OKLAHOMA HEALTH CARE AUTHORITY
REGULARLY SCHEDULED BOARD MEETING
March 8, 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 February 9, 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 – Member 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 Beth VanHorn, Director of Legal Operations & Ken Goodwin, RN, Manager of Medical Authorization Unit

5. Radiology Management Program: Private/Public Partnership For Radiology Management In Soonercare: A Contract Success Story With Med Solutions

    Results of first time contract for radiological management services—savings to the state as a result of case management.

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

a) 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 are pending Gubernatorial approval under Emergency rulemaking. These rules have been REVISED for Permanent Rulemaking.

7.a-1 AMENDING Agency rules at OAC 317:30-5-596.1 to remove service prior authorization requirements for Behavioral Health Case Management services. **(Reference APA WF # 11-27)**

7.a-2 AMENDING Agency rules at OAC 317:30-5-763 and 35-17-3 to remove respiratory therapy as an allowable service within the waiver and remove Hospice when the member is in a nursing facility receiving ADvantage Facility Based Extended Respite. Both services are removed due to lack of utilization. Additionally, rules are revised to remove language allowing for reimbursement to providers of case management transition services when the member fails to transition into the ADvantage waiver program. The revisions are necessary to align OHCA policy with revised operational procedures as approved by the Centers for Medicare and Medicaid Services. Rules are also revised to clarify the types of living arrangements allowable for ADvantage members as well as to make clarifications regarding the member's health, safety and welfare. **(Reference APA WF # 11-39A & B)**

The following rules HAVE previously been reviewed by the Board and are pending Gubernatorial approval under Emergency rulemaking.

7.a-3 AMENDING Agency rules at OAC 317:30-5-95.24 through 30-5-95.31, 30-5-240 through 30-5-240.2, 30-5-241 through 30-5-241.5, 30-5-276, 30-5-281, 30-5-596, 30-5-741 to 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.
(Reference APA WF # 11-27)

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

7.a-4 AMENDING agency rules at OAC 317:30-5-12, 30-5-664.5, 30-5-1154 and 35-5-2, 35-5-8, 35-7-37, 35-7-48, 35-7-60, 35-7-60.1 and REVOKING agency rules at OAC 317:30-5-465, 30-5-466, and 30-5-467 to remove references to the Family Planning Waiver. Section 2303 of the Patient Protection and Affordable Care Act allows individuals receiving Family Planning Waiver services to receive those same services plus additional family planning and family planning related services under the Title XIX State Plan rather than a waiver program. In addition to a broader service package, the State Plan option allows a more efficient way of making future changes to the SoonerPlan program. If approved, the rule change will allow over 32,000 SoonerPlan members and future members to receive the enhanced package of State Plan Family Planning services. The rule revision also includes the removal of language relating to family planning centers, clarification of eligibility rules and other minor policy corrections.
(Reference APA WF # 11-03 A&B)

7.a-5 AMENDING agency rules at OAC 317:30-3-40, 30-3-42, 30-3-57, 30-5-96.2, 30-5-122, 30-5-390, 30-5-410, 30-5-420, 30-5-423, 30-5-480, 30-5-495, 30-5-515, 30-5-535, 30-5-760, 30-5-1011, 30-5-1076, and 35-9-1, 35-9-5, 35-9-25, 35-9-45, 35-9-48.1, 35-9-49, 35-9-97, 35-10-38, 35-15-1, 35-19-3, 35-19-8, 35-19-9, and 40-1-1, 40-5-152, 40-7-4, and 50-1-2, 50-1-3, 50-3-2, 50-5-2, to change language in policy that references "mental retardation" to "intellectual disabilities". Revisions are necessary to comply with Public Law 111-256 (Rosa's Law) that replaces the term mental retardation with intellectual disability, in federal education, health and labor laws.
(Reference APA WF # 11-04 A, B, C & D)

7.a-6 AMENDING agency rules at OAC 317:35-6-15 and 35-7-15 to provide clarification regarding dates of application for SoonerCare services. Current rules are difficult to interpret and, in some instances, obsolete. The revisions will make interpreting rules easier for OHCA staff, contracted agency partners, and applicants to understand when an application is considered received and completed. Rules are further amended to add the Notification of Date of Service feature for hospitals in official agency policy.
(Reference APA WF # 11-08)

7.a-7 AMENDING agency rules at OAC 317:50-3-4 to clarify waiting list procedures for individuals who apply for services but cannot enter the waiver due to capacity limitations. The rules clarify that individuals applying for the waiver but

unable receive services due to capacity limitations are placed on a waiting list and enter the waiver on a first on first off basis.
(Reference APA WF # 11-13)

7.a-8 AMENDING agency rules at OAC 317:50-5-4 to clarify waiting list procedures for individuals who apply for services but cannot enter the waiver due to capacity limitations. The rules clarify that individuals applying for the waiver but unable receive services due to capacity limitations are placed on a waiting list and enter the waiver on a first on first off basis.
(Reference APA WF # 11-14)

7.a-9 AMENDING agency rules at OAC 317:35-5-41.8 to include a brief description of the Long-term Care Partnership program. The Long-term Care Partnership program (LTCP) allows individuals with qualified LTCP insurance policies the opportunity to protect certain assets in determining eligibility for SoonerCare long term care services.
(Reference APA WF # 11-15)

7.a-10 AMENDING agency rules at OAC 317:30-5-42.6, 30-5-306 and 30-5-307 to correspond to new Medicare guidelines regarding payment to End Stage Renal Disease (ESRD) facilities. Currently policy and methodology utilizes Medicare's old composite rate for a defined set of ESRD items and services, while paying separately for services not included in the composite rate, such as drugs and laboratory tests. This payment system is replaced with a new bundled prospective payment system (PPS), in which a single bundled payment to the ESRD facility for each treatment will cover all renal dialysis services. If the change is not made, OHCA will be out of line with Medicare reimbursement rates for this provider type.
(Reference APA WF # 11-19)

7.a-11 AMENDING agency rules at OAC 317:30-3-2 to ensure clarity. Revisions are made to reflect language in 42 CFR 455.414; that provider agreements must be renewed at least every five years. Additionally, revisions are made to revise the contract information for the OHCA Provider Contracting Unit.
(Reference APA WF # 11-20)

7.a-12 AMENDING agency rules at OAC 317: 30-5-1201 and OAC 35-23-2, 35-23-3, 35-23-4 to add Assisted Living services as a compensable service under the Living Choice demonstration program for the elderly and those with physical disabilities. Assisted Living services are personal care and supportive services that are furnished to Living Choice members who reside in an OHCA certified assisted living center. Additionally, rules are revised to add Private Duty Nursing as an allowable service and revise the re-enrollment policy to allow members who have been in Living Choice for the maximum 365 days, and have been re-institutionalized for a minimum of 90 consecutive days, the opportunity to re-enroll in the Living Choice program for an additional 365 days.

Finally, rules are revised to include coverage for people who have transitioned to the community from institutions for mental disease.
(Reference APA WF # 11-21 A&B)

7.a-13 AMENDING agency rules at OAC 317:30-5-326.1, 30-5-327, 30-5-327.1, 35-3-2, and REVOKING agency rules at 317:30-5-327.2 and ADDING rules at OAC 317:30-5-328 to clarify OHCA's current policy concerning meals and lodging, travel distance, and eligibility. This rule will assist with future cost savings and prevent abuse of services. This rule will also ensure services for current and future SoonerCare members.
(Reference APA WF # 11-25 A&B)

7.a-14 ADDING agency rules at OAC 317:30-3-19.1 to explain situations in which a provider agreement and billing privileges may be revoked for improper actions. These situations include noncompliance with enrollment requirements, provider misconduct, and felony convictions, among others. These rules will assist the agency in provider integrity determinations and will align agency policy with CMS's Medicare regulations on provider agreements.
(Reference APA WF # 11-26)

7.a-15 AMENDING agency rules at OAC 317:50-1-4 to clarify waiting list procedures for individuals who apply for services but cannot enter the waiver due to capacity limitations. The rules clarify that individuals applying for the waiver but unable receive services due to capacity limitations are placed on a waiting list and enter the waiver on a first on first off basis.
(Reference APA WF # 11-29)

7.a-16 AMENDING agency rules at OAC 317:30-5-1023 and 30-5-1027 to align current policy with systematic and coding procedures.
(Reference APA WF # 11-30)

7.a-17 AMENDING agency rules at OAC 317:10-1-1 and 10-1-12 to align policy with Department of Central Services (DCS) rules. Rules refer to sections that are not valid; therefore rules need to be revised to reflect new numbering for DCS policy.
(Reference APA WF # 11-31)

7.a-18 AMENDING agency rules at OAC 317:30-5-123, 30-5-482, 30-5-1012, 30-5-1014 and at OAC 317:40-5-3, 40-5-5, 40-5-9, 40-5-13, 40-5-59, 40-5-101, 40-5-113, 40-7-12, 40-7-15, 40-7-21 and REVOKING agency rules at OAC 317:40-5-8 to clarify policy for the termination of Agency Companion providers based on certain background check information and to provide clarification on the limits of background search information for Specialized Foster Care providers regarding involvement in a court action. Additionally policy is revised to require architectural modification contractors to provide evidence of a lead based paint safety certificate; the addition of Adult Day Services for members in

the Homeward Bound Waiver; Targeted Case Management to be billed weekly rather than monthly; removal of the Physical Status Review score as one of criteria for determining the enhanced rate for Community Based Group services and Job Coaching Services, and removal of Adult Day Services as an option to the member's required employment hours. Other minor policy revisions are also included.
(Reference APA WF # 11-32 A&B)

