OKLAHOMA HEALTH CARE AUTHORITY
REGULARLY SCHEDULED BOARD MEETING
February 9, 2012 at 1:00 P.M.
Oklahoma Health Care Authority
2401 NW 23rd, Suite 1-A – Ponca Conference Room
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 January 12, 2012 OHCA Board Minutes
3 Discussion Item – Reports to the Board by Board Committees

    a) Audit/Finance Committee – Member Miller
    b) Rules Committee – Member McVay
    c) Legislative Committee – Member McFall
    d) Strategic Planning Committee - Vice Chairman Armstrong

Item to be presented by Mike Fogarty, Chief Executive Officer

4. Discussion Item – Chief Executive Officer's Report

    a) Financial Update – Carrie Evans, Chief Financial Officer
    b) Medicaid Director's Update – Garth Splinter, State Medicaid Director
    c) Legislative Update – Nico Gomez, Deputy Chief Executive Officer

Item to be presented by Stan Ruffner, Durable Medical Equipment (DME) Program Director

5. Discussion Item – Update on OHCA's Durable Medical Equipment Reuse Program

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

6. Announcements of Conflicts of Interest Panel Recommendations for all action items regarding this board meeting.

Item to be presented by Cindy Roberts, Deputy CEO – Planning, Policy & Integrity Division

7. a) Action Item - 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) Action Item - Consideration and Vote Upon promulgation of Emergency rules as follows:

    7.b-1 AMENDING Agency rules at OAC 317:30-5-95.24 through 30-5-95.31, 30-5-240, 30-5-240.1, 30-5-240.2, 30-5-241, 30-5-241.1 through 30-5-241.5, 30-5-276, 30-5-281, 30-5-596, 30-5-596.1 and 30-5-741 to revert certain rules related to Behavioral Health services to their original state from 2008. In 2008, certain parts of rules related to Behavioral Health services were removed from the rules and placed into the Behavioral Health Manual. However, to comply with Oklahoma

law, 75 Okla.Stat. § 308.2, the sections that were removed need to be placed back into the rules for them to be enforceable and binding on the behavioral health providers. Additionally, Inpatient and Outpatient Behavioral Health, Psychologist and Licensed Behavioral Health Professional (LBHP) rules are being revised to remove the guidelines for obtaining authorizations to provide services. Authorization requirements will be placed in the Behavioral Health Provider Manual and the rule revisions will reference the Manual. The authorization requirements are procedural in nature and are more appropriate in the context of a billing manual rather than the Agency's administrative rules. **(Reference APA WF # 11-27)**

c) Action Items - Consideration and Vote Upon Permanent rules as follows:

Adoption of Permanent Rules as required by the Administrative Procedures Act.

The following rules HAVE previously been approved by the Board and have Gubernatorial approval under Emergency Rulemaking.

7.c-1 AMENDING Agency rules at OAC 317:35-5-42 to comply with the Tax Relief, Unemployment Insurance Reauthorization, and Job Creation Act of 2010 which requires state Medicaid agencies to disregard federal tax refunds or advance payments with respect to refundable tax credits as income and as resources for purposes of determining eligibility. **(Reference APA WF # 11-02)**

7.c-2 AMENDING Agency rules at OAC 317:45-9-4, 45-11-10, 45-11-12, 45-11-24, and 45-13-1 to ensure Insure Oklahoma cost-sharing rules comply with Federal law on Native American cost-sharing exemptions. Native American adults are exempt from Insure Oklahoma—Individual Plan co-pays or premiums when they receive services provided by Indian Health Services, Tribal Programs, and Urban Indian Clinics (I/T/U) providers or through referral by contract health services. Native American children are exempt from cost-sharing regardless of whether they receive services provided by I/T/U providers or through referral by contract health services. **(Reference APA WF # 11-05)**

7.c-3 ADDING Agency rules at OAC 317:30-5-58 and 2-1-15 and AMENDING Agency rules at 317:2-1-2 to implement and establish guidelines for the Supplemental Hospital Offset Payment Program (SHOPP) as authorized by 63 Okla. Stat. §§ 3241.1 through 3241.6. OHCA is required by the SHOPP Act to assess all in-state hospitals, unless specifically exempted, an assessment fee of 2.5%. Funds derived from the assessment are used to garner federal matching funds which will be used to maintain SoonerCare provider reimbursement rates as well as pay participating hospitals a quarterly access payment. **(Reference APA WF # 11-18A & B)**

The following rules HAVE NOT previously been reviewed by the Board.

7.c-4 AMENDING agency rules at OAC 317:30-5-291, 317:30-5-296, and 317:30-5-676 to revise PT/OT/ST rules to ensure clarity in policy that there is no coverage for adults for services rendered by individually-contracted providers, but there is coverage for adults in an outpatient hospital setting. **(Reference APA WF # 11-07)**

7.c-5 AMENDING agency rules at OAC 317:30-3-5 to clarify OHCA's current policy that pregnancy-related services are exempt from cost-sharing requirements. The

rules are also revised to remove reference to another section of policy that is no longer in effect. **(Reference APA WF # 11-16)**

7.c-6 AMENDING agency rules at OAC 317:30-5-211.2 to exempt durable medical equipment repairs with a cost per item of less than $250.00 from the prescription requirement. **(Reference APA WF # 11-17)**

Item to be presented by Becky Pasternik-Ikard, Deputy State Medicaid Director-SoonerCare Operations

8. 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 **Brilinta™ (ticagrelor)** and **Xarelto® (rivaroxaban)** to the utilization and scope prior authorization program under OAC 317:30-5-77.2(e).

Item to be presented by Chairman Roggow

9. Discussion Item – Proposed Executive Session as Recommended by the Director of Legal Services and Authorized by the Open Meetings Act, 25 Oklahoma Statutes § 307(B) (1), (4) and (7)

   A. Status of Pending Suits

   Status of Pending suits and claims

1.	2010 DMH Administrative Claiming	DAB A-10-73	CMS Departmental Appeals Board
2.	Association for Direct Care Trainers v. OHCA	CJ-08-4237	Oklahoma County, OK
3.	Status of Claim Regarding Optum Health Care		

10. New Business

11. ADJOURNMENT

NEXT BOARD MEETING
March 8, 2012
Oklahoma Health Care Authority
2401 NW 23rd, Suite 1-A
Ponca Conference Room
Oklahoma City, OK 73107

MINUTES OF A REGULARLY SCHEDULED BOARD MEETING
OF THE HEALTH CARE AUTHORITY BOARD
January 12, 2012
Held at the Oklahoma Health Care Authority
Oklahoma City, Oklahoma

Manner and Time of Notice of Meeting: A public notice was placed on the front door of the Oklahoma Health Care Authority on January 10, 2012.

Pursuant to a roll call of the members, a quorum was declared to be present, and Chairman Roggow called the meeting to order at 1:02 PM.

BOARD MEMBERS PRESENT: Vice-Chairman Armstrong, Member McVay, Member Bryant, Member Miller, Member Robison, Member McFall, and Chairman Roggow

OTHERS PRESENT:

Josh Cook, HP
Charlie Brodt, HP

OTHERS PRESENT:

Will Widman, HP

DISCUSSION AND POSSIBLE VOTE ON APPROVAL OF BOARD MINUTES OF THE REGULARLY SCHEDULED BOARD MEETING HELD DECEMBER 8, 2011.

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: Member McFall moved for approval of the December 8, 2011 board minutes as published. Vice-Chairman Armstrong seconded.

FOR THE MOTION: Vice-Chairman Armstrong, Member Bryant, Member Miller, Member Robison, Member McFall, and Chairman Roggow

ABSTAINED: Member McVay

ITEM 3/REPORTS TO THE BOARD BY BOARD COMMITTEES

Member Miller reported that the Audit Finance Committee did not meet.

Member McVay reported that the Rules Committee met and were educated by Traylor Rains of OHCA's policy unit on the Permanent Rules Making process.

Vice-Chairman Armstrong reported that the Strategic Planning Committee did meet prior to the board meeting, and that the Board would hear more about this during the Chief Executive Officer's report.

ITEM 4/CHIEF EXECUTIVE OFFICER'S REPORT

FINANCIAL UPDATE
Carrie Evans, Chief Financial Officer

Ms. Evans reported that the Revenues for OHCA through September, accounting for receivables, were **$1,544,967,185** or **(.4%) under** budget. Expenditures for OHCA, accounting for encumbrances, were **$1,480,525,005** or 1.6% **under** budget. The state dollar budget variance through November is **$16,904,613 positive.**

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

Expenditures:		
Medicaid Program Variance		8.0
Administration		2.9
Revenues:		
Taxes and Fees		1.5
Drug Rebate		3.1
Overpayments/Settlements		1.4
Total FY 12 Variance	**$**	**16.9**

For a detailed report, see Item 4a of the January 12, 2012 board packet.

MEDICAID DIRECTOR'S UPDATE
Garth Splinter, MD – Deputy State Medicaid Director

Dr. Splinter went over the data sheet highlighting the fact that the overall SoonerCare Enrollment for November 2011 remains pretty level. He discussed costs associated with Medical Home and SoonerCare Traditional. Dr. Splinter made the Board aware that there is a duplicate count issue related to Online Enrollment that may be affecting our numbers. The full scope of the problem is not known, but as we understand more about this and its impact on the numbers, the Board will be updated. He reported that in state providers are up to around 28,000.

Von Lawson, Director of Opportunities for Living Life (OLL), gave an update on the Living Choice and Medically Fragile Waiver programs, and the progress that has been made in each. Von also introduced OLL staff.

For a detailed report, see Item 4b of the January 12, 2012 board packet.

CEO Fogarty, discussed a piece of legislation passed in 2011, the Information Technology Consolidation and Coordination Act. It applies to all state agencies except Higher Ed, and consolidates all IT functions under the Office of State Finance (OSF) for increased efficiencies. The magnitude of this bill is huge and it was passed with an extraordinarily aggressive time frame for implementation. The bill contained a provision that might allow an exception or extension for those agencies that might lose federal funding or

violate federal law due to implementation. Another reason for exception or extension would be for those agencies with IT systems that are unique to the business of that particular agency. The OHCA has been granted an extension so that a thorough due diligence can be performed before IT personnel and assets are transferred. Jerry Scherer, OHCA's Chief Information Officer, reiterated that this had presented an opportunity to enter into many collaborative initiatives with OSF and other state agencies, and that OHCA would continue these collaborations. Carrie Evans, Chief Financial Officer, reported that a quick review indicated that OHCA would lose approximately $3 million dollars in federal funding annually if our IT personnel are moved to OSF. Several Board members expressed concern about the interruption of services to members and providers, as OHCA's computer systems are specific to OHCA and are very complex.

ITEM 5/ELECTRONIC ACCESS TO SOONERCARE MEMBER HEALTH INFORMATION

Adolph Maren, Planning Project Manager – Policy, Planning & Integrity

Mr. Maren gave the Board an overview of how provider's electronic access to our member's health information will work including how permission to access is authenticated, authorized and consented to by the member. He also described how it will be accessed during emergency situations.

For a detailed report, please see Items 5 of the January 12, 2012 board packet.

ITEM 6/MARKETING PLAN FOR SOONERENROLL ONLINE ENROLLMENT EDUCATION FOR PROVIDERS

Jennie Melendez, Marketing Coordinator – Communications, Outreach & Reporting

Ms. Melendez presented the Marketing Plan for outreach and education to providers regarding Online Enrollment and is a follow up to questions asked by Member McFall at a previous Board meeting. Online Enrollment has been very successful, but many providers did not know about this option when asked about SoonerCare. It is also important to establish connections with community partners in those areas where computer access might not be readily available. A survey is going out to providers and partners asking how we might best assist them in spreading the message about online enrollment.

ITEM 7/ANNOUNCEMENTS OF CONFLICTS OF INTEREST PANEL RECOMMENDATIONS FOR ALL ACTION ITEMS REGARDING THIS BOARD MEETING

Ms. Lynn Rambo-Jones stated that the Conflicts of Interest Panel met and found no conflicts regarding action items.

ITEM 8/CONSIDERATION AND VOTE UPON THE RECOMMENDATIONS OF THE STATE PLAN AMENDMENT RATE COMMITTEE

Carrie Evans, Chief Financial Officer

Ms. Evans presented the following rates as published on agenda. For full details of the rates see Item 8A of the January 12, 2012 board packet.

Consideration and vote to amend the methodology for the calculation of Estimated Acquisition Cost for pharmaceuticals purchased by OHCA: Wholesale Acquisition Cost plus 5.6%, effective February 1, 2012.

MOTION: Member McFall moved for approval of the methodology presented in Item 8a. Member McVay seconded.

FOR THE MOTION: Vice Chairman Armstrong, Member McVay, Member Bryant,Member Miller, Member Robison, Member McFall, and Chairman Roggow

ITEM 9a&b/CONSIDERATION AND VOTE REGARDING RECOMMENDATIONS MADE BY THE DRUG UTILIZATION REVIEW BOARD UNDER 63 OKLAHOMA STATUTES § 5030.3

Nancy Nesser, PharmD. JD, Pharmacy Director

Before moving to the Action Item, Dr. Nesser recognized Dr. Ron Graham, retiring Pharmacy Director at OU College of Pharmacy and introduced Dr. Terry Cothran, the incoming Pharmacy Director.

Dr. Nesser presented the following recommendations for approval:

9b) Consideration and vote to add Multiple Sclerosis medications, Daliresp, Horizant and Gralise to the utilization and scope prior authorization program under Oklahoma Administrative Code (OAC) 317:30-5-77.2(e).

MOTION: Member McFall moved for approval of Item 9b as recommended. Vice-Chairman Armstrong seconded.

FOR THE MOTION: Vice-Chairman Armstrong, Member McVay, Member Bryant, Member Miller, Member Robison, Member McFall, and Chairman Roggow

ITEM 10/CONSIDERATION AND VOTE TO AUTHORIZE EXPENDITURE OF FUNDS

Lynn Rambo-Jones, Deputy Counsel – Legal Services

a) Consideration and vote to authorize expenditure of funds for the Online Enrollment Program Management Organization Services.

MOTION: Member Bryant moved for approval to authorize expenditure of funds as presented. Member McVay seconded.

FOR THE MOTION: Vice-Chairman Armstrong, Member McVay, Member Bryant, Member Miller, Member Robison, Member McFall, and Chairman Roggow

b) Consideration and vote to authorize expenditure of funds for the Focus on Excellence – Nursing Facility Surveys.

MOTION: Member McVay moved for approval to authorize expenditure of funds as presented. Member McFall seconded.

FOR THE MOTION: Vice-Chairman Armstrong, Member McVay, Member Bryant, Member Miller, Member Robison, Member McFall, and Chairman Roggow

ITEM 11/PROPOSED EXECUTIVE SESSION AS RECOMMENDED BY THE DIRECTOR OF LEGAL SERVICES AND AUTHORIZED BY THE OPEN MEETINGS ACT, 25 OKLAHOMA STATUTES §307(B) (1), (4) AND (7)

Lynn Rambo-Jones advised that there was no need for Executive Session for this board meeting.

ITEM 12/NEW BUSINESS

There was no new business

ITEM 13/ADJOURNMENT

MOTION: Member Robison moved for adjournment. Member McVay seconded.

FOR THE MOTION: Vice-Chairman Armstrong, Member McVay, Member Bryant, Member Miller, Member Robison, Member McFall, and Chairman Roggow

FINANCIAL REPORT

For the Six Months Ended December 31, 2011
Submitted to the CEO & Board
February 9, 2012

- Revenues for OHCA through December, accounting for receivables, were **$1,808,829,272** or **(.1%) under** budget.

- Expenditures for OHCA, accounting for encumbrances, were **$1,749,949,100** or **1.3% under** budget.

