own health or safety. The clinical judgment of cognitive impairment is based on MSQ performance in combination with a more general evaluation of cognitive function from interaction with the person during the UCAT assessment.

(3) **"Developmental Disability"** means a severe, chronic disability of an individual that:

(A) is attributable to a mental or physical impairment or combination of mental and physical impairments;
(B) is manifested before the individual attains age 22;
(C) is likely to continue indefinitely;
(D) results in substantial functional limitations in three or more of the following areas of major life activity:
(i) self-care;
(ii) receptive and expressive language;
(iii) learning;
(iv) mobility;
(v) self-direction;
(vi) capacity for independent living; and
(vii) economic self-sufficiency; and
(E) reflects the individual's need for a combination and sequence of special, interdisciplinary, or generic services, supports, or

other assistance that is of lifelong or extended duration and is individually planned and coordinated.

(4) **"IADL"** means the instrumental activities of daily living.

(5) **"Instrumental activities of daily living"** means those activities that reflect the member's ability to perform household chores and tasks within the community essential for sustaining health and safety such as:

(A) shopping,
(B) cooking,
(C) cleaning,
(D) managing money,
(E) using a telephone,
(F) doing laundry,
(G) taking medication, and
(H) accessing transportation.

(6) **" Level of Care Service**s.**"** To be eligible for level of care services, meeting the minimum UCAT criteria established for SNF or hospital level of care demonstrates the individual must:

(A) require a treatment plan involving the planning and administration of services that require the skills of licensed or otherwise certified technical or professional personnel, and are provided directly or under the supervision of such personnel;

(B) have a physical impairment or combination of physical, mental and/or functional impairments;

(iii) require professional nursing supervision (medication, hygiene and/or dietary assistance);

(C) lack the ability to adequately and appropriately care for self or communicate needs to others;

(D) require medical care and treatment in order to minimize physical health regression or deterioration;

(E) require care that is not available through family and friends, Medicare, Veterans Administration, or other federal entitlement program with the exception of Indian Health Services; and

(F) require care that cannot be met through Medicaid State Plan Services, including Personal Care, if financially eligible.

(7) **"Mental Retardation"** means that the person has, as determined by a PASRR level II evaluation, substantial limitations in functional ability due to significantly sub-average intellectual functioning related to an event occurring before the age of 18.

(8) **"MSQ"** means the mental status questionnaire.

(9) **"Progressive degenerative disease process that responds to treatment"** means a process such as, but not limited to, Multiple Sclerosis (MS), Parkinson's Disease, Human Immunodeficiency Virus (HIV), or Acquired Immunodeficiency Syndrome (AIDS), that, untreated, systematically impairs normal body function which leads to acute illness and/or disability but that reacts positively to a medically prescribed treatment intervention (usually medication) which arrests or significantly delays the destructive action of the process.

317:50-1-3. Medically Fragile Program overview

(a) The Medically Fragile Waiver program is a Medicaid Home and Community Based Services Waiver used to finance non-institutional long-term care services for a targeted group of physically disabled adults when there is a reasonable expectation that the person's health, due to disease process or

disability, would, without appropriate services, deteriorate and require skilled nursing facility or hospital level of care to arrest the deterioration. Medically Fragile Waiver program members must be SoonerCare eligible and must not reside in an institution, room and board licensed residential care facility, or licensed assisted living facility. The number of members who may receive Medically Fragile Waiver services is limited.

(1) To receive Medically Fragile Waiver services, individuals must meet the following criteria:

(A) be 19 years of age or older;

(B) if developmentally disabled, not have mental retardation or a cognitive impairment related to the developmental disability.

(C) have a chronic medical condition which results in prolonged dependency on medical care for which daily skilled intervention is necessary and is characterized by one or more of the following:

(i) a life threatening condition characterized by reasonably frequent periods of acute exacerbation which requires frequent medical supervision and/or physician consultation and which, in the absence of such supervision or consultation, would require hospitalization;

(ii) require frequent time consuming administration of specialized treatments which are medically necessary;

(iii) be dependent on medical technology such that without the technology, a reasonable level of health could not be maintained.

(2) In addition, the individual must meet the following criteria:

(A) meet service eligibility criteria [see OAC 317:50-1-3(d)]; and

(B) meet program eligibility criteria [see OAC 317:50-1-3(e)].

(b) Home and Community Based Waiver Services are outside the scope of state plan Medicaid services. The Medicaid waiver allows the OHCA to offer certain Home and Community Based services to an annually capped number of persons who are categorically needy (refer to OKDHS form 08AX001E, Schedule VIII. B. 1) and without such services would be institutionalized.

(c) Services provided through the Medically Fragile Waiver are:

(1) case management;

(2) respite;

(3) adult day health care;

(4) environmental modifications;

(5) specialized medical equipment and supplies;

(6) physical therapy, occupational therapy, respiratory therapy, speech therapy or consultation;

(7) advanced supportive/restorative assistance;

(8) skilled nursing;

(9) home delivered meals;

(10) hospice care;

(11) medically necessary prescription drugs within the limits of the waiver;

(12) personal care (state plan), Medically Fragile Waiver personal care;

(13) Personal Emergency Response System (PERS);

(14) Self Direction; and

(15) SoonerCare medical services within the scope of the State Plan.

(d) A service eligibility determination is made using the following criteria:

(1) an open Medically Fragile Waiver Program waiver slot, as authorized by the waiver document approved by the Centers for Medicare and Medicaid Services (CMS), is available to assure federal participation in payment for services to the member. If it is determined that all Medically Fragile Waiver slots are filled, the member cannot be certified as eligible for Medically Fragile Waiver services and the member's name is

placed on a waiting list for entry as an open slot becomes available. Medically Fragile Waiver slots and corresponding waiting lists, if necessary, are maintained.

(2) the member is in the Medically Fragile Waiver targeted service group. The target group is an individual who is age 19 or older with a physical disability and who does not have mental retardation or a cognitive impairment.

(3) the individual does not pose a physical threat to self or others as supported by professional documentation.

(4) members of the household or persons who routinely visit the household, as supported by professional documentation, do not pose a threat of harm or injury to the individual or other household visitors.

(e) The Medically Fragile Waiver program eligibility determination is made through the service plan approval process. The following criteria are used to make the determination that an individual is not eligible:

(1) if the individual's needs as identified by UCAT and other professional assessments cannot be met through Medically Fragile Waiver program services, SoonerCare State Plan services and other formal or informal services. The State, as part of the waiver program approval authorization, assures CMS that each waiver member's health, safety, or welfare can be maintained in their home. If an individual's identified needs cannot be met through provision of Medically Fragile Waiver program or SoonerCare State Plan services and other formal or informal services are not in place or immediately available to meet those needs, the individual's health, safety or welfare in their home cannot be assured.

(2) if the individual poses a physical threat to self or others as supported by professional documentation.

(3) if other members of the household or persons who routinely visit the household who, as supported by professional documentation, pose a threat of harm or injury to the individual or other household visitors.

(4) if the individual's needs are being met, or do not require Medically Fragile Waiver services to be met, or if the individual would not require institutionalization if needs are not met.

(5) if, after the service and care plan is developed, the risk to individual health and safety is not acceptable to the individual, or to the interdisciplinary service plan team, or to the OHCA.

(f) Professional documentation is provided to support the recommendation for redetermination of program eligibility. The service providers continue providing services according to the service plan as provider safety permits until the member is removed from the Medically Fragile Waiver program. As a part of the procedures requesting redetermination of program eligibility, the OHCA will provide technical assistance to the Provider for transitioning the member to other services.

(g) Individuals determined ineligible for Medically Fragile Waiver program services are notified in writing of the determination and of their right to appeal the decision.

317:50-1-4. Application for Medically Fragile Waiver services

(a) If waiver slots are available, the application process is initiated by the receipt of a UCAT, Part I or by an oral request for services. A written financial application is not required for an individual who is a SoonerCare member at the time of application. A financial application for Medically Fragile Waiver services consists of the Medical Assistance Application form. The form is signed by the applicant, parent, spouse, guardian or someone else acting on the applicant's behalf.

(1) All conditions of financial eligibility must be verified and documented in the case record. When current information is already available that establishes financial eligibility, such information may be used by recording source and date of information. If the applicant also wishes to apply for a State Supplemental Payment, either the applicant or his/her guardian must sign the application form.

(2) An individual residing in a NF or requesting waiver services, or the individual's community spouse may request an assessment of resources available to each spouse by using OKDHS form 08MA011E, Assessment of Assets, when SoonerCare application is not being made. The individual and/or spouse must provide documentation of resources. The assessment reflects all countable resources of the couple (owned individually or as a couple) and establishes the spousal share to be protected when subsequent determination of SoonerCare long-term care eligibility is made.

(3) When SoonerCare application is being made, an assessment of resources must be completed if it was not completed when the individual entered the NF or began receiving waiver services. For applicants of the Medically Fragile waiver, those resources owned by the couple the month the application was made determines the spousal share of resources. If the individual applies for SoonerCare at the time of entry into the Medically Fragile Waiver, Form 08MA011E is not appropriate. However, the spousal share must be determined using the resource information provided on the SoonerCare application form and computed using OKDHS form 08MA12E, Title XIX Worksheet.

(b) **Date of application**. The date of application is the date the signed application is received or the date when the request for SoonerCare is made orally and the financial application form is signed later. The date of the oral request is noted above the date the form is signed.

(c) **Medically Fragile Waiver waiting list procedures.** Medically Fragile Waiver Program "available capacity in the month" is the number of additional members that may be enrolled in the Program in a given month without exceeding, on an annualized basis, the maximum number authorized by the waiver to be served in the waiver year.

317:50-1-5. Medically Fragile Waiver program medical eligibility determination

A medical eligibility determination is made for Medically Fragile Waiver program services based on the Uniform Comprehensive Assessment Tool (UCAT) III assessment, professional judgment and the determination that the member has unmet care needs that require Medically Fragile Waiver Program, SNF or hospital services to assure member health and safety. Medically Fragile Waiver services are initiated to support the informal care that is being provided in the member's home, or, that based on the UCAT, can be expected to be provided in the member's home upon discharge of the member from a SNF or hospital. These services are not intended to take the place of regular care provided by family members and/or by significant others. When there is an informal (not paid) system of care available in the home, Medically Fragile Waiver service provision will supplement the system within the limitations of Medically Fragile Waiver Program policy.

(1) Categorical relationship must be established for determination of eligibility for Medically Fragile Waiver services. If categorical relationship to disability has not already been established, the Level of Care Evaluation Unit (LOCEU) will render a decision on categorical relationship to the disabled using the same definition used by Social Security Administration. A follow-up is required with the Social Security

Administration to be sure their disability decision agrees with the decision of LOCEU.

(2) Community agencies complete the UCAT, Part I and forward the form to the OHCA. If the UCAT, Part I indicates that the applicant does not qualify for SoonerCare long-term care services, the applicant is referred to appropriate community resources.

(3) The member and family are informed of agencies certified to deliver Medically Fragile Waiver case management and in-home care services in the local area to obtain the member's primary and secondary informed choices.

(A) If the member and/or family declines to make a provider choice, that decision is documented on the member choice form.

(B) A rotating system is used to select an agency for the member from a list of all local certified case management and in-home care agencies.

(4) The names of the chosen agencies and the agreement (by dated signature) of the member to receive services provided by the agencies are documented.

(5) If the needs of the member require an immediate interdisciplinary team (IDT) meeting with home health agency nurse participation to develop a care plan and service plan, the need is documented.

(6) If, based upon the information obtained during the assessment, the nurse determines that the member may be at risk for health and safety, OKDHS Adult Protective Services (APS) staff are notified immediately and the referral is documented on the UCAT.

(7) Within ten working days of receipt of a complete Medically Fragile Waiver application, medical eligibility is determined using level of care criteria and service eligibility criteria

(8) Once eligibility has been established, notification is given to the member and the case management provider so that care plan and service plan development may begin. The member's case management provider is notified of the member's name, address, case number and social security number, the units of case management and, if applicable, the number of units of home health agency nurse evaluation authorized for care plan and service plan development, whether the needs of the member require an immediate IDT meeting with home health agency nurse participation and the effective date for member entry into the Medically Fragile Waiver Program.

(9) If the services must be in place to ensure the health and safety of the member upon discharge to the home from the NF, the member will be provided administrative case management to develop and implement the care plan and service plan. The provider of administrative case management follows Medically Fragile Waiver case management procedures for care plan and service plan development and implementation. Once the member returns home, case management is transitioned to the Medically Fragile Waiver case management provider chosen by the member.

(10) If the member has a current certification and requests a change to Medically Fragile Waiver services, a new UCAT is required. The UCAT is updated when a member requests a change from Medically Fragile Waiver services to Personal Care services, or when a member requests a change from the nursing facility to Medically Fragile Waiver services. If a member is receiving Medically Fragile Waiver services and requests to go to a nursing facility, a new medical level of care decision is not needed.

(11) When a UCAT assessment has been completed more than 90 days prior to submission for determination of a medical decision, a new assessment is required.

317:50-1-6. Determining financial eligibility for the Medically Fragile Waiver program

Financial eligibility for Medically Fragile Waiver services is determined using the rules on income and resources according to the category to which the individual is related. Only individuals who are categorically related to ABD may be served through the Medically Fragile Waiver. Income, resources and expenses are evaluated on a monthly basis for all individuals requesting payment for the Medically Fragile Waiver Program. In determining income and resources for the individual categorically related to ABD, the "family" includes the individual and spouse, if any. However, consideration is not given to the income and resources of a spouse included in a TANF case. If an individual and spouse cease to live together for reasons other than institutionalization, income and resources are considered available to each other through the month in which they are separated. Mutual consideration ceases with the month after the month in which the separation occurs. Any amounts which are actually contributed to the spouse after the mutual consideration has ended are considered. Financial eligibility for individuals in Medically Fragile Waiver Program services is as follows:

(1) **Individual without a spouse**. For an individual without a spouse, the following rules are used to determine financial eligibility.

(A) **Income eligibility**. To determine the income of the individual, the rules in (i) through (iii) of this subparagraph apply.

(i) If payment of income is made to the individual and another person(s), the income is considered in proportion to the individual's interest.

(ii) If a legal instrument exists which specifies terms of payment, income is considered according to the terms of the instrument.

(iii) After determination of income, the gross income of the individual cannot exceed the categorically needy standard in OKDHS form 08AX001E, Schedule VIII. B. 1., to be eligible for Medically Fragile Waiver services. If the individual's gross income exceeds that standard, refer to SoonerCare rules for establishing a Medicaid Income Pension Trust [OAC 317:35-5-41.6(a)(6)(B)].

(B) **Resource eligibility**. In order for an individual without a spouse to be eligible for Medically Fragile Waiver services, his/her countable resources cannot exceed the maximum resource standard for an individual listed in OKDHS form 08AX001E, Schedule VIII. D.

(C) **Equity in capital resources**. If the equity in the individual's capital resources is in excess of the maximum resource standards, certification is delayed up to 30 days providing plans are made for the applicant to utilize the excess resource. Certification is made at the point the excess resources have been exhausted, with the effective date of certification being shown as the date on which the resources came within the standard. If the excess capital resources can not reasonably be expected to come within standards in one month, the application is denied.

(2) **Individual with a spouse who receives HCBW services, or is institutionalized in a NF or ICF/MR, or is 65 or over and in a mental health hospital.** For an individual with a spouse who receives HCBW services, or is institutionalized in a NF or ICF/MR, or is 65 or over and in a mental health hospital, resources are determined for each individual as the amount owned by each individual plus one-half of the jointly owned resources of the couple. Once this separation of assets is made, a resource of either spouse is not considered available to the other during the receipt of HCBW program services.

(A) **Income eligibility.** Income is determined separately for an individual and his/her spouse if the spouse is in a HCBW program, or is institutionalized in a NF or ICF/MR, or is 65 or older and in a mental health hospital. The income of either spouse is not considered as available to the other during the receipt of Medically Fragile Waiver services. The rules in (i) - (v) of this subparagraph apply in this situation:

(i) If payment of income is made solely to one or the other, the income is considered available only to that individual.

(ii) If payment of income is made to both, one-half is considered for each individual.

(iii) If payment of income is made to either one or both and another person(s), the income is considered in proportion to either spouse's interest (if payment is to that spouse) or one-half of the joint interest if no interest is specified.

(iv) If a legal instrument exists which specifies terms of payment, income is considered according to the terms of the instrument.

(v) After determination of income, the gross income of the individual cannot exceed the categorically needy standard in OKDHS form 08AX001E, Schedule VIII. B. 1., to be eligible for Medically Fragile Waiver services. If the individual's gross income exceeds this standard, refer to SoonerCare rules for establishing a Medicaid Income Pension Trust [OAC 317:35-5-41.6(a)(6)(B)].

(B) **Resource eligibility.** In order for an individual with a spouse who receives HCBW services, or is institutionalized in a NF or ICF/MR, or is 65 or older and in a mental health hospital to be eligible for the Medically Fragile Waiver services, his/her countable resources cannot exceed the maximum resource standard for an individual listed in OKDHS form 08AX001E, Schedule VIII. D.

(C) **Equity in capital resources.** If the equity in the individual's capital resources is in excess of the maximum resource standards, certification is delayed up to 30 days providing plans are made for the applicant to utilize the excess resource. Certification is made at the point the excess resources have been exhausted, with the effective date of certification being shown as the date on which the resources came within the standard. If the excess capital resources can not reasonably be expected to come within standards in one month, the application is denied.

(3) **Individual with a spouse in the home who is not in a Home and Community Based Waiver Program.** When only one individual of a couple in their own home is in a HCBW Program, income and resources are determined separately. However, the income and resources of the individual who is not in the HCBW program (community spouse) must be included on the application form. At redetermination of eligibility, the community spouse's income must be included in the review process. During any month that the individual is receiving Medically Fragile Waiver program services, the income of the community spouse is not considered available to that individual. The following rules are used to determine the income and resources of each:

(A) **Income eligibility**. To determine the income of both spouses, the rules in (i) - (v) of this subparagraph apply.

(i) If payment of income is made solely to one or the other, the income is considered available only to that individual.

(ii) If payment of income is made to both, one-half is considered for each individual.

(iii) If payment of income is made to either one or both and another person(s), the income is considered in proportion to either spouse's interest (if payment is to that spouse) or one-half of the joint interest if no interest is specified.

(iv) If a legal instrument exists which specifies terms of payment, income is considered according to the terms of the instrument.

(v) After determination of income, the gross income of the individual in the Medically Fragile Waiver program cannot exceed the categorically needy standard in OKDHS form 08AX001E, Schedule VIII. B. 1., to be eligible for care. If the individual's gross income exceeds this standard, refer to SoonerCare rules for establishing a Medicaid Income Pension Trust [OAC 317:35-5-41.6(a)(6)(B)].

(B) **Resource eligibility**. To determine resource eligibility, it is necessary to determine the amount of resources for both spouses for the month of the individual's application for the Medically Fragile Waiver program. Of the resources available to the couple (both individual and joint ownership) an amount will be protected for the community spouse which will not be considered available to the spouse receiving Medically Fragile Waiver program services. The amount determined as the spousal share is used for all subsequent applications for SoonerCare, regardless of changes in the couple's resources. The protected spousal share cannot be changed for any reason. When application for SoonerCare is made at the same time the individual begins receiving Medically Fragile program services, OKDHS Form 08MA012E, Title XIX Worksheet, is used.

(i) The first step in the assessment process is to establish the total amount of resources for the couple during the month of application of the spouse into the Medically Fragile Waiver program (regardless of payment source).

(ii) The community spouse's share is equal to one-half of the total resources of the couple not to exceed the maximum amount of resource value that can be protected for the community spouse, as shown on OKDHS form 08AX001E, Schedule XI.

(iii) The minimum resource standard for the community spouse, as established by the OHCA, is found on OKDHS form 08AX001E, Schedule XI. When the community spouse's share is less than the minimum standard, an amount may be deemed from the other spouse's share to ensure the minimum resource standard for the community spouse. If the community spouse's share equals or exceeds the minimum resource standard, deeming cannot be done.

(iv) If deeming is necessary to meet the minimum resource standard for the community spouse, the amount that is deemed must be legally transferred to the community spouse within one year of the effective date of certification for SoonerCare. At the first redetermination of eligibility, the worker must document that the resources have been transferred. After the first year of SoonerCare eligibility, resources of the community spouse will not be available to the other spouse and resources cannot be deemed to the community spouse.

(v) After the month in which the institutionalized spouse and community spouse have met the resource standard and the institutionalized spouse is determined eligible for benefits, no resources of the community spouse, regardless of value, will be considered available to the institutionalized spouse. If the resources of the community spouse grow to exceed the original

deemed amount, the State cannot require the community spouse to apply any of these excess resources toward the cost of the care of the institutionalized spouse.

(vi) When determining eligibility for SoonerCare, the community spouse's share of resources is protected and the remainder considered available to the spouse receiving Medically Fragile Waiver program services.

(vii) The resources determined in (i) - (vi) of this subparagraph for the individual receiving Medically Fragile Waiver program services cannot exceed the maximum resource standard for an individual as shown in OKDHS form 08AX001E, Schedule VIII. D.

(viii) Once the dollar value of the community spouse's share of resources is established for the month of the other spouse's entry into the Medically Fragile Waiver program, that amount is used when determining resource eligibility for a subsequent SoonerCare application for Long-Term Care for either spouse.

(ix) Once a determination of eligibility for SoonerCare is made, either spouse is entitled to a fair hearing. A fair hearing regarding the determination of the community spouse's resource allowance is held within 30 days of the date of the request for the hearing. Either spouse is entitled to a fair hearing if dissatisfied with a determination of:

(I) the community spouse's monthly income allowance;

(II) the amount of monthly income otherwise available to the community spouse;

(III) determination of the spousal share of resource;

(IV) the attribution of resources (amount deemed); or

(V) the determination of the community spouse's resource allowance.

(x) The rules on determination of income and resources are applicable only when an individual receiving Medically Fragile Waiver program services is likely to remain under care for 30 consecutive days. The 30-day requirement is considered to have been met even if a hospital stay interrupts it or the individual is deceased before the 30-day period ends.

(C) **Excess resources**. If the equity in the individual's capital resources is in excess of the maximum resource standards, certification is delayed up to 30 days providing plans are made for the applicant to utilize the excess resource. Certification is made at the point the excess resources have been exhausted, with the effective date of certification being shown as the date on which the resources came within the standard. If the excess capital resources cannot reasonably be expected to come within standards in one month, the application is denied.

(4) **Transfer of assets on or after August 11, 1993 but before February 8, 2006.** An institutionalized individual, an institutionalized individual's spouse, the guardian or legal representative of the individual or individual's spouse who disposes of assets on or after August 11, 1993 but before February 8, 2006 for less than fair market value on or after the look-back date specified in (A) of this paragraph subjects the individual to a penalty period for the disposal of such assets.

(A) For an institutionalized individual, the look-back date is 36 months before the first day the individual is both institutionalized and has applied for SoonerCare. However, in the case of payments from a trust or portions of a trust that are treated as transfers of assets, the look back date is 60 months.

(B) For purposes of this paragraph, an "institutionalized" individual is one who is receiving HCBW program services.
(C) The penalty period begins the first day of the first month during which assets have been transferred and which does not occur in any other period of ineligibility due to an asset transfer. When there have been multiple transfers, all transferred assets are added together to determine the penalty.
(D) The penalty period consists of a period of ineligibility (whole number of months) determined by dividing the total uncompensated value of the asset by the average monthly cost ($2,000) to a private patient in an SNF or Hospital level of care in Oklahoma. In this calculation, any partial month is dropped. There is no limit to the length of the penalty period for these transfers. Uncompensated value is defined as the difference between the fair market value at the time of transfer less encumbrances and the amount received for the resource.
(E) Assets are defined as all income and resources of the individual and the individual's spouse, including any income or resources which the individual or such individual's spouse is entitled to but does not receive because of action:
(i) by the individual or such individual's spouse;
(ii) by a person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual or such individual's spouse; or
(iii) by any person, including any court or administrative body acting at the direction or upon the request of the individual or such individual's spouse.
(F) A penalty would not apply if:
(i) the title to the individual's home was transferred to:
(I) the spouse;
(II) the individual's child who is under age 21 or is blind or totally disabled as determined by Social Security;
(III) a sibling who has equity interest in the home and resided in the home for at least one year immediately prior to the institutionalization of the individual; or
(IV) the individual's son or daughter who resided in the home and provided care for at least two years immediately prior to the individual's institutionalization.
(ii) the individual can show satisfactorily that the intent was to dispose of assets at fair market value or that the transfer was exclusively for a purpose other than eligibility. It is presumed that any transfer of assets made for less than fair market value was made in order to qualify the individual for SoonerCare. In order to rebut this presumption, the individual must present compelling evidence that a transfer was made for reasons other than to qualify for SoonerCare. It is not sufficient for an individual to claim that assets were transferred solely for the purposes of allowing another to have them with ostensibly no thought of SoonerCare if the individual qualifies for SoonerCare as a result of the transfer.
(iii) the transfer was to the community spouse or to another person for the sole benefit of the community spouse in an amount equal to the community spouse's asset allowance.
(iv) the asset was transferred to the individual's child who is blind or totally disabled as determined by Social Security. The transfer may be to a trust established for the benefit of the individual's child.

(v) the asset was transferred to or from the spouse (either community or institutionalized) or to another person for the sole benefit of the spouse if the assets are not subsequently transferred to still another person for less than fair market value.

(vi) the asset is transferred to a trust established solely for the benefit of a disabled individual under the age of 65.

(vii) the denial would result in undue hardship. Such determination should be referred to OKDHS State Office for a decision.

(G) The individual is advised by a written notice of a period of ineligibility due to transfer of assets. The notice explains the period of ineligibility for payment of Medically Fragile Waiver program services and the continuance of eligibility for other SoonerCare services.

(H) The penalty period can be ended by either all assets being restored or commensurate return being made to the individual.

(I) Once the restoration or commensurate return is made, eligibility is re-determined considering the value of the restored asset or the amount of commensurate return.

(J) The restoration or commensurate return will not entitle the member to benefits for the period of time that the asset remained transferred. An applicant cannot be certified for Medically Fragile Waiver program services for a period of asset ineligibility.

(K) When assests are held by an individual with another person or persons, whether held in joint tenancy or tenancy in common or similar arrangement, and the individual's ownership or control of the asset is reduced or eliminated is considered a transfer.

(L) When a transfer of assets by the spouse of an individual results in a period of ineligibility and the spouse who made such transfer subsequently becomes institutionalized, the period of ineligibility will be apportioned between the two institutionalized spouses.

(5) **Transfer of assets on or after February 8, 2006.** An institutionalized individual, an institutionalized individual's spouse, the guardian or legal representative of the individual or individual's spouse who disposes of assets on or after February 8, 2006 for less than fair market value on or after the look-back date specified in (A) of this paragraph subjects the individual to a penalty period for the disposal of such assets.

(A) For an institutionalized individual, the look-back date is 60 months before the first day the individual is both institutionalized and has applied for SoonerCare. However, individuals that have purchased an Oklahoma Long-Term Care Partnership Program approved policy may be completely or partially exempted from this Section depending on the monetary extent of the insurance benefits paid.

(B) For purposes of this paragraph, an "institutionalized" individual is one who is receiving ADvantage program services.

(C) The penalty period will begin with the later of:

(i) the first day of a month during which assets have been transferred for less than fair market value; or

(ii) the date on which the individual is:

(I) eligible for medical assistance; and

(II) receiving institutional level of care services that, were it not for the imposition of the penalty period, would be covered by SoonerCare.

(D) The penalty period:

(i) cannot begin until the expiration of any existing period of ineligibility;

(ii) will not be interrupted or temporarily suspended once it is imposed;

(iii) when there have been multiple transfers, all transferred assets are added together to determine the penalty.