7.a-19 AMENDING agency rules at OAC 317:45-1-3 and 45-1-4 to clarify in-network is defined as the highest percentage reimbursement network approved by OHCA. The rules are also revised to clarify that OHCA will only reimburse expenses related to the highest percentage network.
(Reference APA WF # 11-33)

7.a-20 AMENDING agency rules at OAC 317:35-18-1, 35-18-2, 35-18-3, 35-18-4, 35-18-5, 35-18-6, 35-18-7, 35-18-9, 35-18-10, 35-18-11 to remove pilot specific requirements and replace with language that is applicable to all PACE providers. Additional revisions include revising the Nursing Facility Level of Care criteria to be more specific to PACE eligibility criteria and cleaning up rules for clarity.
(Reference APA WF # 11-35)

7.a-21 AMENDING agency rules at OAC 317:30-5-696 and 30-5-698 to allow for permanent restoration of a tooth when done as part of a Cvek Pulpotomy. The Cvek Pulpotomy is a procedure that better maintains the vitality of exposed pulps, especially in young patients. Allowing permanent restoration with the Cvek Pulpotomy will reduce the need for root canals. Finally, rules are revised to allow dentists to choose the proper type of crown that best serves the member’s oral environment.
(Reference APA WF # 11-36)

7.a-22 AMENDING agency rules at OAC 317:30-5-211.10 to remove the requirement for a certificate of medical necessity for positive airway pressure devices (BiPAP and CPAP) as such CMNs are no longer used for authorization decisions. The agency’s Medical Authorization Unit and physicians rely on documentation from sleep studies and other medical records to prior authorize.
(Reference APA WF # 11-38)

7.a-23 AMENDING agency rules at OAC 317:35-17-1, 35-17-2, 35-17-3, 35-17-4, 35-17-5, 35-17-11, 35-17-12, 35-17-14, 35-17-15, 35-17-16, 35-17-17, 35-17-18, 35-17-19, 35-17-21.1 and 35-17-24 to include the following: removal of language requiring transportation to be provided by Adult Day Health Care Centers; clarification of family support services versus waiver services; addition of language clarifying "client support moderate risk", "client support high risk" and addition of language describing "client support low risk" and "environmental low risk"; the addition of eligibility language clarifying member reauthorization,

recertification and redetermination; clarification regarding the member's level of need in order to be eligible for waiver services; policy is revised to remove language allowing a financial eligibility assessment for individuals who are not applying for waiver services; clarification regarding when a new level of care determination is required; removal of language requiring recertification of the member by a case manager and requiring an OKDHS nurse to provide medical certification, and at a minimum annually; language added regarding plan of care documentation when more than one member of the household receives waiver services; clarification regarding the use of family members as paid providers; clarification of conditions requiring a member's service plan goals to be amended; removal of policy regarding the expedited eligibility determination process (SPEED); other minor clean-up language.
(Reference APA WF # 11-39 A & B)

7.a-24 AMENDING agency rules at OAC 317:35-5-4, 35-5-43 and 35-22-1 to revise eligibility policy for clarity and updates. All changes are minor and will not affect programs or budget. The revisions include changing a form number and altering punctuation to ensure the meaning and intention of the policy is clear.
(Reference APA WF # 11-40)

7.a-25 AMENDING agency rules at OAC 317:35-13-7 to address sanctioning of members who abuse SoonerCare benefits. For members who OHCA has determined to have abused their benefits, sanctions are put in place such that on the first violation, the member's eligibility will be suspended for up to six months; for the second violation, the member's eligibility will be suspend for up to twelve months; and for the third violation, the member's eligibility will be suspended indefinitely. All sanctions, including the length of the penalty period, are subject to administrative due process.
(Reference APA WF # 11-42)

7.a-26 AMENDING agency rules at OAC 317:30-5-7 to allow reimbursement for a pain management procedure when performed during an anesthesia session.
(Reference APA WF # 11-43)

Item to be presented by Nancy Nesser, Director, Pharmacy Services

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 **prenatal vitamins, Soliris® (eculizumab),** and **Onfi® (clobazam)** 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

10. New Business

11. ADJOURNMENT

NEXT BOARD MEETING
April 12, 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
February 9, 2012
Held at the Oklahoma Health Care Authority
Oklahoma City, Oklahoma

Manner and Time of Notice of Meeting: A statutorily required public meeting notice was placed on the front door of the Oklahoma Health Care Authority on February 8, 2012, 12:30 p.m. Advance public meeting notice is provided to the Oklahoma Secretary of State. As statutory public notice, the agency placed its agenda on its website on February 9, 2012, 11:12 a.m.

Pursuant to a roll call of the members, a quorum was declared to be present, and Chairman Roggow called the meeting to order at 1:05 PM.

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

OTHERS PRESENT:	OTHERS PRESENT:
Becky Moore, OAHCP	Debbie Spaeth, Quest MHSA
Charlie Brodt, HP	Shelly Keast, OUCOP
Brent Wilborn, OKPCA	Susan Hernandez, OUCOP
Shirley Russell, OKDHS	Jo'nel Weber, OUCOP
Azure Herrera-Lamons, OAHCP	Nichole Burland, OHCA
Georgia Berry, C Works	Jennifer King, OHCA

DISCUSSION AND POSSIBLE VOTE ON APPROVAL OF BOARD MINUTES OF THE REGULARLY SCHEDULED BOARD MEETING HELD January 12, 2012.

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 January 12, 2012 board minutes as published. Member McVay seconded.
FOR THE MOTION:	Member McVay, Member Bryant, Member Miller, Member Robison, Member McFall, and Chairman Roggow
BOARD MEMBER ABSENT:	Vice-Chairman Armstrong

ITEM 3 / REPORTS TO THE BOARD BY BOARD COMMITTEES

Member Miller reported that the Audit Finance Committee met prior to the Board meeting. He reported that the first 2 quarters had overpayments of approximately $3.8 million to be recovered. He expressed his opinion that acquiring more staff for this audit area would significantly increase this dollar amount. One thing being done is some "predictive modeling" programs which could help identify more cases. He gave examples of one provider with an error rate of 96% along with others over 90%. This is money which OHCA can recover.

The state auditor and inspector should complete their single state audit by the end of February with their report due at the end of March 2012. Member Miller reported that there is a $19 million positive variance. The Executive team decided to revise the budget for the current fiscal year and go ahead and make the final payment instead of deferring it to the next fiscal year.

He mentioned the Governor's State of the State address and her statement that she is requesting that OHCA's budget be decreased by $147 million. This amount is the state share for children's behavioral health which has been directed to OHCA in the past and that now may need to be given to the Oklahoma Department of Mental Health and Substance Abuse Services.

Member McVay reported that the Rules Committee met and were educated by Traylor Rains of OHCA's policy unit on the rules to be presented.

Member McFall reported that the Legislative Committee met and received a brief review of bills affecting the Agency. He will let Mr. Gomez elaborate in his presentation.

Vice-Chairman Armstrong was absent so the Strategic Planning Committee did not meet.

ITEM 4 / CHIEF EXECUTIVE OFFICER'S REPORT

Mike Fogarty, Chief Executive Officer

Mr. Fogarty introduced Mr. Michael Jones a Financial Management Specialist with CMS out of Dallas Region.who is at the Agency performing a routine quarterly review.

4.a. FINANCIAL UPDATE

Carrie Evans, Chief Financial Officer

Ms. Evans reported that the Agency is under budget with a variance of $19.7 million state, under budget in the Medicaid program spending as well as Administration, and over budget on all revenue items. In looking ahead to January it looks to continue under budget so the executive team decided to revise the FY'13 budget request (provided separately in handout). The only difference on the revised copy is the removal of a $55 million state dollar request which would have covered 2 runs in FY'13 which are now going to be covered in FY'12. For a detailed report, see Item 4a of the February 9, 2012 board packet.

4.b. MEDICAID DIRECTOR'S UPDATE

Garth Splinter, MD, Deputy State Medicaid Director

Dr. Splinter reviewed the data sheet highlighting the fact that the overall SoonerCare Enrollment for December 2011 by 477 individuals and that dual eligibles increase slightly. He reported on a $600,000 HIE grant for which OHCA will be the State Designated Entity.This grant is for 12 months and is to assist with mental health providers obtaining electronic health records. Dr.

Splinter made the Board aware that Insure Oklahoma has requested an increase from 200% to 220%. OHCA is waiting upon a response from the Governor's office. Dr. Splinter then drew the Board's attention to a new section of his report on SoonerCare Health Status. This listed statistics related to prenatal, delivery, and postpartum care for SFY'2011. Member Robison asked if there is data showing the effect, if any, that prenatal care has had from prior years. Dr. Splinter will request a report related to this data for presentation at a future board meeting. For a detailed report, see Item 4b of the February 9, 2012 board packet.

4.c. LEGISLATIVE UPDATE

Nico Gomez, Deputy Chief Executive Officer

Mr. Gomez gave a brief review of the 53rd Legislature which recently convened with the State of the State Address by Governor Fallin. He reported that her budget will be focusing on water, taxes, job creation, decreasing infant mortality rates and the health of Oklahoma's citizens.

In regards to current bills there have been 3800 bills submited; the Agency is currently tracking 200, and have reviewed 84. Mr. Gomez briefly mentioned HB2273 and SB1161. For more detailed information see Item 4.c. of the February 12, 2012 board packet.

Mr. Gomez informed the Board that the House Appropriation A & B Committee was meeting at 4:00 p.m. after the Board meeting and that they were invited to attend.