- The state dollar budget variance through December is **$19,733,822 positive.**

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

Expenditures:		
Medicaid Program Variance		6.6
Administration		4.3
Revenues:		
Taxes and Fees		3.1
Drug Rebate		4.1
Overpayments/Settlements		1.6
Total FY 12 Variance	**$**	**19.7**

ATTACHMENTS

OKLAHOMA HEALTH CARE AUTHORITY
Summary of Revenues & Expenditures: OHCA
Fiscal Year 2012, For the Six Months Ended December 31, 2011

REVENUES	FY12 Budget YTD	FY12 Actual YTD	Variance	% Over/ (Under)
State Appropriations	$ 504,654,532	$ 504,654,532	$ -	0.0%
Federal Funds	1,082,426,166	1,060,938,645	(21,487,521)	(2.0)%
Tobacco Tax Collections	28,021,493	30,928,860	2,907,367	10.4%
Quality of Care Collections	25,622,214	25,778,099	155,885	0.6%
Prior Year Carryover	55,003,490	55,003,490	-	0.0%
Federal Deferral - Interest	161,212	161,212	-	0.0%
Drug Rebates	87,137,036	98,427,243	11,290,207	13.0%
Medical Refunds	20,175,437	24,221,010	4,045,573	20.1%
Other Revenues	8,320,763	8,716,180	395,417	4.8%
TOTAL REVENUES	**$ 1,811,522,344**	**$ 1,808,829,272**	**$ (2,693,072)**	**(0.1)%**

EXPENDITURES	FY12 Budget YTD	FY12 Actual YTD	Variance	% (Over)/ Under
ADMINISTRATION - OPERATING	**$ 21,971,269**	**$ 19,325,848**	**$ 2,645,421**	**12.0%**
ADMINISTRATION - CONTRACTS	**$ 60,884,454**	**$ 50,366,840**	**$ 10,517,614**	**17.3%**
MEDICAID PROGRAMS				
Managed Care:				
SoonerCare Choice	16,075,966	14,857,601	1,218,365	7.6%
Acute Fee for Service Payments:				
Hospital Services	446,726,603	442,813,086	3,913,517	0.9%
Behavioral Health	156,748,158	161,257,979	(4,509,821)	(2.9)%
Physicians	219,003,392	218,367,894	635,497	0.3%
Dentists	73,449,003	73,455,181	(6,178)	(0.0)%
Other Practitioners	38,124,860	35,145,195	2,979,665	7.8%
Home Health Care	11,333,503	10,652,544	680,960	6.0%
Lab & Radiology	26,968,524	25,719,268	1,249,256	4.6%
Medical Supplies	24,018,657	23,682,457	336,200	1.4%
Ambulatory Clinics	42,250,221	40,612,807	1,637,414	3.9%
Prescription Drugs	185,547,371	186,326,929	(779,558)	(0.4)%
Miscellaneous Medical Payments	15,761,566	17,176,220	(1,414,653)	(9.0)%
OHCA TFC	-	-	-	0.0%
Other Payments:				
Nursing Facilities	246,056,594	244,917,365	1,139,229	0.5%
ICF-MR Private	29,195,534	28,157,334	1,038,200	3.6%
Medicare Buy-In	72,524,816	72,048,438	476,378	0.7%
Transportation	14,029,133	13,772,349	256,784	1.8%
EHR-Incentive Payments	34,604,750	34,604,750	-	0.0%
Part D Phase-In Contribution	37,012,238	36,689,016	323,222	0.9%
Total OHCA Medical Programs	**1,689,430,889**	**1,680,256,412**	**9,174,477**	**0.5%**
OHCA Non-Title XIX Medical Payments	89,382	-	89,382	0.0%
TOTAL OHCA	**$ 1,772,375,994**	**$ 1,749,949,100**	**$ 22,426,894**	**1.3%**
REVENUES OVER/(UNDER) EXPENDITURES	**$ 39,146,350**	**$ 58,880,172**	**$ 19,733,822**	

OKLAHOMA HEALTH CARE AUTHORITY

Total Medicaid Program Expenditures
by Source of State Funds
Fiscal Year 2012, For the Six Months Ended December 31, 2011

Category of Service	Total	Health Care Authority	Quality of Care Fund	HEEIA	Medicaid Program Fund	BCC Revolving Fund	Other State Agencies
SoonerCare Choice	$ 15,084,224	$ 14,846,977	$ -	$ 226,623	$ -	$ 10,624	$ -
Inpatient Acute Care	395,342,726	295,572,628	243,343	6,543,183	25,157,813	1,511,411	66,314,348
Outpatient Acute Care	125,577,325	117,678,188	20,802	5,249,435	-	2,628,901	
Behavioral Health - Inpatient	59,965,262	56,673,866	-	-	-	2,658	3,288,738
Behavioral Health - Outpatient	10,208,793	10,199,271	-	-	-	-	9,522
Behavioral Health Facility- Rehab	114,250,314	92,548,534	-	240,092	-	63,811	21,397,877
Behavioral Health - Case Management	-	-	-	-	-	-	
Residential Behavioral Management	10,732,929	-	-	-	-	-	10,732,929
Targeted Case Management	28,210,906	-	-	-	-	-	28,210,906
Therapeutic Foster Care	1,769,839	1,769,839	-	-	-	-	-
Physicians	244,598,183	182,776,336	29,050	7,945,676	30,659,934	4,902,574	18,284,612
Dentists	73,491,720	69,358,856	-	36,539	4,053,473	42,853	-
Other Practitioners	35,439,072	34,416,961	223,182	293,878	489,169	15,883	-
Home Health Care	10,652,550	10,625,402	-	6	-	27,142	-
Lab & Radiology	27,313,959	25,026,156	-	1,594,691	-	693,112	-
Medical Supplies	24,069,091	22,408,246	1,237,974	386,633	-	36,237	-
Ambulatory Clinics	47,610,177	40,420,817	-	927,805	-	191,990	6,069,566
Personal Care Services	6,239,038	-	-	-	-	-	6,239,038
Nursing Facilities	244,917,365	156,663,161	68,244,155	-	19,993,733	16,317	-
Transportation	13,772,349	12,439,925	1,295,676	-	33,602	3,147	-
GME/IME/DME	72,203,159	-	-	-	-	-	72,203,159
ICF/MR Private	28,157,334	23,132,819	4,600,069	-	424,445	-	-
ICF/MR Public	28,745,706	-	-	-	-	-	28,745,706
CMS Payments	108,737,454	107,456,090	1,281,364	-	-	-	-
Prescription Drugs	195,671,597	163,823,598	-	9,344,668	21,508,947	994,383	-
Miscellaneous Medical Payments	17,176,539	16,420,976	-	319	711,750	43,493	-
Home and Community Based Waiver	79,204,958	-	-	-	-	-	79,204,958
Homeward Bound Waiver	44,481,489	-	-	-	-	-	44,481,489
Money Follows the Person	1,519,347	-	-	-	-	-	1,519,347
In-Home Support Waiver	12,001,292	-	-	-	-	-	12,001,292
ADvantage Waiver	86,662,148	-	-	-	-	-	86,662,148
Family Planning/Family Planning Waiver	3,806,253	-	-	-	-	-	3,806,253
Premium Assistance*	29,222,949	-	-	29,222,949	-	-	-
EHR Incentive Payments	34,604,750	34,604,750					
Total Medicaid Expenditures	**$ 2,231,440,796**	**$1,488,863,394**	**$ 77,175,617**	**$ 62,012,497**	**$ 103,032,866**	**$ 11,184,534**	**$ 489,171,887**

* Includes $29,052,895.01 paid out of Fund 245

OKLAHOMA HEALTH CARE AUTHORITY

Summary of Revenues & Expenditures:
Other State Agencies
Fiscal Year 2012, For the Six Months Ended December 31, 2011

		FY12 Actual YTD
REVENUE		
Revenues from Other State Agencies	$	187,343,044
Federal Funds		316,218,834
TOTAL REVENUES	**$**	**503,561,878**
EXPENDITURES		**Actual YTD**
Department of Human Services		
Home and Community Based Waiver	$	79,204,958
Money Follows the Person		1,519,347
Homeward Bound Waiver		44,481,489
In-Home Support Waivers		12,001,292
ADvantage Waiver		86,662,148
ICF/MR Public		28,745,706
Personal Care		6,239,038
Residential Behavioral Management		8,478,944
Targeted Case Management		20,627,465
Total Department of Human Services		**287,960,386**
State Employees Physician Payment		
Physician Payments		18,284,612
Total State Employees Physician Payment		**18,284,612**
Education Payments		
Graduate Medical Education		32,450,000
Graduate Medical Education - PMTC		1,954,542
Indirect Medical Education		29,677,651
Direct Medical Education		8,120,966
Total Education Payments		**72,203,159**
Office of Juvenile Affairs		
Targeted Case Management		1,324,423
Residential Behavioral Management - Foster Care		19,367
Residential Behavioral Management		2,234,618
Multi-Systemic Therapy		9,522
Total Office of Juvenile Affairs		**3,587,930**
Department of Mental Health		
Targeted Case Management		-
Hospital		3,288,738
Mental Health Clinics		21,397,877
Total Department of Mental Health		**24,686,615**
State Department of Health		
Children's First		1,058,953
Sooner Start		1,135,993
Early Intervention		2,829,824
EPSDT Clinic		1,261,561
Family Planning		39,129
Family Planning Waiver		3,739,320
Maternity Clinic		56,654
Total Department of Health		**10,121,434**
County Health Departments		
EPSDT Clinic		426,661
Family Planning Waiver		27,804
Total County Health Departments		**454,465**
State Department of Education		**68,520**
Public Schools		**2,301,722**
Medicare DRG Limit		**64,133,658**
Native American Tribal Agreements		**3,188,697**
Department of Corrections		**215,244**
JD McCarty		**1,965,446**
Total OSA Medicaid Programs	**$**	**489,171,887**
OSA Non-Medicaid Programs	**$**	**40,959,396**
Accounts Receivable from OSA	**$**	**26,569,405**

OKLAHOMA HEALTH CARE AUTHORITY
SUMMARY OF REVENUES & EXPENDITURES:
Fund 230: Nursing Facility Quality of Care Fund
Fiscal Year 2012, For the Six Months Ended December 31, 2011

REVENUES	Total Revenue	State Share
Quality of Care Assessment	$ 25,758,902	$ 25,758,902
Interest Earned	19,197	19,197
TOTAL REVENUES	**$ 25,778,099**	**$ 25,778,099**

EXPENDITURES	FY 12 Total $ YTD	FY 12 State $ YTD	Total State $ Cost
Program Costs			
NF Rate Adjustment	$ 66,347,683	$ 23,785,644	
Eyeglasses and Dentures	144,752	51,894	
Personal Allowance Increase	1,751,720	627,992	
Coverage for DME and supplies	1,237,974	443,814	
Coverage of QMB's	516,378	185,121	
Part D Phase-In	1,281,364	1,281,364	
ICF/MR Rate Adjustment	2,448,365	877,739	
Acute/MR Adjustments	2,151,705	771,386	
NET - Soonerride	1,295,676	464,500	
Total Program Costs	**$ 77,175,617**	**$ 28,489,454**	**$ 28,489,454**
Administration			
OHCA Administration Costs	$ 273,774	$ 136,887	
DHS - 10 Regional Ombudsman	-	-	
OSDH-NF Inspectors	-	-	
Mike Fine, CPA	2,500	1,250	
Total Administration Costs	**$ 276,274**	**$ 138,137**	**$ 138,137**
Total Quality of Care Fee Costs	**$ 77,451,891**	**$ 28,627,591**	
TOTAL STATE SHARE OF COSTS			**$ 28,627,591**

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

OKLAHOMA HEALTH CARE AUTHORITY

SUMMARY OF REVENUES & EXPENDITURES:

Fund 245: Health Employee and Economy Improvement Act Revolving Fund

Fiscal Year 2012, For the Six Months Ended December 31, 2011

REVENUES	FY 11 Carryover	FY 12 Revenue	Total Revenue
Prior Year Balance	$ 21,470,039	$ -	$ 18,206,511
State Appropriations			
Tobacco Tax Collections	-	25,438,016	25,438,016
Interest Income	-	263,841	263,841
Federal Draws	4,432,268	19,360,372	19,360,372
All Kids Act	(7,396,736)	145,895	145,895
TOTAL REVENUES	$ 18,505,571	$ 45,208,125	$ 63,268,741

EXPENDITURES	FY 11 Expenditures	FY 12 Expenditures	Total $ YTD
Program Costs:			
Employer Sponsored Insurance		$ 28,705,983	$ 28,705,983
College Students		170,054	170,054
All Kids Act		346,912	346,912
Individual Plan			
SoonerCare Choice	$ 220,395	$ 79,012	
Inpatient Hospital	6,522,454	2,338,300	
Outpatient Hospital	5,186,733	1,859,444	
BH - Inpatient Services	-	-	
BH Facility - Rehabilitation Services	238,988	85,677	
Physicians	7,882,406	2,825,843	
Dentists	29,564	10,599	
Other Practitioners	286,795	102,816	
Home Health	6	2	
Lab and Radiology	1,573,443	564,079	
Medical Supplies	378,593	135,726	
Ambulatory Clinics	918,462	329,269	
Prescription Drugs	9,244,942	3,314,312	
Miscellaneous Medical	-	-	
Premiums Collected	-	(1,174,461)	
Total Individual Plan	$ 32,482,781	$ 10,470,616	
College Students-Service Costs	$ 262,677	$ 94,170	
All Kids Act- Service Costs	$ 60,047	$ 21,527	
Total Program Costs	$ 62,028,455	$ 39,809,262	
Administrative Costs			
Salaries	$ 13,534	$ 789,490	$ 803,024
Operating Costs	29,081	69,334	98,415
Health Dept-Postponing	-	-	-
Contract - HP	256,445	1,235,094	1,491,538
Total Administrative Costs	$ 299,059	$ 2,093,918	$ 2,392,977
Total Expenditures			$ 42,202,239
NET CASH BALANCE	$ 18,206,511		$ 21,066,502

OKLAHOMA HEALTH CARE AUTHORITY

SUMMARY OF REVENUES & EXPENDITURES:

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

Fiscal Year 2012, For the Six Months Ended December 31, 2011

REVENUES	FY 12 Revenue	State Share
Tobacco Tax Collections	$ 507,665	$ 507,665
TOTAL REVENUES	**$ 507,665**	**$ 507,665**

EXPENDITURES	FY 12 Total $ YTD	FY 12 State $ YTD	Total State $ Cost
Program Costs			
SoonerCare Choice	$ 10,624	$ 2,667	
Inpatient Hospital	1,511,411	379,364	
Outpatient Hospital	2,628,901	659,854	
Inpatient Free Standing	2,658	667	
MH Facility Rehab	63,811	16,016	
Case Mangement	0	-	
Nursing Facility	16,317	4,096	
Physicians	4,902,574	1,230,546	
Dentists	42,853	10,756	
Other Practitioners	15,883	3,987	
Home Health	27,142	6,813	
Lab & Radiology	693,112	173,971	
Medical Supplies	36,237	9,096	
Ambulatory Clinics	191,990	48,190	
Prescription Drugs	994,383	249,590	
Transportation	3,147	790	
Miscellaneous Medical	43,493	10,917	
Total Program Costs	$ 11,184,534	$ 2,807,318	**$ 2,807,318**
TOTAL STATE SHARE OF COSTS			**$ 2,807,318**

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

SoonerCare Programs

December 2011 Data for February 2012 Board Meeting

SOONERCARE ENROLLMENT/EXPENDITURES

Delivery System			Monthly Enrollment Average SFY2011	Enrollment December 2011	Total Expenditures December 2011	Average Dollars Per Member Per Month December 2011
SoonerCare Choice Patient-Centered Medical Home			449,392	**477,285**	**$121,716,040**	
	Lower Cost	*(Children/Parents; Other)*		432,213	$85,209,094	$197
	Higher Cost	*(Aged, Blind or Disabled; TEFRA; BCC)*		45,072	$36,506,946	$810
SoonerCare Traditional			239,274	**231,335**	**$176,788,032**	
	Lower Cost	*(Children/Parents; Other)*		124,378	$56,594,420	$455
	Higher Cost	*(Aged, Blind or Disabled; TEFRA; BCC & HCBS Waiver)*		106,957	$120,193,613	$1,124
SoonerPlan			31,082	**40,682**	**$704,518**	$17
Insure Oklahoma			32,181	**31,624**	**$9,250,783**	
	Employer-Sponsored Insurance		19,095	17,747	$4,462,987	$251
	Individual Plan		13,085	13,877	$4,787,796	$345
TOTAL			**751,928**	**780,926**	**$308,459,374**	

The enrollment totals above include all members enrolled during the report month; therefore, some members may not have expenditure data.
Custody expenditures are excluded. Non-member specific expenditures of $103,311,423 are excluded.

Net Enrollee Count Change from Previous Month Total	(477)

New Enrollees	17,585

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

Qualifying Group	Age Group	Enrollment
Aged/Blind/Disabled	*Child*	19,363
Aged/Blind/Disabled	*Adult*	130,816
Other	*Child*	173
Other	*Adult*	20,467
PACE	*Adult*	85
TEFRA	*Child*	412
Living Choice	*Adult*	95
OLL Enrollment		**171,411**

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

Medicare and SoonerCare	Monthly Average SFY2011	Enrolled December 2011
Dual Enrollees	**103,906**	**107,909**

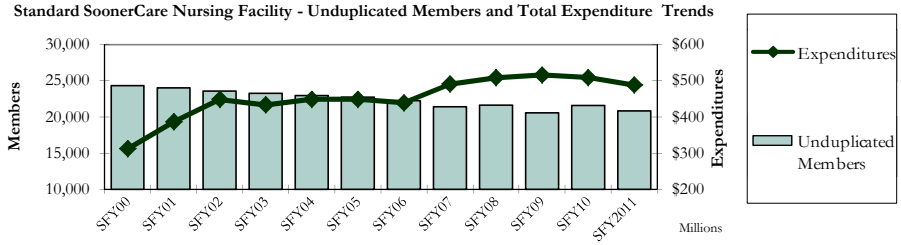
		Monthly Average SFY2011	Enrolled December 2011	PER MEMBER PER MONTH
Long-Term Care Members		**15,733**	**15,759**	**$3,138**
	Child	92	88	
	Adult	15,641	15,671	

SFY2011 Long-Term Care

Statewide LTC Occupancy Rate - 71.0%
SoonerCare funded LTC Bed Days 68.2%

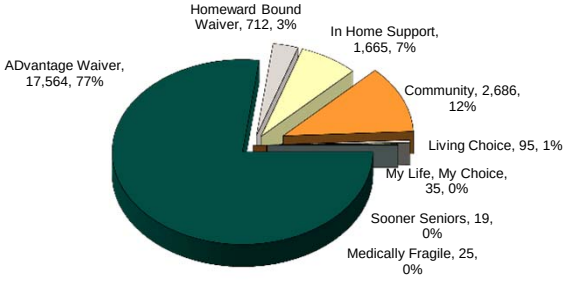
Data as of October 2011

Standard SoonerCare Nursing Facility - Unduplicated Members and Total Expenditure Trends



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

Waiver Enrollment Breakdown Percent



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

SoonerCare Programs

SOONERCARE CONTRACTED PROVIDER INFORMATION

Provider Counts		Monthly Average SFY2011	Enrolled December 2011
Total Providers		**29,026**	**38,234**
	In-State	20,585	28,156
	Out-of-State	8,442	10,078

Program	% of Capacity Used
SoonerCare Choice	38%
SoonerCare Choice I/T/U	13%
Insure Oklahoma IP	3%

Select Provider Type Counts	*In-State Monthly Average SFY2011**	*In-State Enrolled December 2011***	Total Monthly Average SFY2011	Total Enrolled December 2011
Physician	*6,489*	*7,628*	*11,777*	13,701
Pharmacy	*901*	*872*	*1,230*	1,152
Mental Health Provider***	*935*	*3,849*	*982*	3,906
Dentist	*798*	*987*	*901*	1,123
Hospital	*187*	*195*	*739*	933
Licensed Behavioral Health Practitioner***	*503*	*3,358*	*524*	3,392
Extended Care Facility	*392*	*373*	392	373

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

Total Primary Care Providers	*4,461*	*4,833*	6,467	6,692
Patient-Centered Medical Home	*1,476*	*1,736*	1,502	1,763

Including Physicians, Physician Assistants and Advance Nurse Practitioners.