(E) The penalty period consists of a period of ineligibility determined by dividing the total uncompensated value of the asset by the average monthly cost to a private patient in a nursing facility in Oklahoma shown on OKDHS form 08AX001E. In this calculation, the penalty must include a partial month disqualification based upon the relationship between that fractional amount and the average monthly cost to a private patient in a nursing facility in Oklahoma. There is no limit to the length of the penalty period for these transfers. Uncompensated value is defined as the difference between the fair market value at the time of transfer less encumbrances and the amount received for the resource.

(F) Assets are defined as all income and resources of the individual and the individual's spouse, including any income or resources which the individual or such individual's spouse is entitled to but does not receive because of action:

(i) by the individual or such individual's spouse;

(ii) by a person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual or such individual's spouse; or

(iii) by any person, including any court or administrative body acting at the direction or upon the request of the individual or such individual's spouse.

(G) Special Situations.

(i) Separate Maintenance or Divorce.

(I) There shall be presumed to be a transfer of assets if an applicant or member receives less than half of the couple's resources pursuant to a Decree of Separate Maintenance or a Decree of Divorce.

(II) There shall be presumed to be a transfer of assets if the income is reduced to an amount lower than the individual's own income plus half of the joint income. The transfer penalty shall be calculated monthly.

(III) Assets which were exempt lose the exempt character when not retained by the applicant or member in the divorce or separate maintenance. These assets, if received by the other spouse, are counted when determining the penalty.

(IV) The applicant or member may rebut the presumption of transfer by showing compelling evidence that the uneven division of income or resources was the result of factors unrelated to SoonerCare eligibility.

(ii) Inheritance from a spouse.

(I) Oklahoma law provides that a surviving spouse is entitled to a minimum portion of a deceased spouse's probate estate. The amount depends on several factors.

(II) It is considered a transfer if the deceased spouse's will places all, or some, of the statutory share the applicant or member is entitled to receive in a trust which the applicant or member does not have unfettered access to or leaves less than the statutory amount to the applicant or member, who does not then elect to receive the statutory share in probate proceedings.

(H) A penalty would not apply if:

(i) the title to the individual's home was transferred to:

(I) the spouse; or

(II) the individual's child who is under age 21 or is blind or totally disabled as determined by Social Security; or

(III) a sibling who has equity interest in the home and resided in the home for at least one year immediately prior to the institutionalization of the individual; or

(IV) the individual's son or daughter who resided in the home and provided care for at least two years immediately prior to the individual's institutionalization.

(ii) the individual can show satisfactorily that the intent was to dispose of assets at fair market value or that the transfer was exclusively for a purpose other than eligibility. It is presumed that any transfer of assets made for less than fair market value was made in order to qualify the individual for SoonerCare. In order to rebut this presumption, the individual must present compelling evidence that a transfer was made for reasons other than to qualify for SoonerCare. It is not sufficient for an individual to claim that assets were transferred solely for the purposes of allowing another to have them with ostensibly no thought of SoonerCare if the individual qualifies for SoonerCare as a result of the transfer.

(iii) the transfer was to the community spouse or to another person for the sole benefit of the community spouse in an amount equal to the community spouse's asset allowance. "Sole benefit" means that the amount transferred will be used for the benefit of the community spouse during his or her expected life.

(iv) the asset was transferred to the individual's child who is blind or totally disabled as determined by Social Security. The transfer may be to a trust established for the benefit of the individual's child.

(v) the asset was transferred to or from the spouse (either community or institutionalized) or to another person for the sole benefit of the spouse if the assets are not subsequently transferred to still another person for less than fair market value. "Sole benefit" means that the amount transferred will be used for the benefit of the spouse (either community or institutionalized) during his or her expected life.

(vi) the asset is transferred to a trust established solely for the benefit of a disabled individual under the age of 65.

(vii) the denial would result in undue hardship. Undue hardship exists when application of a transfer of assets penalty would deprive the individual of medical care such that the individual's health or life would be endangered; or of food, clothing, shelter, or other necessities of life.

(I) An undue hardship does not exist if the individual willingly transferred assets for the purpose of qualifying for SoonerCare services through the use of the undue hardship exemption.

(II) Such determination should be referred to OKDHS State Office for a decision.

(III) If the undue hardship exists because the applicant was exploited, legal action must be pursued to return the transferred assets to the applicant before a hardship waiver will be granted. Pursuing legal action means an APS referral

has been made to the district attorney's office or a lawsuit has been filed and is being pursued against the perpetrator.

(I) The individual is advised by a written notice of a period of ineligibility due to transfer of assets, a timely process for determining whether an undue hardship waiver will be granted and a process for an adverse determination appeal. The notice explains the period of ineligibility for payment of Medically Fragile Waiver program services and the continuance of eligibility for other SoonerCare services.

(J) The penalty period can be ended by either all assets being restored or commensurate return being made to the individual.

(K) Once the restoration or commensurate return is made, eligibility is re-determined considering the value of the restored asset or the amount of commensurate return.

(L) The restoration or commensurate return will not entitle the member to benefits for the period of time that the asset remained transferred. An applicant cannot be certified for Medically Fragile Waiver program services for a period of asset ineligibility.

(M) Assets which are held by an individual with another person or persons, whether held in joint tenancy or tenancy in common or similar arrangement, and the individual's ownership or control of the asset is reduced or eliminated is considered a transfer. The exception to this rule is if ownership of a joint account is divided according to the amount contributed by each owner.

(i) Documentation must be provided to show each co-owner's contribution;

(ii) The funds contributed by the applicant or SoonerCare member end up in an account owned solely by the applicant or member.

(N) When a transfer of assets by the spouse of an individual results in a period of ineligibility and the spouse who made such transfer subsequently becomes institutionalized, the period of ineligibility will be apportioned between the two institutionalized spouses.

(6) **Commensurate return.** Commensurate return for purposes of this Section is defined as actual money payment or documentation of money spent on the member's behalf; i.e., property taxes, medical debts, nursing care expenses, etc., corresponding to the market value of the transferred property. The definition does not include personal services, labor or provision of rent-free shelter. It also does not include a monetary value assigned and projected for future payment either by cash or provision of services. Any transfer of property within the five years prior to application or during receipt of assistance must be analyzed in regard to commensurate return as well as determination of intent.

317:50-1-7. Certification for Medically Fragile Waiver program services

(a) **Financial certification period for Medically Fragile Waiver program services**. The financial certification period for the Medically Fragile Waiver program is 12 months.

(b) **Medical Certification period for Medically Fragile Waiver program services**. The medical certification period for Medically Fragile Waiver program services is 12 months. Reassessment and redetermination of medical eligibility is completed in coordination with the annual recertification of the member's service plan. If documentation supports a reasonable expectation that the member will not continue to meet medical eligibility criteria or have a need for long term care services for more than 12 months, an independent evaluation of medical eligibility is completed before the end of the current medical certification period.

317:50-1-8. Redetermination of eligibility for Medically Fragile Waiver services

A redetermination of medical and financial eligibility must be completed prior to the end of the certification period.

317:50-1-9. Member annual level of care re-evaluation and annual re-authorization of service plan

(a) Annually, the case manager reassesses the member's needs and the service plan, especially with respect to progress of the member toward service plan goals and objectives. Based on the reassessment, the case manager develops a new service plan with the member and service providers, as appropriate, and submits the new service plan for certification along with the supporting documentation and the assessment of the existing service plan. The case manager initiates the fourth quarter monitoring to allow sufficient time for certification of a new service plan prior to the expiration date on the existing service plan.

(b) At a maximum of every 11 months, the case manager makes a home visit to evaluate the Medically Fragile Waiver member using the UCAT, Parts I and III and other information as necessary as part of the annual service plan development process.

(1) The case manager's assessment of a member done within a 60-day period prior to the existing service plan end date is the basis for medical eligibility redetermination.

(2) As part of the service plan recertification process, the member is evaluated for the continued need for Skilled Nursing Facility or hospital level of care.

(3) Based on evaluation of the UCAT, a determination of continued medical eligibility is made and recertification of medical eligibility is done prior to the expiration date of current medical eligibility certification. If medical eligibility recertification is not made prior to current medical eligibility expiration, the existing medical eligibility certification is automatically extended until recertification is determined or for 60 days, whichever is less. If the member no longer meets medical eligibility, upon making the level of care determination, the member's "medical eligibility end date" is updated in the system. The member's case manager is notified that the member has been determined to no longer meet medical eligibility for Medically Fragile Waiver services as of the effective date of the eligibility determination. The member is notified and if the member requests, the case manager helps the member arrange alternate services in place of Medically Fragile Waiver services.

317:50-1-10. Medically Fragile Waiver services during hospitalization or NF placement

If a member requires hospital or nursing facility services, the case manager assists the member in accessing institutional care, periodically monitors the member's progress during the institutional stay and, as appropriate, updates the service plan and prepares services to start on the date the member is discharged from the institution and returns home.

(1) **Hospital discharge.** When the member returns home from a hospital or when notified of the member's anticipated discharge date, the case manager notifies relevant providers and coordinates the resumption of services.

(2) **NF placement of less than 30 days.** When the member returns home from a NF stay of 30 days or less or when notified of the member's anticipated discharge date the case manager notifies relevant providers and

coordinates the resumption of Medically Fragile Waiver services in the home.

(3) **NF placement greater than 30 days.** When the member is scheduled to be discharged and return home from a SNF stay that is greater than 30 days, the member's case manager expedites the restart of Medically Fragile Waiver services for the member.

317:50-1-11. Closure or termination of Medically Fragile Waiver services

(a) **Voluntary closure of** Medically Fragile Waiver **services**. If the member requests a lower level of care than Medically Fragile Waiver services or if the member agrees that Medically Fragile Waiver services are no longer needed to meet his/her needs, a medical decision is not needed. The closure request is completed and signed by the member and the case manager and placed in the member's case record. Documentation is made of all circumstances involving the reasons for the voluntary termination of services and alternatives for services if written request for closure cannot be secured.

(b) **Closure due to financial or medical ineligibility**. The process for closure due to financial or medical ineligibility is described in this subsection.

(1) **Financial ineligibility**. Anytime it is determined that a member does not meet the financial eligibility criteria, the member and provider are notified of financial ineligibility. A medical eligibility redetermination is not required when a financial ineligibility period does not exceed the medical certification period.

(2) **Medical ineligibility.** When the member is found to no longer be medically eligible for Medically Fragile Waiver services, the individual and provider are notified of the decision.

(c) **Closure due to other reasons**. Refer to OAC 317:50-1-3(e) - (f).

(d) **Resumption of** Medically Fragile Waiver **services.** If a member approved for Medically Fragile Waiver services has been without services for less than 90 days and has a current medical and financial eligibility determination, services may be resumed using the previously approved service plan. If a member decides he/she desires to have his/her services restarted after 90 days, the member must request the services.

317:50-1-12. Eligible providers

Medically Fragile Program service providers, must be certified by the Oklahoma Health Care Authority (OHCA) and all providers must have a current signed SoonerCare contract on file with the Medicaid Agency (Oklahoma Health Care Authority).

(1) The provider programmatic certification process verifies that the provider meets licensure, certification and training standards as specified in the Waiver document and agrees to Medically Fragile Program Conditions of Participation. Providers must obtain programmatic certification to be Medically Fragile Program certified.

(2) The provider financial certification process verifies that the provider uses sound business management practices and has a financially stable business.

(3) Providers may fail to gain or may lose Waiver Program certification due to failure to meet either programmatic or financial standards.

(4) At a minimum, provider financial certification is reevaluated annually.

(5) Providers of Medical Equipment and Supplies, Environmental Modifications, Personal Emergency Response Systems, Hospice, and SNF Respite services do not have a programmatic evaluation after the initial certification.

(6) OHCA may authorize a legally responsible family member (spouse or legal guardian) of an adult member to be SoonerCare reimbursed under the 1915(c) Medically Fragile Program as a service provider, if the provider meets all of the following authorization criteria and monitoring provisions:

(A) Authorization for a legally responsible family member to be the care provider for a member may occur only if the member is offered a choice of providers and documentation demonstrates that:

(i) either no other provider is available; or

(ii) available providers are unable to provide necessary care to the member; or

(iii) the needs of the member are so extensive that the spouse or legal guardian who provides the care is prohibited from working outside the home due to the member's need for care.

(B) The service must:

(i) meet the definition of a service/support as outlined in the federally approved Waiver document;

(ii) be necessary to avoid institutionalization;

(iii) be a service/support that is specified in the individual service plan;

(iv) be provided by a person who meets the provider qualifications and training standards specified in the Waiver for that service;

(v) be paid at a rate that does not exceed that which would otherwise be paid to a provider of a similar service and does not exceed what is allowed by the OHCA for the payment of personal care or personal assistance services;

(vi) not be an activity that the spouse or legal guardian would ordinarily perform or is responsible to perform. If any of the following criteria are met, assistance or care provided by the spouse or guardian will be determined to exceed the extent and/or nature of the assistance they would be expected to ordinarily provide in their role as spouse or guardian:

(I) spouse or guardian has resigned from full-time/part-time employment to provide care for the member; or

(II) spouse or guardian has reduced employment from full-time to part-time to provide care for the member; or

(III) spouse or guardian has taken a leave of absence without pay to provide care for the member; or

(IV) spouse or guardian provides assistance/care for the member 35 or more hours per week without pay and the member has remaining unmet needs because no other provider is available due to the nature of the assistance/care, special language or communication, or intermittent hours of care requirements of the member.

(C) The spouse or legal guardian who is a service provider will comply with the following:

(i) not provide more than 40 hours of services in a seven day period;

(ii) planned work schedules must be available in advance to the member's Case Manager, and variations to the schedule must be noted and supplied two weeks in advance to the Case Manager unless change is due to an emergency;

(iii) maintain and submit time sheets and other required documentation for hours paid; and

(iv) be documented in the service plan as the member's care provider.

(D) In addition to case management, monitoring, and reporting activities required for all Waiver services, the state is obligated to additional monitoring requirements when members elect to use a spouse or legal guardian as a paid service provider. The OHCA will monitor through documentation submitted by the Case Manager the following:

(i) at least quarterly reviews by the Case Manager of expenditures and the health, safety, and welfare status of the individual member; and

(ii) face-to-face visits with the member by the Case Manager on at least a semi annual basis.

(7) The OHCA periodically performs a programmatic audit of Case Management, Home Care (providers of Skilled Nursing, State Plan Personal Care, In-Home Respite, Advanced Supportive/Restorative Assistance and Therapy Services), and Self-Directed service providers. If due to a programmatic audit, a provider Plan of Correction is required, the OHCA stops new case referrals to the provider until the Plan of Correction has been approved and implemented. Depending on the nature and severity of problems discovered during a programmatic audit, at the discretion of the OHCA, members determined to be at risk for health or safety may be transferred from a provider requiring a Plan of Correction to another provider.

(8) As additional providers are certified or if a provider loses certification, the OHCA provides notice to appropriate personnel in counties affected by the certification changes.

317:50-1-13. Coverage

Individuals receiving Waiver services must have been determined to be eligible for the program and must have an approved plan of care. Any Medically Fragile Program service provided must be listed on the approved plan of care and must be necessary to prevent institutionalization of the member. Waiver services which are expansions of Oklahoma Medicaid State Plan services may only be provided after the member has exhausted these services available under the State Plan.

(1) To allow for development of administrative structures and provider capacity to adequately deliver Self-Directed services and Supports, availability of Self-Direction is limited to Medically Fragile Program members that reside in counties that have sufficient provider capacity to offer the Self-Directed Service option as determined by OHCA.

(2) Case Managers within the Self-Directed Services approved area will provide information and materials that explain the service option to the members. The OHCA provides information and material on Self-Direction to Case Managers for distribution to members.

(3) The member may request to Self-Direct their services from their Case Manager or call the Medically Fragile Program toll-free number to request the Self-Directed Services option.

317:50-1-14. Description of services

Services included in the Medically Fragile Program are as follows:

(1) **Case Management.**

(A) Case Management services are services that assist a member in gaining access to medical, social, educational or other services, regardless of payment source of services, that may benefit the member in maintaining health and safety. Case managers initiate and oversee necessary assessments and reassessments to establish or reestablish Waiver program eligibility. Case managers develop the member's comprehensive plan of care, listing only services which are necessary to prevent institutionalization of the member, as determined through

assessments. Case managers initiate the addition of necessary services or deletion of unnecessary services, as dictated by the member's condition and available support. Case managers monitor the member's condition to ensure delivery and appropriateness of services and initiate plan of care reviews. If a member requires hospital or skilled nursing facility services, the case manager assists the member in accessing institutional care and, as appropriate, periodically monitors the member's progress during the institutional stay and helps the member transition from institution to home by updating the service plan and preparing services to start on the date the member is discharged from the institution. Case Managers must meet Medically Fragile Waiver Program minimum requirements for qualification and training prior to providing services to members. Prior to providing services to members choosing to Self-Direct their services, Case Managers are required to receive training and demonstrate knowledge regarding the Self-Directed Service delivery model.

(B) Providers may only claim time for billable Case Management activities described as follows:

(i) A billable case management activity is any task or function defined under OAC 317:50-1-15(1)(A)that only a Medically Fragile case manager because of skill, training or authority, can perform on behalf of a member;

(ii) Ancillary activities such as clerical tasks like mailing, copying, filing, faxing, drive time or supervisory/administrative activities are not billable case management activities, although the administrative cost of these activities and other normal and customary business overhead costs have been included in the reimbursement rate for billable activities.

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

(i) Standard Rate: Case Management services are billed using a Standard rate for reimbursement for billable service activities provided to a member who resides in a county with population density greater than 25 persons per square mile.

(ii) Very Rural/Difficult Service Area Rate: Case Management services are billed using a Very Rural/Difficult Service Area rate for billable service activities provided to a member who resides in a county with population density equal to or less than 25 persons per square mile. An exception would be services to members that reside in OHCA identified zip codes in Osage County adjacent to metropolitan areas of Tulsa and Washington Counties. Services to these members are prior authorized and billed using the Standard rate.

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

(2) **Respite.**

(A) Respite services are provided to members who are unable to care for themselves. They are provided on a short-term basis because of the absence or need for relief of the primary caregiver. Payment for respite care does not include room and board costs unless more than seven hours are provided in a nursing facility. Respite care will only be utilized when other sources of care and support have been exhausted.

Respite care will only be listed on the plan of care when it is necessary to prevent institutionalization of the member. Units of services are limited to the number of units approved on the plan of care.

(B) In-Home Respite services are billed per 15-minute unit service. Within any one-day period, a minimum of eight units must be provided with a maximum of 28 units provided. The service is provided in the member's home.

(C) Facility-Based Extended Respite is filed for a per diem rate, if provided in Nursing Facility. Extended Respite must be at least eight hours in duration.

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

(3) **Environmental Modifications.**

(A) Environmental Modifications are physical adaptations to the home, required by the member's plan of care, which are necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence in the home and without which, the member would require institutionalization. Adaptations or improvements to the home which are not of direct medical or remedial benefit to the Waiver member are excluded.

(B) All services require prior authorization.

(4) **Specialized Medical Equipment and Supplies.**

(A) Specialized Medical Equipment and Supplies are devices, controls, or appliances specified in the plan of care, which enable members to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live. Also included are items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid state plan. This service excludes any equipment and/or supply items which are not of direct medical or remedial benefit to the Waiver member. This service is necessary to prevent institutionalization.

(B) Specialized Medical Equipment and Supplies are billed using the appropriate HCPC procedure code. Reoccurring supplies which are shipped to the member are compensable only when the member remains eligible for Waiver services, continues to reside in the home and is not institutionalized in a hospital, skilled nursing facility or nursing home. It is the provider's responsibility to verify the member's status prior to shipping these items. Payment for medical supplies is limited to the Medicare rate, or the SoonerCare rate, or actual acquisition cost plus 30 percent.

(5) **Advanced Supportive/Restorative Assistance.**

(A) Advanced Supportive/Restorative Assistance services are maintenance services to assist a member who has a chronic, yet stable, condition. These services assist with activities of daily living which require devices and procedures related to altered body functions. This service is for maintenance only and is not utilized as a treatment service.

(B) Advanced Supportive/Restorative Assistance service is billed per 15-minute unit of service. The number of units of this service a member may receive is limited to the number of units approved on the plan of care.

(6) **Nursing.**

(A) Nursing services are services listed in the plan of care which are within the scope of the Oklahoma Nursing Practice Act and are provided by a registered professional nurse, or licensed practical or vocational nurse under the supervision of a registered nurse, licensed to practice in the State. Nursing services includes skilled nursing and/or private duty nursing. Skilled nursing is provided on an intermittent or part-time basis. Private duty nursing is individual and continuous care provided to a participant at home by licensed nurses. The provision of the nursing service will work to prevent or postpone the institutionalization of the member.

(B) Nursing services are services of a maintenance or preventive nature provided to members with stable, chronic conditions. These services are not intended to treat an acute health condition and may not include services which would be reimbursable under either Medicaid or Medicare's Home Health Program. This service primarily provides nurse supervision to the Personal Care Assistant or to the Advanced Supportive/Restorative Assistance Aide and assesses the member's health and prescribed medical services to ensure that they meet the member's needs as specified in the plan of care. A skilled nursing assessment/evaluation on-site visit is made to each member for whom Advanced Supportive/Restorative Assistance services are authorized to evaluate the condition of the member and medical appropriateness of services. An assessment/evaluation visit report will be made to the Medically Fragile Waiver case manager in accordance with review schedule determined in consultation between the Case Manager and the Skilled Nurse, to report the member's condition or other significant information concerning each advanced supportive/restorative care member.

(i) The case manager may recommend authorization of Skilled Nursing services as part of the interdisciplinary team planning for the member's service plan and/or assessment/evaluation of:

(I) the member's general health, functional ability and needs and/or

(II) the adequacy of personal care and/or advanced supportive/restorative assistance services to meet the member's needs including providing on-the-job training and competency testing for personal care or advanced supportive/restorative care aides in accordance with rules and regulations for delegation of nursing tasks as established by the Oklahoma Board of Nursing.

(ii) In addition to assessment/evaluation, the case manager may recommend authorization of Skilled Nursing services for the following:

(I) preparing a one-week supply of insulin syringes for a blind diabetic, who can safely self-inject the medication but cannot fill his/her own syringe. This service would include monitoring the member's continued ability to self-administer the insulin;

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

(III) monitoring a member's skin condition when a member is at risk for skin breakdown due to immobility or incontinence, or

the member has a chronic stage II decubitus ulcer requiring maintenance care and monitoring;

(IV) providing nail care for the diabetic member or member with circulatory or neurological compromise;

(V) providing consultation and education to the member, member's family and/or other informal caregivers identified in the service plan, regarding the nature of the member's chronic condition. Provide skills training (including return skills demonstration to establish competency) to the member, family and/or other informal caregivers as specified in the service plan for preventive and rehabilitative care procedures.

(C) Nursing service can be billed for service plan development and/or assessment/evaluation services or, for other services within the scope of the Oklahoma Nursing Practice Act including private duty nursing. Nursing services are billed per 15-minute unit of service. A specific procedure code is used to bill for assessment/evaluation/service plan development skilled nursing services and other procedure codes are used to bill for all other authorized nursing services. A maximum of eight units per day of skilled nursing for assessment/evaluation and/or service plan development are allowed. An agreement by a provider to perform a nurse evaluation is also an agreement, to provide the nurse assessment identified in the Medicaid in-home care services for which the provider is certified and contracted. Reimbursement for a nurse evaluation is denied if the provider that produced the nurse evaluation fails to provide the nurse assessment identified in the Medicaid in-home care services for which the provider is certified and contracted.

(7) **Home Delivered Meals.**

(A) Home Delivered Meals provide one meal per day. A home delivered meal is a meal prepared in advance and brought to the member's home. Each meal must have a nutritional content equal to at least one third of the Recommended Daily Allowance as established by the Food and Nutrition Board of the National Academy of Sciences. Meals are only provided to members who are unable to prepare meals and lack an informal provider to do meal preparation.

(B) Home Delivered Meals are billed per meal, with one meal equaling one unit of service. The limit of the number of units a member is allowed to receive is limited on the member's plan of care. The provider must obtain a signature from the member or the member's representative at the time the meals are delivered. In the event that the member is temporarily unavailable (i.e., doctor's appointment, etc.) and the meal is left, the provider must document the reason a signature is not obtained. The signature logs must be available for review.

(8) **Occupational Therapy services.**

(A) Occupational Therapy services are those services that increase functional independence by enhancing the development of adaptive skills and performance capacities of members with physical disabilities and related psychological and cognitive impairments. Services are provided in the member's home and are intended to help the member achieve greater independence to reside and participate in the community. Treatment involves the therapeutic use of self-care, work and play activities and may include modification of the tasks or environment to enable the member to achieve maximum independence, prevent further disability, and maintain health. Under a physician's order, a licensed occupational therapist evaluates the member's

rehabilitation potential and develops an appropriate written therapeutic regimen. The regimen utilizes paraprofessional occupational therapy assistant services, within the limits of their practice, working under the supervision of the licensed occupational therapist. The regimen includes education and training for informal caregivers to assist with and/or maintain services, where appropriate. The therapist will ensure monitoring and documentation of the member's rehabilitative progress and will report to the member's case manager and physician to coordinate necessary addition and/or deletion of services, based on the member's condition and ongoing rehabilitation potential.

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

(9) **Physical Therapy services.**

(A) Physical Therapy services are those services that prevent physical disability through the evaluation and rehabilitation of members disabled by pain, disease or injury. Services are provided in the member's home and are intended to help the member achieve greater independence to reside and participate in the community. Treatment involves use of physical therapeutic means such as massage, manipulation, therapeutic exercise, cold or heat therapy, hydrotherapy, electrical stimulation and light therapy. Under a physician's order, a licensed physical therapist evaluates the member's rehabilitation potential and develops an appropriate, written therapeutic regimen. The regimen utilizes paraprofessional physical therapy assistant services, within the limits of their practice, working under the supervision of the licensed physical therapist. The regimen includes education and training for informal caregivers to assist with and/or maintain services, where appropriate. The therapist will ensure monitoring and documentation of the member's rehabilitative progress and will report to the member's case manager and physician to coordinate necessary addition and/or deletion of services, based on the member's condition and ongoing rehabilitation potential.

(B) Physical Therapy services are billed per 15-minute units of service. Payment is not allowed solely for written reports or record documentation.

(10) **Speech and Language Therapy services.**

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

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

(B) Speech/Language Therapy services are billed per 15-minute unit of service. Payment is not allowed solely for written reports or record documentation.

(11) **Respiratory Therapy Services.**

(A) Respiratory therapy services are provided for a member who, but for the availability of in-home respiratory services, would require respiratory care as an inpatient in a hospital or nursing facility. Services are provided in the member's home under the care of a physician who is familiar with the technical and medical components of home ventilator support and the physician must determine medically that in-home respiratory care is safe and feasible for the member. Treatment involved s use of therapeutic means such as: evaluation, respiratory treatments, chest physiotherapy, and/or development and oversight of a therapeutic maintenance program. Under a physician's order, a registered respiratory therapist evaluates the member and develops an appropriate, written therapeutic regimen. The regimen includes education and training for informal caregivers to assist with and/or maintain services, where appropriate. The therapist will ensure monitoring and documentation of the member's progress and will report to the member's case manager and physician to coordinate necessary addition and/or deletion of services, based on the member's condition and ongoing rehabilitation potential.