CEO Fogarty related information about a Health Policy conference he attended on "Best Practices" and that he is always happy to share information about PCMH. He will be attending an upcoming conference in Atlanta at the CDC in relation to tribal partnerships.

ITEM 5 / UPDATE ON OHCA'S DURABLE MEDICAL EQUIPMENT REUSE PROGRAM

Stan Ruffner, Durable Medical Equipment Program Director

Mr. Ruffner gave an overview of the program through a PowerPoint presentation entitled *"OHCA DME Reuse Program".* He reported that AbleTech located at 33rd and Lincoln received the contract and that the website should be up and running by March 1st. Mr. Ruffner introduced Dana Northrup who is a Senior Planning Coordinator with OHCA who worked diligently with him on this program to get it up and running. Mr. Ruffner informed the Board that there will be a booth at the State Capitol Building on May 10th for Team Day. For a detailed report, please see Item 5 of the February 9, 2012 board packet.

ITEM 6 / ANNOUNCEMENTS OF CONFLICTS OF INTEREST PANEL RECOMMENDATIONS FOR ALL ACTION ITEMS REGARDING THIS BOARD MEETING

Ms. Nicole Nantois stated that the Conflicts of Interest Panel met and found no conflicts regarding action items.

ITEM 7 / ITEMS 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.

MOTION:Member McFall moved for approval. Member McVay seconded.

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

BOARD MEMBER ABSENT: Vice-Chairman Armstrong

7.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)**

MOTION: Member Miller moved for approval of 7.b-1. Member Bryant seconded.

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

BOARD MEMBER ABSENT: Vice-Chairman Armstrong

7.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)**

MOTION: Member Bryant moved for approval of Rules 7.c-1, 7.c-2, and 7.c-3 as presented. Member Robison seconded.

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

BOARD MEMBER ABSENT: Vice-Chairman Armstrong

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 Physical Therapy/Occupational Therapy/Speech Therapy 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)**

MOTION: Member McFall moved for approval of Rules 7.c-4, 7.c-5, & 7.c-6 as presented. Member McVay seconded.

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

BOARD MEMBER ABSENT: Vice-Chairman Armstrong

ITEM 8 / 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).

MOTION:	Member McFall moved for approval. Member Bryant seconded.
FOR THE MOTION:	Member McVay, Member Bryant, Member Miller, Member Robison, Member McFall, and Chairman Roggow
BOARD MEMBER ABSENT:	Vice-Chairman Armstrong

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)

Nicole Nantois advised that there was a need for Executive Session for this board meeting.

MOTION:	tMember McFall moved for Executive Session. Member McVay seconded.
FOR THE MOTION:	Member McVay, Member Bryant, Member Miller, Member Robison, Member McFall, and Chairman Roggow
BOARD MEMBER ABSENT:	Vice-Chairman Armstrong

12 / NEW BUSINESS

There was no new business

13 / ADJOURNMENT

MOTION:	Member McFall moved for adjournment. Member Bryant seconded.
FOR THE MOTION:	Member McVay, Member Bryant, Member Miller, Member Robison, Member McFall and Chairman Roggow

BOARD MEMBER ABSENT: Vice-Chairman Armstrong

Meeting adjourned at 2:53 p.m., 2/9/2012

NEXT BOARD MEETING
April 12, 2012
Oklahoma Health Care Authority
2401 NW 23rd, Suite 1-A, Ponca Conference Room
Oklahoma City, OK 73107

Kay Davis
Acting Board Secretary

*Minutes Approved:*_____

*Initials:*_____

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

REVENUES	FY12 Budget YTD	FY12 Actual YTD	Variance	% Over/ (Under)
State Appropriations	$ 569,898,121	$ 569,898,121	$ -	0.0%
Federal Funds	1,222,136,891	1,197,956,275	(24,180,616)	(2.0)%
Tobacco Tax Collections	33,144,544	35,595,315	2,450,771	7.4%
Quality of Care Collections	29,825,685	30,031,797	206,112	0.7%
Prior Year Carryover	55,003,490	55,003,490	-	0.0%
Federal Deferral - Interest	193,776	193,776	-	0.0%
Drug Rebates	110,205,081	121,537,478	11,332,397	10.3%
Medical Refunds	25,038,010	30,922,366	5,884,356	23.5%
Other Revenues	9,094,926	9,520,421	425,495	4.7%
TOTAL REVENUES	**$ 2,054,540,523**	**$ 2,050,659,040**	**$ (3,881,484)**	**(0.2)%**

EXPENDITURES	FY12 Budget YTD	FY12 Actual YTD	Variance	% (Over)/ Under
ADMINISTRATION - OPERATING	**$ 25,553,083**	**$ 22,573,095**	**$ 2,979,988**	**11.7%**
ADMINISTRATION - CONTRACTS	**$ 70,187,198**	**$ 59,539,013**	**$ 10,648,185**	**15.2%**
MEDICAID PROGRAMS				
Managed Care:				
SoonerCare Choice	19,423,552	17,298,088	2,125,464	10.9%
Acute Fee for Service Payments:				
Hospital Services	504,578,508	496,962,727	7,615,781	1.5%
Behavioral Health	190,875,756	205,411,099	(14,535,343)	(7.6)%
Physicians	233,216,235	227,277,436	5,938,799	2.5%
Dentists	83,402,135	83,085,732	316,403	0.4%
Other Practitioners	43,478,431	41,217,412	2,261,018	5.2%
Home Health Care	13,007,404	12,222,907	784,497	6.0%
Lab & Radiology	30,344,776	28,155,648	2,189,129	7.2%
Medical Supplies	27,908,388	27,092,919	815,469	2.9%
Ambulatory Clinics	47,973,353	45,219,151	2,754,202	5.7%
Prescription Drugs	216,089,081	215,510,007	579,073	0.3%
Miscellaneous Medical Payments	18,495,568	19,155,752	(660,184)	(3.6)%
OHCA TFC	-	-	-	0.0%
Other Payments:				
Nursing Facilities	283,365,445	282,294,636	1,070,809	0.4%
ICF-MR Private	33,865,859	32,605,169	1,260,691	3.7%
Medicare Buy-In	85,481,468	82,789,455	2,692,013	3.1%
Transportation	16,381,585	16,098,296	283,289	1.7%
EHR-Incentive Payments	36,409,947	36,409,947	-	0.0%
Part D Phase-In Contribution	37,012,237	36,689,016	323,221	0.9%
Total OHCA Medical Programs	**1,921,309,730**	**1,905,495,398**	**15,814,332**	**0.8%**
OHCA Non-Title XIX Medical Payments	89,382	-	89,382	0.0%
TOTAL OHCA	**$ 2,017,139,393**	**$ 1,987,607,506**	**$ 29,531,887**	**1.5%**
REVENUES OVER/(UNDER) EXPENDITURES	**$ 37,401,131**	**$ 63,051,534**	**$ 25,650,403**	

OKLAHOMA HEALTH CARE AUTHORITY

Total Medicaid Program Expenditures
by Source of State Funds
Fiscal Year 2012, For the Seven Months Ended January 31, 2012

Category of Service	Total	Health Care Authority	Quality of Care Fund	HEEIA	Medicaid Program Fund	BCC Revolving Fund	Other State Agencies
SoonerCare Choice	$ 17,563,120	$ 17,285,608	$ -	$ 265,032	$ -	$ 12,481	$ -
Inpatient Acute Care	436,055,870	330,936,597	283,901	7,152,421	29,350,782	1,710,980	66,621,189
Outpatient Acute Care	140,515,153	131,776,862	24,269	5,834,686	-	2,879,336	
Behavioral Health - Inpatient	67,715,407	65,477,784	-	-	-	2,658	2,234,966
Behavioral Health - Outpatient	18,298,082	18,288,560	-	-	-	-	9,522
Behavioral Health Facility- Rehab	137,132,066	119,524,591	-	271,081	-	70,869	17,265,525
Behavioral Health - Case Management	-	-	-	-	-	-	
Residential Behavioral Management	9,983,905	-	-	-	-	-	9,983,905
Targeted Case Management	35,279,834	-	-	-	-	-	35,279,834
Therapeutic Foster Care	2,046,638	2,046,638	-	-	-	-	-
Physicians	256,226,290	186,078,338	33,892	8,709,077	35,769,924	5,395,283	20,239,778
Dentists	83,128,748	78,522,161	-	43,016	4,516,710	46,861	-
Other Practitioners	41,539,275	40,369,673	260,379	321,863	570,697	16,663	-
Home Health Care	12,222,914	12,191,508	-	7	-	31,399	-
Lab & Radiology	29,908,634	27,412,010	-	1,752,986	-	743,638	-
Medical Supplies	27,526,142	25,605,857	1,444,303	433,223	-	42,759	-
Ambulatory Clinics	52,436,250	45,007,125	-	1,039,025	-	212,026	6,178,073
Personal Care Services	7,184,123	-	-	-	-	-	7,184,123
Nursing Facilities	282,294,636	180,374,661	78,780,218	-	23,123,105	16,652	-
Transportation	16,098,296	14,542,927	1,512,406	-	39,352	3,612	-
GME/IME/DME	72,500,255	-	-	-	-	-	72,500,255
ICF/MR Private	32,605,169	26,794,180	5,315,803	-	495,186	-	-
ICF/MR Public	33,421,330	-	-	-	-	-	33,421,330
CMS Payments	119,478,471	117,989,041	1,489,430	-	-	-	-
Prescription Drugs	226,345,148	189,293,790	-	10,835,141	25,093,772	1,122,445	-
Miscellaneous Medical Payments	19,156,071	18,277,912	-	319	830,376	47,464	-
Home and Community Based Waiver	90,101,767	-	-	-	-	-	90,101,767
Homeward Bound Waiver	50,337,636	-	-	-	-	-	50,337,636
Money Follows the Person	1,751,081	-	-	-	-	-	1,751,081
In-Home Support Waiver	13,744,605	-	-	-	-	-	13,744,605
ADvantage Waiver	98,897,740	-	-	-	-	-	98,897,740
Family Planning/Family Planning Waiver	4,147,297	-	-	-	-	-	4,147,297
Premium Assistance*	33,173,704	-	-	33,173,704	-	-	-
EHR Incentive Payments	36,409,947	36,409,947					
Total Medicaid Expenditures	**$ 2,505,225,606**	**$1,684,205,768**	**$ 89,144,601**	**$ 69,831,582**	**$ 119,789,902**	**$ 12,355,126**	**$ 529,898,626**