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

***Due to federal regulations, OHCA must have an approved agreement on file for all providers providing care to our members. To meet this requirement OHCA is directly contracting with providers that had previously billed through a group or agency. This contributed to the increase in the provider counts for Licensed Behavioral Health Practitioners and Mental Health Providers.

SOONERCARE HEALTH STATUS

SFY2011 Delivery and Related Services		
Total women with a delivery	**31,961**	**5.72% of women enrolled**
Total Delivery Costs	**$134,197,436**	**average $4,190**
Women with prenatal visits	31,186	97% of total
Total paid for prenatal care*	$47,860,292	average $1,535
Women with postpartum visits	25,866	81% of total
Total paid for postpartum care*	$540,988	average $21
Total prenatal, delivery, and postpartum	**$182,598,716**	**average $5,700**

*Providers may bill a bundled code that includes prenatal, delivery and postpartum services. Bundled payments are included in the delivery costs.

SFY2011 Delivery Cost and Percent

*Bundled payments are included in the delivery costs.

ELECTRONIC HEALTH RECORDS (EHR) INCENTIVE STATISTICS

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

As Of 2/6/2012	January 2012		Since Inception	
	Number of Payments	Payment Amount	Total Number of Payments	Total Payment Amount
Eligible Professionals	13	$276,250	1,057	$22,475,417
Eligible Hospitals	3*	$1,312,622	69	$50,087,837
Totals	16	$1,588,872	1,126	$72,563,254

*Current Eligible Hospitals Paid
CHEROKEE NATION - WW HASTINGS
CLAREMORE IND HSP
CORDELL MEMORIAL HOSPITAL

OHCA DME REUSE PROGRAM

OHCA Board Meeting February 2012

SOONERCARE

House Bill 2777

Retrieve and donate DME to individuals who are disabled or elderly

* Voluntary Donations
* Donations Dedicated to SoonerCare for 60 Days after Donation

Contractor


Oklahoma's Assistive
Technology Program
ABLE Tech
Oklahoma ABLE Tech

Overview

* Retrieve
* Refurbish
* Reassign

Products

Augmentative Communication Devices	Bath Benches
CPAP (Continuous Positive Airway Pressure Devices)	Commodes
Gait Trainers	Hospital Beds
Nebulizers	Standers
Manual Wheelchairs	Power Wheelchairs (non-custom)

How does it work?

* SoonerCare purchased DME when no longer needed may be donated
* DME purchased through Medicare and Private Insurance may be donated
* DME is sanitized and refurbished to a reusable condition

oklahoma health care authority

Oklahoma's Assistive Technology Program

ABLE Tech

Oklahoma ABLE Tech

* Clients access Website to see what is available
* Clients contact an 800 # to donate or request equipment
* Pilot location – Oklahoma County
* Equipment is matched to a customer's needs and delivered free of charge

7.b-1 TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
Subchapter 5. Individual Providers And Specialties
Part 6. Inpatient Psychiatric Hospitals
317:30-5-95.24. [AMENDED]
317:30-5-95.25. [AMENDED]
317:30-5-95.26. [AMENDED]
317:30-5-95.27. [AMENDED]
317:30-5-95.28. [AMENDED]
317:30-5-95.29. [AMENDED]
317:30-5-95.30. [AMENDED]
317:30-5-95.31. [AMENDED]
Part 21. Outpatient Behavioral Health Services
317:30-5-240. [AMENDED]
317:30-5-240.1 [AMENEDED]
317:30-5-240.2 [AMENDED]
317:30-5-241. [AMENDED]
317:30-5-241.1. [AMENDED]
317:30-5-241.2. [AMENDED]
317:30-5-241.3. [AMENDED]
317:30-5-241.4. [AMENDED]
317:30-5-241.5. [AMENDED]
Part 25 Psychologists
317:30-5-276. [AMENDED]
317:30-5-281. [AMENDED]
Part 67. Behavioral Health Case Management Services
317:30-5-596. [AMENDED]
317:30-5-596.1. [AMENDED]
Part 83. Residential Behavior Management Services in Foster Care Setting
317:30-5-741. [AMENDED]
(Reference APA WF # 11-27)

FINDING OF EMERGENCY: The Agency finds that a compelling public interest exists which necessitates promulgation of emergency rules and requests emergency approval of rules to transition substantive requirements for SoonerCare behavioral health services from the Billing Manual to the Agency's administrative rules as well as remove the guidelines for obtaining authorizations to provide SoonerCare behavioral health services. Failure to make these changes would put the Agency's rules out of line with Agency practice thereby placing the Agency's Federal Financial Participation (FFP) for behavioral health services at risk. The Agency was left with no choice but to remove the prior authorization (PA) requirements for behavioral health services when the contractor for the behavioral health utilization program was unable to meet the technical requirements necessary to perform their contractual obligations. In order to ensure that SoonerCare behavioral health providers continued to be reimbursed for services provided, the Agency removed the PA requirement so that claims could be processed through the Agency's claims processing system. Additionally, the Agency moved service requirements from the behavioral health billing manual to its administrative rules in order to comply with the Oklahoma Administrative Procedures Act. In order to successfully recoup funds that were reimbursed to providers inappropriately because of fraudulent or erroneous billing, the Agency

is required to promulgate the requirements through the Oklahoma APA.
ANALYSIS: Agency Behavioral Health rules are revised in order to sufficiently and accurately set forth the substantive requirements for providing covered SoonerCare behavioral health services. Provider credentials and coverage guidelines will be transferred from the current Behavioral Health Provider Manual to the Agency's Behavioral Health rules in order to comply with rule promulgation requirements set forth in Oklahoma Administrative Procedures Act (APA). These revisions will not only ensure that the Agency remains in compliance with the APA, but also provides the Agency the necessary legal basis to successfully maintain program integrity. Additionally, Outpatient Behavioral Health, Psychologist and Licensed Behavioral Health Professional (LBHP) rules are being revised to remove the guidelines for obtaining authorizations to provide services. Authorization requirements will be placed in the Behavioral Health Provider Manual and the rule revisions will reference the Manual. The authorization requirements are procedural in nature and are more appropriate in the context of a billing manual rather than the Agency's administrative rules.

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

MEDICAL ADVISORY COMMITTEE: The Medical Advisory Committee considered the proposed rule revisions on January 19, 2012, and recommended Board approval.

AUTHORITY: The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Sections 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: Transition substantive requirements for SoonerCare behavioral health services from the Billing Manual to the Agency's administrative rules as well as remove the guidelines for obtaining authorizations to provide SoonerCare behavioral health services.

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

317:30-5-95.24. ~~Pre-authorization~~ Prior Authorization of inpatient psychiatric services for children
(a) All inpatient psychiatric services for members under 21 years of age must be prior authorized by the OHCA or its designated agent. All inpatient acute and residential psychiatric services will be prior authorized for an approved length of stay. Additional information will be required for a SoonerCare compensable approval on enhanced treatment units or in special population programs. Residential treatment at this level is a longer term treatment that requires a higher staff to member ratio because it is constant, intense, and immediate reinforcement of new behaviors to develop an understanding of

the behaviors. The environment of specialized residential treatment centers requires special structure and configuration (e.g., sensory centers for autistic members) and specialized training for the staff in the area of the identified specialty. The physician will see the child at least one time a week. A PRTF will not be considered a specialty treatment program for SoonerCare without prior approval of the OHCA behavioral health unit. A treatment program that has been approved as a specialized treatment program must maintain medical records that document the degree and intensity of the psychiatric care delivered to the children.

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

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

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

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

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

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

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

(E) Lack of social or emotional reciprocity;

(F) Lack of attachment to caretakers;

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

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

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

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

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

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

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

(N) Stereotyped and repetitive motor mannerisms (e.g., hand or finger flapping or twisting or complex whole body movements);
(O) Persistent occupation with parts of objects;
(3) Member is medically stable, but has co-morbid medical conditions which require specialized medical care during treatment;
(4) Full scale IQ below 40 (profound mental retardation intellectual disability).

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

(d) The designated agent will prior authorize all services for an approved length of stay based on the medical necessity criteria described in ~~in the OHCA Behavioral Health Provider Manual~~ OAC 317:30-5-95.25 through 317:30-5-95.31.

(e) Out of state placements must be approved by the agent designated by the OHCA and subsequently approved by the OHCA, Medical Services Behavioral Health Division. Requests for admission to Psychiatric Residential Treatment Facilities or acute care units will be reviewed for consideration of level of care, availability, suitability, and proximity of suitable services. A prime consideration for placements will be proximity to the family or guardian in order to involve the family or guardian in Active Treatment, including discharge and reintegration planning. Out of state facilities are responsible for insuring appropriate medical care as needed under SoonerCare provisions as part of the per-diem rate. Out of state facilities are responsible for ~~insuring~~ ensuring appropriate medical care as needed under SoonerCare provisions as part of the per-diem rate.

(f) Inpatient psychiatric services in all acute hospitals and psychiatric residential treatment facilities are limited to the approved length of stay. OHCA, or its designated agent, will approve lengths of stay using the current OHCA Behavioral Health medical necessity criteria ~~and following the current OHCA Behavioral Health Provider Manual~~ as described in OAC 317:30-5-95.25 through OAC 317:30-5-95.31. The approved length of stay applies to both hospital and physician services. The Child and Adolescent Level of Care Utilization System ~~(CALOCUS)~~ (CALOCUS®) is a level of care assessment that will be used as a tool to determine the most appropriate level of care treatment for a member by LBHPs in the community.

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

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

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

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

(2) Conditions are directly attributable to a psychiatric disorder as the

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

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

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

For continued stay acute psychiatric admissions for children must meet all of the conditions set forth in (1) to (4) of this subsection.
(1) An Axis I primary diagnosis from the most recent edition of "The Diagnostic and Statistical Manual of Mental Disorders" (DSM) with the exception of V-Codes, adjustment disorders, and substance abuse related disorders, accompanied by a detailed description of the symptoms supporting the diagnosis. In lieu of a qualifying Axis I diagnosis, children 18-20 years of age may have an Axis II diagnosis of any personality disorder. Adjustment or substance related disorders may be a secondary Axis I diagnosis.
(2) Patient continues to manifest a severity of illness that requires an acute level of care as defined in the admission criteria and which could not be provided in a less restrictive setting.
(A) Documentation of regression is measured in behavioral terms.
(B) If condition is unchanged, evidence of re-evaluation of treatment objectives and therapeutic interventions.
(3) Conditions are directly attributable to a mental disorder as the primary need for professional attention (this does not include placement issues, criminal behavior, status offenses).
(4) Documented efforts of working with the child's family, legal guardians and/or custodians and other human service agencies toward a tentative discharge date.

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

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

Inpatient chemical dependency detoxification admissions for children must meet the terms and conditions contained in (1), (2), (3), and one of (4)(A) through (D) of this subsection.

(1) Any psychoactive substance dependency disorder described in the most recent edition of "The Diagnostic and Statistical Manual of Mental Disorders" (DSM) with detailed symptoms supporting the diagnosis and need for medical detoxification, except for cannabis, nicotine, or caffeine dependencies.

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

(3) It has been determined by the OHCA designated agent that the current disabling symptoms could not be managed or have not been manageable in a lesser intensive treatment program.

(4) Requires secure 24-hour nursing/medical supervision as evidenced by:

(A) Need for active and aggressive pharmacological interventions.

(B) Need for stabilization of acute psychiatric symptoms.

(C) Need extensive treatment under physician direction.

(D) Physiological evidence or expectation of withdrawal symptoms which require 24-hour medical supervision.

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

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

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

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

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

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

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

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

(4) Child must be medically stable.

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

(A) Suicidal ideation and/or threat.

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

(C) Serious threats or evidence of physical aggression.

(D) Current incapacitating psychosis or depression.

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

(A) Intensive behavioral management.

(B) Intensive treatment with the family/guardian and child in a structured milieu.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(A) Intensive behavioral management.

(B) Intensive treatment with the family/guardian and child in a structured milieu.

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

(6) Documented efforts of working with child's family, legal guardian and/or custodian and other human service agencies toward a tentative discharge date.

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

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

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

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

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

PART 21. OUTPATIENT BEHAVIORAL HEALTH SERVICES

317:30-5-240. Eligible providers

All outpatient behavioral health providers eligible for reimbursement under OAC 317:30-5-240 et seq. must be an accredited or Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) certified organization/agency in accordance with Section(s) 3-317, 3-323A, 3-306.1 and 3-415 of Title 43A of the Oklahoma Statutes and have a current contract on file with the Oklahoma Health Care Authority. Eligibility requirements for independent professionals (e.g., physicians and Licensed Behavioral Health Professionals), who provide outpatient behavioral health services and bill under their own 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.

"Certifying Agency" means the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS).

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

"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 and certification 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 or be certified by the certifying agency in accordance with Section(s) 3-317, 3-323A, 3-306.1, or 3-415 of Title 43A of the Oklahoma Statutes;

(2) State-operated programs under the direction of ODMHSAS must be accredited by one of the accrediting bodies or be certified by the certifying agency in accordance with Section (s) 3-317, 3-323A, 3-306.1 or 3-415 of Title 43A of the Oklahoma Statues;

(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 or ODMHSAS certification in accordance with Section(s) 3-317-, 3-323A, 3-306.1 or 3-415 of Title 43A of the Oklahoma Statutes, provider specific credentials are required for the following:

(1) Substance Abuse agencies (OAC 450:18-1-1);

(2) ~~Evidenced~~ Evidence Based Best Practices but not limited to:

(A) Assertive Community Treatment (OAC 450:55-1-1);

(B) Multi-Systemic Therapy (Office of Juvenile Affairs); and

(C) Peer Support/Community Recovery Support;

(3) Systems of Care (OAC 340:75-16-46);
(4) Mobile and Facility-based Crisis Intervention (OAC 450:23-1-1);
(5) Case Management (OAC 450:50-1-1);
(6) RBMS in group homes (OAC 377:10-7) or foster care settings (OAC 340:75-8-4);
(7) Day Treatment - CARF, JCAHO, ~~and~~ or COA will be required as of December 31, 2009; and
(8) Partial Hospitalization/Intensive Outpatient CARF, JCAHO, ~~and~~ or COA will be required as of December 31, 2009.

(c) **Provider enrollment and contracting.**

(1) Organizations who have JCAHO, CARF, COA or AOA accreditation or ODMHSAS certification in accordance with Section(s) 3-317, 3-323A, 3-306.1 or 3-415 or Title 43A of the Oklahoma Statutes will supply the documentation from the accrediting body or certifying agency, along with other information as required for contracting purposes to the OHCA. The contract must include copies of all required state licenses, accreditation and certifications.

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

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

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

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

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

(A) One of the LBHPs;

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

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

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

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

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

(3) Demonstrate the ability to provide each of the following outpatient behavioral health treatment services as described in OAC 317:30-5-241 et

seq., as applicable to their program. Providers must provide proper referral and linkage to providers of needed services if their agency does not have appropriate services.

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

(4) Be available 24 hours a day, seven days a week, for Crisis Intervention services.
(5) Provide or have a plan for referral to physician and other behavioral health services necessary for the treatment of the behavioral disorders of the population served.
(6) Comply with all applicable Federal and State Regulations.
(7) Have appropriate written policy and procedures regarding confidentiality and protection of information and records, member grievances, member rights and responsibilities, and admission and discharge criteria, which shall be posted publicly and conspicuously.
(8) Demonstrate the ability to keep appropriate records and documentation of services performed.
(9) Maintain and furnish, upon request, a current report of fire and safety inspections of facilities clear of any deficiencies.
(10) Maintain and furnish, upon request, all required staff credentials including certified transcripts documenting required degrees.