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

(12) **Hospice Services.**

(A) Hospice is palliative and/or comfort care provided to the member and his/her family when a physician certifies that the member has a terminal illness and has six months or less to live and orders Hospice Care. A hospice program offers palliative and supportive care to meet the special needs arising out of the physical, emotional and spiritual stresses which are experienced during the final stages of illness and during dying and bereavement. The member signs a statement choosing hospice care instead of routine medical care that has the objective to treat and cure the member's illness. Once the member has elected hospice care, the hospice medical team assumes responsibility for the member's medical care for the terminal illness in the home environment. Hospice care services include nursing care, physician services, medical equipment and supplies, drugs for symptom control and pain relief, home health aide and personal care services, physical, occupational and/or speech therapy, medical social services, dietary counseling and grief and bereavement counseling to the member and/or family. A Hospice plan of care must be developed by the hospice team in conjunction with the member's case manager before hospice services are provided. The hospice services must be related to the palliation or management of the member's terminal illness, symptom control, or to enable the individual to maintain activities of daily living and basic functional skills. Hospice may be provided to the member in a Nursing Facility (NF) only when the member is placed in the NF for Medically Fragile Facility Based Extended Respite. Hospice provided as part of Facility Based Extended A member that is eligible for Medicare Hospice provided as a Medicare Part A benefit, is not eligible to receive Medically Fragile Hospice services.

(B) Hospice services are billed per diem of service for days covered by a Hospice plan of care and during which the Hospice provider is responsible for providing Hospice services as needed by the member or member's family.

(13) **Medically Fragile Waiver Personal Care.**

(A) Medically Fragile Personal Care is assistance to a member in carrying out activities of daily living such as bathing, grooming and toileting, or in carrying out instrumental activities of daily living, such as preparing meals and doing laundry, to assure personal health and safety of the individual or to prevent or minimize physical health regression or deterioration. Personal Care services do not include service provision of a technical nature, i.e. tracheal suctioning, bladder catheterization, colostomy irrigation, and operation/maintenance of equipment of a technical nature.

(B) Medically Fragile Home Care Agency Skilled Nursing staff working in coordination with a Case Manager are responsible for development and monitoring of the member's Personal Care plan.

(C) Medically Fragile Personal Care services are prior authorized and billed per 15-minute unit of service with units of service limited to the number of units on the approved plan of care.

(14) **Personal Emergency Response System.**

(A) Personal Emergency Response System (PERS) is an electronic device which enables certain individuals at high risk of institutionalization to secure help in an emergency. The individual may also wear a portable "help" button to allow for mobility. The system is connected to the person's phone and programmed to signal, in accordance with member preference, a friend, a relative or a response center once a "help" button is activated. The response center is staffed by trained professionals. For an Medically Fragile Program member to be eligible to receive PERS service, the member must meet all of the following service criteria:

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

(ii) lives alone and has no regular caregiver, paid or unpaid, and therefore is left alone for long periods of time;

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

(iv) has a health and safety plan detailing the interventions beyond the PERS to assure the member's health and safety in his/her home;

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

(vi) the service avoids premature or unnecessary institutionalization of the member.

(B) PERS services are billed using the appropriate HCPC procedure code for installation, monthly service or purchase of PERS. All services are prior authorized in accordance with the Medically Fragile approved plan of care.

(15) **Prescription drugs.** Members are eligible for a maximum of six prescriptions per month with a limit of three brand name prescriptions. Seven additional generic prescriptions per month are allowed if medically necessary. Medically necessary prescriptions beyond the three brand name or thirteen total prescriptions will be covered with prior authorization. More information on prescription drugs is provided at 317:30-5-72.

(16) **Self-Direction.**

(A) Self-Direction is a method of service delivery that allows waiver members to determine supports and services they need to live successfully in a home or community based setting. A member choosing Self-Direction is the employer of record for his/her Personal Care and Advanced Supportive/Restorative Care service providers and must have an approved plan of care prior to initiation of any Self-Directed activities.

(B) The OHCA uses the following criteria to determine a member's service eligibility to participate in the Self-Directed Services program:

(i) residence in the Self-Directed services approved area;

(ii) member's health and safety with Self-Directed services can reasonably be assured based on a review of service history records and a review of member capacity and readiness to assume employer responsibilities under Self-Direction with any one of the following findings as basis to deny a request for Self-Direction due to inability to assure member health and safety;

(I) the member does not have the ability to make decisions about his/her care or service planning and the member's "authorized representative" is not willing to assume Self-Directed services responsibilities, or

(II) the member is not willing to assume responsibility, or to enlist an "authorized representative" to assume responsibility, in one or more areas of Self-Direction such as in service planning, or in assuming the role of employer of the Personal Services Assistant (PSA) or Advanced Personal Services Assistant (APSA) service provider, or in monitoring and managing health or in preparation for emergency backup, or

(III) the member has a recent history of self-neglect or self-abuse as evidenced by Adult Protective Services intervention within the past 12 months and does not have an "authorized representative" with capacity to assist with Self-Direction responsibilities;

(C) The member voluntarily makes an informed choice to Self-Direct services. As part of the informed choice, decision making process for Self-Direction, the OHCA staff or the Case Manager provides consultation and assistance as the member completes a self-assessment of preparedness to assume the role of employer for their Personal Services Assistant. The orientation and enrollment process will provide the member with a basic understanding of what will be expected of them under Self-Direction, the supports available to assist them to successfully perform employer responsibilities and an overview of the potential risks involved.

(D) The OHCA uses the following criteria to determine that based upon documentation, a person is no longer allowed to participate in the Self-Directed Services option:

(i) the member does not have the ability to make decisions about his/her care or service planning and the member's "authorized representative" is not willing to assume Self-Direction responsibilities; or

(ii) the member is not willing to assume responsibility, or to enlist an "authorized representative" to assume responsibility, in one or more areas of Self-Direction such as in service planning, or in assuming the role of employer of the PSA or APSA service

providers, or in monitoring and managing health or in preparation for emergency backup; or

(iii) the member has a recent history of self-neglect or self-abuse as evidenced by Adult Protective Services intervention and does not have an "authorized representative" with capacity to assist with Self-Direction responsibilities; or

(iv) the member abuses or exploits their employee; or

(v) the member falsifies time-sheets or other work records; or

(vi) the member, even with Case Manager and Financial Management Services assistance, is unable to operate successfully within their Individual Budget Allocation; or

(vii) inferior quality of services provided by member/employer's employee, or the inability of the member/employer's employee to provide the number of service units the member requires, jeopardizes the member's health and/or safety.

(E) The member may designate a family member or friend as an "authorized representative" to assist in the service planning process and in executing member employer responsibilities. If the member chooses to designate an "authorized representative", the designation and agreement identifying the "willing adult" to assume this role and responsibility is documented with dated signatures of the member, the designee and the member's Case Manager or the OHCA staff.

(i) A person having guardianship or power of attorney or other court sanctioned authorization to make decisions on behalf of the member has legal standing to be the member's designated "authorized representative".

(ii) An individual hired to provide Personal Services Assistance to a member may not be designated the "authorized representative" for the member.

(F) Self-Directed Services are delivered as authorized on the service plan and are limited to Personal Care, and Advanced Supportive/Restorative Care. The member employs the Personal Services Assistant (PSA) and/or the Advanced Personal Services Assistant (APSA) and is responsible, with assistance from the Administrative Financial Management Services (FMS), for ensuring that the employment complies with State and Federal Labor Law requirements. The member:

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

(ii) provides instruction and training to the PSA or APSA on tasks to be done and works with the Case Manager to obtain skilled nursing services assistance with training when necessary. Prior to performing an Advanced Personal Services Assistance 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 where and how the PSA or APSA works, hours of work, what is to be accomplished and, within Individual Budget Allocation limits, wages to be paid for the work;

(iv) supervises and documents employee work time; and,

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

(G) Financial Management Services are program administrative services provided to participating Self-Directed Service employer/members by agencies contracted with the OHCA. Financial Management Services are employer related assistance that provides Internal Revenue Service (IRS) fiscal reporting agent and other financial management tasks and functions including, but not limited to:

(i) employer payroll, at a minimum of semi monthly, and associated withholding for taxes, or for other payroll withholdings performed on behalf of the member as employer of the PSA or APSA;

(ii) other employer related payment disbursements as agreed to with the member and in accordance with the member's Individual Budget Allocation;

(iii) responsibility for obtaining criminal and abuse registry background checks, on behalf of the member, on prospective hires for PSAs or APSAs;

(iv) providing to the member, as needed, assistance with employer related cognitive tasks, decision-making and specialized skills that may include assistance with Individual Budget Allocation planning and support for making decisions including training and providing reference material and consultation regarding employee management tasks such as recruiting, hiring, training and supervising the member's Personal Services Assistant or Advanced Personal Services Assistant; and

(H) The service of Personal Services Assistance is billed per 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 Service Plan.

(I) The service of Advanced Personal Services Assistance is billed per 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 Service Plan.

(J) Self-Directed Services rates are determined using the Individual Budget Allocation (IBA) Expenditure Accounts Determination process for each member. The IBA Expenditure Accounts Determination process includes consideration and decisions about the following:

(i) The Individual Budget Allocation (IBA) Expenditure Accounts Determination constrains total SoonerCare reimbursement for Self-Directed services to be less than expenditures for equivalent services using agency providers.

(ii) The PSA and APSA service unit rates are calculated by the OHCA during the Self-Directed service eligibility determination process. The OHCA sets the PSA and APSA unit rates at a level that is not less than 80 percent and not more than 95 percent of the comparable Agency Personal Care (for PSA) or Advanced Supportive/Restorative (for APSA) service rate. The allocation of portions of the PSA and/or APSA rate to cover salary, mandatory taxes, and optional benefits (including Worker's Compensation insurance, if available) is determined individually for each member using the Self-Directed Services Individualized Budget Allocation Expenditure Accounts Determination Process.

(iii) The IBA Expenditure Accounts Determination process defines the level of program financial resources required to meet the member's need for Self-Directed services. If the member's need for services changes due to a change in health/disability status and/or a change in the level of support available from other sources, the Case Manager, based upon an updated assessment, amends the service plan to increase Self-Directed service units appropriate to meet additional member need. The OHCA, upon favorable review, authorizes the amended plan and updates the member's IBA. Service amendments based on changes in member need for services do not change an existing PSA or APSA rate. The member, with assistance from the FMS, reviews and revises the IBA Expenditure Accounts calculation annually or more often to the extent appropriate and necessary.

317:50-1-15. Reimbursement

(a) Rate methodologies for Waiver services are set in accordance with the rate setting process by the State Plan Amendment Rate Committee (SPARC) and approved by the Oklahoma Health Care Authority Board.

(1) The rate for SNF Respite is set equivalent to the rate for skilled nursing facility services that require providers having equivalent qualifications;

(2) The rate for units of Home-Delivered Meals are set equivalent to the rate established by the Oklahoma Department of Human Services for the equivalent services provided for the Home-Delivered Meals Program that require providers having equivalent qualifications;

(3) The rates for units of Personal Care and In-Home Respite are set equivalent to State Plan Agency Personal Care unit rate which require providers having equivalent qualifications;

(4) The rates for Advanced Supportive/Restorative Assistance is set equivalent to 1.077 of the State Plan Agency Personal Care unit rate;

(5) Self-Directed rates are determined using the Individual Budget Allocation (IBA) Expenditure Accounts Determination process for each member.

317:50-1-16. Billing procedures for Medically Fragile Waiver services

(a) Billing procedures for long-term care medical services are contained in the OKMMIS Billing and Procedure Manual. Questions regarding billing procedures which cannot be resolved through a study of the manual should be referred to the OHCA.

(b) The approved Medically Fragile Waiver service plan is the basis for the MMIS service prior authorization, specifying:

(1) service;

(2) service provider;

(3) units authorized; and

(4) begin and end dates of service authorization.

(c) As part of Medically Fragile Waiver quality assurance, provider audits are used to evaluate whether paid claims are consistent with service plan authorizations and documentation of service provision. Evidence of paid claims that are not supported by service plan authorization and/or documentation of service provision will be turned over to the OHCA Provider Audit Unit for follow-up investigation.

(d) Service time of Personal Care, Case Management, Nursing, Advanced Supportive/ Restorative Assistance, In-Home Respite and Self Direction may be documented through the Interactive Voice Response Authentication (IVRA) system when provided in the home. Providers are required to use the IVRA system after access to the system is made available by OKDHS. The IVRA system provides alternate backup solutions should the automated system be unavailable. In the event of IVRA backup system failure, the provider will document time in accordance with their agency backup plan. The agency's backup procedures are only permitted when the IVRA system is unavailable.

6.b-2 CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
Subchapter 5. Individual Providers and Specialties
Part 79. Dentists
317:30-5-700. through 700.1 [AMENDED]
(Reference APA WF # 10-17)

FINDING OF EMERGENCY: The Agency finds that a compelling public interest exists which necessitates promulgation of emergency rules and requests emergency approval of rule revisions to clarify SoonerCare dental rules regarding eligibility requirements for orthodontic services, list documentation required in order to receive prior authorization, create limits on the types of orthodontic therapy allowed, and list progress reporting requirements. In a time of shrinking state revenues, the revisions will reduce the number of non-critical orthodontic procedures resulting in an overall reduction in SoonerCare dental expenditures.

ANALYSIS: Dental rules are revised to include that members must obtain a referral from a primary care dentist before services will be authorized, add specific member requirements that must be met before eligibility for orthodontic services are considered, documentation required in order to receive prior authorization, limits on the types of orthodontic therapy allowed, and the addition of progress reporting requirements.

BUDGET IMPACT: Agency staff has determined that the revisions are budget neutral.

MEDICAL ADVISORY COMMITTEE: The Medical Advisory Committee considered the proposed rule revisions on May 20, 2010, and recommended Board approval.

PROPOSED EFFECTIVE DATE: Immediately upon Governor's approval

AUTHORITY: The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 and Section 5051.3 of Title 63 of Oklahoma Statutes, 42 CFR 440.100

RESOLUTION:
Resolved, that the Oklahoma Health Care Authority Board does hereby approve the Administrative Rules, subject to the Administrative Procedure Act, as indicated:
Revise Agency Dental rules to require members to obtain a referral from a primary care dentist before orthodontic services will be authorized, specify member requirements that must be met before eligibility for orthodontic services are considered, list documentation required in order to receive prior authorization, create limits on the types of orthodontic therapy allowed, and add progress reporting requirements.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 79. DENTISTS

317:30-5-700. Orthodontic services
(a) In order to be eligible for SoonerCare Orthodontic services, members must be referred through a primary care dentist; a member can receive a referral

from a primary care dentist to the orthodontist only after meeting the following:

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

(2) the member has been fully restored and has received post operative treatment;

(3) the member has received a six month hygiene evaluation indicating no additional treatments are required;

(4) the member remains caries free for one year; and

(5) the member is in good gingival health.

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

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

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

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

(4) fixed appliances only; and

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

~~(b)~~ (c) Reimbursement for Orthodontic services is limited to:

(1) Orthodontists, or

(2) General or Pediatric dental practitioners who have completed at least 200 certified hours of continuing education in the field of orthodontics practice in an under served area, and successfully completed at least 25 comprehensive cases to include 10 or more extraction cases.

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

(B) Verification of the continuing education hours and the number of cases completed are reviewed by the OHCA Dental Unit every two years.

~~(c)~~ (d) The following limitations apply to orthodontic services:

(1) Cosmetic orthodontic services are not a covered benefit of the ~~Oklahoma State Medicaid~~ SoonerCare Program and no requests should be submitted;

(2) All orthodontic procedures require prior authorization for payment;

(3) Prior authorization for orthodontic treatment is not a notification of the ~~patient's~~ member's eligibility and does not guarantee payment. Payment for authorized services depends on the ~~client's~~ member's eligibility at the beginning of each treatment year;

(4) The ~~client~~ member must be ~~Medicaid-eligible~~ SoonerCare-eligible and under 18 years of age at the time the request for prior authorization for treatment is received by the OHCA ~~and on the date that the last year of orthodontic service is to begin~~. Services cannot be added or approved after eligibility has expired:

(A) ~~Clients~~ Members receive a permanent Medical Identification Card;

(B) It is the orthodontist's responsibility to verify that the ~~patient~~ member has current ~~Medicaid~~ SoonerCare eligibility and the date of birth indicates the ~~client~~ member is under age 18.

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

~~(e)~~ (f) The interview information is unavailable to OHCA except through the provider's recommendation of treatment. The interview process for OHCA ~~clients~~ members is equivalent to that of private pay patients.
~~(f)~~ (g) Providers are not obligated to accept a ~~client~~ member when it appears that the ~~client~~ member will not cooperate in the orthodontic hygiene treatment program, does not return to the general dentist for preventative visits or is not willing to keep eligibility for ~~Medicaid~~ SoonerCare current.

317:30-5-700.1. Orthodontic prior authorization
(a) The following records and documentation, plainly labeled with the ~~patient's~~ member's full name, recipient identification number (RID), and the orthodontist's name are required for prior authorization of orthodontic services ~~for a child~~ and must be submitted to the Dental ~~Authorization~~ Unit of the OHCA ~~for review~~ when the member has a total score of not less than 30 points or meets other eligibility critera in paragraph (d).

(1) Completed currently approved ADA dental claim form;

(2) Completed and scored Handicapping Labio-Lingual Deviations Index with Diagnosis of Angle's classification;

(3) Detailed description of any oromaxillofacial anomaly;

(4) Estimated length of treatment;

(5) ~~Delineation of each stage, the service to be provided and length of treatment required for each stage if multi-stage treatment is indicated~~ Intraoral photographs showing teeth in centric occlusion and/or photographs of trimmed anatomically occluded diagnostic casts. A lingual view of casts may be included to verify impinging overbites;

~~(6) Properly occluded and anatomically trimmed study models or 3-D model images;~~

~~(7)~~ (6) Cephalometric x-rays with tracing, and panoramic film, ~~and facial photographs~~ with a request for prior authorization of comprehensive orthodontic treatment;

~~(8)~~ (7) If diagnosed as a surgical case, submit ~~An~~ an oral surgeon's written opinion that orthognathic surgery ~~or bone grafting~~ is indicated and the surgeon is willing to provide this service; ~~and~~

~~(9)~~ (8) Additional pertinent information as determined necessary by the orthodontist or as requested by the ~~OHCA's Orthodontic Consultant~~ OHCA.

(b) ~~Models~~ All images, x-rays, and ~~all~~ required documentation must be submitted in one package. OHCA is not responsible for lost or damaged materials.
(c) All records and documentation submitted in a request for prior authorization for orthodontic treatment are reviewed by the OHCA Orthodontic Consultant for compensability and length of treatment. Any documentation on which a decision is made will not be returned.
(d) Some children not receiving a minimum score of 30 on the Handicapping Labio-Lingual Deviation Index (HLD) may have other conditions to be considered. In the event an orthodontist believes there are other medical, social, or emotional conditions impacting the general health of the child, he/she refers to the conditions listed on the EPSDT exception section found on the HLD. The following guidelines and restrictions apply to other conditions:

(1) Other medical, social, or emotional conditions are limited to those conditions that affect the medical, social or emotional function of the child.

(2) Other medical, social, or emotional conditions are not scored if the sole condition sought to be improved is the cosmetic appearance of the child.

(3) Such other medical, social, or emotional conditions must be demonstrated by objective evidence such as supported documentation outside the child's immediate family (i.e., a child's teacher, primary care physician, ~~mental~~ behavioral health provider, school counselor).

(4) Objective evidence must be submitted with the HLD.

(5) When such other medical, social, or emotional conditions are reflected on the HLD, the OHCA Orthodontic Consultant must review the data and use his or her professional judgment to score the value of the conditions.

(6) The OHCA Orthodontic Consultant may consult with and utilize the opinion of the orthodontist who completes the form.

(e) If it is determined that the malocclusion is not severe enough to warrant medically necessary orthodontic services or the ~~patient's~~ member's age precludes approval, a computer generated notice is issued to the provider and ~~recipient~~ member with notice of the denial, the reason for the denial, and appeal rights (see OAC 317:2-1 for grievance procedures and process).

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

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

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

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

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

(2) Claim and payment are made as follows:

(A) Payment for the first year of treatment includes the banding, wires, and adjustments as well as all ancillary services, including the removal of appliances, and the construction and placing of retainers. ~~The authorization number must be included on all claims submitted for processing.~~

~~(B) The provider files one claim at the beginning of each treatment year for the entire year.~~

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

(g) Relative Value Units (RVU's) have been developed by OHCA for the first year's treatment and each subsequent year's treatment. The allowable charge is computed by multiplying the RVU by the current conversion factor.

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

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

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

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

(1) Study models must be properly poured and adequately trimmed without large voids or positive bubbles present.
(2) Centric occlusion must be clearly indicated by pencil lines on the study models, making it possible to occlude the teeth on the models in centric occlusion.
(3) 3-D model images are ~~encouraged~~ preferred.
(4) Study models not in compliance with the above described diagnostic guidelines are not accepted. The provider ~~is asked to~~ may send new ~~models~~ images that meet these requirements. If the provider does not respond, the request for treatment is denied.
(5) All measurements are made or judged on the basis of greater than or more than the minimal criteria. Measurement, counting, recording, or consideration is performed only on teeth that have erupted and may be seen on the study models.

6.b-3 CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
Subchapter 5. Individual Providers and Specialties
Part 65. Case Management Services for Over 21
317:30-5-586.1. [REVOKED]
317:30-5-589. [REVOKED]
Part 67. Behavioral Health Case Management Services
317:30-5-595. [AMENDED]
317:30-5-596. [AMENDED]
(Reference APA WF # 10-19)

FINDING OF EMERGENCY: The Agency finds that a compelling public interest exists which necessitates promulgation of emergency rules and requests emergency approval of rule revisions to amend policy by removing language that allows case managers travel time to and from meetings for the purpose of development or implementation of the individual plan of care as a reimbursable service. The revision is needed to ensure that policy aligns with the agency's State Plan methodology.

ANALYSIS: Targeted Case Management rules are revised to provide clarity to SoonerCare providers. Currently policy conflicts with the agency's State Plan Amendment methodology which includes behavioral health case manager's travel time as a component of the case management rate. Additionally, rules are revised to revoke sections that were previously combined with other areas of policy and are no longer needed.

BUDGET IMPACT: Agency staff has determined that the revisions are budget neutral.

MEDICAL ADVISORY COMMITTEE: The Medical Advisory Committee considered the proposed rule revisions on May 20, 2010, and recommended Board approval.

PROPOSED EFFECTIVE DATE: Immediately upon Governor's approval.

AUTHORITY: The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes

RESOLUTION:
Resolved, that the Oklahoma Health Care Authority Board does hereby approve the Administrative Rules, subject to the Administrative Procedure Act, as indicated:
Revise Agency rules to provide guidance to SoonerCare targeted case management providers by clarifying that provider travel time is a component of the case management rate and is not separately reimbursable and to revoke sections of rules that were previously combined with other areas of policy and are no longer needed.

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 65. CASE MANAGEMENT SERVICES FOR OVER 21

317:30-5-586.1. Prior authorization [REVOKED]
~~(a) Prior authorization of behavioral health services and requirements to be authorized to provide case management services are mandatory. The provider~~

~~must request prior authorization from the OHCA or its designated agent. In order for the services to be prior authorized, member information requested must be submitted. Member information includes but is not limited to the following:~~

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

~~(2) Treatment history; and~~

~~(3) Current psychiatric social information; and~~

~~(4) Psychiatric history; and~~

~~(5) Fully developed case management service plan, with goals, objectives, and time frames for services.~~

~~(b) SoonerCare members will be considered for prior authorization after receipt of complete and appropriate information submitted by the provider. Based on diagnosis, functional assessment, history and other SoonerCare services being received, the SoonerCare member may be approved to receive case management services. SoonerCare members who reside in nursing facilities, residential behavior management services, group or foster homes, or ICF/MR's may not receive SoonerCare compensable case management services. A SoonerCare member may be approved for a time frame of one to six months. The OHCA or its designated agent will review the request in accordance with the guidelines for prior authorization in the Outpatient Behavioral Health Provider Manual. Requests will be reviewed by licensed behavioral health professionals under OAC 317:30-5-240.~~

~~(c) A prior authorization decision may be appealed by the member if filed within 20 days of receipt of the decision. Until July 1, 2006, a provider may request a reconsideration from OHCA's designated agent within five working days of receipt of the decision. The designated agent's decision regarding a reconsideration requests is final.~~

~~(d) Providers seeking prior authorization will follow OHCA's designated agent's Outpatient Behavioral Health Prior Authorization Manual guidelines for submitting requests on behalf of the SoonerCare member.~~

317:30-5-589. Documentation of records [REVOKED]

~~All behavioral health case management services rendered must be reflected by documentation in the records. In addition to a complete behavioral health case management service plan documentation of each session must include, but is not limited to:~~

~~(1) date;~~

~~(2) person(s) to whom services are rendered;~~

~~(3) start and stop times for each service;~~

~~(4) original signature of the service provider (original signatures for faxed items must be added to the clinical file within 30 days);~~

~~(5) credentials of the service provider;~~

~~(6) specific service plan needs, goals and/or objectives addressed;~~

~~(7) specific activities performed by the behavioral health case manager on behalf of the child related to advocacy, linkage, referral, or monitoring used to address needs, goals and/or objectives;~~

~~(8) progress or barriers made towards goals and/or objectives;~~

~~(9) member (family when applicable) response to the service;~~

~~(10) any new service plan needs, goals, and/or objectives identified during the service; and~~

~~(11) member satisfaction with staff intervention.~~

PART 67. BEHAVIORAL HEALTH CASE MANAGEMENT SERVICES

317:30-5-595. Eligible providers

Services are provided by outpatient behavioral health agencies established for the purpose of providing behavioral health outpatient and case management services.

(1) **Provider agency requirements.** Services are provided by outpatient behavioral health agencies contracted with OHCA that meet the requirements under OAC 317:30-5-240. The agency must demonstrate its capacity to deliver behavioral health case management services in terms of the following items:

(A) Agencies must hold current accreditation appropriate to outpatient behavioral health from JCAHO, CARF, COA, or AOA, and maintain the standards of the accreditation at all times.

(B) OHCA reserves the right to obtain a copy of any accreditation audit and/or site visit reports from the provider and/or the accreditation agency.

(C) Agencies that are eligible to contract with OHCA to provide behavioral health case management services to eligible individuals must be community based.

(D) The agency must be able to demonstrate the ability to develop and maintain appropriate patient records including but not limited to assessments, service plans, and progress notes.

(E) An agency must agree to follow the Oklahoma Department of Mental Health and Substance Abuse Services established behavioral health case management rules found in OAC 450:50.

(F) An agency's behavioral health case management staff must serve the target group on a 24 hour on call basis.

(G) Each site operated by a behavioral health outpatient and case management facility must have a separate provider number, per OAC 317:30-5-240.2.

(2) **Provider Qualifications.**

(A) **Service provider education and experience requirements if certified before July 1, 2001.** For case management services to be compensable by SoonerCare, the case manager performing the service must maintain current case management certification from the ODMHSAS and have the following education and experience requirements apply:

(i) Associate degree in a related human service field, OR;

(ii) Two years of college education plus two years or more human service experience, OR;

(iii) Bachelors degree in a related human service field plus one year or more human service experience, OR;

(iv) Masters degree in a related human service field.

(B) **Service provider education and experience requirements if certified after July 1, 2001 and before July 1, 2007.** For behavioral health case management services to be compensable by SoonerCare, the case manager performing the service must have and maintain a current behavioral health case manager certification from the ODMHSAS and have a:

(i) Bachelors or masters degree in a mental health related field including, but not limited to psychology, social work, occupational therapy, family studies, sociology, criminal justice, school guidance and counseling; OR

(ii) A current license as a registered nurse in Oklahoma with experience in behavioral health care; OR

(iii) Certification as an alcohol and drug counselor allowed to provide substance abuse case management to those with alcohol and/or other drug dependencies or addictions as a primary or secondary DSM-IV Axis I diagnosis; and

(iv) Current case management certification from the ODMHSAS.

(C) **Service provider education and experience requirements if certified after July 1, 2007.** For behavioral health case management services to be compensable by SoonerCare, the case manager performing the service must have and maintain a current behavioral health case manager certification from the ODMHSAS and meet either (i), (ii), or (iii) below, and (iv):

(i) Certified Behavioral Health Case Manager III meets the Licensed Behavioral Health Professional status as defined at OAC 317:30-5-240, and passes the ODMHSAS web-based Case Management Competency Exam.