* Includes $32,972,726.34 paid out of Fund 245

OKLAHOMA HEALTH CARE AUTHORITY

Summary of Revenues & Expenditures:
Other State Agencies
Fiscal Year 2012, For the Seven Months Ended January 31, 2012

		FY12 Actual YTD
REVENUE		
Revenues from Other State Agencies	$	213,074,629
Federal Funds		342,378,674
TOTAL REVENUES	**$**	**555,453,303**
EXPENDITURES		**Actual YTD**
Department of Human Services		
Home and Community Based Waiver	$	90,101,767
Money Follows the Person		1,751,081
Homeward Bound Waiver		50,337,636
In-Home Support Waivers		13,744,605
ADvantage Waiver		98,897,740
ICF/MR Public		33,421,330
Personal Care		7,184,123
Residential Behavioral Management		7,731,456
Targeted Case Management		26,516,740
Total Department of Human Services		**329,686,478**
State Employees Physician Payment		
Physician Payments		20,239,778
Total State Employees Physician Payment		**20,239,778**
Education Payments		
Graduate Medical Education		32,450,000
Graduate Medical Education - PMTC		2,251,638
Indirect Medical Education		29,677,651
Direct Medical Education		8,120,966
Total Education Payments		**72,500,255**
Office of Juvenile Affairs		
Targeted Case Management		1,590,625
Residential Behavioral Management - Foster Care		17,831
Residential Behavioral Management		2,234,618
Multi-Systemic Therapy		9,522
Total Office of Juvenile Affairs		**3,852,596**
Department of Mental Health		
Targeted Case Management		-
Hospital		2,234,966
Mental Health Clinics		17,265,525
Total Department of Mental Health		**19,500,491**
State Department of Health		
Children's First		1,183,971
Sooner Start		1,137,326
Early Intervention		3,239,769
EPSDT Clinic		1,313,910
Family Planning		39,693
Family Planning Waiver		4,077,527
Maternity Clinic		64,395
Total Department of Health		**11,056,592**
County Health Departments		
EPSDT Clinic		473,744
Family Planning Waiver		30,077
Total County Health Departments		**503,822**
State Department of Education		**75,122**
Public Schools		**2,673,607**
Medicare DRG Limit		**64,133,658**
Native American Tribal Agreements		**3,188,697**
Department of Corrections		**215,244**
JD McCarty		**2,272,287**
Total OSA Medicaid Programs	**$**	**529,898,626**
OSA Non-Medicaid Programs	**$**	**46,157,901**
Accounts Receivable from OSA	**$**	**20,603,224**

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

REVENUES	Total Revenue	State Share
Quality of Care Assessment	**$ 30,012,600**	**$ 30,012,600**
Interest Earned	**19,197**	**19,197**
TOTAL REVENUES	**$ 30,031,797**	**$ 30,031,797**

EXPENDITURES	FY 12 Total $ YTD	FY 12 State $ YTD	Total State $ Cost
Program Costs			
NF Rate Adjustment	$ 76,574,893	$ 27,452,099	
Eyeglasses and Dentures	167,065	59,893	
Personal Allowance Increase	2,038,260	730,716	
Coverage for DME and supplies	1,444,303	517,783	
Coverage of QMB's	602,441	215,975	
Part D Phase-In	1,489,430	1,489,430	
ICF/MR Rate Adjustment	2,806,576	1,006,157	
Acute/MR Adjustments	2,509,227	899,558	
NET - Soonerride	1,512,406	542,198	
Total Program Costs	**$ 89,144,601**	**$ 32,913,809**	**$ 32,913,809**
Administration			
OHCA Administration Costs	$ 318,689	$ 159,345	
DHS - 10 Regional Ombudsman	-	-	
OSDH-NF Inspectors	-	-	
Mike Fine, CPA	2,500	1,250	
Total Administration Costs	**$ 321,189**	**$ 160,595**	**$ 160,595**
Total Quality of Care Fee Costs	**$ 89,465,790**	**$ 33,074,404**	
TOTAL STATE SHARE OF COSTS			**$ 33,074,404**

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 Seven Months Ended January 31, 2012

REVENUES	FY 11 Carryover	FY 12 Revenue	Total Revenue
Prior Year Balance	$ 17,037,771	$ -	$ 13,786,269
State Appropriations			
Tobacco Tax Collections	-	29,276,027	29,276,027
Interest Income	-	317,729	317,729
Federal Draws	4,432,268	20,710,236	20,710,236
All Kids Act	(7,384,710)	157,921	157,921
TOTAL REVENUES	$ 14,085,329	$ 50,461,913	$ 64,090,262

EXPENDITURES		FY 11 Expenditures	FY 12 Expenditures	Total $ YTD
Program Costs:				
	Employer Sponsored Insurance		$ 32,585,172	$ 32,585,172
	College Students		200,978	200,978
	All Kids Act		374,299	374,299
Individual Plan				
	SoonerCare Choice		$ 257,613	$ 92,354
	Inpatient Hospital		7,131,692	2,556,712
	Outpatient Hospital		5,765,635	2,066,980
	BH - Inpatient Services		-	-
	BH Facility - Rehabilitation Services		269,545	96,632
	Physicians		8,639,876	3,097,396
	Dentists		35,440	12,705
	Other Practitioners		314,605	112,786
	Home Health		7	3
	Lab and Radiology		1,730,455	620,368
	Medical Supplies		425,146	152,415
	Ambulatory Clinics		1,028,643	368,769
	Prescription Drugs		10,702,596	3,836,881
	Miscellaneous Medical		-	-
	Premiums Collected		-	(1,386,255)
Total Individual Plan			$ 36,301,255	$ 11,627,745
	College Students-Service Costs		$ 290,418	$ 104,115
	All Kids Act- Service Costs		$ 66,205	$ 23,735
Total Program Costs			$ 69,818,328	$ 44,916,044
Administrative Costs				
	Salaries	$ 13,534	$ 914,351	$ 927,885
	Operating Costs	29,081	74,887	103,968
	Health Dept-Postponing	-	-	-
	Contract - HP	256,445	1,235,094	1,491,538
Total Administrative Costs		$ 299,059	$ 2,224,332	$ 2,523,391
Total Expenditures				$ 47,439,435
NET CASH BALANCE		$ 13,786,269		$ 16,650,827

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 Seven Months Ended January 31, 2012

REVENUES	FY 12 Revenue	State Share
Tobacco Tax Collections	**$ 584,260**	**$ 584,260**
TOTAL REVENUES	**$ 584,260**	**$ 584,260**

EXPENDITURES	FY 12 Total $ YTD	FY 12 State $ YTD	Total State $ Cost
Program Costs			
SoonerCare Choice	$ 12,481	$ 3,133	
Inpatient Hospital	1,710,980	429,456	
Outpatient Hospital	2,879,336	722,713	
Inpatient Free Standing	2,658	667	
MH Facility Rehab	70,869	17,788	
Case Mangement	0	-	
Nursing Facility	16,652	4,180	
Physicians	5,395,283	1,354,216	
Dentists	46,861	11,762	
Other Practitioners	16,663	4,182	
Home Health	31,399	7,881	
Lab & Radiology	743,638	186,653	
Medical Supplies	42,759	10,732	
Ambulatory Clinics	212,026	53,219	
Prescription Drugs	1,122,445	281,734	
Transportation	3,612	907	
Miscellaneous Medical	47,464	11,914	
Total Program Costs	$ 12,355,126	$ 3,101,137	**$ 3,101,137**
TOTAL STATE SHARE OF COSTS			**$ 3,101,137**

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.

FINANCIAL REPORT

For the Seven Months Ended January 31, 2012
Submitted to the CEO & Board
March 8, 2012

- Revenues for OHCA through January, accounting for receivables, were **$2,050,659,040** or **(.4%) under** budget.

- Expenditures for OHCA, accounting for encumbrances, were **$1,987,607,506** or **1.8% under** budget.