317:30-5-241. Covered Services

(a) Outpatient behavioral health services are covered for adults and children as set forth in this Section ~~and following the requirements as defined in the OHCA BH Provider Manual,~~ unless specified otherwise, and when provided in accordance with a documented individualized service plan, developed to treat the identified behavioral health and/or substance abuse disorder(s).
(b) All services are to be for the goal of improvement of functioning, independence, or well-being of the member. The services and treatment plans are to be recovery focused, trauma and co-occurring specific. The member must be able to actively participate in the treatment. Active participation means that the member must have sufficient cognitive abilities, communication skills, and short-term memory to derive a reasonable benefit from the treatment.
~~(c) All outpatient BH services will require authorization through OHCA, or its designated agent, following established medical necessity criteria. Providers are required to follow these criteria and guidelines under the OHCA BH Provider Manual. OHCA does retain final administrative review over both prior authorization and review of services as required by 42 CFR 431.10.~~
~~(d) Unauthorized services will not be SoonerCare compensable, unless designated by OHCA.~~
(c) In order to be reimbursed for services, providers must submit a completed Customer Data Core (CDC) to OHCA or its designated agent. The CDC must be reviewed, updated and resubmitted by the provider every six months. Reimbursement is made only for services provided while a current CDC is on file with OHCA or its designated agent. For further information and instructions regarding the CDC, refer to the Behavioral Health Provider Manual.
(d) All outpatient BH services must be provided following established medical necessity criteria. Some outpatient behavioral health services may require

authorization. For information regarding services requiring authorization and the process for obtaining them, refer to the Behavioral Health Provider Manual. OHCA does retain the final administrative review over both authorization and review of services as required by 42 CFR 431.10.

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

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

(1) **Screening.**

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

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

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

(2) **Assessment.**

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

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

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

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

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

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

(ii) Source of information;

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

(iv) Gender;

(v) Birth Date;

(vi) Home address;

(vii) Telephone number;

(viii) Referral source;

(ix) Reason for referral;
(x) Person to be notified in case of emergency;
(xi) Presenting reason for seeking services;
(xii) Start and stop time for each unit billed;
(xiii) Signature of parent of guardian participating in face-to-face assessment. Signature required for members over the age of 14;
(xiv) Bio-Psychosocial information which must include:
(I) Identification of the member's strengths, needs, abilities and preferences;
(II) History of the presenting problem;
(III) Previous psychiatric treatment history, include treatment for psychiatric; substance abuse; drug and alcohol addiction; and other addictions;
(IV) Health history and current biomedical conditions and complications;
(V) Alcohol, Drug, and/or other addictions history;
(VI) Trauma, abuse, neglect, violence, and/or sexual assault history of self and/or others, include Department of Human Services involvement;
(VII) Family and social history, include MH, SA, Addictions, Trauma/Abuse/Neglect;
(VIII) Educational attainment, difficulties and history;
(IX) Cultural and religious orientation;
(X) Vocational, occupational and military history;
(XI) Sexual history, including HIV, AIDS, and STD at-risk behaviors;
(XII) Marital or significant other relationship history;
(XIII) Recreation and leisure history;
(XIV) Legal or criminal record, including the identification of key contacts, (i.e. attorneys, probation officers, etc.);
(XV) Present living arrangements;
(XVI) Economic resources;
(XVII) Current support system including peer and other recovery supports.
(xv) Mental status and Level of Functioning information, including questions regarding:
(I) Physical presentation, such as general appearance, motor activity, attention and alertness, etc.;
(II) Affective process, such as mood, affect, manner and attitude, etc.;
(III) Cognitive process, such as intellectual ability, social-adaptive behavior, thought processes, thought content, and memory, etc; and
(IV) Full Five Axes DSM diagnosis.
(xvi) Pharmaceutical information to include the following for both current and past medications;
(I) Name of medication;
(II) Strength and dosage of medication;
(III) Length of time on the medication; and
(IV) Benefit(s) and side effects of medication.
(xvii) LBHP's interpretation of findings and diagnosis;
(xviii) Signature and credentials of LBHP who performed the face-to-face behavioral assessment;
(xix) Client Data Core Elements reported into designated OHCA representative.

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

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

(A) **Definition.** The Behavioral Health Service Plan is developed based on information obtained in the assessment and includes the evaluation of all pertinent information by the practitioners and the member. It includes a discharge plan. It is a process whereby an individualized rehabilitation plan is developed that addresses the ~~member's~~ member's strengths, functional assets, weaknesses or liabilities, treatment goals, objectives and methodologies that are specific and time limited, and defines the services to be performed by the practitioners and others who comprise the treatment team. BH Service Plan Development is performed with the direct active participation of the member and a member support person or advocate if requested by the member. In the case of children under the age of 18, it is performed with the participation of the parent or guardian and the child as age and developmentally appropriate, and must address school and educational concerns and assisting the family in caring for the child in the least restrictive level of care. For adults, it is focused on recovery and achieving maximum community interaction and involvement including goals for employment, independent living, volunteer work, or training.

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

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

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

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

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

(iii) specific goals for the member;

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

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

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

(vii) any needed referrals for service;

(viii) specific discharge criteria;

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

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

(xi) all changes in service plan must be documented in a service plan update (low complexity) or within the service plan until time for the update (low complexity).

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

(xiii) Service plan updates must address the following:

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

(II) progress, or lack of, on previous service plan goals and/or objectives;
(III) a statement documenting a review of the current service plan and an explanation if no changes are to be made to the service plan;
(IV) change in goals and/or objectives (including target dates) based upon member's progress or identification of new need, challenges and problems;
(V) change in frequency and/or type of services provided;
(VI) change in practitioner(s) who will be responsible for providing services on the plan;
(VII) change in discharge criteria;
(VIII) description of the member's involvement in, and responses to, the treatment plan, and his/her signature and date; and
(IX) service plans are not valid until all signatures are present. The required signatures are: from the member (if 14 or over), the parent/guardian (if younger than 18 or otherwise applicable), and the primary LBHP.

(E) **Service limitations:**

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

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

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

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

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

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

(i) date;
(ii) start and stop time for each session/unit billed and physical location where service was provided;
(iii) signature of the provider;
(iv) credentials of provider;
(v) specific problem(s), goals and/or objectives addressed;
(vi) methods used to address problem(s), goals and objectives;

(vii) progress made toward goals and objectives
(viii) patient response to the session or intervention; and
(ix) any new problem(s), goals and/or objectives identified during the session.

(D) Service Limitations. Testing for a child younger than three must be medically necessary and meet established Child (0-36 months of Age) criteria as set forth in the Behavioral Health Provider Manual. Evaluation and testing is clinically appropriate and allowable when an accurate diagnosis and determination of treatment needs is needed. Eight hours/units of testing per patient over the age of two, per provider is allowed every 12 months. There may be instances when further testing is appropriate based on established medical necessity criteria found in the Behavioral Health Provider Manual. Justification for additional testing beyond allowed amount as specified in this section must be clearly explained and documented in the medical record. Testing units must be billed on the date the actual testing, interpretation, scoring, and reporting are performed. A maximum of 12 hours of therapy and testing, per day per rendering provider are allowed. A child who is being treated in an acute inpatient setting can receive separate psychological services by a physician or psychologist as the inpatient per diem is for "non-physician" services only. A child receiving Residential level treatment in either an therapeutic foster care home, or group home may not receive additional individual, group or family counseling or psychological testing unless allowed by the OHCA or its designated agent. Psychologists employed in State and Federal Agencies, who are not permitted to engage in private practice, cannot be reimbursed for services as an individually contracted provider. For assessment conducted in a school setting the Oklahoma State Department of Education requires that a licensed supervisor sign the assessment. Individuals who qualify for Part B of Medicare: Payment is made utilizing the SoonerCare allowable for comparable services. Payment is made to physicians, LBHPs or psychologists with a license to practice in the state where the services is performed or to practitioners who have completed education requirements and are under current board approved supervision to become licensed.

317:30-5-241.2. Psychotherapy

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

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

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

service may be used for adults who are hearing impaired and require the use of language interpreter.

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

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

(b) **Group Psychotherapy.**

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

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

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

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

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

(c) **Family Psychotherapy.**

(1) **Definition.** Family Psychotherapy is a face-to-face psychotherapeutic interaction between a LBHP ~~or CADC~~ and the member's family, guardian, and/or support system. CADCs are permitted to provide family psychotherapy through June 30, 2013; effective July 1, 2013 all family psychotherapies must be provided by LBHPs. It is typically inclusive of the identified member, but may be performed if indicated without the member's presence. When the member is an adult, his/her permission must be obtained in writing. Family psychotherapy must be provided for the direct benefit of

the SoonerCare member to assist him/her in achieving his/her established treatment goals and objectives and it must take place in a confidential setting. This service may include the Evidence Based Practice titled Family Psychoeducation.

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

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

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

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

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

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

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

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

(1) **Definition.** Partial hospitalization services are services that (1) Are reasonable and necessary for the diagnosis or active treatment of the member's condition; (2) Are reasonably expected to improve ~~or maintain~~ the member's condition and functional level and to prevent relapse or hospitalization and (3) ~~Are provided in accordance with services outlined in 42 CFR 410.43.~~ Include the following:

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

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

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

(D) Drugs and biologicals furnished for therapeutic purposes.

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

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

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

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

~~requirements. The treatment plan is directed under the supervision of a physician.~~ All services in the PHP are provided by a clinical team which must contain at least one of each of the professionals listed in (A) – (C) below and may contain one or more of each of the professionals listed in (D) – (F) below. The treatment plan is directed under the supervision of a physician and the number of professionals and paraprofessionals required on the clinical team is dependent on the size of the program.

(A) A licensed physician;

(B) Registered nurse; and

(C) One or more of the licensed behavioral health professionals (LBHP) listed in 30-5-240.3(a).

(D) Masters or bachelors level Behavioral Health Rehabilitation Specialist;

(E) Certified Case Manager; or

(F) Certified Alcohol and Drug Counselor (CADC).

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

(4) **Limitations.** Services are limited to children 0-20 only. Services must be offered at a minimum of 3 hours per day, 5 days per week. Therapeutic services are limited to 4 billable hours per day ~~and must be prior authorized~~. PHP services are all inclusive with the exception of physician services and drugs that cannot be self-administered, those services are separately billable. ~~Refer to OHCA BH Provider Billing Manual for further definition.~~ Group size is limited to a maximum of 8 individuals as clinically appropriate given diagnostic and developmental functioning. Occupational, Physical and Speech therapy will be provided by the Independent School District (ISD).

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

(5) **Service requirements.**

(A) Therapeutic Services are to include the following:

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

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

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

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

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

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

(C) Interchangeable therapies which include the following:

(i) Case Management (face-to-face);

(ii) BHRS/ alcohol and other drug abuse education;

(iii) Medication Training and Support; and

(iv) Expressive therapy.

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

clinical need. Records must be documented according to Section OAC 317:30-5-248.

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

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

(B) Medical director must be a licensed psychiatrist.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(4) **Limitations.**

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

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

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

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

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

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

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

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

(ii) Start and stop times for each day attended and the physical location in which the service was rendered;
(iii) Specific goal(s) and objectives addressed during the week;
(iv) Type of Skills Training provided each day and/or during the week including the specific curriculum used with member;
(v) Member satisfaction with staff intervention(s);
(vi) Progress, or barrier to, made towards goals, objectives;
(vii) New goal(s) or objective(s) identified;
(viii) Signature of the lead BHRS; and
(ix) Credentials of the lead BHRS.

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

(1) **Definition.** Medication Training and Support is a documented review and educational session by a registered nurse, or physician assistant focusing on a member's response to medication and compliance with the medication regimen. The review must include an assessment of medication compliance and medication side effects. Vital signs must be taken including pulse, blood pressure and respiration and documented within the medical or clinical record. A physician is not required to be present, but must be available for consult. Medication Training and Support is designed to maintain the member on the appropriate level of the least intrusive medications, encourage normalization and prevent hospitalization.

(2) **Limitations.**

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

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

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

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

(4) **Documentation requirements** - Medication Training and Support documented review must focus on:
(A) a member's response to medication;
(B) compliance with the medication regimen;
(C) medication benefits and side effects;
(D) vital signs, which include pulse, blood pressure and respiration; and
(E) documented within the progress notes/medication record.

317:30-5-241.4 Crisis Intervention

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

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

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

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

(b) **Facility Based Crisis Stabilization (FBCS).** FBCS services are emergency psychiatric and substance abuse services aimed at resolving crisis situations. The services provided are emergency stabilization, which includes a protected environment, chemotherapy, detoxification, individual and group treatment, and medical assessment.

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

(2) **Limitations.** The unit of service is per hour. Providers of this service must meet the requirements delineated in the OAC 450:23. Documentation of records must comply with OAC 317:30-5-248.

317:30-5-241.5 Support services

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

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

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

(3) **Qualified professionals.** Providers of PACT services are specific teams within an established organization and must be operated by or contracted with and certified by the ODMHSAS in accordance with 43A O.S. 319 and OAC 450:55. The team leader must be an LBHP.

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

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

(A) PACT assessments (initial and comprehensive);

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

PACT. The start and stop times for this service should be recorded in the chart.

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

(B) Behavioral health service plan (moderate and low complexity by a non-physician (treatment planning and review) is a process by which the information obtained in the comprehensive assessment, course of treatment, the member, and/or treatment team meetings is evaluated and used to develop a service plan that has individualized goals, objectives, activities and services that will enable a member to improve. The initial assessment serves as a guide until the comprehensive assessment is completed. It is to focus on recovery and must include a discharge plan. It is performed with the direct active participation by the member. SoonerCare compensation for this service includes only the face to face time with the member. The start and stop times for this service should be recorded in the chart.

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

(D) Individual and family psychotherapy;

(E) Individual rehabilitation;

(F) Recovery support services;

(G) Group rehabilitation;

(H) Group psychotherapy;

(I) Crisis Intervention;

(J) Medication training and support services;

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

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

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

behavioral, interpersonal, communication, self help, safety and daily living skills.

(2) **Target population.** This service is limited to children with serious emotional disturbance who are in an ODMHSAS contracted systems of care community based treatment program, or are under OKDHS or OJA custody residing within a RBMS level of care, who need intervention and support in their living environment to achieve or maintain stable successful treatment outcomes.

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

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

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

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

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

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

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

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

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

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

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

(2) **Target population.** Adults 18 and over with SMI and/or AOD disorder(s).
(3) **Qualified professionals.** Recovery Support Specialists (RSS) must be trained/credentialed through ODMHSAS.
(4) **Limitations.** The RSS cannot bill for more than one individual during the same time period. This service can be an individual or group service. Groups have no restriction on size.
(5) **Documentation requirements.** Providers must comply with requirements listed in OAC 317:30-5-248.
(6) **Service requirements.**
(A) CRS/RSS staff utilizing their knowledge, skills and abilities will:
(i) teach and mentor the value of every individual's recovery experience;
(ii) model effective coping techniques and self-help strategies;
(iii) assist members in articulating personal goals for recovery; and
(iv) assist members in determining the objectives needed to reach his/her recovery goals.
(B) CRS/RSS staff utilizing ongoing training must:
(i) proactively engage members and possess communication skills/ability to transfer new concepts, ideas, and insight to others;
(ii) facilitate peer support groups;
(iii)assist in setting up and sustaining self-help (mutual support) groups;
(iv) support members in using a Wellness Recovery Action Plan (WRAP);
(v) assist in creating a crisis plan/Psychiatric Advanced Directive;
(vi) utilize and teach problem solving techniques with members;
(vii) teach members how to identify and combat negative self-talk and fears;
(viii) support the vocational choices of members and assist him/her in overcoming job-related anxiety;
(ix) assist in building social skills in the community that will enhance quality of life. Support the development of natural support systems;
(x) assist other staff in identifying program and service environments that are conducive to recovery; and
(xi) attend treatment team and program development meetings to ensure the presence of the member's voice and to promote the use of self-directed recovery tools.

PART 25. PSYCHOLOGISTS

317:30-5-276. Coverage by category
(a) **Outpatient Behavioral Health Services.** Outpatient behavioral health services are covered for children as set forth in this Section ~~and following the requirements as defined in the OHCA BH Provider Manual~~, unless specified otherwise, and when provided in accordance with a documented individualized service plan medical record, developed to treat the identified behavioral health and/or substance abuse disorder(s).
(1) All services are to be for the goal of improvement of functioning, independence, or wellbeing of the member. The services and treatment plans are to be recovery focused, trauma and co-occurring specific. The member must be able to actively participate in the treatment. Active participation means that the member must have sufficient cognitive abilities, communication skills, and short-term memory to derive a reasonable benefit from the treatment.

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

(2) In order to be reimbursed for services, providers must submit a completed Customer Data Core (CDC) to OHCA or its designated agent. The CDC must be reviewed, updated and resubmitted by the provider every six months. Reimbursement is made only for services provided while a current CDC is on file with OHCA or its designated agent. For further information and instructions regarding the CDC, refer to the Behavioral Health Provider Manual.

(3) Some outpatient behavioral health services may require authorization. For information regarding services requiring authorization and the process for obtaining them, refer to the Behavioral Health Provider Manual. OHCA does retain the final administrative review over both authorization and review of services as required by 42 CFR 431.10.

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

(c) **Children.** Coverage for children includes the following services ~~(all services, except Initial or Level of Care Assessment, health and behavior codes and/or Crisis Intervention services, require authorization by OHCA, or its designated agent)~~:

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

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

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

(4) Group and/or Interactive Group psychotherapy in an outpatient setting must be performed in the psychologist's office, clinic, or other confidential setting. Group therapy is a face to face interaction between a therapist and two or more unrelated patients (though there may be siblings in the same group, just not siblings only) to facilitate emotional, psychological, or behavioral changes. All group therapy records must indicate group size. Maximum total group size is six patients for

children four years of age up to the age of 18. Groups 18-20 year olds can include eight individuals. Group therapy must be provided for the benefit of a SoonerCare eligible child four years of age or older as a specifically identified component of an individual treatment plan. Multi-family group therapy size is limited to eight family units.