(ii) Certified Behavioral Health Case Manager II— a bachelors or masters degree in a behavioral health field, earned from a regionally accredited college or university recognized by the United States Department of Education, which includes psychology, social work/sociology, occupational therapy, family studies, human resources/services counseling, human developmental psychology, gerontology, early childhood development, chemical dependency studies, school guidance/counseling/education, rehabilitative services, education and/or criminal justice; a current license as a registered nurse in Oklahoma with experience in behavioral health care; or a current certification as an alcohol and drug counselor in Oklahoma, and pass the ODMHSAS web-based Case Management Competency Exam, and complete seven hours of ODMHSAS specified CM training.(After July 1, 2010: Any bachelors or masters degree earned from a regionally accredited college or university recognized by the USDE).

(iii) Certified Behavioral Health Case Manager I meets the requirements in either (I) or (II), and (III):

(I) completed 60 college credit hours; or

(II) has a high school diploma with 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

(III) passes the ODMHSAS web-based Case Management Competency Exam, and completes 14 hours of ODMHSAS specified CM training.

(D) **Wraparound Facilitator Case Manager** - meets the qualifications for CM II or CM III and has the following:

(i) Successful completion of the ODMHSAS training for wraparound facilitation within six months of employment; and

(ii) Participate in ongoing coaching provided by ODMHSAS and employing agency; and

(iii) Successfully complete wraparound credentialing process within nine months of beginning process; and

(iv) Direct supervision or immediate access and a minimum of one hour weekly clinical consultation with a Qualified Mental Health Professional, as required by ODMHSAS;

(E) **Intensive Case Manager** - meets the provider qualifications of a Case Manager II or III and has the following:

(i) A minimum of ~~2~~ two years Behavioral Health Case Management experience, crisis ~~intervention~~ diversion experience, and

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

(F) All certified case managers must fulfill the continuing education requirements as outlined under OAC 450:50-5-4.

317:30-5-596. Coverage by category

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

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

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

(i) Behavioral health case management services are provided to assist eligible individuals in gaining access to needed medical, social, educational and other services essential to meeting basic human needs. The behavioral health case manager provides assessment of case management needs, development of a case management care plan, referral, linkage, monitoring and advocacy on behalf of the member to gain access to appropriate community resources. The behavioral health case manager must monitor the progress in gaining access to services and continued appropriate utilization of necessary community resources. Behavioral case management is designed to promote recovery, maintain community tenure, and to assist individuals in accessing services for themselves following the case management guidelines established by ODMHSAS. In order to be compensable, the service must be performed utilizing the Strengths Based model of case management. This model of case management assists individuals in identifying and securing the range of resources, both environmental and personal, needed to live in a normally interdependent way in the community. The focus for the helping process is on strengths, interests, abilities, knowledge and capacities of each person, not on their diagnosis, weakness or deficits. The relationship between the service member and the behavioral health case manager is characterized by mutuality, collaboration, and partnership. Assistive activities are designed to occur primarily in the community, but may take place in the behavioral health case manager's office, if more appropriate. The community based behavioral health case management agency will coordinate with the member and family (if applicable) by phone or face-to-face, to identify immediate needs for return to home/community no more than 72 hours after notification that the member/family requests case management services. For member's discharging from ~~an~~ a higher level of care than outpatient, the higher level of care facility is responsible for scheduling an appointment with a case management agency for transition and post discharge services. The case manager will make contact with the member and family (if applicable) for transition from the higher level of care than outpatient back to the community, within 72 hours of discharge, and then conduct a follow-up appointment/contact within seven days. The case manager will provide linkage/referral to physicians/medication services, counseling services, rehabilitation and/or support services as described in the case management service plan. Case Managers may also provide crisis diversion (unanticipated, unscheduled situation requiring supportive assistance, face-to-face or telephone, to resolve immediate problems before they become overwhelming and severely impair the individual=s

ability to function or maintain in the community) to assist member(s) from progression to a higher level of care. During the follow-up phase of these referrals or links, the behavioral health case manager will provide aggressive outreach if appointments or contacts are missed within two business days of the missed appointments. Community/home based case management to assess the needs for services will be scheduled as reflected in the case management service plan, but not less than one time per month. The member/parent/guardian has the right to refuse behavioral health case management and cannot be restricted from other services because of a refusal of behavioral health case management services.

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

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

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

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

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

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

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

(IV) Supportive activities such as non face-to-face communication with the member and/or parent/guardian/family member ~~or the behavioral health case manager's travel time to and from meetings for the purpose of development or implementation of the individual plan of care~~.

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

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

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

(VIII) Transitioning from institutions to the community. Individuals (except individuals ages 22 to 64 who reside in an

institution for mental diseases (IMD) or individuals who are inmates of public institutions) may be considered to be transitioning to the community during the last 60 consecutive days of a covered, long-term, institutional stay that is 180 consecutive days or longer in duration. For a covered, short term, institutional stay of less than 180 consecutive days, individuals may be considered to be transitioning to the community during the last 14 days before discharge. These time requirements are to distinguish case management services that are not within the scope of the institution's discharge planning activities from case management required for transitioning individuals with complex, chronic, medical needs to the community.

(B) Levels of Case Management

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

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

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

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

(ii) Managing finances; or

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

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

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

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

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

(viii) Mentoring or tutoring; ~~or~~

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

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

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

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

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

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

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

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

6.b-4 CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
Subchapter 3. General Provider Policies
Part 1. General Scope and Administration
317:30-3-2.1. [AMENDED]
(Reference APA WF # 10-26)

FINDING OF EMERGENCY: The Agency finds that a compelling public interest exists which necessitates promulgation of emergency rules and requests emergency approval of rule revisions to the Agency's program integrity and audit rules. Rules are revised to give providers the option of requesting OHCA to perform a full-scope audit or utilize an extrapolation method to determine overpayments, if during a review a sample indicates an error rate greater than 10 percent of paid claims.

ANALYSIS: Program integrity audit/review rules are revised to give providers the option of requesting OHCA to perform a full-scope audit or utilize an extrapolation method to determine overpayments, if during a review a sample indicates an error rate greater than 10 percent of paid claims. If the full-scope audit produces an error rate less than the initial error rate, OHCA will bear the cost of the full-scope audit. However, if it produces an error rate equal to or greater than that of the initial audit, the provider will be responsible for the cost of the full-scope audit and repayment of the identified overpayment resulting from the review method chosen.

BUDGET IMPACT: Agency staff has determined that the revisions are budget neutral.

MEDICAL ADVISORY COMMITTEE: The Medical Advisory Committee considered the proposed rule revisions on May 20, 2010, and recommended Board approval.

PROPOSED EFFECTIVE DATE: Immediately upon Governor's approval

AUTHORITY: The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes

RESOLUTION:
Resolved, that the Oklahoma Health Care Authority Board does hereby approve the Administrative Rules, subject to the Administrative Procedure Act, as indicated:
Revise Agency program integrity rules to give providers the option of requesting OHCA to perform a full-scope audit or utilize an extrapolation method to determine overpayments, if during a review a sample indicates an error rate greater than 10 percent of paid claims.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 3. GENERAL PROVIDER POLICIES
PART 1. GENERAL SCOPE AND ADMINISTRATION

317:30-3-2.1. Program Integrity Audits/Reviews
(a) This section applies to all contractors/providers:

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

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

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

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

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

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

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

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

(5) A final audit/review report.

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

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

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

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

(d) If sampling reveals an error rate of 10% or less, the provider will be required to reimburse OHCA for any overpayments noted during the review.

(e) In those instances when the probability sample results in an error rate in excess of 10%, the results of a probability sample may be used by OHCA to extrapolate the amount to be recovered.

~~(f) Burden of Proof. When the provider disagrees with the findings based on the sampling and extrapolation methodology that was used, the burden of proof of compliance rests with the provider.~~

~~(1) The provider must present evidence to show that the sample was invalid. The evidence must include an additional sample of claims, from the same universe, selected on the basis of recognized and generally accepted sampling methods sufficient to ensure a minimum 95% confidence level.~~

~~(2) The provider's intent to perform additional audit/review work must be communicated to the agency within the time constraints of the designated appeal. Any such audit must:~~

~~(A) be arranged and paid for by the provider;~~

~~(B) be conducted by an independent certified public accountant or peer review organization;~~

~~(C) demonstrate that a statistically significant higher number of claims and records not reviewed in the agency's sample were in compliance with program regulations; and~~

~~(D) be submitted to the agency with all supporting documentation within 120 days of the agency's original final report. Time extensions may be granted, for an additional period not to exceed ninety days, upon written request from the provider.~~

(f) SoonerCare contracted providers shall have the option of requesting OHCA perform a full-scope audit or utilize an extrapolation method to determine overpayments, if during a review a statistical sample indicates an error rate greater than 10% of paid claims.

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

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

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

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

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

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

6.b-5 CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
Subchapter 3. General Provider Policies
317: 30-3-24. [AMENDED]
CHAPTER 35. MEDICAL ASSISTANCE FOR ADULTS AND CHILDREN-ELIGIBILITY
Subchapter 5. Eligibility and Countable Income
Part 5. Countable Income and Resources
317:35-5-43. [AMENDED]
(Reference APA WF # 10-28A & 10-28B)

FINDING OF EMERGENCY: The Agency finds that a compelling public interest exists which necessitates promulgation of emergency rules and requests emergency approval of rule revisions to delineate third party liability procedures when determining eligibility for SoonerCare. With the implementation of the Online Enrollment process, OHCA staff will be responsible for processing SoonerCare applications for a significant population of Oklahomans. The process for obtaining and handling third party liability information is updated to ensure the utilization of all available resources for SoonerCare members.

ANALYSIS: In 2007, the OHCA received a Transformation Grant through the Centers for Medicare and Medicaid Services (CMS) to develop a web based online application and eligibility determination system in order to improve the ease and efficiency of enrollment. The Online Enrollment process allows potential members to apply for SoonerCare electronically. Soon, the OHCA will assume responsibility for determining eligibility for certain groups of individuals under SoonerCare through this process. As OHCA will now be making eligibility determinations, our rules regarding Third Party Liability are in need of revision to update procedures to be followed by both OKDHS and OHCA employees.

BUDGET IMPACT: Agency staff has determined that the revisions are budget neutral.

MEDICAL ADVISORY COMMITTEE: The Medical Advisory Committee considered the proposed rule revisions on May 20, 2010, and recommended Board approval.

PROPOSED EFFECTIVE DATE: Immediately upon Governor's approval

AUTHORITY: The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; State Medicaid Manual, Chapter 3, Section 3904.5; Oklahoma State Statute '56-1010.4C

RESOLUTION:
Resolved, that the Oklahoma Health Care Authority Board does hereby approve the Administrative Rules, subject to the Administrative Procedure Act, as indicated:
Revise Agency Third Party Liability (TPL) rules to reflect changes in the TPL recovery process due to the separation of agency responsibilities after implementation of Online Enrollment.

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

317:30-3-24. Third party liability

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

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

(2) It is possible that other resources are available but are unknown to OHCA. Providers will routinely question SoonerCare members to determine whether any other resources are available. In some instances, coverage may not be obvious, for example, the member may be covered by a policy on which he/she is not the subscriber (e.g., a child whose absent parent maintains medical and hospital coverage).

(3) If the provider receives payment from another source after OHCA has made payment, it is necessary that the provider reimburse OHCA for the ~~Title XIX (Medicaid)~~ SoonerCare payment. The provider may retain the primary insurance payment, if any, that represents payment for services that are not covered services under SoonerCare. By accepting the OHCA's payment, the provider agrees to accept it as payment in full and, therefore, cannot retain any portion of other resource money as payment for reduced charges on covered services. Other than SoonerCare copayments, a provider cannot bill a member for any unpaid portion of the bill or for a claim that is not paid because of provider administrative error. If, after reimbursing OHCA and retaining a portion of the other payment in satisfaction of any non-covered services there is money remaining, it must be refunded to the member.

(4) If a member is covered by a private health insurance policy or plan, he/she is required to inform medical providers of the coverage, including:

(A) provision of applicable policy numbers;

(B) assignment payments to medical providers;

(C) provision of information to OHCA of any coverage changes; and

(D) release of money received from a health insurance plan to the provider if the provider has not already received payment or to the OHCA if the provider has already been paid by the OHCA.

(5) Members are responsible for notifying their providers of the intent to make application for SoonerCare coverage and of any retroactive eligibility determinations. Members may be responsible for any financial liability if they fail to notify the provider of the eligibility determinations and as a result, the provider is unable to secure payment from OHCA.

(6) Members must present evidence of SoonerCare and any other health insurance coverage to a medical provider each time services are requested. Members may be responsible for any financial liability if they fail to furnish the necessary information before the receipt of services and as a result, the provider is unable to secure payment from OHCA.

CHAPTER 35. MEDICAL ASSISTANCE FOR ADULTS AND CHILDREN-ELIGIBILITY
SUBCHAPTER 5. ELIGIBILITY AND COUNTABLE INCOME
PART 5. COUNTABLE INCOME AND RESOURCES

317:35-5-43. Third party resources; insurance, workers' compensation and Medicare

Federal Regulations require that all reasonable measures to ascertain legal liability of third parties to pay for care and services be taken. In instances where such liability is found to exist after SoonerCare has been made available, reimbursement to the extent of such legal liability must be sought. The applicant or member must fully disclose to OHCA that another resource may be available to pay for care. If OKDHS obtains information regarding other available resources from a third party, the worker must complete OKDHS Form 08AD050E, and submit to OHCA, Third Party Liability Unit. Certification or payment in behalf of an eligible individual may not be withheld because of the liability of a third party when such liability or the amount cannot be currently established or is not currently available to pay the individual's medical expense. The rules in this Section also apply when an individual categorically related to pregnancy-related services plans to put the child up for adoption. Any agreement with an adoption agency or attorneys shall include payment of medical care and must be ~~determined~~ considered as a ~~possible~~ possibly liable third party ~~liability~~, regardless of whether agreement is made during prenatal, delivery or postpartum periods.

(1) **Insurance.**

(A) **Private insurance.** An individual requesting SoonerCare is responsible for identifying and providing information on any private medical insurance. He/she is also responsible for reporting subsequent changes in insurance coverage.

(B) **Government benefits.** Individuals requesting SoonerCare who are also eligible for Civilian Health and Medical Programs for Uniformed Services (CHAMPUS), must disclose that the coverage is available. ~~Payments from CHAMPUS for medical care are not considered as income in determining eligibility.~~ They are~~, however,~~ considered ~~as~~ a third party liability ~~sources~~ source.

(2) **Workers' Compensation.** An applicant for SoonerCare or a SoonerCare member that requires medical care because of a work injury or occupational disease must notify OHCA/TPL immediately and assist OHCA in ascertaining the facts related to the injury or disease (such as date, details of the accident, etc.). The OHCA periodically matches data with the Worker's Compensation Court on all cases under its jurisdiction. When any information regarding an applicant for SoonerCare or a SoonerCare member

is obtained, the member must assist OHCA ~~must then attempt to~~ with the ~~subrogate~~ subrogation claim with the employer/insurer.

(3) **Third party liability (accident or injury).** When medical services are required for an applicant of SoonerCare or a SoonerCare member as the result of an accident or injury known to the worker, the member is responsible for reporting to OHCA/TPL the persons involved in the accident, date and details of the accident and possible insurance benefits which might be made available. If an automobile accident involves more than one car it is necessary to report liability insurance on all cars involved.

(A) If OKDHS receives information regarding a SoonerCare member or applicant seeking medical services due to an accident, the worker ~~completes OKDHS Form 08AD050E and~~ submits ~~it with~~ any ~~additional~~ information available to OHCA/TPL.

(B) If OHCA receives a claim for payment from SoonerCare funds and the diagnosis indicates the need for services may have resulted from an accident or injury involving third party liability, OHCA will attempt to contact the member to obtain details of the incident. If additional contact is necessary with the member, the local OKDHS office or OHCA representative may be requested by the OHCA/TPL Unit to submit ~~OKDHS Form 08AD050E~~ the appropriate information. ~~The worker completes this form and submits it to the OHCA/TPL to take the appropriate action.~~

(4) **Medicare eligibility.** If it appears the applicant may be eligible for Medicare but does not have a Medicare card or other verification, the ~~worker clears~~ information is cleared with the Social Security Office and ~~enters~~ the findings ~~and~~ entered with the date of the verification in the ~~case~~ record. If the applicant did not enroll for Part A or Part B at the time he/she became eligible for Medicare and is now subject to pay an escalated premium for Medicare enrollment, he/she is not required to do so. Payment can be made for services within the scope of SoonerCare.

(5) **Absent parent.**

(A) Applicants are required to cooperate with the Oklahoma Department of Human Services Oklahoma Child Support Services (OCSS) in the assignment of child/spousal support rights. The families involved are those with a minor child(ren) in the home. The child(ren) must be related to AFDC, AB or AD and have a parent(s) absent from the home. Any support collected on behalf of these families will be paid to them as if they were receiving non-public assistance child support services, with one exception. The exception is regarding child support collected for foster care child(ren) in OKDHS temporary custody. This support is paid to OKDHS Children and Family Services Division (CFSD). The child support income continues to be counted in determining SoonerCare eligibility. The rules in OAC 317:10 are used, with the following exceptions:

(i) In the event the family already has an existing child support case, the only action required is a memo to the appropriate ~~Oklahoma Child Support Services (~~OCSS~~)~~ district office notifying them of the certification.

(ii) Child/spousal support is always counted as income less any applicable income disregard. This income inclusion applies whether it is redirected to the ~~OCSS~~ CFSD or retained by the member.

(iii) Children who are in custody of OKDHS may be exempt from referral to OCSS. Should the pursuit of the OCSS services be determined to be detrimental to the OKDHS CFSD service plan, an exemption may be approved.

(B) Cash medical support may be ordered to be paid to the OHCA by the non-custodial parent if there is no access to health insurance at a reasonable cost or if the health insurance is determined not accessible to the child according to ~~OKDHS~~ OCSS Rules. Reasonable is deemed to be 5% or less of the non-custodial parent's gross income. The administration and collection of cash medical support will be determined by OKDHS OCSS and will be based on the income guidelines and rules that are applicable at the time. However, at no time will the non-custodial parent be required to pay more than 5% of his/her gross income for cash medical support unless payment in excess of 5% is ordered by the Court. The disbursement and hierarchy of payments will be determined pursuant to OKDHS/OCSS guidelines.

6.b-6 CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
Subchapter 5. Individual Providers and Specialties
Part 21. Outpatient Behavioral Health Services
317:30-5-240. [AMENDED]
317:30-5-240.1. through 317:30-5-240.3. [AMENDED]
317:30-5-241. [AMENDED]
317:30-5-241.2 through 317:30-5-241.3. [AMENDED]
317:30-5-241.5. [AMENDED]
317:30-5-248. [AMENDED]
(Reference APA WF # 10-29)

FINDING OF EMERGENCY: The Agency finds that a compelling public interest exists which necessitates promulgation of emergency rules and requests emergency approval of rule revisions to amend policy by clarifying the definition and credential requirements for Behavioral Health Rehabilitation Specialist (BHRS). The revisions are needed to ensure that policy aligns with the Oklahoma Department of Mental Health Substance Abuse Services (ODMHSAS) policy. Inconsistency between the policies may lead to uncertainty and confusion among SoonerCare BHRS providers which could impede access to care for a very vulnerable SoonerCare population.

ANALYSIS: Outpatient Behavioral Health Rules are revised to provide clarity and consistency to policy. Currently policy conflicts with ODMHSAS definition and credential requirements for BHRS. Additionally, rules are revised to clean up discrepancies between OHCA and ODMHSAS policy for consistency.

BUDGET IMPACT: Agency staff has determined that the revisions are budget neutral.

MEDICAL ADVISORY COMMITTEE: The Medical Advisory Committee considered the proposed rule revisions on May 20, 2010, and recommended Board approval.

PROPOSED EFFECTIVE DATE: Immediately upon Governor's approval

AUTHORITY: The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes

RESOLUTION:
Resolved, that the Oklahoma Health Care Authority Board does hereby approve the Administrative Rules, subject to the Administrative Procedure Act, as indicated:
Revise Agency Outpatient Behavioral Health rules to provide clarity and consistency to policy defining the credentialing requirements for behavioral health rehabilitation specialists.

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

317:30-5-240. Eligible providers

All outpatient behavioral health providers eligible for reimbursement under OAC 317:30-5-240 et seq. must be an accredited organization/agency and have a current contract on file with the Oklahoma Health Care Authority. Eligibility requirements for independent professionals (e.g., physicians and ~~psychologists~~ Licensed Behavioral Health Professionals), who provide outpatient behavioral health services and bill under their own ~~taxpayer identification~~ national provider identification (NPI) number are covered under OAC 317:30-5-1 and OAC 317:30-5-275. Other outpatient ambulatory clinics (e.g. Federally Qualified Health Centers, Indian Health Clinics, school-based clinics) that offer outpatient behavioral health services are covered elsewhere in the agency rules.

317:30-5-240.1. Definitions

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

"Accrediting body" means one of the following:

(A) Accreditation Association for Ambulatory Health Care (AAAHC);

(B) American Osteopathic Association (AOA);

(C) Commission on Accreditation of Rehabilitation Facilities (CARF);

(D) Council on Accreditation of Services for Families and Children, Inc. (COA);

(E) The Joint Commission (TJC) formerly known as Joint Commission on Accreditation of Healthcare Organizations; or

(F) other OHCA approved accreditation.

"Adult" means an individual 21 and over, unless otherwise specified.

"AOD" means Alcohol and Other Drug.

"AODTP" means Alcohol and Other Drug Treatment Professional.

"BH" means behavioral health, which relates to mental, substance abuse, addictions, gambling, and other diagnosis and treatment.

"BHAs" means Behavioral Health Aides.

"BHRS" means Behavioral Health Rehabilitation Specialist.

"Child" means an individual younger than 21, unless otherwise specified.

~~**"CHMCs"** means Community Mental Health Centers who are state operated or privately contracted providers of behavioral health services for adults with severe mental illnesses, and youth with serious emotional disturbances.~~

"CM" means case management.

"CMHC's" means Community Mental Health Centers who are state operated or privately contracted providers of behavioral health services for adults with severe mental illnesses, and youth with serious emotional disturbances.

"Cultural competency" means the ability to recognize, respect, and address the unique needs, worth, thoughts, communications, actions, customs, beliefs and values that reflect an individual=s racial, ethnic, age group, religious, sexual orientation, and/or social group.

"DSM" means the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association.

"EBP" means an Evidence Based Practice per the Substance Abuse & Mental Health Services Administration (SAMHSA).

"FBCS" means Facility Based Crisis Stabilization.

"FSPs" means Family Support Providers.

"ICF/MR" means Intermediate Care Facility for the Mentally Retarded.

"Institution" means an inpatient hospital facility or Institution for Mental Disease (IMD).

"IMD" means Institution for Mental Disease as per 42 CFR 435.1009 as a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care and related services. The regulations indicate that an institution is an IMD if its overall character is that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases. Title XIX of the Social Security Act provides that, except for individuals under age 21 receiving inpatient psychiatric care, Medicaid (Title XIX) does not cover services to IMD patients under 65 years of age [section 1905(a)(24)(B)].
"LBHP" means a Licensed Behavioral Health Professional.
"MST" means the EBP Multi-Systemic Therapy.
"OAC" means Oklahoma Administrative Code, the publication authorized by 75 O.S. 256 known as The Oklahoma Administrative Code, or, prior to its publication, the compilation of codified rules authorized by 75 O.S. 256(A)(1)(a) and maintained in the Office of Administrative Rules.
"Objectives" means a specific statement of planned accomplishments or results that are specific, measurable, attainable, realistic, and time-limited.
"ODMHSAS" means the Oklahoma Department of Mental Health and Substance Abuse Services.
"ODMHSAS contracted facilities" means those providers that have a contract with the ODMHSAS to provide mental health or substance abuse treatment services, and also contract directly with the Oklahoma Health Care Authority to provide Outpatient Behavioral Health Services.
"OHCA" means the Oklahoma Health Care Authority.
"OJA" means the Office of Juvenile Affairs.
"Provider Manual" means the OHCA BH Provider Billing Manual.
"RBMS" means Residential Behavioral Management Services within a group home or therapeutic foster home.
"Recovery" means an ongoing process of discovery and/or rediscovery that must be self defined, individualized and may contain some, if not all, of the ten fundamental components of recovery as outlined by SAMHSA.
"RSS" means Recovery Support Specialist.
"SAMHSA" means the Substance Abuse and Mental Health Services Administration.
"SED" means Severe Emotional Disturbance.
"SMI" means Severely Mentally Ill.
"Trauma informed" means the recognition and responsiveness to the presence of the effects of past and current traumatic experiences in the lives of members.

317:30-5-240.2 Provider participation standards

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

(1) Private, Community-based Organizations must be accredited as a provider of outpatient behavioral health services from one of the accrediting bodies and be an incorporated organization governed by a board of directors;

(2) State-operated programs under the direction of ODMHSAS must be accredited by one of the accrediting bodies;

(3) Freestanding Psychiatric Hospitals must be licensed and certified by the State Survey Agency as meeting Medicare psychiatric hospital standards and JCAHO accreditation;

(4) General Medical Surgical Hospitals must be appropriately licensed and certified by the State Survey Agency as meeting Medicare standards, including a JCAHO or AOA accreditation;
(5) Federally Qualified Health Centers/Community Health Centers facilities that qualify under OAC 317:30-5-660;
(6) Indian Health Services/Tribal Clinics/Urban Tribal Clinics facilities that qualify under Federal regulation;
(7) Rural Health Clinics facilities that qualify under OAC 317:30-5-355;
(8) Public Health Clinics and County Health Departments;
(9) Public School Systems.

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

(c) **Provider enrollment and contracting.**
(1) Organizations who have JCAHO, CARF, COA or AOA accreditation will supply the documentation from the accrediting body, along with other information as required for contracting purposes to the OHCA. The contract must include copies of all required state licenses, accreditation and certifications.
(2) If the contract is approved, a separate provider identification number for each outpatient behavioral health service site will be assigned. Each site operated by an outpatient behavioral health facility must have a separate provider contract and site-specific accreditation and/or certification as applicable. A site is defined as an office, clinic, or other business setting where outpatient behavioral health services are routinely performed. When services are rendered at the member's residence, a school, or when provided occasionally at an appropriate community based setting, a site is determined according to where the professional staff perform administrative duties and where the member's chart and other records are kept. Failure to obtain and utilize site specific provider numbers will result in disallowance of services.
(3) Effective 07/01/10, all behavioral health providers are required to have an individual contract with OHCA in order to receive SoonerCare reimbursement. This requirement includes outpatient behavioral health agencies and all individual rendering providers who work within an agency setting. Individual contracting requirements are set forth in the OHCA BH Provider Manual.

(d) **Standards and criteria.** Eligible organizations must meet each of the following:
(1) Have a well-developed plan for rehabilitation services designed to meet the recovery needs of the individuals served.
(2) Have a multi-disciplinary, professional team. This team must include all of the following:

(A) One of the LBHPs;
(B) A BHRS, if individual or group rehabilitative services for behavioral health disorders are provided;
(C) An AODTP, if treatment of alcohol and other drug disorders is provided;
(D) A registered nurse or physician assistant, with a current license to practice in the state in which the services are delivered if Medication Training and Support service is provided;
(E) The member for whom the services will be provided, and parent/guardian for those under 18 years of age.
(F) A member treatment advocate if desired and signed off on by the member.

(3) Demonstrate the ability to provide each of the following outpatient behavioral health treatment services as described in OAC 317:30-5-241 et seq., as applicable to their program. Providers must provide proper referral and linkage to providers of needed services if their agency does not have appropriate services.
(A) Assessments and Treatment Plans;
(B) Psychotherapies;
(C) Behavioral Health Rehabilitation services;
(D) Crisis Intervention services;
(E) Support Services; and
(F) Day Treatment/Intensive Outpatient.