- The state dollar budget variance through January is **$25,650,403 positive.**

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

Expenditures:		
Medicaid Program Variance		11.7
Administration		4.9
Revenues:		
Taxes and Fees		2.7
Drug Rebate		4.1
Overpayments/Settlements		2.3
Total FY 12 Variance	**$**	**25.7**

ATTACHMENTS

SoonerCare Programs

January 2012 Data for March 2012 Board Meeting

SOONERCARE ENROLLMENT/EXPENDITURES

Delivery System			Monthly Enrollment Average SFY2011	Enrollment January 2012	Total Expenditures January 2012	Average Dollars Per Member Per Month January 2012
SoonerCare Choice Patient-Centered Medical Home			449,392	**479,051**	**$103,414,874**	
	Lower Cost	*(Children/Parents; Other)*		434,117	$71,463,402	$165
	Higher Cost	*(Aged, Blind or Disabled; TEFRA; BCC)*		44,934	$31,951,471	$711
SoonerCare Traditional			239,274	**235,794**	**$152,580,626**	
	Lower Cost	*(Children/Parents; Other)*		128,353	$39,866,692	$311
	Higher Cost	*(Aged, Blind or Disabled; TEFRA; BCC & HCBS Waiver)*		107,441	$112,713,934	$1,049
SoonerPlan			31,082	**41,549**	**$456,978**	$11
Insure Oklahoma			32,181	**31,465**	**$7,869,525**	
	Employer-Sponsored Insurance		19,095	17,685	$3,997,726	$226
	Individual Plan		13,085	13,780	$3,871,799	$281
TOTAL			**751,928**	**787,859**	**$264,322,003**	

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 $15,521,744 are excluded.

Net Enrollee Count Change from Previous Month Total	6,933

New Enrollees	22,568

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

Qualifying Group	Age Group	Enrollment
Aged/Blind/Disabled	*Child*	19,396
Aged/Blind/Disabled	*Adult*	131,210
Other	*Child*	179
Other	*Adult*	20,565
PACE	*Adult*	89
TEFRA	*Child*	424
Living Choice	*Adult*	101
OLL Enrollment		**171,964**

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 January 2012
Dual Enrollees	**103,906**	**107,995**

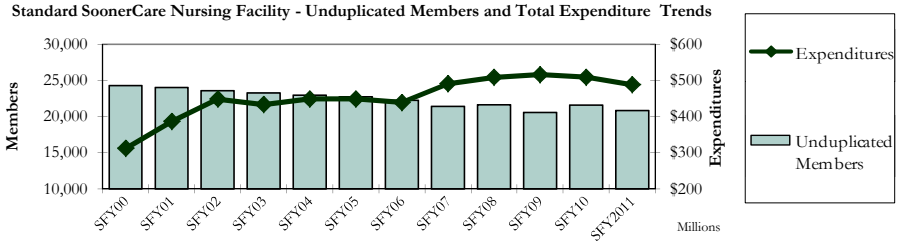
		Monthly Average SFY2011	Enrolled January 2012	PER MEMBER PER MONTH
Long-Term Care Members		**15,733**	**15,839**	**$3,166**
	Child	92	88	
	Adult	15,641	15,751	

SFY2011 Long-Term Care

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

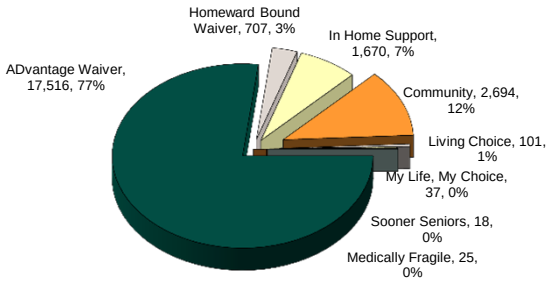
Data as of October 2011

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 January 2012
Total Providers		**29,026**	**38,821**
	In-State	20,585	28,628
	Out-of-State	8,442	10,193

Program	% of Capacity Used
SoonerCare Choice	38%
SoonerCare Choice I/T/U	14%
Insure Oklahoma IP	3%

Select Provider Type Counts	*In-State Monthly Average SFY2011**	*In-State Enrolled January 2012***	Total Monthly Average SFY2011	Total Enrolled January 2012
Physician	*6,489*	*7,676*	*11,777*	13,798
Pharmacy	*901*	*875*	*1,230*	1,156
Mental Health Provider****	*935*	*4,067*	*982*	4,125
Dentist	*798*	*995*	*901*	1,136
Hospital	*187*	*195*	*739*	948
Licensed Behavioral Health Practitioner****	*503*	*3,453*	*524*	3,488
Extended Care Facility	*392*	*366*	392	366

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

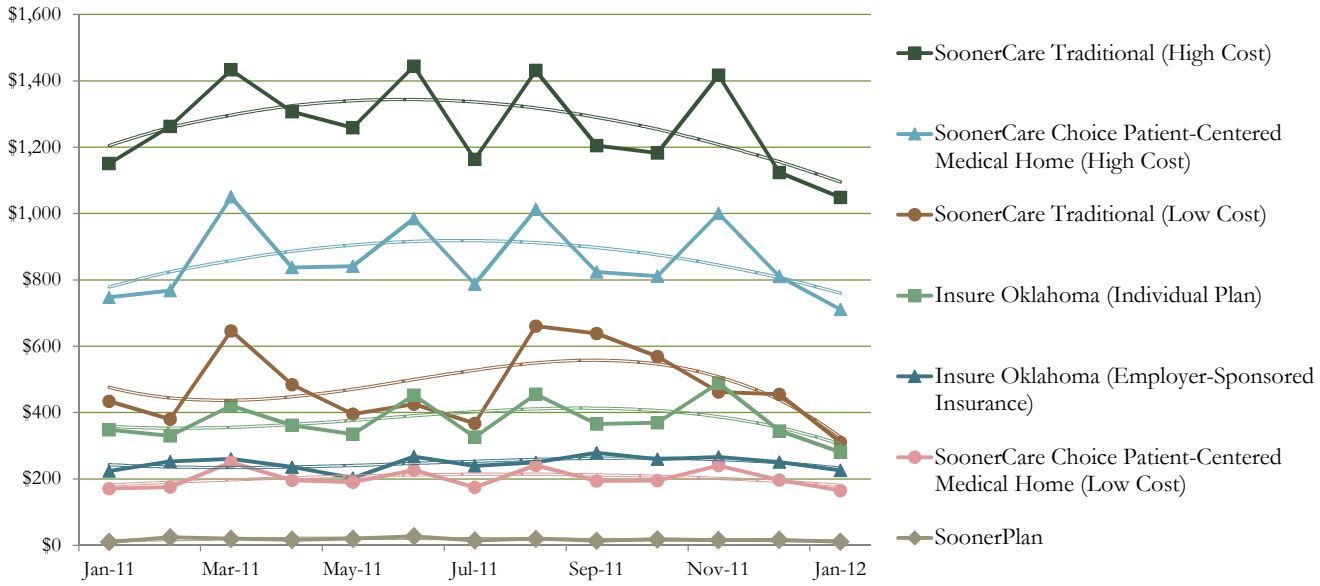
Total Primary Care Providers	*4,461*	*4,881*	6,467	6,764
Patient-Centered Medical Home	*1,476*	*1,759*	1,502	1,786

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 PER MEMBER PER MONTH (PMPM) TRENDS



*In January 2012 there was a change in billing which led to a marked decrease in physician and hospital claims. This has been corrected which should lead to an increase in February claims.

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 2/27/2012	February 2012		Since Inception	
	Number of Payments	Payment Amount	Total Number of Payments	Total Payment Amount
Eligible Professionals	31	$658,750	1,079	$22,942,917
Eligible Hospitals	5*	$1,055,348	72	$50,537,837
Totals	36	$1,714,098	1,151	$73,480,754

*Current Eligible Hospitals Paid
LAWTON IND HSP
MUSKOGEE COMMUNITY HOSPITAL
OKEENE MUN HSP
PERRY MEM HSP AUTH
SHARE MEMORIAL HOSPITAL

OHCA BOARD MEETING

MARCH 08, 2012 OHCA BOARD MEETING

OHCA REQUEST BILLS:

- HB 2273 – Rep. Doug Cox – Allows OHCA to pay for professional expenses for OHCA CEO and Physicians; Permits Prior Authorizations for Hepatitis C and HIV prescriptions;
- SB 1161 – Sen. Gary Stanislawski – Authorizes OHCA to employ one Program Integrity auditor for every $100,000,000 expended in state and federal funds if the return on investment, including cost avoidance, is greater than the total direct and indirect costs of the employee. Program integrity auditors shall not count toward any full-time equivalent limitations on the agency.

After the February 20th and 27th Senate bill deadlines and as of noon, Wednesday, February 29th, 2012, the Oklahoma Legislature is currently tracking a total of 2,673 bills. OHCA is currently tracking 203 bills. They are broken down as follows:

- OHCA Request 02
- Direct Impact 43
- Agency Interest 30
- Employee Interest 46
- 2011 Carryover 82

SENATE AND HOUSE DEADLINES

Remaining Deadlines

March 1, 2012	Deadline for Reporting Double-Assigned Senate Bills reported from 2nd Committee and Deadline for Reporting House Bills and Joint Resolutions from House Committees
March 15, 2012	Deadline for Third Reading of a Bill in the House of Origin (House/Senate)
March 29, 2012	Deadline for Reporting Double-Assigned House Bills from lst Committee
April 05, 2012	Deadline for Reporting Single Assigned House Bills in Senate Committees
April 12, 2012	Deadline for Reporting Double-Assigned House Bills from 2nd Committee and Deadline for Reporting Senate Bills and Joint Resolutions from House Committees
April 26, 2012	Deadline for Third Reading of Bills in Opposite Chamber
May 25, 2012	Sine Die Adjournment of the Second Session of the 53rd Legislature

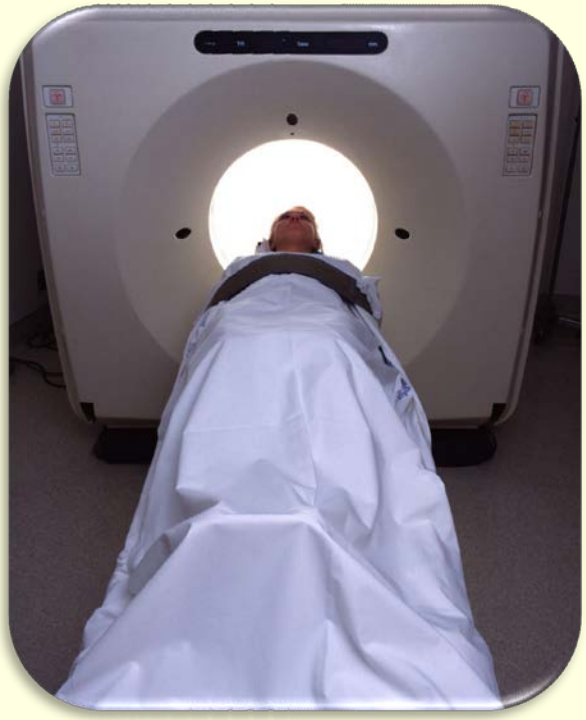
A Legislative Bill Tracking Report will be included in your handout at the Board Meeting.