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

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

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

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

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

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

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

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

PART 26. LICENSED BEHAVIORAL HEALTH PROVIDERS

317:30-5-281. Coverage by Category

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

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

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

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

(2) In order to be reimbursed for services, providers must submit a completed Customer Data Core (CDC) to OHCA or its designated agent. The CDC must be reviewed, updated and resubmitted by the provider every six months. Reimbursement is made only for services provided while a current CDC is on file with OHCA or its designated agent. For further information and instructions regarding the CDC, refer to the Behavioral Health Provider Manual.

(3) Some outpatient behavioral health services may require authorization. For information regarding services requiring authorization and the process for obtaining them, refer to the Behavioral Health Provider Manual. OHCA does retain the final administrative review over both authorization and review of services as required by 42 CFR 431.10.

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

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

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

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

(B) Assessments for Children's Level of Care determination of medical necessity must follow a specified assessment process through OHCA or their designated agent. Only one assessment is allowable per provider per member. If there has been a break in service over a six month period, or the assessment is conducted for the purpose of determining a

child's need for inpatient psychiatric admission, then an additional unit can be authorized by OHCA, or their designated agent.

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

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

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

(5) Assessment/Evaluation and testing is provided by a psychologist, certified psychometrist, psychological technician of a psychologist or a LBHP utilizing tests selected from currently accepted assessment test batteries. For assessments conducted in a school setting, the Oklahoma State Department of Education requires that a licensed supervisor sign the assessment. Eight hours/units of testing per patient (over the age of two), per provider is allowed ~~with authorization~~ every 12 months. There may be instances when further testing is appropriate based on established medical necessity criteria found in the Behavioral Health Provider Manual. Justification for additional testing beyond allowed amount as specified in this section must be clearly explained and documented in the medical record. Test results must be reflected in the service plan or medical record. The service plan must clearly document the need for the testing and what the testing is expected to achieve. ~~Any testing performed for a child under three must be prior authorized.~~ Testing for a child younger than three must be medically necessary and meet established Child (0-36 months of Age) criteria as set forth in the Behavioral Health Provider Manual. Testing units must be billed on the date the testing, interpretation, scoring, and/or reporting was performed and supported by documentation.

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

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

considered an integral component of the behavioral health services listed above.

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

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

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

PART 67. BEHAVIORAL HEALTH CASE MANAGEMENT SERVICES

317:30-5-596. Coverage by category

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

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

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

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

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

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

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

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

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

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

(II) Face-to-face meetings with the member and/or the parent/guardian/family member for the implementation of activities delineated in the individual plan of care.
(III) Face-to-face meetings with treatment or service providers, necessary for the implementation of activities delineated in the individual plan of care.
(IV) Supportive activities such as non face-to-face communication with the member and/or parent/guardian/family member.
(V) Non face-to-face communication with treatment or service providers necessary for the implementation of activities delineated in the individual plan of care.
(VI) Monitoring of the individual plan of care to reassess goals and objectives and assess progress and or barriers to progress.
(VII) Crisis diversion (unanticipated, unscheduled situation requiring supportive assistance, face-to-face or telephone, to resolve immediate problems before they become overwhelming and severely impair the individual's ability to function or maintain in the community) to assist member(s) from progression to a higher level of care.
(VIII) Transitioning from institutions to the community. Individuals (except individuals ages 22 to 64 who reside in an institution for mental diseases (IMD) or individuals who are inmates of public institutions) may be considered to be transitioning to the community during the last 60 consecutive days of a covered, long-term, institutional stay that is 180 consecutive days or longer in duration. For a covered, short term, institutional stay of less than 180 consecutive days, individuals may be considered to be transitioning to the community during the last 14 days before discharge. These time requirements are to distinguish case management services that are not within the scope of the institution's discharge planning activities from case management required for transitioning individuals with complex, chronic, medical needs to the community.

(B) Levels of Case Management

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

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

Intensive Case Management is targeted to adults with serious and persistent mental illness (including ~~member's~~ members in PACT programs) and Wraparound Facilitation Case Management is targeted to children with serious mental illness and emotional disorders (including ~~member's~~ members in a System of Care Network) who are deemed high risk and in need of more intensive CM services. It is designed to ensure access to community agencies, services, and people whose functions are to provide the support, training and assistance required for a stable, safe, and healthy community life, and decreased need for higher levels of care. To produce a high fidelity

wraparound process, a facilitator can facilitate between 8 and 10 families. To ensure that these intense needs are met, case manager caseloads are limited ~~to 25~~ between 10-15 caseloads. The ICM shall be a Certified Behavioral Health Case Manager, have a minimum of 2 years Behavioral Health Case Management experience, crisis diversion experience, must have attended the ODMHSAS 6 hours ICM training, and 24 hour availability is required.

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

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

(ii) Managing finances; or

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

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

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

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

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

(viii) Mentoring or tutoring;

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

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

(xi) monitoring financial goals;

(xii) services to nursing home residents;

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

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

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

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

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

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

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

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

(F) **Documentation requirements.** The service plan must include general goals and objectives pertinent to the overall recovery needs of the member. Progress notes must relate to the service plan and describe the specific activities performed. Behavioral health case management service plan development is compensable time if the time is spent communicating with the participation by, as well as, reviewed and signed by the member, the behavioral health case manager, and a licensed behavioral health professional as defined at OAC 317:30-5-240.3(a). All behavioral health case management services rendered must be reflected by

documentation in the records. In addition to a complete behavioral health case management service, plan documentation of each session must include but is not limited to:

(i) date;

(ii) person(s) to whom services are rendered;

(iii) start and stop times for each service;

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

(v) credentials of the service provider;

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

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

(viii) progress and barriers made towards goals, and/or objectives;

(ix) member (family when applicable) response to the service;

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

(xi) member satisfaction with staff intervention.

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

317:30-5-596.1. Prior authorization

(a) ~~Prior authorization of behavioral health case management services is mandatory. The provider must request prior authorization from the OHCA, or its designated agent.~~ Prior to providing behavioral health case management services provider must submit to OHCA, or its designated agent member information which includes but is not limited to the following:

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

(2) Treatment history;

(3) Current psycho social information;

(4) Psychiatric history; and

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

(b) SoonerCare members who are eligible for services will be considered for ~~prior authorization~~ behavioral health case management services after receipt of complete and appropriate information submitted by the provider in accordance with the guidelines for behavioral health case management services developed by OHCA or its designated agent. Based on diagnosis, functional assessment, history and other SoonerCare services being received, the SoonerCare member may be ~~approved to receive~~ eligible for case management services. SoonerCare members who reside in nursing facilities, residential behavior management services, group or foster homes, or ICF/MR's may not receive SoonerCare compensable case management services unless transitioning from a higher level of care than outpatient. ~~A SoonerCare member may be approved for a time frame of one to twelve months. The OHCA, or its designated agent will review the initial request in accordance with the guidelines for prior authorization in the Outpatient Behavioral Health Service Provider Manual. An initial request for case management services requires the provider to submit specific documentation to OHCA, or its~~

~~designated agent.~~ A fully developed individual plan of service is not required ~~at the time of initial request~~ prior to providing the service. The provider will be given a time frame to develop the individual plan of service while working with the child and his/her family ~~and corresponding units of service will be approved prior to the completion of the service plan. Prior authorization requests will be reviewed by licensed behavioral health professionals as defined at OAC 317:30-5-240~~.

PART 83. RESIDENTIAL BEHAVIOR MANAGEMENT SERVICES IN FOSTER CARE SETTINGS

317:30-5-741. Coverage by category

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

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

(1) Medical necessity criteria is delineated ~~in the OHCA Behavioral Health Provider Manual.~~ as follows:

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

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

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

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

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

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

7.c-1 TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 35. MEDICAL ASSISTANCE FOR ADULTS AND CHILDREN-ELIGIBILITY TITLE
Subchapter 5. Eligibility and Countable Income
Part 5. Countable Income and Resources
OAC 317:35-5-42. [AMENDED]
(Reference APA WF # 11-02)

SUMMARY: Rules are amended to comply with the Tax Relief, Unemployment Insurance Reauthorization, and Job Creation Act of 2010 which requires state Medicaid agencies to disregard federal tax refunds or advance payments with respect to refundable tax credits as income and as resources for purposes of determining eligibility.

BUDGET IMPACT: Agency staff has determined that these revisions will not result in any additional costs to the agency. The proposed rule simply ensures those who are eligible for SoonerCare services will be deemed eligible by eligibility workers and systems. The effect on state revenues, if any, will be negligible.

MEDICAL ADVISORY COMMITTEE: The Medical Advisory Committee considered the proposed rule revisions on May 19, 2011 and recommended Board approval.

AUTHORITY: The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; Public Law 111-312, the Tax Relief, Unemployment Insurance Reauthorization, and Job Creation Act of 2010.

PUBLIC HEARING: A public hearing was held on January 17, 2012. No comments were received before, during, or after the hearing.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 35. MEDICAL ASSISTANCE FOR ADULTS AND CHILDREN-ELIGIBILITY
SUBCHAPTER 5. ELIGIBILITY AND COUNTABLE INCOME
PART 5. COUNTABLE INCOME AND RESOURCES

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

(a) **General.** The term income is defined as that gross gain or gross recurrent benefit which is derived from labor, business, property, retirement and other benefits, and many other forms which can be counted on as currently available for use on a regular basis. When an individual's income is reduced due to recoupment of an overpayment or garnishment, the gross amount before the recoupment or garnishment is counted as income.

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

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

both enter a nursing facility, their income and resources are considered separately.

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

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

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

(1) The coupon allotment under the Food Stamp Act of 1977;

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

(3) Educational grants (excluding work study), scholarships, etc., that are contingent upon the student regularly attending school. The student's classification (graduate or undergraduate) is not a factor;

(4) Loans (regardless of use) if a bona fide debt or obligation to pay can be established. Criteria to establish a loan as bona fide includes:

(A) An acknowledgment of obligation to repay or evidence that the loan was from an individual or financial institution in the loan business. If the loan agreement is not written, an OKDHS Form 08AD103E, Loan Verification, should be completed by the borrower attesting that the loan is bona fide and signed by the lender verifying the date and amount of loan. When copies of written agreements or OKDHS Form 08AD103E are not available, detailed case documentation must include information that the loan is bona fide and how the debt amount and date of receipt was verified.

(B) If the loan was from a person(s) not in the loan business, the borrower's acknowledgment of obligation to repay (with or without interest) and the lender's verification of the loan are required to indicate that the loan is bona fide.

(C) Proceeds of a loan secured by an exempt asset are not an asset;

(5) One-third of child support payments received on behalf of the disabled minor child;

(6) Indian payments (including judgment funds or funds held in trust) distributed by the Secretary of the Interior (BIA) or distributed by the tribe subject to approval by the Secretary of the Interior. Also, any interest or investment income accrued on such funds while held in trust or any purchases made with judgment funds, trust funds, interest or investment income accrued on such funds. Any income from mineral leases, from tribal business investments, etc. However, any interest or income derived from the principal or produced by purchases made with funds after distribution is considered as any other income;

(7) Special allowance for school expenses made available upon petition (in writing) for funds held in trust for the student;

(8) Title III benefits from State and Community Programs on Aging;

(9) Payment for supportive services or reimbursement of out-of-pocket expenses made to individual volunteers serving as foster grandparents,

senior health aides, or senior companions, and to persons serving in the Service Corps of Retired Executives (SCORE) and Active Corps of Executives (ACE);
(10) Payments to volunteers under the Domestic Volunteer Services Act of 1973 (VISTA), unless the gross amount of VISTA payments equals or exceeds the state or federal minimum wage, whichever is greater;
(11) The value of supplemental food assistance received under the Child Nutrition Act or the special food service program for children under the national School Lunch Act;
(12) Any portion of payments made under the Alaska Native Claims Settlement Act to an Alaska Native which are exempt from taxation under the Settlement Act;
(13) Reimbursements from an employer for out-of-pocket expenditures and allowances for travel or training to the extent the funds are used for expenses directly related to such travel or training and uniform allowance if the uniform is uniquely identified with company names or logo;
(14) Assistance or services from the Vocational Rehabilitation program such as transportation expenses to a rehabilitation center, extra clothing, lunches, grooming needed for a training program and any other such complementary payments;
(15) Experimental Housing Allowance Program (EHAP) payments made under Annual Contributions Contracts entered into prior to January 1, 1975, under Section 23 of the U.S. Housing Act of 1937, as amended;
(16) Payments made by a public or private non-profit child care agency for a child placed in foster care or subsidized adoption;
(17) Governmental rental or housing subsidies by governmental agencies, e.g., HUD (received in-kind or in cash) for rent, mortgage payments or utilities;
(18) LIHEAP payments for energy assistance and payments for emergency situations under Emergency Assistance to Needy Families with Children;
(19) Payments made from the Agent Orange Settlement Fund or any other fund established pursuant to the settlement in the In Re Agent Orange product liability litigation, M.D.L. No. 381 (E.D.N.Y.);
(20) Payments made from the Radiation Exposure Compensation Trust Fund as compensation for injuries or deaths resulting from the exposure to radiation from nuclear testing and uranium mining;
(21) Federal major disaster and emergency assistance provided under the Disaster Relief Act of 1974, and comparable disaster assistance provided by States, local governments and disaster assistance organizations;
(22) Income of a sponsor to the sponsored eligible alien;
(23) Income that is set aside under an approved Plan for Achieving Self-Support for Blind or Disabled People (PASS). The Social Security Administration approves the plan, the amount of income excluded and the period of time approved. A plan can be approved for an initial period of 18 months. The plan may be extended for an additional 18 months if needed, and an additional 12 months (total 48 months) when the objective involves a lengthy educational or training program;
(24) Payments made to individuals because of their status as victims of Nazi persecution (PL 103-286);
(25) Payments received under the Civil Liberties Act of 1988. These payments are to be made to individuals of Japanese ancestry who were detained in internment camps during World War II;
(26) Payments received as a result of participation in a class action lawsuit entitled "Factor VIII or IX Concentrate Blood Products Litigation". These payments are made to hemophilia patients who are

infected with HIV. However, if the payments are placed in an interest-bearing account, or some other investment medium that produces income, the income generated by the account may be countable as income to the individual;

(27) Payments made to certain Vietnam veterans' children with spina bifida (PL 104-204);

(28) Payments made to certain Korea service veterans' children with spina bifida (PL 108-183);

(29) Payments made to the children of women Vietnam veterans who suffer from certain birth defects (PL 106-419);

(30) Additional payments of regular unemployment compensation in the amount of $25 per week ending June 30, 2010, and any amount of emergency unemployment compensation paid through May 31, 2010, as authorized under the American Recovery and Reinvestment Tax Act of 2009; and

(31) Wages paid by the Census Bureau for temporary employment related to Census activities.

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

(1) Gross income is listed for purposes of determining eligibility. It may be derived from many sources, and some items may be automatically disregarded by the computer when so provided by state or federal law.

(2) If a member is determined to be categorically needy and is also an SSI recipient, any change in countable income (see OAC 317:35-5-42(d)(3) to determine countable income) will not affect receipt of SoonerCare and amount of State Supplemental Payment (SSP) as long as the amount does not cause SSI ineligibility. Income which will be considered by SSI in the retrospective cycle is documented in the case with computer update at the time that SSI makes the change (in order not to penalize the member twice). If the SSI change is not timely, the worker updates the computer using the appropriate date as if it had been timely. If the receipt of the income causes SSI ineligibility, the income is considered immediately with proper action taken to reduce or close the SoonerCare benefit and SSP case. Any SSI overpayment caused by SSA not making timely changes will result in recovery by SSI in the future. When the worker becomes aware of income changes which will affect SSI eligibility or payment amount, the information is to be shared with the SSA office.

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

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

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

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

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

(III) by using BENDEX and SDX.

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

(iii) The Veterans Administration allows their recipients the opportunity to request a reimbursement for medical expenses not

covered by SoonerCare. If a recipient is eligible for the readjustment payment, it is paid in a lump sum for the entire past year. This reimbursement is disregarded as income and a resource in the month it is received; however, any amount retained in the month following receipt is considered a resource.

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

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

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

(v) Veterans or their surviving spouse who receive a VA pension may have their pension reduced to $90 by the VA if the veteran does not have dependents, is SoonerCare eligible, and is residing in a nursing facility that is approved under SoonerCare. Section 8003 of Public Law 101-508 allows these veterans' pensions to be reduced to $90 per month. None of the $90 may be used in computing any vendor payment or spenddown. In these instances, the nursing home resident is entitled to the $90 reduced VA pension as well as the regular nursing facility maintenance standard. Any vendor payment or spenddown will be computed by using other income minus the monthly nursing facility maintenance standard minus any applicable medical deduction(s). Veterans or their surviving spouse who meet these conditions will have their VA benefits reduced the month following the month of admission to a SoonerCare approved nursing facility.

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

(C) **Lump sum payments.**

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

(ii) Lump sum payments used to establish dedicated bank accounts by representative payees in order to receive and maintain retroactive SSI benefits for disabled/blind children under age 18 are excluded as income. The interest income generated from dedicated bank

accounts is also excluded. The dedicated bank account consisting of the retroactive SSI lump sum payment and accumulated interest is excluded as a resource in both the month received and any subsequent months.

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

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

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

(i) If royalty income is received monthly but in irregular amounts, an average based on the previous six months' royalty income is computed and used to determine income eligibility. Exception: At any time that the county becomes aware of and can establish a trend showing a dramatic increase or decrease in royalty income, the previous two month's royalty income is averaged to compute countable monthly income.