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

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

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

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

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

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

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

317:30-5-240.3 Staff Credentials

(a) **Licensed Behavioral Health Professional (LBHPs).** LBHPs are defined as follows:

(1) Allopathic or Osteopathic Physicians 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 with a license to practice in the state in which services are provided or those actively and regularly receiving board approved supervision, and extended supervision by a fully licensed clinician if board's supervision requirement is met but the individual is not yet licensed, to become licensed by one of the licensing boards listed in (A) through (F) of this paragraph. The exemptions from licensure under 59 '1353(4) (Supp. 2000) and (5), 59 '1903(C) and (D) (Supp. 2000), 59 '1925.3(B) (Supp. 2000) and (C), and 59 '1932(C) (Supp. 2000) and (D) do not apply to Outpatient Behavioral Health Services.

(A) Psychology,
(B) Social Work (clinical specialty only),
(C) Professional Counselor,
(D) Marriage and Family Therapist,
(E) Behavioral Practitioner, or
(F) Alcohol and Drug Counselor.

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

(4) A Physician Assistant who is licensed in good standing in this state and has received specific training for and is experienced in performing mental health therapeutic, diagnostic, or counseling functions.

(b) ~~**Alcohol and other Drug Treatment Professionals (AODTPs).** AODTPs are defined as follows:~~ **Certified Alcohol and Drug Counselors (CADC's).** CADC's are defined as having a current certification as a CADC in the state in which services are provided.

~~(1) Licensed to practice as an Alcohol and Drug Counselor in the state in which services are provided, or those actively and regularly receiving board approved supervision to become licensed; (2) Certified as an Advanced Alcohol and Drug Counselor as recognized and approved by an ODMHSAS AOD treatment certifying and/or licensing body;~~

~~(3) Certified as an Alcohol and Drug Counselor as recognized and approved by an ODMHSAS AOD treatment certifying and/or licensing body; or~~

~~(4) A Licensed Behavioral Health Professional with a current license, or those actively and regularly receiving board approved supervision to become licensed, and extended supervision by a fully licensed clinician if board's supervision requirement is met but the individual is not yet licensed, to practice who can demonstrate competency in the area of alcohol and drug counseling and treatment.~~

(c) **Behavioral Health Rehabilitation Specialists (BHRS).** BHRSs are defined as follows:

(1) Before 07/01/10:

~~(1)~~(A) Bachelor or master degree in a behavioral health related field including, psychology, social work, occupational therapy, human resources/services counseling, human developmental psychology, gerontology, early childhood development, chemical dependency, rehabilitative services, sociology, school guidance and counseling, education, criminal justice family studies, earned from a regionally accredited college or university recognized by the United States Department of Education; or

~~(2)~~ Bachelor or master degree that demonstrates the individual completed and passed equivalent college level course work to meet the degree requirements of (1) of this subsection, as reviewed and approved by OHCA or its designated agent; or

~~(3)~~(B) A current license as a registered nurse in the state where services are provided; or

~~(4)~~(C) Certification as an Alcohol and Drug Counselor. They are allowed to provide substance abuse rehabilitative treatment to those with alcohol and/or other drug dependencies or addictions as a primary or secondary DSM-IV Axis I diagnosis; or

~~(5)~~(D) Current certification as a Behavioral Health Case Manager II or III from ODMHSAS as described in OAC ~~317:30-5-585(1)~~ 317:30-5-595 (2)(C)(i) and 317:30-5-595 (2)(C) (ii).

(2) On or After 7/01/10:

(A) Bachelor degree earned from a regionally accredited college or university recognized by the United States Department of Education and completion of the ODMHSAS training as a Behavioral Health Rehabilitation Specialist; or

(B) CPRP (Certified Psychiatric Rehabilitation Practitioner) credential; or

(C) Certification as an Alcohol and Drug Counselor; or

(D) A current license as a registered nurse in the state where services are provided and completion of the ODMHSAS training as a Behavioral Health Specialist; or

(E) If qualified as a BHRS prior to 07/01/10 and have a ODMHSAS credential on file.

(d) **Multi-Systemic Therapy (MST) Provider**. Masters level who work on a team established by OJA which may include Bachelor level staff.

(e) **Community Recovery Support Specialist (RSS).** The community/recovery support worker must meet the following criteria:

~~(1) The community/recovery support worker must meet the following criteria:~~

~~(A)~~ (1) High School diploma or GED;

~~(B)~~ (2) Minimum one year participation in local or national member advocacy or knowledge in the area of behavioral health recovery;

~~(C)~~ (3) current or former member of behavioral health services; and

~~(D)~~ (4) successful completion of the ODMHSAS Recovery Support Provider Training and Test.

(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; and

(5) treatment plans must be overseen and approved by a LBHP; and

(6) must function under the general direction of a LBHP or systems of care team, with a LBHP 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) treatment plans must be overseen and approved by a LBHP; and

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

317:30-5-241. Covered Services

(a) Outpatient behavioral health services are covered for adults and children as set forth in this Section and following the requirements as defined in the OHCA BH Provider Billing Manual, unless specified otherwise, and when provided in accordance with a documented individualized service plan, developed to treat the identified behavioral health and/or substance abuse disorder(s).
(b) All services are to be for the goal of improvement of functioning, independence, or well being of the member. The services and treatment plans are to be recovery focused, trauma and co-occurring specific. The member must be able to actively participate in the treatment. Active participation means that the member must have sufficient cognitive abilities, communication skills, and short-term memory to derive a reasonable benefit from the treatment.
(c) All outpatient BH services will require ~~prior~~ authorization through OHCA, or its designated agent, following established medical necessity criteria. Providers are required to follow these criteria and guidelines under the OHCA BH Provider Billing Manual. ~~The OHCA or its designated agent who performs the services identified in paragraph (1) of this subsection uses its independent medical judgment to perform both the review of services and the prior authorization of services.~~ OHCA does retain final administrative review over both prior authorization and review of services as required by 42 CFR 431.10.
(d) ~~Non prior authorized~~ Unauthorized services will not be SoonerCare compensable, unless designated by OHCA ~~with the exception of the initial 1-4 sessions (to be used prior to completion of the Service Plan), Assessment Service Plan (moderate complexity), Crisis Intervention, and Adult Facility Based Crisis Stabilization~~.

317:30-5-241.2 Psychotherapy

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

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

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

(3) **Qualified professionals**. With the exception of a qualified interpreter if needed, only the member and the LBPH or ~~AODTP~~ CADC, for substance abuse (SA) only, should be present and the setting must protect and assure confidentiality. Ongoing assessment of the member's status and response to treatment as well as psycho-educational intervention are appropriate components of individual counseling. The counseling must be

goal directed, utilizing techniques appropriate to the service plan and the member's developmental and cognitive abilities. Individual/Interactive counseling must be provided by a LBHP or CADC ~~when treatment is for a mental illness and by an AODTP~~ when treatment is for an alcohol or other drug disorder only.

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

(b) **Group Psychotherapy**.

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

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

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

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

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

(c) **Family Psychotherapy**.

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

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

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

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

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

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

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

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

(1) **Clinical restrictions**.

(A) Individual. Only the BHRS and member are present for the session.

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

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

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

(4) **Limitations.**

(A) **Transportation**. Travel time to and from BHR treatment is not compensable.

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

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

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

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

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

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

(1) **Definition**. Medication Training and Support is a documented review and educational session by a registered nurse, or physician assistant focusing on a member's response to medication and compliance with the medication regimen. The review must include an assessment of medication compliance and medication side effects. Vital signs must be taken including pulse, blood pressure and respiration and documented within the ~~progress notes~~ medical or clinical record. A physician is not required to be present, but must be available for consult. Medication Training and Support is designed to maintain the member on the appropriate level of the least intrusive medications, encourage normalization and prevent hospitalization.

(2) **Limitations**.

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

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

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

317:30-5-241.5 Support services

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

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

(2) **Target population**. Individuals 18 years of age or older with serious and persistent mental illness and co-occurring disorders.

(3) **Qualified professionals**. Providers of PACT services are specific teams within an established organization and must be operated by or contracted with and certified by the ODMHSAS in accordance with 43A O.S. 319 and OAC 450:55.

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

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

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

(2) **Target population**. This service is limited to children with serious emotional disturbance who are in an ODMHSAS contracted systems of care community based treatment program, or are under OKDHS or OJA custody residing within a RBMS level of care, who need intervention and support in their living environment to achieve or maintain stable successful treatment outcomes.

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

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

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

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

development and enhancement of the family's specific problem-solving skills, coping mechanisms, and strategies for the child's symptom/behavior management.

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

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

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

(d) **Community Recovery Support**.

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

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

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

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

317:30-5-248. Documentation of records

All outpatient behavioral health services must be reflected by documentation in the member~~'~~s records.

(1) For Behavioral Health ~~and Alcohol and Drug~~ Assessments (see OAC 317:30-5-241), no progress notes are required.

(2) For Behavioral Health Services Plan ~~and Alcohol and/or Substance Abuse Services, Treatment Plan~~ (see OAC 317:30-5-241), no progress notes are required.

(3) Treatment Services must be documented by progress notes.

(A) Progress notes shall chronologically describe the services provided, the member's response to the services provided and the member's progress, or lack of, in treatment and must include the following:

(i) Date;

(ii) Person(s) to whom services were rendered ~~must be HIPAA compliant if other individuals in session are mentioned~~;

(iii) Start and stop time for each timed treatment session or service;

(iv) Original signature of the therapist/service provider; in circumstances where it is necessary to fax a service plan to someone for review and then have them fax back their signature, this is acceptable; however, the provider must obtain the original signature for the clinical file within 30 days and no stamped or ~~Xeroxed~~ photocopied signatures are allowed. Electronic signatures are acceptable following OAC 317:30-3-4.1 and 317:30-3-15;

(v) Credentials of therapist/service provider;

(vi) Specific ~~treatment~~ service plan ~~problems(s)~~ need(s), goals and/or objectives addressed;

(vii) Services provided to address need(s), goals and/or objectives;

(viii) Progress or barriers to progress made in treatment as it relates to the goals and/or objectives;

(ix) Member (and family, when applicable) response to the session or intervention; ~~(what did the member do in session? What did the provider do in session?);~~

(x) Any new need(s), goals and/or objectives identified during the session or service.

(4) In addition to the items listed ~~in (1) of~~ above in this subsection:

(A) Crisis Intervention Service notes must also include a detailed description of the crisis and level of functioning assessment;

(B) a list/log/sign in sheet of participants for each Group rehabilitative or ~~counseling~~ psychotherapy session and facilitating BHRS, LBHP, or ~~AODTP~~ CADC must be maintained; and

(C) for medication training and support, vital signs must be recorded in the ~~progress note~~ medical record, but are not required on the behavioral health services plan;

(5) Progress notes for intensive outpatient behavioral health, substance abuse, or integrated BHR programs may be in the form of daily or weekly summary notes and must include the following:

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

(B) Start and stop times for each day attended;

(C) Specific goal(s) and/or objectives addressed during the week;

(D) Type of Skills Training provided each day and/or during the week;

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

(F) Progress~~,~~ or barriers ~~to,~~ made toward goals, objectives;

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

(H) Signature of the lead BHRS; and

(I) Credentials of the lead BHRS.

(6) Concurrent documentation between the clinician and member can be billed as part of the treatment session time, but must be documented clearly in the progress notes and signed by the member (or note if the member is unable/refuses to sign).

6.b-7 CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
Subchapter 5. Individual Providers and Specialties
Part 6. Inpatient Psychiatric Hospitals
317:30-5-95. [AMENDED]
317:30-5-95.4. through 317:30-5-95.6. [AMENDED]
317:30-5-95.8. through 317:30-5-95.10. [AMENDED]
317:30-5-95.13. through 317:30-5-95.16. [AMENDED]
317:30-5-95.18. through 317:30-5-95.20. [AMENDED]
317:30-5-95.22. through 317:30-5-95.40. [AMENDED]
317:30-5-95.42. [AMENDED]
317:30-5-96.2.through 317:30-5-96.4. [AMENDED]
317:30-5-96.7. [AMENDED]
(Reference APA WF # 10-30)

FINDING OF EMERGENCY: The Agency finds that a compelling public interest exists which necessitates promulgation of emergency rules and requests emergency approval of rule revisions to amend policy by modifying Residential Treatment Center (RTC) requirements for Community Based transitional level of care. The revision is needed to ensure that a lower level of RTC is available for members who can be transitioned back into the community. Without revising RTC requirements for Community Based transitional level of care, members are placed in a higher level of care setting which may not be appropriate to the members needs. Additionally, rules are revised to add the Child and Adolescent Level of Care Utilization System (CALOCUS) to be used when determining level of care. The CALOCUS tool will assist in determining the appropriate level of care for SoonerCare members.

ANALYSIS: Modifications to the RTC rules allow the requirements for Community Based transitional level of care to be less restrictive as a step-down from standard RTC. By reducing the treatment requirements for the Community Based Transitional level of care, this allows facilities to step down that member to a lower level of RTC care and focus on transitioning the member back into the community, which supports RTC diversion.

BUDGET IMPACT: Agency staff has determined that the revisions expect to yield a total annual savings of approximately $500,000/year; $125,000 State Share Savings.

MEDICAL ADVISORY COMMITTEE: The Medical Advisory Committee considered the proposed rule revisions on May 20, 2010, and recommended Board approval.

PROPOSED EFFECTIVE DATE: Immediately upon Governor's approval

AUTHORITY: The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes

RESOLUTION:
Resolved, that the Oklahoma Health Care Authority Board does hereby approve the Administrative Rules, subject to the Administrative Procedure Act, as indicated:

Revise Agency Inpatient Behavioral Health rules to allow the requirements for Community Based Transitional level of care to be less restrictive as a step-down from standard residential treatment centers as well as to add the Child and Adolescent Level of Care Utilization System (CALOCUS) to be used when making a level of care determination.

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

317:30-5-95. General provisions and eligible providers

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

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

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

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

~~(3) **"JCAHO"** means Joint Commission on Accreditation of Healthcare Organizations.~~

~~(4)~~(3) **"Licensed independent practitioner (LIP)"** means any individual permitted by law and by the licensed hospital to provide care and services, without supervision, within the scope of the individual's license and consistent with clinical privileges individually granted by the licensed hospital. Licensed independent practitioners may include Advanced Practice Nurses (APN) with prescriptive authority and Physician Assistants.

~~(5)~~(4) **"Psychiatric Residential Treatment Facility (PRTF)"** means a facility other than a hospital.

~~(6)~~(5) **"Restraint"** means any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a ~~patient~~ member to move his or her arms, legs, body, or head freely, or drug or medication when it is used as a restriction to manage the ~~patient's~~ member's behavior or restrict the ~~patient's~~ member's freedom of movement and is not the standard treatment or dosage for the ~~patient's~~ member's condition. Restraint does not include devices such as orthopedically prescribed devices, surgical dressings or bandages, protective helmets, or other methods that involve the physical holding of a ~~patient~~ member for the purpose of conducting routine physical examinations or tests, or to protect the ~~patient~~ member from falling out of bed, or to permit the ~~patient~~ member to participate in activities without the risk of physical harm (this does not include physical escort).

~~(7)~~(6) **"Seclusion"** means the involuntary confinement of a ~~patient~~ member alone in a room or area from which the ~~patient~~ member is physically prevented from leaving and may only be used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the ~~patient~~ member, a staff member, or others.

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

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

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

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

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

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

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

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

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

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

(C) the date the attestation is signed;

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

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

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

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

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

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

317:30-5-95.4. Individual plan of care for adults ages 21 to 64

(a) Before admission to a psychiatric hospital or immediately after admission, the attending physician or staff physician must establish a written plan of care for each ~~applicant or recipient~~ member age 21 to 64. The plan of care must include:

(1) Diagnoses, symptoms, complaints, and complications indicating the need for admission;

(2) A description of the functional level of the individual;

(3) Objectives;

(4) Any order for medication, treatments, restorative and rehabilitative services, activities, therapies, social services, diet and special procedures recommended for the health and safety of the ~~patient~~ member;

(5) Plans for continuing care, including review and modification to the plan of care; and

(6) Plans for discharge.

(b) The attending or staff physician and other treatment team personnel involved in the ~~recipient's~~ member's care must review each plan of care at least every seven days.

(c) All plans of care and plan of care reviews must be clearly identified as such in the ~~patient's~~ member's medical records. All must be signed and dated by the physician, RN, MHP, ~~patient~~ member, and other treatment team members that provide individual, family and group therapy in the required review interval. If the ~~patient~~ member has designated an advocate, the advocate's signature is also required on all plans of care and plan of care reviews.

(d) The plan of care must document appropriate ~~patient~~ member participation in the development and implementation of the treatment plan.

317:30-5-95.5. Physician review of prescribed medications for adults age 21 to 64

All prescribed medications for adults age 21 to 64 must be reviewed by the physician at least every seven days; the review must be documented in the ~~patient's~~ member's medical record by the physician signing his/her name and title and dating the orders.

317:30-5-95.6. Medical, psychiatric and social evaluations for adults age 21 to 64

The record for an adult ~~patient~~ member age 21 to 64 must contain complete medical, psychiatric and social evaluations.

(1) The evaluations must be completed as follows:

(A) History and Physical must be completed within 48 hours of admission by a licensed independent practitioner [M.D., D.O., Advanced Practice Nurse (A.P.N.), or Physician Assistant (P.A.)].

(B) Psychiatric Evaluation must be completed within 48 hours of admission by a M.D. or D.O.

(C) Psychosocial Evaluation must be completed within 72 hours of admission by a licensed independent practitioner (M.D., D.O., A.P.N., or P.A.) or a mental health professional as defined in ~~OAC 317:30-5-240(c)~~ OAC 317:30-5-240.3.

(2) The evaluations must be clearly identified as such and must be signed and dated by the evaluator.

317:30-5-95.8. Nursing services for adults age 21 to 64

Each facility providing nursing services to adults age 21 to 64 must have a qualified Director of Psychiatric Nursing. In addition to the Director of Nursing, there must be adequate numbers of registered nurses, licensed practical nurses, and mental health workers to provide nursing care necessary

under the active treatment program and to maintain progress notes on each ~~patient~~ member. A registered nurse must document ~~patient~~ member progress at least weekly. The progress notes must contain recommendations for revisions in the treatment plan, as needed, as well as an assessment of the ~~patient's~~ member's progress as it relates to the treatment plan goals and objectives.

317:30-5-95.9. Therapeutic services for adults age 21 to 64

An interdisciplinary team of a physician, mental health professional(s), registered nurse, and other staff who provide services to adult ~~patients~~ members age 21 to 64 in the facility oversee all components of the active treatment and provide services appropriate to their respective discipline. The team developing the individual plan of care must include, at a minimum, the following:

(1) Allopathic or Osteopathic Physician with a current license and a board certification/eligible in psychiatry, or a current resident in psychiatry practicing as described in OAC 317:30-5-2(a)(1)(U); and

(2) a mental health professional licensed to practice by one of the following boards:

(A) Psychology (health service specialty only);

(B) Social Work (clinical specialty only);

(C) Licensed Professional Counselor;

(D) Licensed Behavioral Practitioner;

(E) Licensed Marital and Family Therapist; ~~or~~

(F) Licensed Alcohol and Drug Counselor; or

~~(F)~~ (G) Advanced Practice Nurse (certified in a psychiatric mental health specialty, licensed as a registered nurse with a current certification of recognition from the Board of Nursing in the state in which the services are provided); and

(3) a registered nurse with a minimum of two years of experience in a mental health treatment setting.

317:30-5-95.10. Discharge plan for adults age 21 to 64

Each adult ~~patient~~ member age 21 to 64 must have a discharge plan that includes a recapitulation of the ~~patient's~~ member's hospitalization, recommendations for follow-up and aftercare to include referral to medication management, out-patient behavioral health counseling and/or case management to include the specific appointment information (time, ~~dae~~ date and name, address and telephone number of provider and related community services), and a summary of the ~~patient's~~ member's condition at discharge. All discharge and aftercare plans must be documented in the ~~patient's~~ member's medical records.

317:30-5-95.13. Certification and recertification of need for inpatient care for inpatient acute psychiatric services for persons over 65 years of age

The certification and recertification of need for inpatient care for persons over 65 years of age must be in writing and must be signed and dated by the physician who has knowledge of the case and the need for continued inpatient psychiatric care. The certification and recertification documents for all ~~Medicaid patients~~ SoonerCare members must be maintained in the ~~patient's~~ member's medical records or in a central file at the facility where the ~~patient~~ member is or was a resident.

(1) **Certification.** A physician must certify for each applicant or ~~recipient~~ member that inpatient services in a psychiatric hospital are or were needed. The certification must be made at the time of admission or, if an individual applies for assistance while in a psychiatric hospital,

before ~~the Medicaid agency~~ OHCA, or its designated agent, authorizes payment.

(2) **Recertification.** A physician must recertify for each applicant or ~~recipient~~ member that inpatient services in the psychiatric hospital are needed. Recertification must be made at least every 60 days after certification.

317:30-5-95.14. Individual plan of care for persons over 65 years of age receiving inpatient acute psychiatric services

(a) Before admission to a psychiatric hospital or immediately after admission, the attending physician or staff physician must establish a written plan of care for each applicant or ~~recipient~~ member. The plan of care must include:

(1) Diagnoses, symptoms, complaints, and complications indicating the need for admission;

(2) A description of the functional level of the individual;

(3) Objectives;

(4) Any order for medication, treatments, restorative and rehabilitative services, activities, therapies, social services, diet and special procedures recommended for the health and safety of the ~~patient~~ member;

(5) Plans for continuing care, including review and modification to the plan of care, and

(6) Plans for discharge.

(b) The attending or staff physician and other treatment team personnel involved in the ~~recipient's~~ member's care must review each plan of care at least every seven days.

(c) All plans of care and plan of care reviews must be clearly identified as such in the ~~patient's~~ member's medical records. All must be signed and dated by the physician, RN, MHP, ~~patient~~ member and other treatment team members that provide individual, family and group therapy in the required review interval. If the ~~patient~~ member has designated an advocate, the advocate's signature is also required on all plans of care and plan of care reviews.

(d) The plan of care must document appropriate ~~patient~~ member participation in the development and implementation of the treatment plan.

317:30-5-95.15. Physician review of prescribed medications for persons over 65 years of age receiving inpatient acute psychiatric services

All prescribed medications for persons over 65 years of age receiving inpatient acute psychiatric services must be reviewed by the physician at least every seven days; the review must be documented in the ~~patient's~~ member's medical record by the physician signing his/her name and title and dating the orders.

317:30-5-95.16. Medical psychiatric and social evaluations for persons over 65 years of age receiving inpatient acute psychiatric services

The record of a member over 65 years of age receiving inpatient acute psychiatric services must contain complete medical, psychiatric and social evaluations.

(1) The evaluations must be completed as follows:

(A) History and Physical must be completed within 48 hours of admission by a licensed independent practitioner [M.D., D.O., Advanced Practice Nurse (A.P.N.), or Physician Assistant (P.A.)].

(B) Psychiatric Evaluation must be completed within 48 hours of admission by a M.D. or D.O.

(C) Psychosocial Evaluation must be completed within 72 hours of admission by a licensed independent practitioner or a licensed

behavioral health professional (LBHP) as defined in ~~OAC 317:30-5-240(c)~~ OAC: 317:30-5-240.3.

(2) The evaluations must be clearly identified as such and must be signed and dated by the evaluator.

317:30-5-95.18. Nursing services for persons over 65 years of age receiving inpatient acute psychiatric services

Each facility providing inpatient acute psychiatric services to adults over 65 must have a qualified Director of Psychiatric Nursing. In addition to the Director of Nursing, there must be adequate numbers of registered nurses, licensed practical nurses, and mental health workers to provide nursing care necessary under the active treatment program and to maintain progress notes on each ~~patient~~ member. A registered nurse must document ~~patient~~ member progress at least weekly. The progress notes must contain recommendations for revisions in the treatment plan, as needed, as well as an assessment of the ~~patient's~~ member's progress as it relates to the treatment plan goals and objectives.

317:30-5-95.19. Therapeutic services for persons over 65 years of age receiving inpatient acute psychiatric services

An interdisciplinary team of a physician, LBHPs, registered nurse, and other staff who provide services to members over 65 years of age who are receiving inpatient acute psychiatric services in the facility oversee all components of the active treatment and provide services appropriate to their respective discipline. The team developing the individual plan of care must include, at a minimum, the following:

(1) Allopathic or Osteopathic Physician with a current license and a board certification/eligible in psychiatry, or a current resident in psychiatry practicing as described in OAC 317:30-5-2(a)(1)(U); and

(2) a LBHP licensed to practice by one of the following boards:

(A) Psychology (health service specialty only);

(B) Social Work (clinical specialty only);

(C) Licensed Professional Counselor;

(D) Licensed Behavioral Practitioner;

(E) Licensed Marital and Family Therapist; ~~or~~

(F) Licensed Alcohol and Drug Counselor; or

~~(F)~~ (G) Advanced Practice Nurse (certified in a psychiatric mental health specialty, licensed as a registered nurse with a current certification of recognition from the Board of Nursing in the state in which the services are provided); and

(3) a registered nurse with a minimum of two years of experience in a mental health treatment setting.

317:30-5-95.20. Discharge plan for persons over 65 years of age receiving inpatient acute psychiatric services

Each ~~patient~~ member over 65 years of age receiving inpatient acute psychiatric services must have a discharge plan that includes a recapitulation of the ~~patient's~~ member's hospitalization, recommendations for follow-up and aftercare to include referral to medication management, out-patient behavioral health counseling and/or case management to include the specific appointment information (time, date and name, address and telephone number of provider and related community services), and a summary of the ~~patient's~~ member's condition at discharge. All discharge and aftercare plans must be documented in the ~~patient's~~ member's medical records.

317:30-5-95.22 Coverage for children

(a) In order for services to be covered, services in acute hospitals, free-standing hospitals, and Psychiatric Residential Treatment Facilities must meet the requirements in OAC 317:30-5-95.25 through 317:30-5-95.30. OHCA rules that apply to inpatient psychiatric coverage for children are found in Sections OAC 317:30-5-95.24 through 317:30-5-95.42.

(b) **Definitions.** The following words and terms, when used in Sections OAC 317:30-5-95.22 through 317:30-5-95.42, shall have the following meaning, unless the context clearly indicates otherwise:

(1) **"Acute care"** means care delivered in a psychiatric unit of a general hospital or free-standing psychiatric hospital that provides assessment, medical management and monitoring, and short-term intensive treatment and stabilization to individuals experiencing acute episodes of behavioral health disorders.

(2) **"Border Placement"** means a placement in a facility that is in one of the states that borders Oklahoma (Arkansas, Colorado, Kansas, Missouri, New Mexico, and Texas). Border "status" may include other states that routinely provide PRTF services. Providers are subject to the same OHCA rules and program requirements as in-state providers, including claims submission procedures and are paid the same daily per diem as Oklahoma providers.

(3) **"Chemical Dependency/Substance Abuse services/ Detoxification"** means services offered to individuals with a substance-related disorder whose biomedical and emotional/behavioral problems are sufficiently severe to require inpatient care.

(4) **"Community Based Extended"** means a PRTF with 16 beds or more but less than 30 beds. The typical facility is not a locked facility.

(5) **"Community based transitional residential treatment"** means a level of care designed for children that require the continued structure, psychiatric intervention of 24 hour care but are ready to begin transitioning from more intense residential treatment into the community. It is the intent that members admitted to this level of care should be able to attend public school. Community based transitional are non- secure PRTFs with 16 beds or less.

~~(4)~~ (6) **"Designated Agent"** means the entity contracted with the OHCA to provide certain services to meet federal and state statutory obligations of the OHCA.

~~(5)~~ (7) **"Enhanced Treatment Unit or Specialized Treatment Unit"** means an intensive residential treatment unit that provides a program of care to a population with a special need or issues requiring increased staffing requirements, co-morbidities, environmental accommodations, specialized treatment programs, and longer lengths of stay.