Radiology Management Program

Public-Private Partnership between
Oklahoma Health Care Authority
& MedSolutions

Then & Now

- Prior to Implementation
- Since Implementation



Goals

- Assist our Providers and Members
- Improved Access
- Medically Appropriate Imaging

Outcomes

- Prior Authorization Requests (PAR) Processed
- Reduced Turnaround Time
- Reallocation of Resources within the Medical Authorization Unit

Contract Incentives for Cost Savings

- 10% - 25% Reduction = 10% of Annual Fee
- Over 25% Reduction = 20% of Annual Fee
- State dollar payments to Contractor cannot exceed State dollar savings

Cost Comparison Methodology

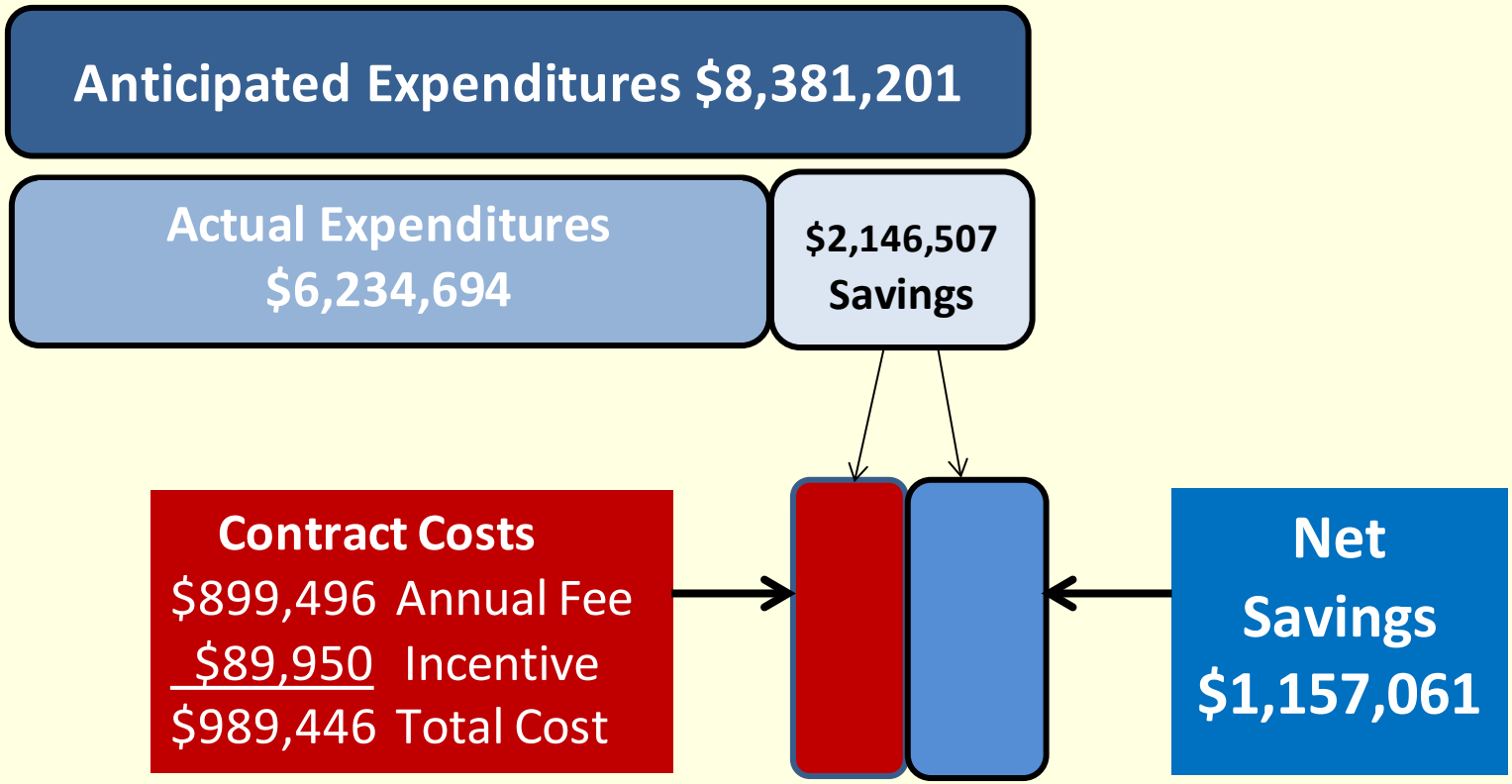
- Base Year 2009
- State Dollars Paid
- Per Covered Member Per Month (PMPM)

  - Adjusted for
    - Rate Changes
    - FMAP Changes
    - Coverage Changes

Cost Savings

2009 Base Year	1st Year of Contract
Average Monthly Member Count - 539,932	Average Monthly Member Count - 602,536
Total Expenditures $23.2 Million	Total Expenditures $19.0 Million
Adj. State Dollars PMPM $14.78	State Dollars PMPM $11.22

Savings in State Funds



7.a-1 **TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY**
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
Subchapter 5. Individual Providers and Specialties
Part 67. Behavioral Health Case Management Services
317:30-5-596.1 [AMENDED]
(Reference APA WF # 11-27)

SUMMARY: SoonerCare behavioral health case management rules are revised remove the service prior authorization requirement.

BUDGET IMPACT: Agency staff has determined that these revisions will be 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, and Sections 5003 through 5016 of Title 63 of the Oklahoma Statutes.

PUBLIC HEARING: A public hearing was held on February 22, 2012. Written comments were received before the public hearing regarding these changes and were considered during the rulemaking process.

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~~.

7.a-2 TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
Subchapter 5. Individual Providers and Specialties
Part 85. ADvantage Waiver Program Services
317:30-5-763. [AMENDED]
317:30-17-3. [AMENDED]
(Reference APA WF # 11-39A & B)

SUMMARY: OHCA rules for the ADvantage Waiver are revised to remove respiratory therapy as an allowable service within the waiver and remove Hospice when the member is in a nursing facility receiving ADvantage Facility Based Extended Respite. Both services are removed due to lack of utilization. Additionally, rules are revised to remove language allowing for reimbursement to providers of case management transition services when the member fails to transition into the ADvantage waiver program. The revisions are necessary to align OHCA policy with revised operational procedures as approved by the Centers for Medicare and Medicaid Services. Rules are also revised to clarify the types of living arrangements allowable for ADvantage members as well as to make clarifications regarding the member's health, safety and welfare.

BUDGET IMPACT: Agency staff has determined that these revisions will result in an annual budget savings of $15,000 to the Oklahoma Department of Human Services, who administers the ADvantage Waiver.

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 the Oklahoma Statutes; Medically Fragile 1915(c) Home and Community Based Services (HCBS) Waiver program as approved by The Centers for Medicare and Medicaid Services (CMS)

PUBLIC HEARING: A public hearing was held on February 22, 2012. No written comments were received before or during the public hearing regarding these changes.

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 85. ADVANTAGE PROGRAM WAIVER SERVICES

317:30-5-763. Description of services

Services included in the ADvantage Program are as follows:

(1) **Case Management.**

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

prevent institutionalization of the member, as determined through assessments. Case managers initiate the addition of necessary services or deletion of unnecessary services, as dictated by the member's condition and available support. Case managers monitor the member's condition to ensure delivery and appropriateness of services and initiate plan of care reviews. If a member requires hospital or nursing facility services, the case manager assists the member in accessing institutional care and, as appropriate, periodically monitors the member's progress during the institutional stay and helps the member transition from institution to home by updating the service plan and preparing services to start on the date the member is discharged from the institution. Case Managers must meet ADvantage Program minimum requirements for qualification and training prior to providing services to ADvantage members. Prior to providing services to members receiving Consumer-Directed Personal Assistance Services and Supports (CD-PASS), Case Managers are required to receive training and demonstrate knowledge regarding CD-PASS service delivery model, "Independent Living Philosophy" and demonstrate competency in Person-centered planning.

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

(i) A billable case management activity is any task or function defined under OAC 317:30-5-763(1)(A) that only an ADvantage case manager because of skill, training or authority, can perform on behalf of a member;

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

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

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

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

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

(2) **Respite.**

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

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

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

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

(3) **Adult Day Health Care.**

(A) Adult Day Health Care is furnished on a regularly scheduled basis for one or more days per week in an outpatient setting. It provides both health and social services which are necessary to ensure the optimal functioning of the member. Physical, occupational, ~~respiratory~~ and/or speech therapies may only be provided as an enhancement to the basic Adult Day Health Care service when authorized by the plan of care and billed as a separate procedure. Meals provided as part of this service do not constitute a full nutritional regimen. ~~Transportation between the member's residence and the service setting is provided as a part of Adult Day Health Care.~~ Personal Care service enhancement in Adult Day Health Care is assistance in bathing and/or hair washing authorized by the plan of care and billed as a separate procedure. Most assistance with activities of daily living, such as eating, mobility, toileting and nail care, are services that are integral to the Adult Day Health Care service and are covered by the Adult Day Health Care basic reimbursement rate. Assistance with bathing and/or hair care is not a usual and customary adult day health care service. Enhanced personal care in adult day health care for assistance with bathing and/or hair washing will be authorized when an ADvantage waiver member who uses adult day health care requires assistance with bathing and/or hair washing to maintain health and safety.