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

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

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

~~(i) Advance payments of EITC or refunds of EITC received as a result of filing a federal income tax return are considered as earned income in the month after they are received.~~

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

~~(iii)~~ (ii) Money from the sale of whole blood or blood plasma is

considered as self-employment income subject to necessary business expense and appropriate earned income disregards.

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

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

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

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

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

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

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

(F) **Inconsequential or irregular income.** Inconsequential or irregular receipt of income in the amount of $10 or less per month or $30 or less per quarter is disregarded. The disregard is applied per individual for each type of inconsequential or irregular income. To determine whether the income is inconsequential or irregular, the gross amount of earned income and the gross minus business expense of self-employed income are considered.

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

(i) **Daily.** Income received on a daily basis is converted to a

weekly amount then multiplied by 4.3.

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

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

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

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

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

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

(d) **Computation of income.**

(1) **Earned income.** The general income exclusion of $20 per month is allowed on the combined earned income of the eligible individual and eligible or ineligible spouse. See paragraph (6) of this subsection if there are ineligible minor children. After the $20 exclusion, deduct $65 and one-half of the remaining combined earned income.

(2) **Unearned income.** The total gross amount of unearned income of the eligible individual and eligible or ineligible spouse is considered. See paragraph (6) of this subsection if there are ineligible minor children.

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

(4) **Deeming computation for disabled or blind minor child(ren).** An automated calculation is available for computing the income amount to be deemed from parent(s) and the spouse of the parent to eligible disabled or blind minor child(ren) by use of transaction CID. The ineligible minor child in the computation regarding allocation for ineligible child(ren) is defined as: a dependent child under age 18.

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

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

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

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

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

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

(C) After computations in subparagraphs (A) and (B) of this paragraph,

the remaining amount is the ineligible spouse's countable income considered available to the eligible spouse.

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

(A) transportation to and from work;

(B) job performance; and

(C) job improvement.

7.c-2 TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 45. INSURE OKLAHOMA
Subchapter 9. Insure Oklahoma ESI Employee Eligibility
OAC 317:45-9-4. [AMENDED]
Subchapter 11. Insure Oklahoma IP
Part 3. Insure Oklahoma IP Member Health Care Benefits
OAC 317:45-11-10. [AMENDED]
OAC 317:45-11-12. [AMENDED]
Part 5. Insure Oklahoma IP Member Eligibility
OAC 317:45-11-24. [AMENDED]
OAC 317:45-11-25. [AMENDED]
Subchapter 13. Insure Oklahoma Dental Services
OAC 317:45-13-1. [AMENDED]
(Reference APA WF # 11-05)

SUMMARY: Rules are revised to comply with Federal law on Native American cost-sharing exemptions. Native Americans are exempt from Insure Oklahoma co-pays or premiums when they receive services provided by I/T/U providers or through referral by contract health services. Native American children are exempt from all cost-sharing requirements regardless of where the services were rendered.

BUDGET IMPACT: Agency staff has determined that these revisions will result in a state cost of $138,566. This cost, however, was considered as part of a previous rule, which was considered and approved separately.

MEDICAL ADVISORY COMMITTEE: The Medical Advisory Committee considered the proposed rule revisions on May 19, 2011, and recommended Board approval.

AUTHORITY: The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; Section 5006(a) of the American Recovery and Reinvestment Act; 42 CFR 457.535

PUBLIC HEARING: A public hearing was held on January 17, 2012. No comments were received before, during, or after the hearing.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 45. INSURE OKLAHOMA
SUBCHAPTER 9. INSURE OKLAHOMA ESI EMPLOYEE ELIGIBILITY

317:45-9-4. Employee cost sharing

Employees are responsible for up to 15 percent of their health plan premium. The employees are also responsible for up to 15 percent of their dependent's health plan premium if the dependent is included in the program. The combined portion of the employee's cost sharing for health plan premiums cannot exceed three percent of his/her annual gross household income computed monthly. Native American children providing documentation of ethnicity are exempt from cost-sharing requirements, including premium payments and out-of-pocket expenses.

SUBCHAPTER 11. INSURE OKLAHOMA IP
PART 3. INSURE OKLAHOMA IP MEMBER HEALTH CARE BENEFITS

317:45-11-10. Insure Oklahoma IP adult benefits

(a) All IP adult benefits are subject to rules delineated in 317:30 except as specifically set out in this Section. The scope of IP adult benefits described in this Section is subject to specific non-covered services listed in 317:45-11-11.

(b) A PCP referral is required to see any other provider with the exception of the following services:

(1) behavioral health services;

(2) prenatal and obstetrical supplies and services, meaning prenatal care, delivery and 60 days of postpartum care;

(3) family planning supplies and services, meaning an office visit for a comprehensive family planning evaluation, including obtaining a Pap smear;

(4) women's routine and preventive health care services;

(5) emergency medical condition as defined in 317:30-3-1; and

(6) services delivered to American Indians at Indian Health Service, tribal, or urban Indian clinics.

(c) IP covered adult benefits for in-network services, limits, and applicable co-payments are listed in this subsection. In addition to the benefit-specific limits, there is a maximum lifetime benefit of $1,000,000. Dependent children coverage is found at 317:45-11-12. Children are not held to the maximum lifetime benefit. Native American adults providing documentation of ethnicity who receive items and services furnished by the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization or through referral under contract health services are exempt from co-payments. Coverage includes:

(1) Anesthesia / Anesthesiologist Standby. Covered in accordance with 317:30-5-7. Eligible services are covered for covered illness or surgery including services provided by a Certified Registered Nurse Anesthetist (CRNA) or Anesthesiologist Assistant (AA).

(2) Blood and Blood Products. Processing, storage, and administration of blood and blood products in inpatient and outpatient settings.

(3) Chelation Therapy. Covered for heavy metal poisoning only.

(4) Diagnostic X-ray, including Ultrasound. Covered in accordance with 317:30-5-22(b)(2). PCP referral is required. Standard radiology (X-ray or Ultrasound): $0 co-pay. Specialized scanning and imaging (MRI, MRA, PET, or CAT Scan); $25 co-pay per scan.

(5) Emergency Room Treatment, services and supplies for treatment in an emergency. Contracted provider services are subject to a $30 co-pay per occurrence. The emergency room co-pay will be waived if the member is admitted to the hospital or death occurs before admission.

(6) Inpatient Hospital Benefits. Covered in accordance with 317:30-5-41, 317:30-5-47 and 317:30-5-95; $50 co-pay per admission.

(7) Preventive Office Visit. For services of evaluation and medical management (wellness exam); one visit per year with a $10 co-pay. This visit counts as an office visit.

(8) Office Visits/Specialist Visits. Covered in accordance with 317:30-5-9, 317:30-5-10, and 317:30-5-11. For services of evaluation and medical management; up to four visits are covered per month; PCP referral required for specialist visits; $10 co-pay per visit.

(9) Outpatient Hospital/Facility Services.

(A) Includes hospital surgery services in an approved outpatient facility including outpatient services and diagnostic services. Prior authorization required for certain procedures; $25 co-pay per visit.

(B) Therapeutic radiology or chemotherapy on an outpatient basis without limitation to the number of treatments per month for persons with proven malignancies or opportunistic infections; $10 co-pay per visit.

(C) Physical, Occupational and Speech Therapy services. Coverage is limited to one evaluation/re-evaluation visit (unit) per discipline per calendar year and 15 visits (units) per discipline per date of service per calendar year; $10 co-pay per visit.

(10) Maternity (Obstetric). Covered in accordance with 317:30-5-22. Nursery care paid separately under eligible child; $50 inpatient hospital co-pay.

(11) Laboratory/Pathology. Covered in accordance with 317:30-5-20; $0 co-pay.

(12) Mammogram (Radiological or Digital). Covered in accordance with 317:30-5-901; $0 co-pay.

(13) Immunizations. Covered in accordance with 317:30-5-2.

(14) Assistant Surgeon. Covered in accordance with 317:30-5-8.

(15) Dialysis, Kidney dialysis, and services and supplies, either at home or in a facility; $0 co-pay.

(16) Oral Surgery. Services are limited to the removal of tumors or cysts; Inpatient Hospital $50 or Outpatient Hospital/Facility; $25 co-pay applies.

(17) Behavioral Health (Mental Health and Substance Abuse) Treatment (Inpatient). Covered in accordance with 317:30-5-95.1; $50 co-pay per admission.

(18) Behavioral Health (Mental Health and Substance Abuse) Treatment (Outpatient).

(A) Agency services. Covered in accordance with 317:30-5-241 and 317:30-5-596; $10 co-pay per visit.

(B) Individual provider services. Licensed Behavioral Health Professionals (LBHPs) are defined as follows for the purpose of Outpatient Behavioral Health Services and Outpatient Substance Abuse Treatment:

(i) 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 317:30-5-2.

(ii) 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 (I) through (VI) below. The exemptions from licensure under 59 Okla. Stat. '1353(4) and (5), 59 '1903(C) and (D), 59 '1925.3(B) and (C), and 59 '1932(C) and (D) do not apply to Outpatient Behavioral Health Services.

(I) Psychology,
(II) Social Work (clinical specialty only),
(III) Professional Counselor,
(IV) Marriage and Family Therapist,
(V) Behavioral Practitioner, or
(VI) Alcohol and Drug Counselor.

(iii) 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.

(iv) A Physician's 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.

(v) LBHPs must have a valid Insure Oklahoma contract in order to bill for services rendered.

(vi) LBHP services require prior authorization and are limited to 8 therapy services per month per member and 8 testing units per year per member; $10 co-pay per visit.

(19) Durable Medical Equipment and Supplies. Covered in accordance with 317:30-5-210 through 317:30-5-218. A PCP referral and prior authorization is required for certain items. DME/Supplies are covered up to a $15,000 annual maximum; exceptions from the annual DME limit are diabetic supplies, oxygen, home dialysis, and parenteral therapy; $5 co-pay for durable/non-durable supplies and $25 co-pay for durable medical equipment.

(20) Diabetic Supplies. Covered in accordance with 317:30-5-211.15; not subject to $15,000 annual DME limit; $5 co-pay per prescription.

(21) Oxygen. Covered in accordance with 317:30-5-211.11 through 317:30-5-211.12; not subject to $15,000 annual DME limit; $5 co-pay per month.

(22) Pharmacy. Covered in accordance with 317:30-5-72.1 and 317:30-5-72. Prenatal vitamins and smoking cessation products do not count against monthly prescription limits; $5/$10 co-pay per prescription.

(23) Smoking Cessation Products. Products do not count against monthly prescription limits. Covered in accordance with 317:30-5-72.1; $5/$10 co-pay per product.

(24) Nutrition Services. Covered in accordance with 317:30-5-1076; $10 co-pay per visit.

(25) External Breast Prosthesis, Bras and Prosthetic Garments. Covered in accordance with 317:30-5-211.13; $25 co-pay per prosthesis.

(26) Surgery. Covered in accordance with 317:30-5-8; $50 co-pay per inpatient admission and $25 co-pay per outpatient visit.

(27) Home Dialysis. Covered in accordance with 317:30-5-211.13; not subject to $15,000 annual DME limit; $0 co-pay.

(28) Parenteral Therapy. Covered in accordance with 317:30-5-211.14; not subject to $15,000 annual DME limit; $25 co-pay per month.

(29) Family Planning Services and Supplies, including Sterilizations. Covered in accordance with 317:30-3-57; $0 co-pay.

(30) Home Health Medications, Intravenous (IV) Therapy and Supplies. Covered in accordance with 317:30-5-211.15 and 317:30-5-42.16(b)(3).

(31) Fundus photography.

(32) Perinatal dental care for pregnant women. Covered in accordance with 317:30-5-696; $0 co-pay.

317:45-11-12. Insure Oklahoma IP children benefits

(a) IP covered child benefits for in-network services, limits, and applicable co-payments are listed in this Subsection. All IP benefits are subject to rules delineated in 317:30 except as specifically set out in this Section. All services provided must be medically necessary as defined in 317:30-3-1(f). The scope of IP child benefits described in this Section is subject to specific non-covered services listed in 317:45-11-13. Dependent children are not held to the maximum lifetime benefit of $1,000,000. Native American children providing documentation of ethnicity are exempt from co-payments. Coverage includes:

(1) Ambulance services. Covered as medically necessary; $50 co-pay per occurrence; waived if admitted.

(2) Blood and blood products. Processing, storage, and administration of blood and blood products in inpatient and outpatient settings.

(3) Chelation therapy. Covered for heavy metal poisoning only.

(4) Chemotherapy and radiation therapy. Covered as medically necessary; $10 co-pay per visit.

(5) Clinic services including renal dialysis services. Covered as medically necessary; $0 co-pay for dialysis services; $10 co-pay per office visit.
(6) Diabetic supplies. One glucometer, one spring-loaded lancet device, two replacement batteries per year - 100 glucose strips and lancets per month; not included in DME $15,000 max/year; $5 co-pay per billable service. Additional supplies require prior authorization.
(7) Diagnostic X-ray services. Covered as medically necessary; $25 co-pay per scan for MRI, MRA, PET, CAT scans only.
(8) Dialysis. Covered as medically necessary.
(9) Durable medical equipment and supplies. Covered as medically necessary with $15,000 annual maximum; $5 co-pay per item for durable/non-durable supplies; $25 co-pay per item for DME.
(10) Emergency department services. Covered as medically necessary; $30 co-pay per occurrence; waived if admitted.
(11) Family planning services and supplies. Birth control information and supplies; pap smears; pregnancy tests.
(12) Home health services. Home health visits limited to 36 visits per year, prior authorization required, includes medications IV therapy and supplies; $10 co-pay per visit, appropriate pharmacy and DME co-pays will apply.
(13) Hospice services. Covered as medically necessary, prior authorization required; $10 co-pay per visit.
(14) Immunizations. Covered as recommended by ACIP; $0 co-pay.
(15) Inpatient hospital services (acute care only). Covered as medically necessary; $50 co-pay per admission.
(16) Laboratory services. Covered as medically necessary.
(17) Psychological testing. Psychological, neurological and development testing; outpatient benefits per calendar year, prior authorization required issued in four unit increments - not to exceed eight units/hours per testing set; $0 co-pay.
(18) Mental health/substance abuse treatment-outpatient. All outpatient benefits require prior authorization. Outpatient benefits limited to 48 visits per calendar year. Additional units as medically necessary; $10 co-pay per outpatient visit.
(19) Mental health/substance abuse treatment-inpatient. Acute, detox, partial, and residential treatment center (RTC) with 30 day max per year, 2 days of partial or RTC treatment equals 1 day accruing to maximum. Additional units as medically necessary; $50 co-pay per admission. Requires prior authorization.
(20) Nurse midwife services. Covered as medically necessary for pregnancy-related services only; $0 co-pay.
(21) Nutrition services. Covered as medically necessary; $10 co-pay.
(22) Nutritional support. Covered as medically necessary; not included in DME $15,000 max/year. Parenteral nutrition covered only when medically necessary; $25 co-pay.
(23) Other medically necessary services. Covered as medically necessary.
(24) Oral surgery. Covered as medically necessary and includes the removal of tumors and cysts; $25 co-pay for outpatient; $50 co-pay for inpatient hospital.
(25) Outpatient hospital services. Covered as medically necessary and includes ambulatory surgical centers and therapeutic radiology or chemotherapy on an outpatient basis without limitation to the number of treatments per month for children with proven malignancies or opportunistic infections; $25 co-pay per visit; $10 co-pay per visit for therapeutic radiology or chemotherapy.

(26) Oxygen. Covered as medically necessary; not included in DME $15,000 max/year; $5 co-pay per month.
(27) PCP visits. Blood lead screen covered as medically necessary. Hearing services limited to one outpatient newborn screening. Well baby/well child exams follow recommended schedule to age 19; $0 co-pay for preventive visits and well baby/well child exams; $10 co-pay for all other visits.
(28) Physical, occupational, and speech therapy. Covered as medically necessary; prior authorization required; $10 co-pay per visit.
(29) Physician services, including preventive services. Covered as medically necessary; $0 co-pay for preventive visits; $10 co-pay for all other visits.
(30) Prenatal, delivery and postpartum services. Covered as medically necessary; $0 co-pay for office visits; $50 co-pay for delivery.
(31) Prescription drugs and insulin. Limited to six per month; generic preferred. Prenatal vitamins and smoking cessation products do not count toward the six prescription limit; $5-$10 co-pay.
(32) Smoking cessation products. Limited coverage; 90-day supply; products do not count against prescription drug limit; $5-$10 co-pay.
(33) Specialty clinic services. Covered as medically necessary; $10 co-pay.
(34) Surgery. Covered as medically necessary; $25 co-pay for outpatient facility; $50 co-pay for inpatient hospital.
(35) Tuberculosis services. Covered as medically necessary; $10 co-pay per visit.
(36) Ultraviolet treatment-actinotherapy. Covered as medically necessary; prior authorization required after one visit per 365 sequential days; $5 co-pay.

(b) A PCP referral is required to see any other provider with the exception of the following services:
(1) behavioral health services;
(2) prenatal and obstetrical supplies and services, meaning prenatal care, delivery and 60 days of postpartum care;
(3) family planning supplies and services, meaning an office visit for a comprehensive family planning evaluation, including obtaining a Pap smear;
(4) women's routine and preventive health care services;
(5) emergency medical condition as defined in 317:30-3-1; and
(6) services delivered to American Indians at Indian Health Service, tribal, or urban Indian clinics.