~~(6)~~ (8) **"Evidenced Based Practice (EBP)"** according to the Substance Abuse and Mental Health Services Administration (SAMHSA) means programs or practices that are supported by research methodology and have produced consistently positive patterns of results.

(9) **"Freestanding PRTFs"** are generally for profit secure facilities which range from 50 to over 100 beds and are generally staffed higher with RN personnel.

~~(7)~~ (10) **"Out-of-State Placement"** means a placement for intensive or specialized services not available in Oklahoma requiring additional authorization procedures and approval by the OHCA Behavioral Health Unit.

(11) **"Provider Based"** facilities are secure residential treatment facilities that are affiliated with private medical/surgical hospitals. The RN hours per day average 2.4 hours.

(12) **"Public facilities"** are Oklahoma government owned or operated facilities.

~~(8)~~ (13) **"Residential Treatment services"** means psychiatric services that are designed to serve children who need longer term, more intensive treatment, and a more highly structured environment than they can receive in family and other community based alternatives to hospitalization.

~~(9)~~ (14) **"Trauma Informed"** means the recognition and responsiveness to the presence of the effects of past and current traumatic experiences in the lives of ~~patients~~ members.

317:30-5-95.23. Individuals age 21

Individuals eligible for ~~Oklahoma Medicaid~~ SoonerCare may be covered for inpatient psychiatric services before the ~~recipient~~ member reaches age 21 or, if the ~~recipient~~ member was receiving inpatient psychiatric services at the time he or she reached age 21. Services may continue until the ~~recipient~~ member no longer requires the services or the ~~recipient~~ member becomes 22 years of age, whichever comes first. Sections OAC 317:30-5-95.24 through 317:30-5-95.42 apply to coverage for inpatient services in acute care hospitals, freestanding psychiatric hospitals, and PRTFs.

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

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

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

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

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

(A) Marked impairments in the use of multiple nonverbal behaviors such as eye-to-eye gaze, facial expression, body postures, and gestures to regulate social interaction;
(B) Inability to regulate impulse control with frequent displays of aggression or other dangerous behavior toward self and/or others regularly;
(C) Failure to develop peer relationships appropriate to developmental level;
(D) Lack of spontaneously seeking to share enjoyment, interests, or achievements with other people;
(E) Lack of social or emotional reciprocity;
(F) Lack of attachment to caretakers;
(G) Require a higher level of assistance with activities of daily living requiring multiple verbal cues 50 percent of the time to complete tasks;
(H) Delay, or total lack of, the development of spoken language which is not accompanied by an attempt to compensate through alternative modes of communication such as gesture or mime;
(I) Marked impairment in individuals with adequate speech in the ability to initiate or sustain a conversation with others;
(J) Stereotyped and repetitive use of language or idiosyncratic language;
(K) Lack of varied, spontaneous make-believe play or social imitative play appropriate to developmental level;
(L) Encompassing preoccupation with one or more stereotyped and restricted pattern and interest that is abnormal in intensity of focus;
(M) Inflexible adherence to specific, nonfunctional routines or rituals;
(N) Stereotyped and repetitive motor mannerisms (e.g., hand or finger flapping or twisting or complex whole body movements);
(O) Persistent occupation with parts of objects;

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

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

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

(d) The designated agent will prior authorize all services for an approved length of stay based on the medical necessity criteria described in ~~OAC 317:30-5-95.25 through 317:30-5-95.31~~ in the OHCA Behavioral Health Provider Manual.

(e) Out of state placements must be approved by the agent designated by the OHCA and subsequently approved by the OHCA, Medical Services Behavioral Health Division. Requests for admission to Psychiatric Residential Treatment Facilities or acute care units will be reviewed for consideration of level of care, availability, suitability, and proximity of suitable services. A prime consideration for placements will be proximity to the family or guardian in order to involve the family or guardian in Active Treatment, including discharge and reintegration planning. Out of state facilities are responsible for insuring appropriate medical care as needed under SoonerCare provisions as part of the per-diem rate. Out of state facilities are responsible for insuring appropriate medical care as needed under SoonerCare provisions as part of the per-diem rate.

(f) Inpatient psychiatric services in all acute hospitals and psychiatric residential treatment facilities are limited to the approved length of stay. ~~The Agent designated by the~~ OHCA, or its designated agent, will approve

lengths of stay using the current OHCA Behavioral Health medical necessity criteria and following the current ~~inpatient provider manual approved by the~~ OHCA Behavioral Health Provider Manual. The approved length of stay applies to both hospital and physician services. The Child and Adolescent Level of Care Utilization System (CALOCUS) is a level of care assessment that will be used as a tool to determine the most appropriate level of care treatment for a member by LBHPs in the community.

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

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

~~(1) Any DSM-IV-TR Axis I primary diagnosis with the exception of V-codes, adjustment disorders, and substance related disorders, accompanied by a detailed description of the symptoms supporting the diagnosis. In lieu of a qualifying Axis I diagnosis, children 18-21 years of age may have an Axis II diagnosis of any personality disorder.~~

~~(2) Conditions are directly attributable to a mental disorder as the primary need for professional attention (this does not include placement issues, criminal behavior, status offenses). Adjustment or substance related disorder may be a secondary Axis I diagnosis.~~

~~(3) It has been determined by the OHCA designated agent that the current disabling symptoms could not have been managed or have not been manageable in a lesser intensive treatment program.~~

~~(4) Child must be medically stable.~~

~~(5) Within the past 48 hours, the behaviors present an imminent life threatening emergency such as evidenced by:~~

~~(A) Specifically described suicide attempts, suicide intent, or serious threat by the patient.~~

~~(B) Specifically described patterns of escalating incidents of self-mutilating behaviors.~~

~~(C) Specifically described episodes of unprovoked significant physical aggression and patterns of escalating physical aggression in intensity and duration.~~

~~(D) Specifically described episodes of incapacitating depression or psychosis that result in an inability to function or care for basic needs.~~

~~(6) Requires secure 24-hour nursing/medical supervision as evidenced by:~~

~~(A) Stabilization of acute psychiatric symptoms.~~

~~(B) Needs extensive treatment under physician direction.~~

~~(C) Physiological evidence or expectation of withdrawal symptoms which require 24-hour medical supervision.~~

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

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

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

~~(1) Any DSM-IV-TR Axis I primary diagnosis with the exception of V-Codes, adjustment disorders, and substance abuse related disorders, accompanied~~

~~by a detailed description of the symptoms supporting the diagnosis. In lieu of a qualifying Axis I diagnosis, children 18-20 years of age may have an Axis II diagnosis of any personality disorder. Adjustment or substance related disorders may be a secondary Axis I diagnosis.~~

~~(2) Patient continues to manifest a severity of illness that requires an acute level of care as defined in the admission criteria and which could not be provided in a less restrictive setting.~~

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

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

~~(3) Conditions are directly attributable to a mental disorder as the primary need for professional attention (this does not include placement issues, criminal behavior, status offenses).~~

~~(4) Documented efforts of working with child's family, legal guardians and/or custodians and other human service agencies toward a tentative discharge date.~~

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

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

~~Inpatient chemical dependency detoxification admissions for children must meet the terms and conditions contained in (1), (2), (3), and one of (4)(A) through (D) of this subsection.~~

~~(1) Any psychoactive substance dependency disorder described in DSM-IV-TR with detailed symptoms supporting the diagnosis and need for medical detoxification, except for cannabis, nicotine, or caffeine dependencies.~~

~~(2) Conditions are directly attributable to a substance dependency disorder as the primary need for professional attention (this does not include placement issues, criminal behavior, status offenses).~~

~~(3) It has been determined by the OHCA designated agent that the current disabling symptoms could not be managed or have not been manageable in a lesser intensive treatment program.~~

~~(4) Requires secure 24-hour nursing/medical supervision as evidenced by:~~

~~(A) Need for active and aggressive pharmacological interventions.~~

~~(B) Need for stabilization of acute psychiatric symptoms.~~

~~(C) Need extensive treatment under physician direction.~~

~~(D) Physiological evidence or expectation of withdrawal symptoms which require 24-hour medical supervision.~~

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

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

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

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

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

~~(1) Any DSM-IV-TR Axis I primary diagnosis with the exception of V-codes, adjustment disorders, and substance related disorders, accompanied by detailed symptoms supporting the diagnosis. In lieu of a qualifying Axis I diagnosis, children 18-20 years of age may have an Axis II diagnosis of any personality disorder. Adjustment or substance related disorders may be a secondary Axis I diagnosis.~~

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

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

~~(4) Child must be medically stable.~~

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

~~(A) suicidal ideation and/or threat.~~

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

~~(C) Serious threats or evidence of physical aggression.~~

~~(D) Current incapacitating psychosis or depression.~~

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

~~(A) Intensive behavioral management.~~

~~(B) Intensive treatment with the family/guardian and child in a structured milieu.~~

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

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

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

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

~~(1) Any DSM-IV-TR Axis I primary diagnosis with the exception of V codes, adjustment disorders, and substance abuse related disorders, accompanied by detailed symptoms supporting the diagnosis. In lieu of a qualifying Axis I diagnosis, children 18-20 years of age may have an Axis II diagnosis of any personality disorder.~~

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

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

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

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

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

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

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

~~(A) Documentation of regression is measured in behavioral terms.~~
~~(B) If condition is unchanged, there is evidence of re-evaluation of the treatment objectives and therapeutic interventions.~~
~~(5) There is documented continuing need for 24-hour observation and treatment as evidenced by:~~
~~(A) Intensive behavioral management.~~
~~(B) Intensive treatment with the family/guardian and child in a structured milieu.~~
~~(C) Intensive treatment in preparation for re-entry into community.~~
~~(6) Documented efforts of working with child's family, legal guardian and/or custodian and other human service agencies toward a tentative discharge date.~~

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

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

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

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

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

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

317:30-5-95.32. Quality of care requirements for children

(a) At the time of admission of the child to an inpatient psychiatric program, the admitting facility will provide the ~~patient~~ member and their family or guardian with written explanation of the facility's policy regarding the following:

(1) ~~Patient~~ Member rights.
(2) Behavior Management of ~~patients~~ members in the care of the facility.
(3) ~~Patient~~ Member Grievance procedures.
(4) Information for contact with the Office of Client Advocacy.
(5) Seclusion and Restraint policy.

(b) At the time of admission to an inpatient psychiatric program, the admitting facility will provide the ~~patient~~ member and their family or

guardian with the guidelines for the conditions of family or guardian participation in the treatment of their child. The written Conditions of Participation are provided for the facility by the Oklahoma Health Care Authority. These guidelines specify the conditions of the family or guardian's participation in "Active Treatment". The signature of the family member or guardian acknowledges their understanding of the conditions of their participation in "Active Treatment" while the ~~patient~~ member remains in the care of the facility. The conditions include provisions of participation required for the continued ~~Medicaid~~ SoonerCare compensable treatment. ~~Patients~~ Members 18 and over are exempt from the family participation requirement. Families of ~~patients~~ members that have been placed out of state for behavioral health treatment may not be able to attend family therapy each week but should remain active in the ~~patient's~~ member's treatment by telephone and attendance for family therapy at least once a month.
(c) Documented evidence must exist that the treatment program is trauma-informed.

317:30-5-95.33. Individual plan of care for children

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

(1) **"Licensed Behavioral Health Professional (LBHP)"** means licensed psychologists, licensed clinical social workers (LCSW), licensed marital and family therapists (LMFT), licensed professional counselors (LPC), licensed behavioral practitioners (LBP),licensed alcohol and drug counselors (LADC), and advanced practice nurses (APN).

(2) **"Individual plan of Care (IPC)"** means a written plan developed for each member within four calendar days of any admission to a PRTF and is the document that directs the care and treatment of that member. In Community Based Transitional RTC, the IPC must be completed within 7 days. The individual plan of care must be recovery focused, trauma informed, and specific to culture, age and gender and includes:

(A) the complete record of the DSM-IV-TR five-axis diagnosis, including the corresponding symptoms, complaints, and complications indicating the need for admission;

(B) the current functional level of the individual;

(C) treatment goals and measurable time limited objectives;

(D) any orders for psychotropic medications, treatments, restorative and rehabilitative services, activities, therapies, social services, diet and special procedures recommended for the health and safety of the ~~patient~~ member;

(E) plans for continuing care, including review and modification to the plan of care; and

(F) plan for discharge, all of which is developed to improve the child's condition to the extent that the inpatient care is no longer necessary.

(b) The individual plan of care:

(1) must be based on a diagnostic evaluation that includes examination of the medical, psychological, social, behavioral and developmental aspects of the individual member and reflects the need for inpatient psychiatric care;

(2) must be developed by a team of professionals as specified in OAC 317:30-5-95.35 in collaboration with the member, and his/her parents for members under the age of 18, legal guardians, or others in whose care he/she will be released after discharge;

(3) must establish treatment goals that are general outcome statements and reflective of informed choices of the member served. Additionally, the

treatment goal must be appropriate to the ~~patient's~~ member's age, culture, strengths, needs, abilities, preferences and limitations;

(4) must establish measurable and time limited treatment objectives that reflect the expectations of the member served and parent/legal guardian (when applicable) as well as being age, developmentally and culturally appropriate. When modifications are being made to accommodate age, developmental level or a cultural issue, the documentation must be reflected on the individual plan of care. The treatment objectives must be achievable and understandable to the member and the parent/guardian (when applicable). The treatment objectives also must be appropriate to the treatment setting and list the frequency of the service;

(5) must prescribe an integrated program of therapies, activities and experiences designed to meet the objectives;

(6) must include specific discharge and after care plans that are appropriate to the member's needs and effective on the day of discharge. At the time of discharge, after care plans will include referral to medication management, out-patient behavioral health counseling and case management to include the specific appointment date(s), names and addresses of service provider(s) and related community services to ensure continuity of care and reintegration for the member into their family school, and community;

(7) must be reviewed every five to nine calendar days when in acute care and a regular PRTF, ~~and~~ every 11 to 16 calendar days in the OHCA approved longer term treatment programs or specialty PRTF and every 30 days in Community Based Transitional treatment programs by the team specified to determine that services are being appropriately provided and to recommend changes in the individual plan of care as indicated by the member's overall adjustment, progress, symptoms, behavior, and response to treatment;

(8) development and review must satisfy the utilization control requirements for physician re-certification and establishment of periodic reviews of the individual plan of care; and,

(9) each individual plan of care review must be clearly identified as such and be signed and dated individually by the physician, LBHP, member, parent/guardian (for ~~patients~~ members under the age of 18), registered nurse, and other required team members. Individual plans of care and individual plan of care reviews are not valid until completed and appropriately signed and dated. All requirements for the individual plan of care or individual plan of care reviews must be met or a partial per diem recoupment will be merited. In those instances where it is necessary to fax an Individual Plan of Care or Individual Plan of Care review to a parent or OKDHS/OJA worker for review, the parent and/or OKDHS/OJA worker may fax back their signature. The Provider must obtain the original signature for the clinical file within 30 days. Stamped or ~~Xeroxed~~ photocopied signatures are not allowed for any parent or member of the treatment team.

317:30-5-95.34. Active treatment for children

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

(1) **"Expressive group therapy"** means art, music, dance, movement, poetry, drama, psychodrama, structured therapeutic physical activities, experiential (ROPES), recreational, or occupational therapies that encourage the member to express themselves emotionally and psychologically.

(2) **"Family therapy"** means interaction between a LBHP, member and family member(s) to facilitate emotional, psychological or behavioral changes and promote successful communication and understanding.

(3) **"Group rehabilitative treatment"** means behavioral health remedial services, as specified in the individual care plan which are necessary for the treatment of the existing primary behavioral health disorders and/or any secondary alcohol and other drug (AOD) disorders in order to increase the skills necessary to perform activities of daily living.

(4) **"Individual rehabilitative treatment"** means a face to face, one on one interaction which is performed to assist members who are experiencing significant functional impairment due to the existing primary behavioral health disorder and/or any secondary AOD disorder in order to increase the skills necessary to perform activities of daily living.

(5) **"Individual therapy"** means a method of treating existing primary behavioral health disorders and/or any secondary AOD disorders using face to face, one on one interaction between a LBPH and a member to promote emotional or psychological change to alleviate disorders.

(6) **"Process group therapy"** means a method of treating existing primary behavioral health disorders and/or secondary AOD disorders using the interaction between a LBHP as defined in ~~OAC 317:30-5-240(c)~~ OAC 317:30-5-240.3, and two or more ~~patients~~ members to promote positive emotional and/or behavioral change.

(b) Inpatient psychiatric programs must provide "Active Treatment". Active Treatment involves the member and their family or guardian from the time of an admission throughout the treatment and discharge process. Family members must attend family therapy weekly for continued SoonerCare reimbursement. Reasons for exceptions to this requirement must be well documented in the member's treatment plan. For individuals in the age range of 18 up to 21, it is understood that family members and guardians will not always be involved in the member's treatment. Active Treatment also includes an ongoing program of assessment, diagnosis, intervention, evaluation of care and treatment, and planning for discharge and aftercare under the direction of a physician. Evidence based practices such as trauma informed methodology should be utilized to minimize the use of seclusion and restraint.

(c) The components of Active Treatment consist of integrated therapies that are provided on a regular basis and will remain consistent with the member's ongoing need for care. The services and individual plan of care must be recovery focused, trauma informed, and specific to culture, age, and gender. Sixty minutes is the expectation to equal one hour of treatment. The following components meet the minimum standards required for Active Treatment, although an individual child's needs for treatment may exceed this minimum standard:

(1) Individual treatment provided by the physician. Individual treatment provided by the physician is required three times per week for acute care and one time a week in Residential Treatment Facilities. Individual treatment provided by the physician will never exceed ten days between sessions in PRTFs, ~~and~~ never exceed seven days in a specialty PRTF and never exceed 30 days in CBTs. Individual treatment provided by the physician may consist of therapy or medication management intervention for acute and residential programs.

(2) Individual therapy. LBHPs performing this service must use and document an approach to treatment such as cognitive behavioral treatment, narrative therapy, solution focused brief therapy or another widely accepted theoretical framework for treatment. Ongoing assessment of the member's status and response to treatment as well as psycho-educational intervention are appropriate components of individual therapy. Individual

therapy must be provided in a confidential setting. The therapy must be goal directed utilizing techniques appropriate to the individual ~~patient's~~ member's plan of care and the ~~patient's~~ member's developmental and cognitive abilities. Individual therapy must be provided two hours per week in acute care and one hour per week in residential treatment by a LBHP as described in ~~OAC 317:30-5-240(c)~~ OAC 317-30-5-240.3. One hour of family therapy may be substituted for one hour of individual therapy at the treatment team's discretion.

(3) Family therapy. The focus of family therapy must be directly related to the goals and objectives on the individual member's plan of care. Family therapy must be provided one hour per week for acute care and residential treatment for members under the age of 18. One hour of individual therapy addressing relevant family issues may be substituted for a family session in an instance in which the family is unable to attend a scheduled session by a LBHP as described in ~~OAC 317:30-5-240(c)~~ OAC 317:30-5-240.3.

(4) Process group therapy. The focus of process group therapy must be directly related to goals and objectives on the individual member's plan of care. The individual member's behavior and the focus of the group must be included in each member's medical record. This service does not include social skills development or daily living skills activities and must take place in an appropriate confidential setting, limited to the therapist, appropriate hospital staff, and group members. Group therapy must be provided three hours per week in acute care and two hours per week in residential treatment by a LBHP as defined in ~~OAC 317:30-5-240(c)~~ OAC 317-30-5-240.3. In lieu of one hour of process group therapy, one hour of expressive group therapy may be substituted.

(5) Expressive group therapy. Through active expression, inner-strengths are discovered that can help the member deal with past experiences and cope with present life situations in more beneficial ways. The focus of the group must be directly related to goals and objectives on the individual member's plan of care. Documentation must include how the member is processing emotions/feelings. Expressive therapy must be a planned therapeutic activity, facilitated by staff with a relevant Bachelor's degree and/or staff with relevant training, experience, or certification to facilitate the therapy. Expressive group therapy must be provided four hours per week in acute care, ~~and~~ three hours per week in residential treatment and twice a week in CBT. In lieu of one hour of expressive group therapy, one hour of process group therapy may be substituted.

(6) Group Rehabilitative treatment. Examples of educational and supportive services, which may be covered under the definition of group rehabilitative treatment services, are basic living skills, social skills (re)development, interdependent living, self-care, lifestyle changes and recovery principles. Each service provided under group rehabilitative treatment services must have goals and objectives, directly related to the individual plan of care. Group rehabilitative treatment services will be provided two hours each day for all inpatient psychiatric care with the exception of CBT. Group rehabilitative treatment in CBT must be provided 6 times a week. In lieu of two hours of group rehabilitative services per day, one hour of individual rehabilitative services per day may be substituted.

(7) Individual rehabilitative treatment. Services will be for the reduction of psychiatric and behavioral impairment and the restoration of functioning consistent with the requirements of independent living and enhanced self-sufficiency. This service includes educational and

supportive services regarding independent living, self-care, social skills (re)development, lifestyle changes and recovery principles and practices. Each individual rehabilitative treatment service provided must have goals and objectives directly related to the individualized plan of care and the ~~patient's~~ member's diagnosis. One hour of individual rehabilitative treatment service may be substituted daily for the two hour daily group rehabilitative services requirement.

(8) Modifications to active treatment. When a member is too physically ill or their acuity level precludes them from active behavioral health treatment, documentation must demonstrate that alternative clinically appropriate services were provided.

317:30-5-95.35. Credentialing requirements for treatment team members for children

(a) The team developing the individual plan of care for the child must include, at a minimum, the following:

(1) Allopathic or Osteopathic Physician with a current license and a board certification/eligible in psychiatry, or a current resident in psychiatry practicing as described in OAC 317:30-5-2(a)(1)(U), and

(2) a ~~mental~~ behavioral health professional licensed to practice by one of the following boards: Psychology (health service specialty only); Social Work (clinical specialty only); Licensed Professional Counselor, Licensed Behavioral Practitioner ; Licensed Alcohol and Drug Counselor (LADC),(or) Licensed Marital and Family Therapist or Advanced Practice Nurse (certified in a psychiatric mental health specialty, licensed as a registered nurse with a current certification of recognition from the Board of Nursing in the state in which the services are provided), and

(3) a registered nurse with a minimum of two years of experience in a mental health treatment setting.

(b) Candidates for licensure for Licensed Professional Counselor, Social Work (clinical specialty only), Licensed Marital and Family Therapist, Licensed Behavioral Practitioner, Licensed Alcohol and Drug Counselor and Psychology (health services specialty only) can provide individual therapy, family therapy and process group therapy as long as they are involved in the supervision that complies with their respective approved licensing regulations and the Department of Health and their work must be co-signed by a licensed LBHP who is additionally a member on the treatment team. Individuals who have met their supervision requirements and are waiting to be licensed by one of the licensing boards in OAC 317:30-5-95.35(a)(1) must have their work co-signed by a licensed MHP who is additionally a member on the treatment team.

(c) Services provided by treatment team members not meeting the above credentialing requirements are not ~~Medicaid~~ SoonerCare compensable and can not be billed to the ~~Medicaid recipient~~ SoonerCare member.

317:30-5-95.36. Treatment team for inpatient children's services

An interdisciplinary team of a physician, mental health professionals, registered nurse, ~~patient~~ member, parent/legal guardian for members under the age of 18, and other personnel who provide services to members in the facility must develop the individual plan of care, oversee all components of the active treatment and provide the services appropriate to their respective discipline. Based on education and experience, preferably including competence in child psychiatry, the teams must be:

(1) capable of assessing the member's immediate and long range therapeutic needs, developmental priorities and personal strengths and liabilities;

(2) capable of assessing the potential resources of the member's family, and actively involving the family of members under the age of 18 in the ongoing plan of care;
(3) capable of setting treatment objectives;
(4) capable of prescribing therapeutic modalities to achieve the plan objectives;
(5) capable of developing appropriate discharge criteria and plans; and
(6) trained in a recognized behavioral/management intervention program such as MANDT System, Controlling Aggressive Patient Environment (CAPE), SATORI, Professional Assault Crisis Training (PRO-ACT), or a trauma informed methodology with the utmost focus on the minimization of seclusion and restraints.

317:30-5-95.37. Medical, psychiatric and social evaluations for inpatient services for children

The ~~patient's~~ member's medical record must contain complete medical, psychiatric and social evaluations.

(1) These evaluations are considered critical documents to the integrity of care and treatment and must be completed as follows:

(A) History and physical evaluation must be completed within 48 hours of admission by a licensed independent practitioner (M.D., D.O., A.P.N., or P.A.) and within 7 days in a CBT.

(B) Psychiatric evaluation must be completed within 60 hours of admission by a M.D. or D.O and within 7 days in a CBT.

(C) Psychosocial evaluation must be completed within 72 hours of an acute admission ~~and~~ , within seven days of admission to a PRTF and within 7 days in a CBT by a licensed independent practitioner (M.D., D.O., A.P.N., or P.A.) or a mental health professional as defined in ~~OAC 317:30-5-240(c)~~ OAC 317-30-5-240.3.

(2) Each of the evaluations must be clearly identified as such and must be signed and dated by the evaluators.

(3) Each of the evaluations must be completed when the ~~patient~~ member changes levels of care if the existing evaluation is more than 30 days from admission. Evaluations remain current for 12 months from the date of admission and must be updated annually within seven days of that anniversary date.

(4) The history and physical evaluation, psychiatric evaluation and psychosocial evaluation must be completed within the time lines designated in this section or those days will be rendered non-compensable for ~~Medicaid~~ SoonerCare until completed.

317:30-5-95.38. Nursing services for children ~~(inpatient psychiatric acute only)~~

Each facility must have a qualified Director of Psychiatric Nursing. In addition to the Director of Nursing, there must be adequate numbers of registered nurses, licensed practical nurses, and mental health workers to provide nursing care necessary under the active treatment program and to maintain progress notes on each ~~patient~~ member. In a Community Based Transitional RTC, an RN must be on site at least one hour each day and be available 24 hours a day when not on site. A registered nurse must document ~~patient~~ member progress at least weekly except in a CBT where the requirement will be twice a month. The progress note must contain recommendations for revisions in the individual plan of care, as needed, as well as an assessment of the ~~patient's~~ member's progress as it relates to the individual plan of care goals and objectives.

317:30-5-95.39. Seclusion, restraint, and serious incident reporting requirements for children

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

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

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

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

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

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

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

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

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

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

(E) documentation that the member continually was monitored face to face by an assigned, trained staff member, or continually monitored by trained staff using both video and audio equipment during the seclusion/restraint;

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

(i) member's immediate situation;

(ii) member's reaction to intervention;

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

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

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

(H) debriefing of the child within 24 hours by a LBHP;

(I) debriefing of staff within 48 hours; and

(J) notification of the parent/guardian.

(b) Staff must be trained and able to demonstrate competency in the application of restraints, implementation of seclusion, monitoring, assessment, and providing care for a member in restraint or seclusion before performing any of these actions and subsequently on an annual basis. The

PRTF must require appropriate staff to have education, training, and demonstrated knowledge based on the specific needs of the ~~patient~~ member population in at least the following:

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

(2) the use of nonphysical intervention skills;

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

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

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

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

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

(c) Individuals providing staff training must be qualified as evidence by education, training and experience in techniques used to address members' behaviors. The PRTF must document in staff personnel records that the training and demonstration of competency were successfully completed.

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

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

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

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

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

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

317:30-5-95.40. Other required standards

The provider is required to maintain all programs and services according to applicable Code of Federal Regulations (CFR) requirements, ~~JCAHO~~ TJC/AOA standards for Behavioral Health care, State Department of Health's Hospital Standards for Psychiatric Care, and State of Oklahoma Department of Human Services Licensing Standards for Residential Treatment Facilities. Psychiatric Residential Treatment Facilities may substitute CARF accreditation in lieu of ~~JCAHO~~ TJC or AOA accreditation.