(B) Adult Day Health Care is a 15-minute unit. No more than 6 hours are authorized per day. The number of units of service a member may receive is limited to the number of units approved on the member's approved plan of care.

(C) Adult Day Health Care Therapy Enhancement is a maximum one session per day unit of service.

(D) Adult Day Health Personal Care Enhancement is a maximum one per day unit of bathing and/or hair washing service.

(4) **Environmental Modifications.**

(A) Environmental Modifications are physical adaptations to the home, required by the member's plan of care, which are necessary

to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence in the home and without which, the member would require institutionalization. Adaptations or improvements to the home which are not of direct medical or remedial benefit to the waiver member are excluded.

(B) All services require prior authorization.

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

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

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

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

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

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

(7) **Nursing.**

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

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

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

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

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

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

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

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

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

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

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

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

caregivers as specified in the service plan for preventive and rehabilitative care procedures.

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

(8) **Home Delivered Meals.**

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

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

(9) **Occupational Therapy ~~service~~ Services.**

(A) Occupational Therapy services are those services that increase functional independence by enhancing the development of adaptive skills and performance capacities of members with physical disabilities and related psychological and cognitive impairments. Services are provided in the member's home and are intended to help the member achieve greater independence to reside and participate in the community. Treatment involves the therapeutic use of self-care, work and play activities and may include modification of the tasks or environment to enable the member to achieve maximum independence, prevent further disability, and maintain health. Under a physician's order, a licensed occupational therapist evaluates the member's rehabilitation potential and develops an appropriate written therapeutic regimen. The regimen utilizes paraprofessional occupational therapy assistant services, within the limits of their practice, working under the supervision of the licensed occupational therapist. The regimen includes education and training for informal caregivers to assist with and/or maintain

services, where appropriate. The therapist will ensure monitoring and documentation of the member's rehabilitative progress and will report to the member's case manager and physician to coordinate necessary addition and/or deletion of services, based on the member's condition and ongoing rehabilitation potential.

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

(10) **Physical Therapy ~~services~~ Services.**

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

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

(11) **Speech and Language Therapy Services.**

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

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

~~(12) **Respiratory Therapy Services.**~~

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

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

~~(13)~~ (12) **Hospice Services**.

(A) Hospice is palliative and/or comfort care provided to the member and his/her family when a physician certifies that the member has a terminal illness and has six months or less to live and orders hospice care. ADvantage Hospice Care is authorized for a six month period and requires a physician certification of a terminal illness and orders of hospice care. If the member requires more than six months of hospice care, a physician or nurse practitioner must have a face-to-face visit with the member thirty days prior to the initial hospice authorization end date and re-certify that the member has a terminal illness and has six months or less to live and orders additional hospice care. After the initial authorization period, additional periods of ADvantage Hospice may be authorized for a maximum of 60 day increments with physician certification that the member has a terminal illness and has six months or less to live. A member's service plan that includes hospice care must comply with waiver requirements to be within total service plan cost limits.

(B) A hospice program offers palliative and supportive care to meet the special needs arising out of the physical, emotional and spiritual stresses which are experienced during the final stages of illness and during dying and bereavement. The member signs a statement choosing hospice care instead of routine medical care that has the objective to treat and cure the member's illness. Once the member has elected hospice care, the hospice medical team assumes responsibility for the member's medical care for the terminal illness in the home environment. Hospice care services include nursing care, physician services,

medical equipment and supplies, drugs for symptom control and pain relief, home health aide and personal care services, physical, occupational and/or speech therapy, medical social services, dietary counseling and grief and bereavement counseling to the member and/or family. A Hospice plan of care must be developed by the hospice team in conjunction with the member's ADvantage case manager before hospice services are provided. The hospice services must be related to the palliation or management of the member's terminal illness, symptom control, or to enable the individual to maintain activities of daily living and basic functional skills. ~~ADvantage Hospice may be provided to the member in a Nursing Facility (NF) only when the member is placed in the NF for ADvantage Facility Based Extended Respite. Hospice provided as part of Facility Based Extended Respite may not be reimbursed for more than five days during any 30 day period.~~ A member that is eligible for Medicare Hospice provided as a Medicare Part A benefit, is not eligible to receive ADvantage Hospice services.

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

~~(14)~~ (13) **ADvantage Personal Care.**

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

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

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

~~(15)~~ (14) **Personal Emergency Response System.**

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

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

(ii) lives alone and has no regular caregiver, paid or unpaid, and therefore is left alone for long periods of time;
(iii) demonstrates capability to comprehend the purpose of and activate the PERS;
(iv) has a health and safety plan detailing the interventions beyond the PERS to assure the member's health and safety in his/her home;
(v) has a disease management plan to implement medical and health interventions that reduce the possibility of falls by managing the member's underlying medical condition causing the falls; and,
(vi) the service avoids premature or unnecessary institutionalization of the member.

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

~~(16)~~ (15) **Consumer-Directed Personal Assistance Services and Support (CD-PASS).**

(A) Consumer-Directed Personal Assistance Services and Supports are Personal Services Assistance and Advanced Personal Services Assistance that enable an individual in need of assistance to reside in their home and in the community of their choosing rather than in an institution and to carry out functions of daily living, self care, and mobility. CD-PASS services are delivered as authorized on the service plan. The member employs the Personal Services Assistant (PSA) and/or the Advanced Personal Services Assistant (APSA) and is responsible, with assistance from ADvantage Program Administrative Financial Management Services (FMS), for ensuring that the employment complies with State and Federal Labor Law requirements. The member may designate an adult family member or friend, an individual who is not a PSA or APSA to the member, as an "authorized representative" to assist in executing these employer functions. The member:
(i) recruits, hires and, as necessary, discharges the PSA or APSA;
(ii) provides instruction and training to the PSA or APSA on tasks to be done and works with the Consumer Directed Agent/Case Manager to obtain ADvantage skilled nursing services assistance with training when necessary. Prior to performing an Advanced Personal Services Assistance task for the first time, the APSA must demonstrate competency in the tasks in an on-the-job training session conducted by the member and the member must document the attendant's competency in performing each task in the ASPA's personnel file;
(iii) determines where and how the PSA or APSA works, hours of work, what is to be accomplished and, within Individual Budget Allocation limits, wages to be paid for the work;
(iv) supervises and documents employee work time; and,
(v) provides tools and materials for work to be accomplished.

(B) The service Personal Services Assistance may include:
(i) assistance with mobility and with transfer in and out of bed, wheelchair or motor vehicle, or both;

(ii) assistance with routine bodily functions that may include:

(I) bathing and personal hygiene;

(II) dressing and grooming;

(III) eating including meal preparation and cleanup;

(iii) assistance with homemaker type services that may include shopping, laundry, cleaning and seasonal chores;

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

(C) Advanced Personal Services Assistance are maintenance services provided to assist a member with a stable, chronic condition with activities of daily living when such assistance requires devices and procedures related to altered body function if such activities, in the opinion of the attending physician or licensed nurse, may be performed if the individual were physically capable, and the procedure may be safely performed in the home. Advanced Personal Services Assistance is a maintenance service and should never be used as a therapeutic treatment. Members who develop medical complications requiring skilled nursing services while receiving Advanced Personal Services Assistance should be referred to their attending physician who may, if appropriate, order home health services. The service of Advanced Personal Services Assistance includes assistance with health maintenance activities that may include:

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

(ii) remove external catheters, inspect skin and reapplication of same;

(iii) administer prescribed bowel program including use of suppositories and sphincter stimulation, and enemas (Pre-packaged only) with members without contraindicating rectal or intestinal conditions;

(iv) apply medicated (prescription) lotions or ointments, and dry, non-sterile dressings to unbroken skin;

(v) use lift for transfers;

(vi) manually assist with oral medications;

(vii) provide passive range of motion (non-resistive flexion of joint) delivered in accordance with the plan of care, unless contraindicated by underlying joint pathology;

(viii) apply non-sterile dressings to superficial skin breaks or abrasions; and

(ix) use Universal precautions as defined by the Center for Disease Control.

(D) The service Financial Management Services are program administrative services provided to participating CD-PASS employer/members by the OKDHS/ASD. Financial Management Services are employer related assistance that provides Internal Revenue Service (IRS) fiscal reporting agent and other financial management tasks and functions including, but not limited to:

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

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

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

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

(v) for making available Hepatitis B vaccine and vaccination series to PSA and APSA employees in compliance with OSHA standards.

(E) The service of Personal Services Assistance is billed per 15-minute unit of service. The number of units of PSA a member may receive is limited to the number of units approved on the Service Plan.

(F) The service of Advanced Personal Services Assistance is billed per 15-minute unit of service. The number of units of APSA a member may receive is limited to the number of units approved on the Service Plan.

~~(17)~~ (16) **Institution Transition Services.**

(A) Institution Transition Services are those services that are necessary to enable an individual to leave the institution and receive necessary support through ADvantage waiver services in their home and/or in the community.