PART 5. INSURE OKLAHOMA IP MEMBER ELIGIBILITY

317:45-11-24. Member cost sharing

(a) Members are given monthly invoices for health plan premiums. The premiums are due, and must be paid in full, no later than the 15th day of the month prior to the month of IP coverage.
(1) Members are responsible for their monthly premiums, in an amount not to exceed four percent of their monthly gross household income.
(2) Working disabled individuals are responsible for their monthly premiums in an amount not to exceed four percent of their monthly gross household income, based on a family size of one and capped at 250 percent of the Federal Poverty Level. The increase from 200 to 250 percent of the FPL will be phased in over a period of time as determined by the Oklahoma Health Care Authority.
(3) Native Americans providing documentation of ethnicity are exempt from premium payments.

(b) IP coverage is not provided until the premium and any other amounts due

are paid in full. Other amounts due may include but are not limited to any fees, charges, or other costs incurred as a result of Insufficient/Non-sufficient funds.

SUBCHAPTER 13. INSURE OKLAHOMA DENTAL SERVICES

317:45-13-1. Dental services requirements and benefits

The Oklahoma Health Care Authority (OHCA) provides dental services to children who qualify for the Insure Oklahoma Individual Plan (IP). Dental coverage is obtained through direct purchase from the OHCA. The existing cost sharing requirements for IP qualified children apply. Native Americans children providing documentation of their ethnicity are exempt from dental co-pay requirements. Children obtaining medical coverage through IP receive Dental IP coverage. The OHCA contracts with Dental IP providers utilizing the SoonerCare network. The Dental IP providers are reimbursed pursuant to the SoonerCare fee schedule for rendered services.

(1) The Dental IP program is covered as medically necessary and includes coverage for Class A, B, C, and orthodontia services. All coverage is provided as necessary to prevent disease, promote and restore oral health, and treat emergency conditions. Dental services follow the American Academy of Pediatric Dentistry (AAPD) periodicity schedule. Prior authorization is required for certain services.

(2) Class A services are covered as medically necessary and include preventive, diagnostic care such as cleanings, check-ups, X-rays, and fluoride treatments, no co-pay is required.

(3) Class B services are covered as medically necessary and include basic, restorative, endodontic, periodontic, oral and maxillofacial surgery care such as fillings, extractions, periodontal care, and some root canal, $10 co-pay is required.

(4) Class C services are covered as medically necessary and include major, prosthodontic care such as crowns, bridges and dentures, $25 co-pay is required.

(5) Class D services are covered as medically necessary and include orthodontic care. Orthodontic care is not covered for cosmetic purposes or any purposes which are not medical in nature, $25 co-pay is required.

(6) Emergency dental services are covered as medically necessary, no co-pay is required.

7.c-3 TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
Subchapter 5. Individual Providers and Specialties
Part 27. Independent Licensed Physical Therapists
317:30-5-291. [AMENDED]
Part 28. Occupational Therapy Services
317:30-5-296. [AMENDED]
Part 77. Speech and Hearing Services
317:30-5-676. [AMENDED]
(Reference APA WF # 11-07)

SUMMARY: Rules restrict individually-contracted provider services to children, though adults may receive such therapy services in an outpatient hospital setting. Rules are amended to ensure clarity in policy that there is no coverage for adults for services rendered by individually-contracted providers, but there is coverage for adults in an outpatient hospital setting.

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

MEDICAL ADVISORY COMMITTEE: The Medical Advisory Committee considered the proposed rule revisions on May 19, 2011, and recommended Board approval.

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

PUBLIC HEARING: A public hearing was held on January 17, 2012. One public comment was received through the online public comment process prior to the hearing.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 27. INDEPENDENT LICENSED PHYSICAL THERAPISTS

317:30-5-291. Coverage by category

Payment is made to registered physical therapists as set forth in this Section.

(1) **Children.** Initial therapy evaluations do not require prior authorization. All therapy services following the initial evaluation must be prior authorized for continuation of service.

(2) **Adults.** There is no coverage for adults~~.~~ for services rendered by individually contracted providers. Coverage for adults is permitted in an outpatient hospital setting as described in 30-5-42.1.

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

PART 28. OCCUPATIONAL THERAPY SERVICES

317:30-5-296. Coverage by category

Payment is made for occupational therapy services as set forth in this Section.

(1) **Children.** Initial therapy evaluations do not require prior authorization. All therapy services following the initial evaluation must be prior authorized for continuation of service.
(2) **Adults.** There is no coverage for adults~~.~~ for services rendered by individually contracted providers. Coverage for adults is permitted in an outpatient hospital setting as described in 30-5-42.1.
(3) **Individuals eligible for Part B of Medicare.** Services provided to Medicare eligible recipients are filed directly with the fiscal agent.

PART 77. SPEECH AND HEARING SERVICES

317:30-5-676. Coverage by category

Payment is made for speech and hearing services as set forth in this Section.

(1) **Children.** Coverage for children is as follows:

(A) **Preauthorization required.** Initial therapy evaluations and the first three therapy visits do not require prior authorization. All therapy services following the initial evaluation and first three visits must be preauthorized prior to continuation of service.

(B) **Speech/Language Services.** Speech/language therapy services may include speech/language evaluations, individual and group therapy services provided by a state licensed speech/language pathologist.

(C) **Hearing aids.** Hearing and hearing aid evaluations include pure tone air, bone and speech audiometry by a state licensed audiologist. Payment is made for a hearing aid following a recommendation by a Medical or Osteopathic physician and a hearing aid evaluation by a state licensed audiologist.

(2) **Adults.** There is no coverage for adults~~.~~ for services rendered by individually contracted providers. Coverage for adults is permitted in an outpatient hospital setting as described in 30-5-42.1.
(3) **Individuals eligible for Part B of Medicare.** Services provided to Medicare eligible recipients are filed directly with the fiscal agent.

7.c-4 TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
Subchapter 3. General Provider Policies
Part 1. General Scope and Administration
317:30-3-5. [AMENDED]
(Reference APA WF # 11-16)

SUMMARY: Rules are revised to clarify OHCA's current policy that pregnancy-related services are exempt from cost-sharing requirements. Confusion existed among providers as to when pregnant women may be charged a co-pay. This rule makes clear the visit must be pregnancy-related. The rules are also revised to remove reference to another section of policy that is no longer in effect.

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

MEDICAL ADVISORY COMMITTEE: The Medical Advisory Committee considered the proposed rule revisions on September 15, 2011, and recommended Board approval.

AUTHORITY: The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; 42 CFR 447.70

PUBLIC HEARING: A public hearing was held on January 17, 2012. No comments were received before, during, or after the hearing.

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

317:30-3-5. Assignment and Cost Sharing

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

(1) **"Fee-for-service contract"** means the provider agreement specified in OAC 317:30-3-2. This contract is the contract between the Oklahoma Health Care Authority and medical providers which provides for a fee with a specified service involved.

(2) **"Within the scope of services"** means the set of covered services defined at OAC 317:25-7 and the provisions of the SoonerCare Choice contracts in the SoonerCare Program.

(3) **"Outside of the scope of the services"** means all medical benefits outside the set of services defined at OAC 317:25-7 and the provisions of the SoonerCare Choice contracts in the SoonerCare Program.

(b) **Assignment in fee-for-service.** The OHCA's Medicaid State Plan provides that participation in the medical program is limited to providers who accept, as payment in full, the amounts paid by OHCA plus any deductible, coinsurance, or co-payment required by the State Plan to be paid by the member and make no additional charges to the member or others.

(1) OHCA presumes acceptance of assignment upon receipt of an assigned claim. This assignment, once made, cannot be rescinded, in whole or in part by one party, without the consent of the other party.

(2) Once an assigned claim has been filed, the member must not be billed

and the member is not responsible for any balance except the amount indicated by OHCA. The only amount a member may be responsible for is a co-payment, or the member may be responsible for services not covered under the medical programs. In any event, the member should not be billed for charges on an assigned claim until the claim has been adjudicated or other notice of action received by the provider. Any questions regarding amounts paid should be directed to OHCA, Provider Services.

(3) When potential assignment violations are detected, the OHCA will contact the provider to assure that all provisions of the assignment agreement are understood. When there are repeated or uncorrected violations of the assignment agreement, the OHCA is required to suspend further payment to the provider.

(c) **Assignment in SoonerCare.** Any provider who holds a fee for service contract and also executes a contract with a provider in the SoonerCare Choice program must adhere to the rules of this subsection regarding assignment.

(1) If the service provided to the member is outside of the scope of the services outlined in the SoonerCare Contract, then the provider may bill or seek collection from the member.

(2) In the event there is a disagreement whether the services are in or out of the scope of the contracts referenced in (1) of this subsection, the Oklahoma Health Care Authority shall be the final authority for this decision. ~~The provider seeking payment under the SoonerCare Program may appeal to OHCA under the provisions of OAC 317:2-1-2.1.~~

(3) Violation of this provision shall be grounds for a contract termination in the fee-for-service and SoonerCare programs.

(d) **Cost Sharing-Copayment.** Section 1902(a)(14) of the Social Security Act permits states to require certain members to share some of the costs of SoonerCare by imposing upon them such payments as enrollment fees, premiums, deductibles, coinsurance, co-payments, or similar cost sharing charges. OHCA requires a co-payment of some SoonerCare members for certain medical services provided through the fee for service program. A co-payment is a charge which must be paid by the member to the service provider when the service is covered by SoonerCare. Section 1916(e) of the Act requires that a provider participating in the SoonerCare program may not deny care or services to an eligible individual based on such individual's inability to pay the co-payment. A person's assertion of their inability to pay the co-payment establishes this inability. This rule does not change the fact that a member is liable for these charges and it does not preclude the provider from attempting to collect the co-payment.

(1) Co-payment is not required of the following members:

(A) Individuals under age 21. Each member's date of birth is available on the REVS system or through a commercial swipe card system.

(B) Members in nursing facilities and intermediate care facilities for the mentally retarded.

~~(C) Pregnant women.~~

~~(D)~~(C) Home and Community Based Service waiver members except for prescription drugs.

~~(E)~~(D) Native Americans providing documentation of ethnicity in accordance with 317:35-5-25 who receive items and services furnished by the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization or through referral under contract health services.

(2) Co-payment is not required for the following services:

(A) Family planning services. Includes all contraceptives and services rendered.

(B) Emergency services provided in a hospital, clinic, office, or other facility.

(C) Services furnished to pregnant women, if those services relate to the pregnancy or to any other medical condition which may complicate the pregnancy.

(3) Co-payments are required in an amount not to exceed the federal allowable for the following:

(A) Inpatient hospital stays.

(B) Outpatient hospital visits.

(C) Ambulatory surgery visits including free-standing ambulatory surgery centers.

(D) Encounters with the following rendering providers:

(i) Physicians,

(ii) Advanced Practice Nurses,

(iii) Physician Assistants,

(iv) Optometrists,

(v) Home Health Agencies,

(vi) Certified Registered Nurse Anesthetists,

(vii) Anesthesiologist Assistants,

(viii) Durable Medical Equipment providers, and

(ix) Outpatient behavioral health providers.

(E) Prescription drugs.

(i) Zero for preferred generics.

(ii) $0.65 for prescriptions having a SoonerCare allowable payment of $0.00-$10.00.

(iii) $1.20 for prescriptions having a SoonerCare allowable payment of $10.01-$25.00.

(iv) $2.40 for prescriptions having a SoonerCare allowable payment of $25.01-$50.00.

(v) $3.50 for prescriptions having a SoonerCare allowable payment of $50.01 or more.

(F) Crossover claims. Dually eligible Medicare/SoonerCare members must make a co-payment in an amount that does not exceed the federal allowable per visit/encounter for all Part B covered services. This does not include dually eligible HCBS waiver members.

(4) Aggregate cost-sharing liabilities in a given calendar year may not exceed 5% of the member's gross annual income.

7.c-5 TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
Subchapter 5. Individual Providers and Specialties
Part 17. Medical Suppliers
317:30-5-211.2. [AMENDED]
(Reference APA WF # 11-17)

SUMMARY: Rules are amended to exempt durable medical equipment repairs with a cost per item of less than $250.00 from the prescription requirement.

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

MEDICAL ADVISORY COMMITTEE: The Medical Advisory Committee considered the proposed rule revisions on September 15, 2011, and recommended Board approval.

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

PUBLIC HEARING: A public hearing was held on January 17, 2012. Three public comments were received in support of the rule change prior to the hearing through the online public comment process.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 17. MEDICAL SUPPLIERS

317:30-5-211.2. Medical necessity

(a) **Coverage.** Coverage is subject to the requirement that the equipment be necessary and reasonable for the treatment of an illness or injury, or to improve the functioning ~~or~~ of a malformed body member. The member's diagnosis must warrant the type of equipment or supply being purchased or rented.

(b) **Prescription requirements.** All DME, except for equipment repairs with a cost per item of less than $250.00 total parts and labor and hearing aid batteries, require a prescription signed by a physician, a physician assistant, or an advanced practice nurse. Except as otherwise stated in state or federal law, the prescription must be in writing, or given orally and later reduced to writing by the provider filling the order. Prescriptions are valid for no more than one year from the date written. The prescription must include the following information:

(1) date of the order;
(2) name and address of the prescriber;
(3) name and address of the member;
(4) name or description and quantity of the prescribed item;
(5) diagnosis for the item requested;
(6) directions for use of the prescribed item; and
(7) prescriber's signature.

(c) **Certificate of medical necessity.** For certain items or services, the supplier must receive a signed CMN/OHCA CMN from the treating physician. The supplier must have a signed CMN/OHCA CMN in their records before they submit a claim for payment. The CMN/OHCA CMN may be faxed, copied or the original hardcopy.

(d) **Place of service.**

(1) OHCA covers DMEPOS for use in the member's place of residence except if the member's place of residence is a nursing facility.

(2) For members residing in a nursing facility, most medical supplies and/or DME are considered part of the facility's per diem rate. Refer to coverage for nursing facility residents at OAC 317:30-5-211.16.

7.c-5 TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
Subchapter 5. Individual Providers and Specialties
Part 17. Medical Suppliers
317:30-5-211.2. [AMENDED]
(Reference APA WF # 11-17)

SUMMARY: Rules are amended to exempt durable medical equipment repairs with a cost per item of less than $250.00 from the prescription requirement.

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

MEDICAL ADVISORY COMMITTEE: The Medical Advisory Committee considered the proposed rule revisions on September 15, 2011, and recommended Board approval.

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

PUBLIC HEARING: A public hearing was held on January 17, 2012. Three public comments were received in support of the rule change prior to the hearing through the online public comment process.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 17. MEDICAL SUPPLIERS

317:30-5-211.2. Medical necessity

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(1) date of the order;
(2) name and address of the prescriber;
(3) name and address of the member;
(4) name or description and quantity of the prescribed item;
(5) diagnosis for the item requested;
(6) directions for use of the prescribed item; and
(7) prescriber's signature.

(c) **Certificate of medical necessity.** For certain items or services, the supplier must receive a signed CMN/OHCA CMN from the treating physician. The supplier must have a signed CMN/OHCA CMN in their records before they submit a claim for payment. The CMN/OHCA CMN may be faxed, copied or the original hardcopy.

(d) **Place of service.**

(1) OHCA covers DMEPOS for use in the member's place of residence except if the member's place of residence is a nursing facility.

(2) For members residing in a nursing facility, most medical supplies and/or DME are considered part of the facility's per diem rate. Refer to coverage for nursing facility residents at OAC 317:30-5-211.16.

7.c-6 TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 2. GRIEVANCE PROCEDURES AND PROCESS
Subchapter 1. Rules
317:2-1-2. [Amended]
317:2-1-15. [New]
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
Subchapter 5. Individual Providers and Specialties
Part 3. Hospitals
317:30-5-58. [NEW]
(Reference APA WF # 11-18 A & B)

SUMMARY: Rules are revised to establish guidelines for and implement the Supplemental Hospital Offset Payment Program (SHOPP) as authorized by 63 Okla. Stat. §§ 3241.1 through 3241.6. OHCA is required by the SHOPP Act to assess all in-state hospitals, unless specifically exempted, an assessment fee of 2.5%. Funds derived from the assessment will be used to garner federal matching funds which will be used to maintain SoonerCare provider reimbursement rates as well as pay participating hospitals a quarterly access payment.

BUDGET IMPACT: SHOPP legislation authorizes OHCA to implement and provide enforcement of the proposed rule and appropriates $200,000 of the assessment to be used towards any administrative cost. The $200,000 is matched with federal funds at the administrative rate of 50% for a total of $400,000 to be used towards administrative cost. Additionally, OHCA is authorized to retain approximately $83 million to be used to maintain current SoonerCare payments for all providers.

MEDICAL ADVISORY COMMITTEE: The Medical Advisory Committee considered the proposed rule revisions on September 15, 2011, and recommended Board approval.

AUTHORITY: The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; Sections 3241.1 through 3241.6 of Title 63 of the Oklahoma Statutes

PUBLIC HEARING: A public hearing was held on January 17, 2012. No comments were received before, during, or after the hearing.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 2. GRIEVANCE PROCEDURES AND PROCESS
SUBCHAPTER 1. RULES

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. '~~ Okla. Stat. § 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 317:2-1-5. The ALJ's decision may be appealed to the Chief Executive Officer of the OHCA, which is a record review at which the parties do not appear (317:2-1-13).

(7) Member appeals are ordinarily decided within 90 days from the date OHCA receives the member's timely request for a fair hearing unless the member waives this requirement. [Title 42 C.F.R. Section 431.244(f)]

(8) Tax warrant intercept appeals will be heard directly by the ALJ. A decision is normally rendered by the ALJ within 20 days of the hearing before the ALJ.