317:30-5-95.42. Inspection of care of psychiatric facilities providing services to children

(a) There will be an on site Inspection of Care (IOC) of each psychiatric facility that provides care to SoonerCare eligible children which will be performed by the OHCA or its designated agent. The Oklahoma Health Care Authority will designate the members of the Inspection of Care team.
(b) The IOC team will consist of one to three team members and will be comprised of Licensed Behavioral Health Professionals (LBHP) or Registered Nurses.
(c) The inspection will include observation and contact with members. The Inspection of Care Review will consist of members present or listed as facility residents at the beginning of the Inspection of Care visit as well as members on which claims have been filed with OHCA for acute or PRTF levels of care. The review includes validation of certain factors, all of which must be met for the services to be compensable.
(d) Following the on-site inspection, the Inspection of Care Team will report its findings to the facility. The facility will be provided with written notification if the findings of the inspection of care have resulted in any deficiencies. A copy of the final report will be sent to the facility's accrediting agency.
(e) Deficiencies found during the IOC may result in a partial per-diem recoupment or a full per-diem recoupment of the compensation received. The following documents are considered to be critical to the integrity of care and treatment and must be completed within the time lines designated in ~~OAC 317:30-5-95.37(a)(1) and 317:30-5-95.35(a)(2)~~ OAC 317:30-5-95.37:
(1) History and physical evaluation;
(2) Psychiatric evaluation;
(3) Psychosocial evaluation; and
(4) Individual Plan of Care.
(f) For each day that the History and Physical evaluation, Psychiatric evaluation, Psychosocial evaluation and Individual Plan of Care are not contained within the member's records, those days will warrant a full per-diem recoupment of the compensation received. Full per-diem recoupment will only occur for those documents.
(g) If the review findings have resulted in a partial per-diem recoupment of $50.00 per event, the days of service involved will be reported in the notification. If the review findings have resulted in full per diem recoupment status, the non-compensable days of service will be reported in the notification. In the case of non-compensable days full per diem or partial per diem, the facility will be required to refund the amount.
(h) Penalties of non-compensable days which are the result of the facility's failure to appropriately provide and document the services described herein, or adhere to applicable accreditation, certification, and/or state licensing standards, are not compensable or billable to the member or the member's family.

317:30-5-96.2. Payments definitions

The following words and terms, when used in Sections OAC 317:30-5-96.3 through 317:30-5-96.7, shall have the following meaning, unless the context clearly indicates otherwise:

"Allowable costs" means costs necessary for the efficient delivery of ~~patient~~ member care.

"Ancillary Services" means the services for which charges are customarily made in addition to routine services. Ancillary services include, but are not limited to, physical therapy, speech therapy, laboratory, radiology and prescription drugs.

"Border Status" means a placement in a state that does not border Oklahoma but agrees to the same terms and conditions of instate or border facilities.

~~**"Community-Based, transitional (CBT)"** means a non-secure PRTF that furnishes structured, therapeutic treatment services in the context of a family-like, small multiple resident home environment of 16 beds or less.~~

"Developmentally disabled child" means a child with deficits in adaptive behavior originating during the developmental period. This condition may exist concurrently with a significantly ~~subaverage~~ sub average general intellectual functioning.

"Eating Disorders Programs" means acute or intensive residential behavioral, psychiatric and medical services provided in a discreet unit to individuals experiencing an eating disorder.

~~**"Free-standing, Small"** means generally a small, non secure PRTF with 16 beds or more but less than 32 beds. These facilities may or may not have lock-down.~~

~~**"Free-standing, Medium"** means generally a secure PRTF with bed size ranging from 32 to 49 beds. Some may be non-secure.~~

~~**"Free-standing, Large"** means generally a for-profit, secure PRTF with bed size ranging for 50 to over 100 beds. Some may be non secure.~~

"Professional services" means services of a physician, psychologist or dentist legally authorized to practice medicine and/or surgery by the state in which the function is performed.

~~**"Provider-Based PRTF"** means a PRTF that is part of a larger general medical surgical main hospital, and the PRTF is treated as "provider based" under 42 CFR 413.65 and operates under the same license as the main hospital.~~

"Psychiatric Residential Treatment Facility (PRTF)" means a non-hospital with an agreement to provide inpatient psychiatric services to individuals under the age of 21.

~~**"Public"** means a hospital or PRTF owned or operated by the state.~~

"Routine Services" means services that are considered routine in the freestanding PRTF setting. Routine services include, but are not limited to:

(A) room and board;
(B) treatment program components;
(C) psychiatric treatment;
(D) professional consultation;
(E) medical management;
(F) crisis intervention;
(G) transportation;
(H) rehabilitative services;
(I) case management;
(J) interpreter services (if applicable);
(K) routine health care for individuals in good physical health; and
(L) laboratory services for a substance abuse/detoxification program.

"Specialty treatment program/specialty unit" means acute or intensive residential behavioral, psychiatric and medical services that provide care to a population with a special need or issues such as developmentally disabled, mentally retarded, autistic/Asperger's, eating disorders, sexual offenders, or reactive attachment disorders. These members require a higher level of care and staffing ratio than a standard PRTF and typically have multiple problems.

~~**"Sub-Acute Services"** means a planned regimen of 24-hour professionally directed evaluation, care, and treatment for individuals. Care is delivered by an interdisciplinary team to individuals whose sub-acute~~

~~neurological and emotional/behavioral problems are sufficiently severe to require 24-hour care. However, the full resources of an acute care general hospital or medically managed inpatient treatment is not necessary. An example of subacute care is services to children with pervasive developmental disabilities including autism, hearing impaired and dually diagnosed individuals with mental retardation and behavioral problems.~~

"Treatment Program Components" means therapies, activities of daily living and rehabilitative services furnished by physician/psychologist or other licensed mental health professionals.

"Usual and customary charges" refers to the uniform charges listed in a provider's established charge schedule which is in effect and applied consistently to most ~~patients~~ members and recognized for program reimbursement. To be considered "customary" for reimbursement, a provider's charges for like services must be imposed on most ~~patients~~ members regardless of the type of ~~patient~~ member treated or the party responsible for payment of such services.

317:30-5-96.3. Methods of payment

(a) **Reimbursement.** Covered inpatient psychiatric and/or substance abuse services will be reimbursed using one of the following methodologies:

(1) Diagnosis Related Group (DRG);

(2) cost based; or

(3) a predetermined per diem payment.

(b) **Acute Level of Care.**

(1) Psychiatric units within general medical surgical hospitals and Critical Access hospitals. Payment will be made utilizing a DRG methodology. [See OAC 317:30-5-41(b)]. Psychiatric professional (physicians and psychologists) services provided in conjunction with the inpatient stay are separately payable from the DRG paid to the hospital;

(2) Freestanding Psychiatric Hospitals. A predetermined statewide per diem payment will be made for all facility services provided during the inpatient stay. Psychiatric professional (physicians and psychologists) services provided in conjunction with the inpatient stay are separately payable from the per diem paid to the hospital. Rates vary for public and private providers.

(c) **~~Psychiatric~~ Residential ~~Treatment Facility (PRTF).~~ Level of Care**

(1) **Instate ~~Levels of Service~~ Services.**

(A) ~~Community-Based, extended~~ Psychiatric Hospitals or Inpatient Psychiatric Programs. A pre-determined all-inclusive per diem payment will be made for routine, ancillary and professional services. Public facilities will be reimbursed using either the statewide or facility specific interim rates and settled to total allowable costs as determined by analyses of the cost reports (Form CMS 2552) filed with the OHCA.

(B) ~~Community-Based, transitional~~ Psychiatric Residential Treatment Facilities. A pre-determined per diem payment will be made to private PRTFs with 16 beds or less for routine services. All other services are separately billable. A predetermined all-inclusive per diem payment will be made for routine, ancillary and professional services to private facilities with more than 16 beds. Public facilities will be reimbursed using either the statewide or facility specific interim rates and settled to total allowable costs as determined by analyses of the cost reports (Form 2552) filed with the OHCA.

~~(C) Freestanding, Private. A predetermined all-inclusive per diem payment will be made for routine, ancillary and professional services.~~

~~(D) Freestanding, Public. Facilities will be reimbursed using either the statewide or facility specific interim rates and settled to total allowable costs as determined by analyses of the cost reports (Form CMS 2552) filed with the OHCA.~~

~~(E) Provider based. A predetermined all inclusive per diem payment will be made for routine, ancillary and professional services.~~

(2) **Out-of-state services.**

(A) Border and "border status" placements. Facilities are reimbursed in the same manner as in-state hospitals or PRTFs.

(B) Out-of-state placements. In the event comparable services cannot be purchased from an Oklahoma facility and the current payment levels are insufficient to obtain access for the member, the OHCA may negotiate a predetermined, all-inclusive per diem rate for specialty programs/units ~~and/or subacute services~~. An incremental payment adjustment may be made for 1:1 staffing (if clinically appropriate and prior authorized). Payment may be up to, but no greater, than usual and customary charges. The 1:1 staffing adjustment is limited to 60 days annually.

317:30-5-96.4. Outlier intensity adjustment

Subject to approval by the Centers for Medicare and Medicaid Services (CMS), an outlier payment may be made to instate hospitals and PRTFs on a case by case basis, to promote access for those ~~patients~~ members who require expensive care. The intent of the outlier adjustment is to reflect the increased staffing requirements, co-morbidities and longer lengths of stay, for children with developmental disabilities or eating disorders. This adjustment is limited to 60 days annually.

317:30-5-96.7. Cost reports

Each hospital or PRTF submits to the OHCA its Medicare Cost Report (HCFA 2552), including Medicaid-specific information (as appropriate), for the annual cost reporting period. PRTFs who do not file a Medicare Cost Report must submit a cost report in a format designated by the OHCA. Failure to submit the required completed cost report is grounds for the OHCA to determine that a provider is not in compliance with its contractual requirements. The OHCA enters into a Common Audit Agreement with a designated fiscal intermediary to audit Medicaid cost reports.

Hospitals submit a copy of their cost reports to this designated fiscal intermediary. All payments made to providers are subject to adjustment based upon final (audited) cost report information.

6.b-8 CHAPTER 2. GRIEVANCE PROCEDURES AND PROCESS
OAC 317:2-1-2. [AMENDED]
OAC 317:2-1-6. [AMENDED]
OAC 317:2-1-14. [NEW]
(Reference APA WF # 10-31)

FINDING OF EMERGENCY: The Agency finds that a compelling public interest exists which necessitates promulgation of emergency rules and requests emergency approval of rule revisions to the agency's contract and purchasing guidelines. These emergency rule revisions will ensure rules are consistent and in compliance with current Oklahoma law. They will also clarify OHCA's ability to handle contracts and purchases internally, thereby allowing OHCA to make purchases necessary to agency operations without unnecessary delay.

ANALYSIS: OHCA grievance procedure and process rules are revised to provide for an appeals process for purchasing decisions made internally at OHCA, pursuant to 74 Okla. Stat., §85.5 (T). Further revisions are made to clean up simple terminology within the existing language. These revisions are needed to provide immediate consistency and clarity within agency purchasing rules.

BUDGET IMPACT: Agency staff has determined that the revisions are budget neutral.

MEDICAL ADVISORY COMMITTEE: The Medical Advisory Committee considered the proposed rule revisions on May 20, 2010, and recommended Board approval.

PROPOSED EFFECTIVE DATE: Immediately upon Governor's approval

AUTHORITY: The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes

RESOLUTION:
Resolved, that the Oklahoma Health Care Authority Board does hereby approve the Administrative Rules, subject to the Administrative Procedure Act, as indicated:
Revise Agency rules to provide for an appeals process for purchasing decisions made internally at OHCA, pursuant to 74 Okla. Stat., §85.5 (T) as well as to clean up simple terminology within the existing language.

TITLE 317: OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 2. GRIEVANCE PROCEDURES AND PROCESS

317:2-1-2. Appeals
(a) **Member Process Overview.**
(1) The appeals process allows a member to appeal a decision which adversely affects their rights. Examples are decisions involving medical services, prior authorizations for medical services, or discrimination complaints.
(2) In order to file an appeal, the member files a LD-1 form within 20 days of the triggering event. The triggering event occurs at the time

when the Appellant (Appellant is the person who files a grievance) knew or should have known of such condition or circumstance for appeal~~)~~.

(3) If the LD-1 form is not received within 20 days of the triggering event, OHCA sends the Appellant a letter stating the appeal will not be heard because it is untimely. In the case of tax warrant intercept appeals, if the LD-1 form is not received within 30 days of written notice sent by OHCA according to Title 68 O.S. § 205.2, OHCA sends the Appellant a letter stating the appeal will not be heard because it is untimely.

(4) If the LD-1 form is not completely filled out and necessary documentation not included, then the appeal will not be heard.

(5) The staff advises the Appellant that if there is a need for assistance in reading or completing the grievance form that arrangements will be made.

(6) Upon receipt of the member's appeal, a fair hearing before the Administrative Law Judge (ALJ) will be scheduled. The member will be notified in writing of the date and time for this procedure. The member must appear at this hearing and it is conducted according to ~~Section~~ OAC 317:2-1-5. The ALJ's decision may be appealed to the ~~CEO~~ Chief Executive Officer of the OHCA, which is a record review at which the parties do not appear (Section OAC 317:2-1-13).

(7) Member appeals are ~~to be~~ ordinarily decided within 90 days from the date OHCA receives the member's timely request for a fair hearing unless the member waives this requirement. [Title 42 ~~U.S.C.~~ CFR Section 431.244(f)]

(8) Tax warrant intercept appeals will be heard directly by the ALJ. A decision ~~will be~~ is normally rendered by the ALJ within 20 days of the hearing before the ALJ.

(b) **Provider Process Overview.**

(1) The proceedings as described in this Section contain the hearing process for those appeals filed by providers. These appeals encompass all subject matter cases contained in OAC 317:2-1-2(c)(2).

(2) All provider appeals are initially heard by the OHCA Administrative Law Judge under OAC 317:2-1-2(c)(2).

(A) The Appellant (Appellant is the provider who files a grievance) files an LD form requesting a grievance hearing within 20 days of the triggering event. The triggering event occurs at the time when the Appellant knew or should have known of such condition or circumstance for appeal. (LD-2 forms are for provider grievances and LD-3 forms are for nursing home wage enhancement grievances.)

(B) If the LD form is not received within 20 days of the triggering event, OHCA sends the Appellant a letter stating the appeal will not be heard because it is untimely.

(C) The staff advises the Appellant that if there is a need for assistance in reading or completing the grievance form that arrangements will be made.

(D) A decision will be rendered by the ALJ ordinarily within 45 days of the close of all evidence in the case.

(E) The Administrative Law Judge's decision is appealable to OHCA's CEO under OAC 317:2-1-13.

(c) **ALJ jurisdiction.** The administrative law judge has jurisdiction of the following matters:

(1) Member Appeals:

(A) Discrimination complaints regarding the ~~Medicaid~~ SoonerCare program;

(B) Appeals which relate to the scope of services, covered services, complaints regarding service or care, enrollment, disenrollment, and reenrollment in the SoonerCare Program;

(C) Fee for Service appeals regarding the furnishing of services, including prior authorizations;
(D) Appeals which relate to the tax warrant intercept system through the Oklahoma Health Care Authority. Tax warrant intercept appeals will be heard directly by the ALJ. A decision will be rendered by the Administrative Law Judge within 20 days of the hearing before the ALJ;
(E) Complaints regarding the possible violation of the Health Insurance Portability and Accountability Act of 1996 (HIPAA); ~~and~~
(F) Proposed administrative sanction appeals pursuant to OAC 317:35-13-7. Proposed administrative sanction appeals will be heard directly by the ALJ. A decision by the ALJ will ordinarily be rendered within 20 days of the hearing before the ALJ. This is the final and only appeals process for proposed administrative sanctions; and

(2) Provider Appeals:
(A) Whether Pre-admission Screening and Resident Review (PASRR) was completed as required by law;
(B) Denial of request to disenroll member from provider's SoonerCare Choice panel;
(C) Appeals by Long Term Care facilities for nonpayment of wage enhancements, determinations of overpayment or underpayment of wage enhancements, and administrative penalty determinations as a result of findings made under OAC 317:30-5-131.2(b)(5), (e)(8), and (e)(12);
(D) Petitions for Rulemaking;
(E) Appeals of insureds participating in Insure Oklahoma/ O-EPIC which are authorized by OAC 317:45-9-8(a);
(F) Appeals to the decision made by the ~~Business~~ Contracts manager related to ~~Purchasing as found at OAC 317:10-1-5~~ reports of supplier non-compliance to the Central Purchasing Division, Oklahoma Department of Central Services and other appeal rights granted by contract;
(G) Drug rebate appeals;
(H) Nursing home contracts which are terminated, denied, or non-renewed; ~~and~~
(I) Proposed administrative sanction appeals pursuant to OAC ~~317:35-13-7~~ 317:30-3-19. Proposed administrative sanction appeals will be heard directly by the ALJ. A decision will normally be rendered by the ALJ within 20 days of the hearing before the ALJ. This is the final and only appeals process for proposed administrative sanctions~~.~~; and
(J) Contract award appeals.

317:2-1-6. Other grievance procedures and processes

Other grievance procedures and processes include those set out in OAC 317:2-1-7 (Program Integrity Audits/Reviews Appeals); OAC 317:2-1-8 (Nursing Home Provider Contract Appeals); OAC 317:2-1-9 (OHCA's Designated Agent's Appeal Process for QIO Services); OAC 317:2-1-10 (Drug Rebate Appeal Process); OAC 317:2-1-11 [Medicaid Drug Utilization Review Board (DUR) Appeal Process]; ~~and~~ OAC 317:2-1-12 (For Cause Provider Contract Suspension/Termination Appeals Process); and OAC 317:2-1-14 (Contract Award Protest Process).

317:2-1-14. Contract Award Protest Process

Suppliers who respond to a solicitation issued and awarded by the OHCA pursuant to 74 Okla. Stat. 85.5 T may protest the award of a contract under such solicitation.

(1) A supplier shall submit written notice to the Director of Legal Operations of a protest of an award of a contract by OHCA pursuant to 74 Okla. Stat. 85.5 T within ten (10) business days of contract award. The protest shall state supplier facts and reasons for protest.
(2) The Legal Operations Director shall review the supplier's protest and contract award documents. Written notice of the decision by the Legal Operations Director to sustain or deny the supplier's protest will be sent to the supplier within ten (10) business days of receipt of supplier's written notice.
(3) If the Legal Operations Director denies the supplier's protest, the supplier may request a hearing to administratively resolve the matter within twenty (20) business days of receipt of the Legal Operations Director's written denial by filing a form LD-2 with the Docket Clerk.
(4) The process afforded the supplier will be the process found at OAC 317:2-1-2(b)(1) through (2)(D).
(5) The ALJ's decision will constitute the final administrative decision of the OHCA.

DEPARTMENT OF HUMAN SERVICES
AGING SERVICES DIVISION

RATE PROPOSAL

ADVANTAGE WAIVER INCONTINENCE SUPPLIES

June 3, 2010

RECOMMENDATION TO THE
STATE PLAN AMENDMENT RATE COMMITTEE (SPARC)
OKLAHOMA HEALTH CARE AUTHORITY

RATE PROPOSAL
ADVANTAGE INCONTINENCE SUPPLIES

ISSUE

The Oklahoma Health Care Authority, in conjunction with The Oklahoma Department of Human Services (OKDHS) the state agency responsible for administration of the ADvantage Program serving elders and adults with physical disabilities requests establishment of fixed and uniform rates for incontinence supplies. This request is to ensure access to this service and ensure uniform reimbursement for these supplies.

EFFECTIVE DATE:

The Oklahoma Department of Human Services recommends that the new rate become effective July 1, 2010.

PROCEDURE CODE:

The ADvantage case worker must authorize the need for the following incontinence supplies on the member's plan of care.

Incontinence Supplies	Proposed Price
• Adult Small Brief-T4521	$ .78 Ea
• Adult Medium Brief-T4522	$ .85 Ea
• Adult Large Brief-T4523	$ .96 Ea
• Adult Extra Large Brief-T4524	$ 1.13 Ea
• Adult Small Underwear –T4525	$ .86 Ea
• Adult Medium Underwear-T4526	$ 1.01 Ea
• Adult Large Underwear-T4527	$ 1.10 Ea
• Adult Extra Large Underwear-T4528	$ 1.25 Ea
• Disposable /Guard Liner-T4535	$ .59 Ea
• Any Size Reusable Underpad T4537	$13.50 Ea
• Chair Size Reusable Underpad T4540	$14.40 Ea
• Large Disposable Underpad T4541	$ .58 Ea
• Small Disposable Underpad T4542	$ .38 Ea

The following items will be priced using the manual pricing methodology.

- Disposable incontinence product, brief/diaper, bariatric, each – T4543

DESCRIPTION OF SERVICES

Incontinence supplies are provided for those members that receive ADvantage Waiver serving elders and adults with physical disabilities. The incontinence supplies include briefs, underwear, liners and underpads. By providing incontinence supplies it allows the member to have more freedom, assists in reducing skin irritations, other infections, and prevents placement in an institution. The member's Case Manager must authorize the need for incontinence supplies. Once the authorization is approved the incontinence supplies become a part of the goal of the service plan.

The goals of service provisions are:

- To facilitate the member's independence by allowing the choice to remain in his/her home.
- To provide a medically appropriate solution for members experiencing incontinence who are also at risk of institutionalization
- To provide the member self-confidence in social settings and thereby assist in ensuring the member's well being

SoonerCare Durable Medical Equipment providers who have been approved by OKDHS and also have a current contract with the Oklahoma Health Care Authority are eligible to provide these supplies.

ELIGIBILITY REQUIREMENTS

To receive ADvantage Waiver the member must be financially and medically eligible to participate in the program. All services are prior authorized based on assessed need for services.

To receive incontinence supplies in the ADvantage Program, a member's Activities of Daily Living (ADL) Score from the Universal Comprehensive Assessment Tool (UCAT) must be consistent with the determination of the incontinence as defined in the UCAT Assessor Manual.

RATE SETTING METHODOLOGY

Each year the growth for number of ADvantage members continues as does the expenditures for incontinence supplies. In 2005 there were 16,526 ADvantage members receiving ADvantage services. In December 2009 there were 23,751 ADvantage members. From January 2009 to December 2009 the state of Oklahoma spent $ 12,422,546 for incontinence supplies for the members in the ADvantage program. During calendar year 2009 there were 8,829 unduplicated ADvantage members who received A4520 and 3,930 ADvantage members who received A4554.

Currently, the members ADvantage Case Manager must contact the Durable Medical Equipment provider and ask for a price quote on supplying the items needed by the member. In order for a member to receive incontinence supplies the Case Manager must gather individual prices from individual providers and choose the one with the best price. Currently prices for incontinence supplies range from $.24 to $159.58. Due to the need for the price quoting and the wide variance in prices it seems practical to establish a fixed and uniform rate.

The Oklahoma Department of Human Services gathered rate information on incontinence supplies from the following states: Alabama, Arkansas, Colorado, Idaho, Illinois, Iowa, Kansas, Louisiana, Maryland, Minnesota, New Jersey, New Mexico, Nebraska, Nevada, North Carolina, Ohio, Oregon, Pennsylvania, South Carolina, Texas, Wisconsin, Washington, and Wyoming. Within these states there is a combination of drop ship and personal delivery for the incontinence products allowed included in the rate. The following are average rates for these states for each of the products listed:

• Adult Small Brief-T4521	$ .65 Ea
• Adult Medium Brief-T4522	$ .71 Ea
• Adult Large Brief-T4523	$ .85 Ea
• Adult Extra Large Brief-T4524	$ .94 Ea
• Adult Small Underwear –T4525	$ .78 Ea
• Adult Medium Underwear-T4526	$ .85 Ea
• Adult Large Underwear-T4527	$ .97 Ea
• Adult Extra Large Underwear-T4528	$ 1.04 Ea
• Disposable /Guard Liner-T4535	$ .49 Ea
• Any Size Reusable Underpad T4537	*
• Chair Size Reusable Underpad T4540	*
• Large Disposable Underpad T4541	$ .39 Ea
• Small Disposable Underpad T4542	*

After researching other states, gathering information from the DME providers, the rates under procedure code are requested to assure that the state of Oklahoma is spending appropriate amounts for incontinence supplies for ADvantage Waiver members. New rates will be sufficient to cover providers costs of delivering the service based on comparisons of other states.

* Indicates there was either no data for the product or the other states listed do not pay for the product.

FEDERAL LAW FINDING: The agency finds that there is a difference in cost rationally related between the delivery of this service in the public and private sector. The Agency finds that the cost method described here adequately describes the costs at this time and finds that this method adequately compensates state government for these costs.

FINANCIAL IMPACT

These price reductions will represent a 25% decrease in the total spend for incontinence supplies or approximately three million dollars.

DEVELOPMENTAL DISABILITIES SERVICES DIVISION

RATE PROPOSAL

DDSD TARGETED CASE MANAGEMENT

June 3, 2010

RECOMMENDATIONS TO THE
STATE PLAN AMENDMENT RATE COMMITTEE (SPARC)

ISSUE

This is a proposal to implement a weekly rate for Developmental Disabilities Services Division Targeted Case Management (DDSDTCM) services. This service is available to members with developmental disabilities who are eligible under the Medicaid State Plan. Currently, DDSDTCM services are billed on a unit rate based on the monthly cost per case. Due to changes in Federal regulations limiting the duration of targeted case management units, a weekly rate is requested.

RECOMMENDATION

The Oklahoma Department of Human Services recommends an interim rate of $183.95 per weekly unit. Thereafter, on a quarterly basis, the actual year-to-date costs of providing services will be compared with invoiced amounts to determine any over or under recovery of Federal Financial Participation. The rate for subsequent service periods will be adjusted to accommodate this variance. Subsequent to the end of the state fiscal year, a final reconciliation between final allowable costs and total billed amounts will be performed. Any over or under recovery of funding will be factored into the following year's rate computation.

EFFECTIVE DATE: The Oklahoma Department of Human Services recommends the rate become effective the first day of the month following approval from the Oklahoma Health Care Authority Board.

PROCEDURE CODES:

Targeted Case Management = T2023

DESCRIPTION OF SERVICES

The DDSDTCM case manager is an OKDHS-DDSD professional who provides cash management services to service recipients of the Home and Community Based Waivers (HCBW), residents of institutions requesting HCBW services, or individuals being assessed for admission to the HCBW Waiver. Targeted case management services are provided to Medicaid eligible recipients to assist in gaining access to necessary medical, social, educational, or other services. Case managers are responsible for assessing recipients' needs for services; development of individual plans and specific plans of care; referral activities to aid recipients to obtain needed services by linking them with medical, social, educational providers or other programs and services; and monitoring and follow-up activities to ensure individual plans and plans of care are implemented and continue to meet the individual's needs. The case manager's contact may be with the individual, his/her family members, providers, or others and such contact may occur as necessary to ensure services are being adequately furnished, and if changes are necessary to plans of care to ensure services continue to meet the individual's needs. Case management services are provided to the extent they are in the best interest of recipients and are not intended to restrict access to other available services, nor are individuals

required to receive case management services as a condition of receiving other SoonerCare services.

ELIGBILITY REQUIREMENTS

To receive targeted case management services, individuals must be eligible under Oklahoma's Medicaid State Plan; have a developmental disability; and be either (1) served by the Home and Community Based Waivers operated by the Oklahoma Department of Human Services, (2) reside in an institution and request Home and Community Based Waiver services, or (3) assessed for admission to the Home and Community Based Waiver. Residents in institutions may receive targeted case management services for a transition period which does not exceed 180 consecutive days prior to entering the Waiver.