(b) **Provider Process Overview.**

(1) The proceedings as described in this Section contain the hearing process for those appeals filed by providers. These appeals encompass all subject matter cases contained in 317:2-1-2(c)(2).

(2) All provider appeals are initially heard by the OHCA Administrative Law Judge under 317:2-1-2(c)(2).

(A) The Appellant (Appellant is the provider who files a grievance) 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) Unless an exception is provided in 317:2-1-13, the Administrative Law Judge's decision is appealable to OHCA's CEO under 317:2-1-13.

(c) **ALJ jurisdiction.** The administrative law judge has jurisdiction of the following matters:

(1) Member Appeals:

(A) Discrimination complaints regarding the SoonerCare program;

(B) Appeals which relate to the scope of services, covered services, complaints regarding service or care, enrollment, disenrollment, and reenrollment in the SoonerCare Program;

(C) Fee for Service appeals regarding the furnishing of services, including prior authorizations;

(D) Appeals which relate to the tax warrant intercept system through the Oklahoma Health Care Authority. Tax warrant intercept appeals will

be heard directly by the ALJ. A decision will be rendered by the Administrative Law Judge within 20 days of the hearing before the ALJ;
(E) Complaints regarding the possible violation of the Health Insurance Portability and Accountability Act of 1996 (HIPAA);
(F) Proposed administrative sanction appeals pursuant to 317:35-13-7. Proposed administrative sanction appeals will be heard directly by the ALJ. A decision by the ALJ will ordinarily be rendered within 20 days of the hearing before the ALJ. This is the final and only appeals process for proposed administrative sanctions;
(G) Appeals which relate to eligibility determinations made by OHCA;
(H) Appeals of insureds participating in Insure Oklahoma which are authorized by 317:45-9-8(a); and

(2) Provider Appeals:
(A) Whether Pre-admission Screening and Resident Review (PASRR) was completed as required by law;
(B) Denial of request to disenroll member from provider's SoonerCare Choice panel;
(C) Appeals by Long Term Care facilities for nonpayment of wage enhancements, determinations of overpayment or underpayment of wage enhancements, and administrative penalty determinations as a result of findings made under 317:30-5-131.2(b)(5), (e)(8), and (e)(12);
(D) Petitions for Rulemaking;
(E) Appeals to the decision made by the Contracts manager related to reports of supplier non-compliance to the Central Purchasing Division, Oklahoma Department of Central Services and other appeal rights granted by contract;
(F) Drug rebate appeals;
(G) Nursing home contracts which are terminated, denied, or non-renewed;
(H) Proposed administrative sanction appeals pursuant to 317:30-3-19. Proposed administrative sanction appeals will be heard directly by the ALJ. A decision will normally be rendered by the ALJ within 20 days of the hearing before the ALJ. This is the final and only appeals process for proposed administrative sanctions;
(I) Contract award appeals;
(J) Provider appeals of OHCA audit findings pursuant to 317:2-1-7. This is the final and only appeals process for appeals of OHCA audits; and
(K) Oklahoma Electronic Health Records Incentive program appeals related only to incentive payments, incentive payment amounts, provider eligibility determinations, and demonstration of adopting, implementing, upgrading, and meaningful use eligibility for incentives.
(L) Supplemental Hospital Offset Payment Program (SHOPP) annual assessment, Supplemental Payment, fees or penalties as specifically provided in OAC 317:2-1-15.

317:2-1-15. Supplemental Hospital Offset Payment Program (SHOPP) Appeals.

(a) In accordance with Title 63 of the Oklahoma Statutes Section 3241.4 OHCA is authorized to promulgate rules for appeals of annual assessments, fees and penalties to hospitals as defined by the statute. The rules in this Section describe those appeals rights.

(1) OAC 317:30-5-58 subsections (a) through (e) describe the SHOPP Assessments, fees and the penalties for non-payment of the fee or failure to file a cost report, as set out in 63 Okla. Stat. §§ 3241.3 and 3241.4
(2) Appeals filed under this Section are heard by an Administrative Law

Judge (ALJ).

(3) To file an appeal, the provider hospital must file an LD-2 form within thirty (30) days of receipt of the notification from OHCA assessing the annual SHOPP Assessment, a fee or penalty. The penalty, fee or assessment is deducted from the hospital's payment if the assessment is unpaid at the time the appeal is filed. If the hospital prevails in the appeal the amount assessed will be returned to the hospital with their payment.

(4) The hearing will be conducted in accordance with OAC 317:2-1-5.

(b) An individual hospital may appeal an individual assessment at the time of its annual assessment. As provided for above in subsection (3), the appeal must be filed within thirty (30) days of receipt of the notification of assessment by OHCA to the hospital. If the hospital challenges the computation of the hospital's net patient revenue, the assessment rate, or assessment amount then the appeal will proceed in accordance with subsection(4)above.

(c) Individual hospitals that appeal the quarterly assessment are limited to calculation errors in dividing the annual assessment into four parts. Appeals must be filed within thirty 30 days of receipt of the notice of assessment by OHCA to the hospital. The appeal will proceed in accordance with subsection (4) above.

(d) If OHCA determines an overpayment of SHOPP payments has been made to an individual hospital, then the hospital may file an appeal within thirty (30) days of the notice of overpayment. Overpayments are deducted from the hospital's payment. The appeal will proceed in accordance with subsection (4) above.

(e) OHCA recognizes that some individual hospital's claims regarding an inappropriate assessment or overpayment may involve aggregate data. For example an appeal may involve one of the following issues:

(1) total hospitals in the entire SHOPP pool;

(2) total hospitals that are exempt from SHOPP;

(3) total hospitals classified as critical access hospitals;

(4) total net revenue from all hospitals in the pool;

(5) the total amount of monies allocated to each pool in the SHOPP; or

(6) the pro-rata distribution in a pool(s).

(f) If an individual hospital brings an aggregate appeals claim, there are two (2) elements of proof to be met. The ALJ must determine that the hospital can demonstrate by a preponderance of evidence:

(1) that data was made available before the hospital submitted the appeal; and

(2) a specific calculation error has been made statewide that can be shown by the hospital.

(g) The "Upper Payment Limit" and the "Upper Payment limit Gap" are not appealable in the administrative process.

CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 3. HOSPITALS

317:30-5-58. Supplemental Hospital Offset Payment Program

(a) **Purpose.** The Supplemental Hospital Offset Payment Program (SHOPP) is a hospital assessment fee that is eligible for federal matching funds when used to reimburse SoonerCare services in accordance with Section 3241.1 of Title 63 of the Oklahoma Statutes.

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

(1) **"Base Year"** means a hospital's fiscal year ending in 2009, as reported in the Medicare Cost Report or as determined by the Oklahoma Health Care

Authority (OHCA) if the hospital's data is not included in a Medicare Cost Report.

(2) **"Fee"** means supplemental hospital offset assessment pursuant to Section 3241.1 of Title 63 of the Oklahoma Statutes.

(3) **"Hospital"** means an institution licensed by the State Department of Health as a hospital pursuant to Section 1-701.1 of Title 63 of the Oklahoma Statutes maintained primarily for the diagnosis, treatment, or care of patients;

(4) **"Hospital Advisory Committee"** means the Committee established for the purposes of advising the OHCA and recommending provisions within and approval of any state plan amendment or waiver affecting the Supplemental Hospital Offset Payment Program.

(5) **"Medicare Cost Report"** means form CMS-2552-96, the Hospital Cost Report, as it existed on January 1, 2011;

(6) **"NET hospital patient revenue"** means the gross hospital revenue as reported on Worksheet G-2 (Columns 1 and 2, Lines 16, 17 and 18) of the Medicare Cost Report, multiplied by hospital's ratio of total net to gross revenue, as reported on Worksheet G-3(Column 1, Line 3)and Worksheet G-2 (Part I, Column 3, Line 25);

(7) **"Upper payment limit"** means the maximum ceiling imposed by 42 C F R §§ 447.272 and 447.321 on hospital Medicaid reimbursement for inpatient and outpatient services, other than to hospitals owned or operated by state government; and

(8) **"Upper payment limit gap"** means the difference between the upper payment limit and SoonerCare payments not financed using hospital assessments.

(c) **Supplemental Hospital Offset Payment Program.**

(1) Pursuant to 63 Okla. Stat. §§ 3241.1 through 3241.6 the Oklahoma Health Care Authority (OHCA) was mandated to assess hospitals licensed in Oklahoma, unless exempted under (c)(2) of this Section, a supplemental hospital offset payment fee.

(2) The following hospitals are exempt from the SHOPP fee:

(A) a hospital that is owned or operated by the state or a state agency, or the federal government, as determined by OHCA, using most recent Medicare cost report worksheet S-2, column 1, line 18 or other line that indicates ownership, or by a federally recognized Indian tribe or Indian Health Services, as determined by OHCA, using the most recent IHS/Tribal facility list for Oklahoma as updated by the Indian Health Service Office of Resource Access and Partnerships in Partnership with the Centers for Medicaid and State operations.

(B) a hospital that provides more than fifty percent (50%) of its inpatient days under a contract with a state agency other than the OHCA, as determined by OHCA, using data provided by the hospital;

(C) a hospital for which the majority of its inpatient days are for any one of the following services, as determined by OHCA, using the Inpatient Discharge Data File published by the Oklahoma State Department of Health, or in the case of a hospital not included in the Inpatient Discharge Data File, Using substantially equivalent data provided by the hospital:

(i) treatment of a neurological injury;

(ii) treatment of cancer;

(iii) treatment of cardiovascular disease;

(iv) obstetrical or childbirth services; or

(v) surgical care except that this exemption will not apply to any hospital located in a city of less than five hundred thousand (500,000) population and for which the majority of inpatient days are for back, neck, or spine surgery.

(D) a hospital that is certified by the Centers for Medicare and Medicaid Services (CMS) as a long term acute hospital, according to the most recent list of LTCH's published on the CMS http://www.cms.gov/LongTermCareHospitalPPS/08download.asp or as a children's hospital; and

(E) a hospital that is certified by CMS as a critical access hospital, according to the most recent list published by Flex Monitoring Team for Critical Access Hospital (CAH) Information at http:www.flexmonitoring.org/cahlistRA.cgi, which is based on CMS quarterly reports, augmented by information provided by state Flex Coordinators.

(d) **The Supplemental Hospital Offset Payment Program Assessment.**

(1) The SHOPP assessment is imposed on each hospital, except those exempted under (c)(2) of this Section, for each calendar year in an amount calculated as a percentage of each hospital's net hospital patient revenue. The assessment rate until December 31, 2012, is two and one-half percent (2.5%). At no time in subsequent years will the assessment rate exceed four percent (4%).

(2) OHCA will review and determine the amount of annual assessment in December of each year.

(3) A hospital may not charge any patient for any portion of the SHOPP assessment.

(4) The method of collection is as follows:

(A) The OHCA will send a notice of assessment to each hospital informing the hospital of the assessment rate, the hospital's net hospital patient revenue calculation, and the assessment amount owed by the hospital for the applicable year.

(B) The hospital has thirty (30) days from the date of its receipt of a notice of assessment to review and verify the assessment rate, the hospital's net patient revenue calculation, and the assessment amount.

(C) New hospitals will only be added at the beginning of each calendar year.

(D) The annual assessment imposed is due and payable on a quarterly basis. Each quarterly installment payment is due and payable by the fifteenth day of the first month of the applicable quarter (i.e. January 15th, April 15th, etc.)

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

(F) If a hospital fails to timely pay the full amount of a quarterly assessment, OHCA will add to the assessment:

(i) a penalty assessment equal to five percent (5%) of the quarterly amount not paid on or before the due date; and

(ii) on the last day of each quarter after the due date until the assessed amount and the penalty imposed under section (i) of this paragraph are paid in full, an additional five percent (5%) penalty assessment on any unpaid quarterly and unpaid penalty assessment amounts.

(iii) the quarterly assessment including applicable penalties and interest must be paid regardless of any appeals action requested by the facility. If a provider fails to pay the OHCA the assessment within the time frames noted on the invoice to the provider, the assessment, applicable penalty, and interest will be deducted from

the facility's payment. Any change in payment amount resulting from an appeals decision will be adjusted in future payments. In accordance with OAC 317:2-1-15 SHOPP appeals.

(G) The SHOPP assessments excluding penalties and interest are an allowable cost for cost reporting purposes.

(e) **Supplemental Hospital Offset Payment Program Cost Reports.**

(1) The report referenced in paragraph (b)(6) must be signed by the preparer and by the Owner, authorized Corporate Officer or Administrator of the facility for verification and attestation that the reports were compiled in accordance with this section.

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

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

(4) Net hospital patient revenue is determined using the data from each hospital's fiscal year 2009 Medicare Cost Report contained in the Centers for Medicare and Medicaid Services' Healthcare Cost Report Information System file.

(5) If a hospital's fiscal year 2009 Medicare Cost Report is not contained in the Centers for Medicare and Medicaid Services' Healthcare Cost Report Information System file dated December 31, 2010, the hospital will submit a copy of the hospital's 2009 Medicare Cost Report to the Oklahoma Health Care Authority (OHCA) in order to allow the OHCA to determine the hospital's net hospital patient revenue for the base year.

(6) If a hospital commenced operations after the due date for a 2009 Medicare Cost Report, the hospital will submit its initial Medicare Cost Report to Oklahoma Health Care Authority (OHCA) in order to allow the OHCA to determine the hospital's net patient revenue for the base year.

(7) Partial year reports may be prorated for an annual basis. Hospitals whose assessments were based on partial year cost reports will be reassessed the following year using a cost report that contains a full year of operational data.

(8) In the event that a hospital does not file a uniform cost report under 42 U.S.C., Section 1396a(a)(40), the OHCA will provide a data collection sheet for such facility.

(f) **Closure, merger and new hospitals.**

(1) If a hospital ceases to operate as a hospital or for any reason ceases to be subject to the fee, the assessment for the year in which the cessation occurs is adjusted by multiplying the annual assessment by a fraction, the numerator of which is the number of days in the year during which the hospital is subject to the assessment and denominator of which is 365. Within 30 days of ceasing to operate as a hospital, or otherwise ceasing to be subject to the assessment, the hospital will pay the assessment for the year as so adjusted, to the extent not previously paid.

(2) Cost reports required under (e)(5),(e)(6),or (e)(8) of this subsection for assessment calculation must be submitted to OHCA by November 1, 2011 for the 2012 assessment, and for subsequent years' assessment calculation by September 30 of the preceding year.

(g) **Disbursement of payment to hospitals.**

(1) All in-state inpatient hospitals are eligible for hospital access payments each year as set forth in this subsection except for those listed in OAC 317:30-5-58 (c)(2):

(A) In addition to any other funds paid to inpatient critical access hospital for services provided to SoonerCare members, each critical access hospital will receive hospital access payments equal to the amount by which the payment for these services was less than one hundred one percent (101%) of the hospital's cost of providing these services.

(B) In addition to any other funds paid to hospitals for inpatient hospital services to SoonerCare members, each eligible hospital will receive inpatient hospital access payments each year equal to the hospital's pro rata share of the inpatient supplemental payment pool as reduced by payments distributed in paragraph (1)(A) of this Section. The pro rata share will be based upon the hospital's SoonerCare payment for inpatient services divided by the total SoonerCare payments for inpatient services of all eligible hospitals within each class of hospital; not to exceed the UPL for the class.

(2) All in-state outpatient hospitals are eligible for hospital access payments each year as set forth in this subsection except for those listed in OAC 317:30-5-58 (c)(2):

(A) In addition to any other funds paid to outpatient critical access hospital for services provided to SoonerCare members, each critical access hospital will receive hospital access payments equal to the amount by which the payment for these services was less than one hundred one percent (101%) of the hospital's cost of providing these services.

(B) In addition to any other funds paid to hospitals for outpatient hospital services to SoonerCare members, each eligible hospital will receive outpatient hospital access payments each year equal to the hospital's pro rata share of the outpatient supplemental payment pool as reduced by payments distributed in paragraph (2)(A) of this Section. The pro rata share will be based upon the hospital's SoonerCare payment for outpatient services divided by the total SoonerCare payments for outpatient services of all eligible hospitals within each class of hospital; not to exceed the UPL for the class.

(3) If any retrospective audit determines that a class of hospitals has exceeded the inpatient and/or outpatient UPL the overpayment will be recouped and redistributed. If the overpayment cannot be redistributed due to all classes being paid at their UPL, the overpayment will be deposited in to the SHOPP fund.

Recommendation 1: Prior Authorize Brilinta™ (ticagrelor)

The Drug Utilization Review Board recommends prior authorization of Brilinta™ (ticagrelor) with the following criteria:

1. Brilinta™ (ticagrelor) therapy will be approved for members who meet approved diagnostic criteria: The approved diagnosis is acute coronary syndrome (ACS) (unstable angina, non-ST elevation myocardial infarction, or ST elevation myocardial infarction) with or without percutaneous coronary intervention (PCI).
2. Length of approval: 1 year.

As with clopidogrel and prasugrel, the first 90 days will not require prior authorization.

Recommendation 2: Prior Authorize Xarelto® (rivaroxaban)

The Drug Utilization Review Board recommends prior authorization of Xarelto® (rivaroxaban) with the following criteria:

1. For Xarelto® (rivaroxaban) 10 mg the first 35 days will not require prior authorization to allow for use for DVT prophylaxis only.
2. For Xarelto® (rivaroxaban) 15 mg and 20 mg a diagnosis of nonvalvular atrial fibrillation will be required.