RATE SETTING METHODOLOGY

The Developmental Disabilities Services Division Targeted Case Management (DDSDTCM) rate is based on the weekly cost per case to provide targeted case management services. The cost base consists of the annualized cost of direct case management staff, including applicable agency overhead and indirect service costs, which have been computed and allocated in accordance with the Oklahoma Department of Human Services' cost allocation plan. This plan including its methodologies for allocating costs to state and federal programs is reviewed and approved by the Department of Health and Human Services' Division of Cost Allocation. The weekly rate is computed by dividing the annual cost base, including a prior period adjustment necessary to reconcile prior years' allowable costs against total billable amounts, by a projected annual number of weekly units of service. The maximum annual number of billable units of service is estimated to be 130,000. Units of service are defined as one calendar week of targeted case management, provided that a minimum of one contact meeting the description of targeted case management was provided, with or on behalf of an eligible recipient, and documented for the calendar week.

On a quarterly basis, the actual year-to-date costs of providing services will be compared with invoiced amounts to determine any over or under recovery of Federal Financial Participation. The rate for subsequent service periods will be adjusted to accommodate this variance. Subsequent to the end of the state fiscal year, a final reconciliation between final allowable costs and total billed amounts will be performed. Any over or under recovery of funding will be factored into the following year's rate computation.

FEDERAL LAW FINDING: The agency finds that there is a difference in cost rationally related between the delivery of this service in the public and private sector. The Agency finds that the cost method described here adequately describes the costs at this time and finds that this method adequately compensates state government for these costs.

FISCAL IMPACT

Based on the lack of changes to the underlying principles of the DDSDTCM rate setting methodology, the change from a monthly rate to weekly rate will have no fiscal impact.

DEVELOPMENTAL DISABILITIES SERVICES DIVISION - TARGETED CASE MANAGEMENT
WEEKLY RATE
STATE FISCAL YEAR ENDING JUNE 30, 2011

DDSD - Area Offices - TCM		
Salaries / Benefits	$ 20,308,312.00	
Professional Services	$ 49,734.00	
Operating Costs	$ 1,183,459.00	
Sub-Total: DDSD-Area Offices-TCM		$ 21,541,505.00
DDSD Program Support and Staff Training		
Salaries / Benefits	$ 1,606,521.69	
Professional Services	$ 1,338,411.94	
Operating Costs	$ 1,750,605.81	
Sub-Total: DDSD Program Support and Staff Training		$ 4,695,539.45
Agency-Wide Support Services		
Salaries / Benefits	$ 2,013,600.29	
Professional Services	$ 49,637.38	
Operating Costs	$ 1,028,652.87	
Sub-Total: Agency-Wide Support Services		$ 3,091,890.54
Total DDSD TCM Budgeted Costs		$ 29,328,934.99
Prior Budget Year DDSD TCM Expenditures - Cash Basis		$ 1,558,074.92
Total DDSD TCM Budgeted Costs - Cash Basis		**$ 30,887,009.91**

Current State Fiscal Year Budget Under-Run in DDSD Area Office Targeted Case Management		
DDSD Area Office Targeted Case Management	$ 21,541,505.00	
Budget Variance (Actual Costs - Year-to-Date Budget)	-8.05%	
Projected Costs Over(Under) OKDHS DDSD Area Office TCM Budget		**$ (1,734,091.15)**

DDSD TCM Budgeted Costs - Cash Basis		$ 30,887,009.91
Projected Costs Over(Under) DDSD Area Office TCM Budget		$ (1,734,091.15)
Under-Recovery of Costs from State Fiscal Year 2010		$ (5,239,291.82)
Net Expenditures to Recover for State Fiscal Year 2011 - Cash Basis		**$ 23,913,626.94**
Estimated Annual # of Units	130,000	
DDSD - Targeted Case Management - Weekly Rate		**$ 183.95**

Comments: OKDHS costs used to build the Child Welfare Targeted Case Management (CWTCM) rate have been allocated to the program based on OKDHS' Cost Allocation Plan (CAP). The Cost Allocation Plan has been approved by the DHHS - Division of Cost Allocation.

CHILDREN AND FAMILY SERVICES DIVISION

RATE PROPOSAL

CHILD WELFARE TARGETED CASE MANAGEMENT

June 3, 2010

RECOMMENDATIONS TO THE
STATE PLAN AMENDMENT RATE COMMITTEE (SPARC)

ISSUE

This is a proposal to implement a weekly rate for Child Welfare Targeted Case Management (CWTCM) services. This service is available to children under the age of 18 who are in the voluntary, emergency, temporary, or permanent custody of the Oklahoma Department of Human Services (OKDHS) and are in out-of-home care or trial adoption. Currently, CWTCM services are billed on a unit rate based on the monthly cost per case. Due to changes in Federal regulations limiting the duration of targeted case management units, a weekly rate is requested.

RECOMMENDATION

The Oklahoma Department of Human Services recommends an interim rate of $204.29 per weekly unit. Thereafter, on a quarterly basis, the actual year-to-date costs of providing services will be compared with invoiced amounts to determine any over or under recovery of Federal Financial Participation. The rate for subsequent service periods will be adjusted to accommodate this variance. Prior to the end of the state fiscal year, a final reconciliation between final allowable costs and total billed amounts will be performed. Any over or under recovery of funding will be factored into the following year's rate computation.

EFFECTIVE DATE: The Oklahoma Department of Human Services recommends the rate become effective the first day of the month following approval from the Oklahoma Health Care Authority Board.

PROCEDURE CODES:

Targeted Case Management = T2023

DESCRIPTION OF SERVICES

Child Welfare Targeted Case Management services are provided to children in the custody of the Oklahoma Department of Human Services and are currently placed in out-of-home care or trial adoption. Targeted case management services are provided to Medicaid eligible recipients to assist in gaining access to necessary medical, social, educational, or other services. These services include those covered under the Oklahoma Medicaid State Plan as well as those services not covered under the State Plan. Case managers are responsible for assessing recipients' needs for services; development of individual plans and specific plans of care; referral activities to aid recipients to obtain needed services by linking them with medical, social, educational providers or other programs and services; and monitoring and follow-up activities to ensure individual plans and plans of care are implemented and continue to meet the individual's needs. The case manager's contact may be with the individual, his/her family members, providers, or others and such contact may occur as necessary to ensure services are being adequately furnished, and if changes are necessary to plans of care to ensure services continue to meet the individual's needs. Case management services are provided to the extent they

are in the best interest of recipients and are not intended to restrict access to other available services, nor are individuals required to receive case management services as a condition of receiving other SoonerCare services.

ELIGBILITY REQUIREMENTS

To receive targeted case management services, individuals must be eligible under Oklahoma's Medicaid State Plan; under the age of 18; placed in voluntary, emergency, temporary, or permanent custody of OKDHS; and are residing in either out-of-home care or trial adoption.

RATE SETTING METHODOLOGY

The Child Welfare Targeted Case Management (CWTCM) rate is based on the weekly cost per case to provide targeted case management services. The cost base consists of the annualized cost of case management staff, including applicable agency overhead and indirect service costs, which have been computed and allocated in accordance with the Oklahoma Department of Human Services' cost allocation plan. This plan including its methodologies for allocating costs to state and federal programs is reviewed and approved by the Department of Health and Human Services' Division of Cost Allocation. The weekly rate is computed by dividing the annual cost base, including a prior period adjustment necessary to reconcile prior years' allowable costs against total billable amounts, by a projected annual number of weekly units of service. The maximum annual number of billable units of service is estimated to be 123,425. Units of service are defined as one calendar week of targeted case management, provided that a minimum of one contact meeting the description of targeted case management was provided, with or on behalf of an eligible recipient, and documented for the calendar week.

On a quarterly basis, the actual year-to-date costs of providing services will be compared with invoiced amounts to determine any over or under recovery of Federal Financial Participation. The rate for subsequent service periods will be adjusted to accommodate this variance. Subsequent to the end of the state fiscal year, a final reconciliation between final allowable costs and total billed amounts will be performed. Any over or under recovery of funding will be factored into the following year's rate computation.

FEDERAL LAW FINDING: The agency finds that there is a difference in cost rationally related between the delivery of this service in the public and private sector. The Agency finds that the cost method described here adequately describes the costs at this time and finds that this method adequately compensates state government for these costs.

FISCAL IMPACT

Based on the lack of changes to the underlying principles of the CWTCM rate setting methodology, the change from a monthly rate to weekly rate will have no fiscal impact.

CHILD WELFARE - TARGETED CASE MANAGEMENT
WEEKLY RATE
STATE FISCAL YEAR ENDING JUNE 30, 2011

Field Operations - Child Welfare Staff				
Salaries / Benefits	$	12,263,948.43		
Professional Services	$	25,634.69		
Operating Costs	$	1,000,155.63		
Sub-Total: Field Operations - Child Welfare Staff			$	13,289,738.74
Program Support and Staff Training				
Salaries / Benefits	$	2,891,637.58		
Professional Services	$	1,306,841.69		
Operating Costs	$	1,275,888.70		
Sub-Total: Field Support and Training			$	5,474,367.97
Agency-Wide Support Services				
Salaries / Benefits	$	1,774,489.89		
Professional Services	$	85,477.48		
Operating Costs	$	804,841.37		
Sub-Total: Agency-Wide Support Services			$	2,664,808.74
Total Child Welfare TCM Budgeted Costs			$	21,428,915.46
Prior Budget Year Child Welfare TCM Expenditures - Cash Basis			$	1,778,528.10
Total Child Welfare TCM Budgeted Costs - Cash Basis			**$**	**23,207,443.56**

Current State Fiscal Year Budget Over-Run in Field Operation Child Welfare Staff Location				
Field Operations - Child Welfare Staff Budget	$	13,289,738.74		
Anticipated Budget Variance (Actual Costs - Year-to-Date Budget)		8.15%		
Projected Costs Over(Under) OKDHS Field Operations - Child Welfare Staff Budget			**$**	**1,083,113.71**

Child Welfare TCM Budgeted Costs - Cash Basis			$	23,207,443.56
Anticipated Budget Variance (Actual Costs - Year-to-Date Budget)			$	1,083,113.71
Projected Under-Recovery of Costs from State Fiscal Year 2010			$	923,866.35
Net Expenditures to Recover for State Fiscal Year 2011 - Cash Basis			**$**	**25,214,423.62**
Estimated Annual # of Units		123,425		
Child Welfare - Targeted Case Management - Weekly Rate			**$**	**204.29**

Comments: OKDHS costs used to build the Child Welfare Targeted Case Management (CWTCM) rate have been allocated to the program based on OKDHS' Cost Allocation Plan (CAP). The Cost Allocation Plan has been approved by the DHHS - Division of Cost Allocation.

RECOMMENDATIONS TO THE
STATE PLAN AMENDMENT RATE COMMITTEE (SPARC)
OKLAHOMA HEALTH CARE AUTHORITY

ISSUE

This is a proposal to implement a weekly rate for Targeted Case Management services for children under age18 who are who are involved in, or at serious risk of involvement with the juvenile justice system (excludes those who are involuntarily in secure custody of law enforcement or judicial systems) (OJATCM). Currently, OJATCM services are billed on a unit rate based on the monthly cost per case. Due to changes in Federal regulations limiting the duration of targeted case management units, a weekly rate is requested.

RECOMMENDATION

The Oklahoma Office of Juvenile Affairs recommends a rate of $299.44 per weekly unit with reimbursement limited to an annual maximum of 4 units per member/per year.

EFFECTIVE DATE: The Oklahoma Office of Juvenile Affairs recommends the rate become effective the first day of the month following approval from the Oklahoma Health Care Authority Board or the effective date of the approved Oklahoma Medicaid State Plan.

DESCRIPTION OF SERVICES (42 CFR 440.169):

Targeted case management services are defined as services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational and other services. Targeted Case Management includes the following assistance:

- Comprehensive assessment and periodic reassessment of individual needs, to determine the need for any medical, educational, social or other services. These assessment activities include
  - taking client history;
  - identifying the individual's needs and completing related documentation; and
  - gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the eligible individual;
- Development (and periodic revision) of a specific care plan that is based on the information collected through the assessment that
  - specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;
  - includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and
  - identifies a course of action to respond to the assessed needs of the eligible individual;
- Referral and related activities (such as scheduling appointments for the individual) to help the eligible individual obtain needed services including
  - activities that help link the individual with medical, social, educational providers, or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the care plan; and
- Monitoring and follow-up activities:
  - activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the eligible individual's needs, and which may be with the

individual, family members, service providers, or other entities or individuals and conducted as frequently as necessary, and including at least one annual monitoring, to determine whether the following conditions are met:

1. services are being furnished in accordance with the individual's care plan;
2. services in the care plan are adequate; and

changes in the needs or status of the individual are reflected in the care plan. Monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers.

RATE SETTING METHODOLOGY

The reimbursement methodology is based upon qualifying costs for the eligible population from the 2009 Cost Allocation Plan with a unit of service equal to one week. The TCM unit rate is a prospective flat rate based on a qualifying TCM worker contact with the client in the target population or with some other person on behalf of the client during the claim period.

The weekly rate covers both service provision and administrative costs. The rates are based on an average of direct, general and administrative and information technology costs which were obtained from provider agencies within the state. Direct costs include those items necessary for the provision of the service such as salaries, benefits, travel costs, phone, training, and professional clinical consultation. General and administrative costs and information technology are 4% of the total direct costs. The resulting rate is $299.44 per week based on 23,349 contacts per year. Reimbursement is limited to 4 units per member/per year (PMPY).

FEDERAL LAW FINDING: The agency finds that there is a difference in cost rationally related between the delivery of this service in the public and private sector. The Agency finds that the cost method described here adequately describes the costs at this time and finds that this method adequately compensates state government for these costs.

FISCAL IMPACT

Based on the lack of changes to the underlying principles of the OJATCM rate setting methodology, the change from a monthly rate to weekly rate will have no fiscal impact.

JSU

	Gross	Benefits	Total
Juvenile Justice Specialist I	644,281	314,565	958,846
Juvenile Justice Specialist II	5,506,818	2,730,093	8,236,911
Juvenile Justice Specialist III	1,309,066	571,315	1,880,381
Juvenile Justice Specialist IV	1,669,915	776,620	2,446,535
Administrative Technician III	1,167,595	613,800	1,781,395
Administrative Assistant II	190,761	97,023	287,784
Secretary III	187,996	100,574	288,570
District Supervisor	645,570	215,201	860,771
Total JSU Payroll	**11,322,002**	**5,419,191**	**16,741,193**
Professional Services			54,073
Operations			1,650,517
Grand Total JSU	**11,322,002**	**5,419,191**	**18,445,783**

Information Technology

JOLTS Programmer Contracts	205,928
Operations	291,867
Grand Total IT	**497,795**

General Administrative

JSU Worker's Comp	82,371
JSU Admin Contracts	5,510
JSU Admin Operations	69,825
Grand Total General Administrative	**157,706**

Yearly totals		19,101,283.60
yearly average for RMTS % for TCM Rate Base		36.60%
Medicaid TCM	$	6,991,547.33
Total weeks		52
Cost per week	$	134,453
Yearly # of eligible Contacts		23,349
Contacts per week		449
Cost per contact/wk	**$**	**299.44**
Caseload		5,697
Annual Contacts per eligible client		4.10

RECOMMENDATION TO THE STATE PLAN AMENDMET RATE COMMITTEE FOR CHANGES TO DENTAL RATES:
(1) INCREASE OF TWO SURFACE CODES USING MEAN RATES
(2) REDUCTION OF ALL DENTAL RATES BY 3.00%

ISSUE

This is a proposal to reduce expenditures in the dental program. The OHCA considered several options along with input from the Oklahoma Dental Association and recommends a change in reimbursement for posterior restorations and an overall decrease in dental rates.

BACKGROUND

The Oklahoma Health Care Authority Board had previously taken action to reduce SoonerCare program costs effective January 1, 2010. In part, this change was made to comply with the Oklahoma Constitution, Article X, Section 23, which prohibits a state agency from spending more money than is allocated.

Throughout the months of October, 2009 and April, 2010 OHCA negotiated and sought the input of the Oklahoma Dental Association (ODA) regarding ways to reduce program cost. OHCA took a previous action affecting #1 above but the ODA objected. OHCA met with the association in an attempt to diminish any adverse affect on Dental provider compensation as a result of program reduction activities. OHCA presented three options to the ODA for which we requested additional feedback. Based upon ODA's feedback, we proposed to allow the fee to increase for two surface codes to a maximum of $104.07 and the three surface codes to a maximum of $135.96 for amalgam or posterior composite resin restorations. To fund this increase, OHCA will institute an additional across the board reduction of 3.00% to all dental fees which will reduce the aforementioned rates to a maximum of $97.67 for two surface codes and a maximum of $127.60 for three surface codes for amalgam or posterior composite resin restorations effective July 1, 2010. .

State Medicaid programs generally have considerable flexibility in determining the reimbursement methodology and resulting rate for services, within federally-imposed upper limits and specific restrictions. State Medicaid programs must assure that payment rates:

- Be consistent with efficiency, economy and quality of care;
- Are sufficient to enlist enough providers so that Medicaid care and services are available under the state plan at least to the extent that such care and services are available to the general population in that geographic area.

OHCA Finance staff has reviewed various provider payment types and services that are funded by state appropriations from the legislature to the OHCA. The proposed changes for various provider types are outlined below.

PROPOSED RATE AND METHODOLOGY CHANGE

(1) With respect to codes D0120, D0272, D1120, D2150, D7140, D2751 there is no Medicare fee schedule comparison for dentists; OHCA uses the American Dental Association (ADA) current dental terminology (CDT) for proper coding and Relative Value, Inc for data related to value units. A 2001 Dental fee schedule study ranked Oklahoma 5th nationally in dental fees; (See Exhibit A); a more recent study on select dental fees by state indicated that Oklahoma fees are above national average for Medicaid, although they likely lag behind commercial rates. (See Below Survey). The methodology for the change is the mean between amalgam and posterior composite resin restorations.

(2) Fee schedule rates were last updated January 1, 2010. These rates will be reduced by 3.00% but there is no methodology change. The 3.00% reduction is applied across the board and includes the methodology change for amalgam and posterior composite resin restorations.

	DO120 Periodic Oral Evaluation		**D0272 Bitewings, Two Films**		**D1120 Child Prophylaxis**	
	Fee	As % of National Average	Fee	As % of National Average	Fee	As % of National Average
UNITED STATES	$22.74	100%	$15.64	100%	$31.12	100%
Oklahoma	$23.50	103%	$20.14	129%	$33.57	108%

	D2150 Amalgam, Two Surfaces, Permanent		**D7140 Extraction, Erupted Tooth or Exposed Root**		**D2751 Crown, Porcelain Fused to Metal Base**	
	Fee	As % of National Average	Fee	As % of National Average	Fee	As % of National Average
UNITED STATES	$63.34	100%	$53.72	100%	$420.43	100%
Oklahoma	$73.85	117%	$73.86	129%	$537.12	128%

Source: Urban Institute 2008 Medicaid Physician Survey

AGENCY RECOMMENDATION: The Oklahoma Health Care Authority (OHCA) recommends a revision to the current rates and reimbursement structure for all Dental services. First, the OHCA is proposing to move the reimbursement rate for [two surface] codes D2150 AND D2392 to a maximum of $104.07 and [three surface] codes D2160 AND D2393 to a maximum of $135.96 for amalgam or posterior composite resin restorations. Second, OHCA recommends that all Dental codes be reduced an additional 3.00% as agreed upon by ODA in the acceptance of the proposal. Taking into account the additional across the board 3.00% reduction, the aforementioned rates

will be reduced to a maximum of $97.67 for two surface codes and a maximum of $127.60 for three surface codes for amalgam or posterior composite resin restorations effective July 1, 2010.

BUDGET IMPACT

The estimated annual change is considered to be budget neutral.

FEDERAL LAW FINDING: The Oklahoma Health Care Authority finds that neither of these rate changes will cause the agency to violate the assurance in 1902 (a) (30). The reason for this is the abundant number of dental providers now in the program, where Oklahoma falls national in dental reimbursement, and the limited changes being made in the rates.

EFFECTIVE DATE

The proposed effective date for this change is July 1, 2010.

Submitted to the CEO and Board on June 10, 2010
AUTHORITY TO EXPEND FUNDS FOR MMIS SERVICES
State Fiscal Year 2011 MMIS Operations Contract

BACKGROUND

Hewlett-Packard (HP) is contracted to develop, operate and maintain OHCA's MMIS (Medicaid Management Information System). OHCA will continue the implementation of critical new initiatives with the current contractor before awarding a new contract in November 2010. Transition to a new vendor requires a 12-18 month freeze on system modifications.

SCOPE OF WORK – NEW ITEMS

- Electronic Health Records (EHR) Incentive Program – this federal program offers incentives to SoonerCare providers to adopt and use health information technology
- Insure Oklahoma restructuring

CONTRACT PERIOD

State Fiscal Year 2011

CONTRACT AMOUNT AND PROCUREMENT METHOD

- Estimated contract amounts:
  - SFY10 $38,900,609.00
  - SFY11 $38,900,000.00
  - SFY12 $19,500,000.00
- Original contract procured by competitive bid
- Federal matching percentages are 50%, 75%, and 90% depending on the activity

RECOMMENDATION

- Board approval to procure the services and extend the contract as discussed above
- Board approval is contingent on CMS and DCS approval

Submitted to the C.E.O. and Board on June 10, 2010
AUTHORITY FOR EXPENDITURE OF FUNDS
FOX SYSTEMS - MMIS CONSULTANT SERVICES

BACKGROUND

OHCA awarded a contract by competitive bid to Fox Systems in 2009 for consultant services for the MMIS re-procurement, modification and recertification. The contract had both a firm, fixed price component, as well as hourly rates for additional work requested by OHCA. OHCA originally intended to rebid the MMIS in mid-2009. OHCA would like to amend the contract to add more hours related to system improvements and new federal initiatives.

SCOPE OF WORK

Additional hours are required for:

- Work related to obtaining an extension from the Centers for Medicare and Medicaid Services (CMS) and the Department of Central Services (DCS);
- Additional system analysis during the extension year;
- New federal Health Information Technology requirements and provider incentives;
- New federal requirements related to the ICD-10 diagnosis codes;
- Additional system improvements needed by OHCA for new programs and more efficient operations.

CONTRACT PERIOD

Date of award through June 30, 2009 with three (3) renewal options through June 30, 2012

CONTRACT AMOUNT AND PROCUREMENT METHOD

The not to exceed amount for this contract is estimated to increase from $5.3 million to $7.5 million. OHCA will request CMS approval of 90% federal funding for these services resulting in a state dollar increase of $220,000.

RECOMMENDATION

Board approval for OHCA to procure a contract for MMIS consultant services as discussed above. Board approval is contingent on CMS and DCS approval.

Submitted to the C.E.O. and Board on June 10, 2010
AUTHORITY FOR PROCUREMENT
Third Party Collection Services (TPL)

BACKGROUND

OHCA plans to contract with an outside vendor to provide identification, collection and cost avoidance services of third party SoonerCare medical claims.

SCOPE OF WORK

The new vendor will provide the following services:

- Assist and develop claims processing edits to identify third party carrier coverage
- Identify and collect third party coverage through post payment audits
- Identify and collect third party liability of medical claims as required by Federal and State law
- Develop recommendations and assist in maintaining TPL collections throughout the life of the contract as required mandates develop

CONTRACT PERIOD

Date of award through June 30, 2015

CONTRACT AMOUNT AND PROCUREMENT METHOD

- This contract provides for the vendor to be paid a percentage of dollars collected and submitted to OHCA. Therefore, a not to exceed amount is not set for this contract.
- To illustrate, fiscal year 2009 collections were $13 million with a 5.2% fee paid to the vendor in the amount of $685,000.
- Federal matching funds are 50% for the administration of this contract.
- The vendor will be selected through a competitive bidding process with a vendor recommended and awarded by OHCA.

RECOMMENDATION

- Board approval for OHCA to proceed to procure a contract for a comprehensive third party collection service of SoonerCare claims.

Pharmacy Items

Recommendation 1: Prior Authorize Mozobil®, Nplate®, and Arcalyst®

The College of Pharmacy recommends the addition of the Mozobil®, Nplate®, and Arcalyst® to the prior authorization program with product specific criteria. These three drugs will typically be administered in an outpatient clinic or similar setting. The drugs require prior authorization when they are billed through the medical claims system and were brought to the DUR Board to equalize prior authorization requirements for both billing systems.

The DUR Board recommends requiring prior authorization for these drugs and has approved the following criteria:

Mozobil® (plerixafor) criteria for approval:

1. FDA approved indication of use in combination with granulocyte-colony stimulating factor (G-CSF) to mobilize hematopoietic stem cells to the peripheral blood for collection and subsequent autologous transplantation in patients with non-Hodgkin's lymphoma (NHL) and multiple myeloma (MM).
2. MUST have a cancer diagnosis of non-Hodgkins's lymphoma (NHL) or multiple myeloma (MM). This medication is NOT covered for the diagnosis of leukemia.
3. Prescribed by an oncologist only.
4. Patient must be at least 18 years of age.
5. Must be given in combination with the granulocyte-colony stimulating factor (G-CSF) Neupogen® (filgrastim).
6. **Dosing (requires current body weight in kilograms):**
    a. Recommended dose is 0.24 mg/kg, maximum dose is 40mg/day, administered 11 hours prior to apheresis for up to 4 consecutive days. (USE ACTUAL BODY WEIGHT).
    b. Dosing for renal impairment:
        i. Creatinine clearance ≤ 50 mL/min: 0.16 mg/kg, maximum of 27 mg/day.
7. Approval period will be for two months.

Nplate® (romiplostim) criteria for approval:

1. FDA approved indication of chronic immune (idiopathic) thrombocytopenia purpura (ITP) in adults 18 and over.
2. Previous insufficient response with at least two of the following treatments: corticosteroids, immunoglobulins, or splenectomy
3. Recent platelet count of $< 50 \times 10^9$/L
4. Initial dosing of 1 mcg/kg once weekly as a subcutaneous injection with recent patient weight in kilograms provided
5. **Continuation criteria:**
    a. Weekly CBCs with platelet count and peripheral blood smears until stable platelet count (≥ 50 x 109/L for at least 4 weeks without dose adjustment) has been achieved; then obtain monthly thereafter
    b. Dosing adjustments:
        i. Platelets $< 50 \times 10^9$/L, increase dose by 1 mcg/kg
        ii. Platelets $> 200 \times 10^9$/L for 2 consecutive weeks, reduce dose by 1 mcg/kg

iii. Platelets > 400 x 10^9/L, do not dose. Continue to assess platelet count weekly. When platelets < 200 x 10^9/L, resume at a dose reduced by 1 mcg/kg

6. **Discontinuation criteria:**
    a. Platelet count does not increase to a level sufficient to avoid clinically important bleeding after 4 weeks of therapy at the maximum weekly dose of 10 mcg/kg
7. Approval period will be for four weeks initially, and then quarterly.

Arcalyst® (rilonacept) criteria for approval:

1. FDA approved indication of Cryopyrin-Associated Periodic Syndromes (CAPS) verified by genetic testing. This includes Familial Cold Auto-inflammatory Syndrome (FCAS) and Muckle-Wells Syndrome (MWS) in adults and children 12 and older.
2. The member should not be using a tumor necrosis factor blocking agent (e.g. adalimumab, etanercept, and infliximab) or anakinra
3. Should not be initiated in patients with active or chronic infection including hepatitis B, hepatitis C, human immunodeficiency virus, or tuberculosis.
4. Dosing should not be more often than once weekly.
5. **Approved dosing schedule for adults 18 and over:**
    a. Initial treatment: loading dose of 320 mg delivered as two 2mL subcutaneous injections of 160 mg each given on the same day at two different injection sites.
    b. Continued treatment is one 160 mg injection given once weekly.
6. **Approved dosing schedule for pediatric patients aged 12-17 years (must have patient weight in kilograms):**
    a. Initial treatment: loading dose of 4.4 mg/kg, up to a maximum of 320 mg, delivered as one or two subcutaneous injections with a maximum single-injection volume of 2mL.
    b. Continued treatment is 2.2 mg/kg, up to a maximum of 160 mg, given once weekly.
7. Approval period is for one year.