(B) Institution Transition Case Management Services are services as described in OAC 317:30-5-763(1) required by the individual's plan of care, which are necessary to ensure the health, welfare and safety of the individual, or to enable the individual to function with greater independence in the home, and without which, the individual would continue to require institutionalization. ADvantage Transition Case Management Services assist institutionalized individuals that are eligible to receive ADvantage services in gaining access to needed waiver and other State plan services, as well as needed medical, social, educational and other services to assist in the transition, regardless of the funding source for the services to which access is gained. Transition Case Management Services may be authorized for periodic monitoring of an ADvantage member's progress during an institutional stay, and for assisting the

member transition from institution to home by updating the service plan, including necessary Institution Transition Services to prepare services and supports to be in place or to start on the date the member is discharged from the institution. Transition Case Management Services may be authorized to assist individuals that have not previously received ADvantage services but have been referred by the OKDHS/ASD to the Case Management Provider for assistance in transitioning from the institution to the community with ADvantage services support.

(i) Institution Transition Case Management services are prior authorized and billed per 15-minute unit of service using the appropriate HCPC and modifier associated with the location of residence of the member served as described in OAC 317:30-5-763(1)(C).

(ii) A unique modifier code is used to distinguish Institution Transition Case Management services from regular Case Management services.

(C) Institutional Transition Services may be authorized and reimbursed under the following conditions:

(i) The service is necessary to enable the individual to move from the institution to their home;

(ii) The individual is eligible to receive ADvantage services outside the institutional setting;

(iii) Institutional Transition Services are provided to the individual within 180 days of discharge from the institution;

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

(D) If the member has received Institution Transition Services but fails to enter the waiver, any Institution Transition Services ~~authorized and~~ provided are ~~reimbursed as "Medicaid administrative" costs and providers follow special procedures specified by the OKDHS/ASD to bill for services provided~~ not reimbursable.

~~(18)~~ (17) **Assisted Living Services.**

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

specific needs of the participant as determined through individualized assessment and documented on the participant's service plan.

(B) The ADvantage Assisted Living Services philosophy of service delivery promotes service member choice, and to the greatest extent possible, service member control. Members have control over their living space and choice of personal amenities, furnishing and activities in their residence. The Assisted Living Service provider's documented operating philosophy, including policies and procedures, must reflect and support the principles and values associated with the ADvantage assisted living philosophy and approach to service delivery that emphasizes member dignity, privacy, individuality, and independence.

(C) ADvantage Assisted Living required policies for Admission/Termination of services and definitions.

(i) ADvantage-certified Assisted Living Centers (ALCs) are required to accept all eligible ADvantage members who choose to receive services through the ALC subject only to issues relating to:

(I) unit availability;

(II) the compatibility of the participant with other residents; and

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

(ii) The ALC may specify the number of units the provider is making available to service ADvantage participants.

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

(iv) The ALC is responsible for meeting the member's needs for privacy and dignity. Inability to meet those needs will not be recognized as a reason for determining that an ADvantage participant's placement is inappropriate. The ALC agrees to provide or arrange and coordinate all of the services listed in the description of assisted living center services in the Oklahoma State Department of Health regulations (OAC 310:663-3-3) except for specialized services.

(v) In addition, the ADvantage participating ALC agrees to provide or coordinate the following services:

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

(II) Provide up to three meals per day plus snacks sufficient to meet nutritional requirements, including modified special diets, appropriate to members' needs and choices; and

(III) Arrange or coordinate transportation to and from medical appointments.

(vi) The provider may offer any specialized service or unit for residents with Alzheimer's disease and related dementias, physical disabilities or other special needs that the facility intends to market.

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

(viii) Under OAC 310:663-1-2, "personal care" is defined as "assistance with meals, dressing, movement, bathing or other personal needs or maintenance, or general supervision of the physical and mental well-being of a person". For ADvantage Assisted Living Services, assistance with "other personal needs" in this definition includes assistance with toileting, grooming and transferring and the term "assistance" is clarified to mean hands-on help in addition to supervision.

(ix) The specific Assisted Living Services assistance provided along with amount and duration of each type of assistance is based upon the individual member's assessed need for service assistance and is specified in the ALC's service plan which is incorporated as supplemental detail into the ADvantage comprehensive service plan. The ADvantage Case Manager in cooperation with the Assisted Living Center professional staff develops the service plan to meet member needs. As member needs change, the service plan is amended consistent with the assessed, documented need for change in services.

(x) Definition of Inappropriate ALC Placement. Placement or continued placement of an ADvantage member in an ALC is inappropriate if any one or more of the following conditions exist:

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

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

(III) The member has a medical condition that is complex, unstable or unpredictable and treatment cannot be appropriately developed and implemented in the assisted living environment. Documentation must support that ALC attempted to obtain appropriate care for the member; or

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

(xi) Termination of residence when inappropriately placed. Once a determination is made that a member is inappropriately placed, the assisted living center must inform the member and/or the member's representative, if any, and the member's ADvantage Case Manager. The ALC must develop a discharge

plan in consultation with the member, the member's support network and the ADvantage Case Manager. The ALC and Case Manager must ensure that the discharge plan includes strategies for providing increased services, when appropriate to minimize risk and meet the higher care needs of members awaiting a move out of the ALC, if reason for discharge is inability to meet member needs. If voluntary termination of residency is not arranged, the ALC must provide written notice to the member and to the member's representative, with a copy to the member's ADvantage Case Manager, giving the member 30 days notice of the ALC's intent to terminate the residency agreement and move the member to a more appropriate care provider. The 30 day requirement shall not apply when emergency termination of the residency agreement is mandated by the member's immediate health needs or when termination of the residency agreement is necessary for the physical safety of the member or other residents of the ALC. The written notice of involuntary termination of residency for reasons of inappropriate placement must include:

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

(II) the date of the notice;

(III) the date notice was given to the member and the member's representative;

(IV) the date by which the member must leave the ALC; and

(V) notification of appeal rights and process for submitting appeal of termination of Medicaid Assisted Living services to the OHCA.

(D) ADvantage Assisted Living Services provider standards in addition to licensure standards.

(i) Physical environment

(I) The ALC must provide lockable doors on the entry door of each unit and a lockable compartment within each member unit for valuables. Member residents must have exclusive rights to their units with lockable doors at the entrance of their individual and/or shared unit except in the case of documented contraindication. Units may be shared only if a request to do so is initiated by the member resident.

(II) The ALC must provide each unit with a means for each member resident to control the temperature in the individual living unit through the use of a damper, register, thermostat, or other reasonable means that is under the control of the resident and that preserves resident privacy, independence and safety, provided that the Oklahoma State Department of Health may approve an alternate means based on documentation that the design of the temperature control is appropriate to the special needs of each member who has an alternate temperature control.

(III) For ALCS built prior to January 1, 2008, each ALC individual residential unit must have a minimum total living space (including closets and storage area) of 250 square feet; for ALCs built after December 31, 2007, each ALC individual residential unit must have a minimum total

living space (including closets and storage area) of 360 square feet.

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

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

(VI) The member is responsible for furnishing their rental unit. If a member is unable to supply basic furnishings defined as a bed, dresser, nightstand, chairs, table, trash can and lamp, or if the member supplied furnishings pose a health or safety risk, the member's Case Manager in coordination with the ALC must assist the member in obtaining basic furnishings for the unit.

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

(VIII) The ALC must ensure the design of common areas accommodates the special needs of their resident population and that the residential unit accommodates the special needs of the individual in compliance with ADA Accessibility Guidelines (28 CFR Part 36 Appendix A).

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

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

(ii) Sanitation

(I) The ALC must maintain the facility, including its individual units, that is clean, safe, sanitary, insect and rodent free, odorless, and in good repair at all times.

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

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

(IV) The ALC must provide housekeeping in member units that maintains a safe, clean and sanitary environment.

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

(iii) Health and Safety

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

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

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

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

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

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

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

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

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

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

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

(iv) Staff to resident ratios

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

(II) The ALC must ensure that staffing is sufficient to meet the needs of the ADvantage Program residents in accordance with each individual's ADvantage Service Plan.

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

(v) Staff training and qualifications

(I) The ALC must ensure that all staff have qualifications consistent with their job responsibilities.

(II) All staff assisting in, or responsible for, food service must have attended a food service training program offered or approved by the Oklahoma Department of Health;

(III) The ALC must provide staff orientation and ongoing training to develop and maintain the knowledge and skills of staff. All direct care and activity staff receive at least eight hours of orientation and initial training within the first month of their employment and at least four hours annually thereafter. Staff providing direct care on a dementia unit must receive four additional hours of dementia specific training. Annual first aid

and CPR certification do not count towards the four hours of annual training.

(vi) Staff supervision

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

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

(vii) Resident rights

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

(II) The ALC must conspicuously post for display in an area accessible to residents, employees and visitors, the assisted living center's complaint procedures and the name, address and telephone number of a person authorized to receive complaints. A copy of the complaint procedure must also be given to each resident, the resident's representative, or where appropriate, the court appointed guardian. The ALC must ensure that all employees comply with the ALC's complaint procedure.

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

(viii) Incident reporting

(I) The ALC must maintain a record of incidents that occur and report incidents to the member's ADvantage Case Manager, to the ADvantage Program AA and to other entities as required by law or regulation.

(II) Incidents requiring report by licensed Assisted Living Centers are those defined by the Oklahoma State Department of Health (OSDH) in OAC 310:663-19-1.

(III) Reports of incidents must be made to the member's ADvantage Case Manager via facsimile or by telephone within one business day of the reportable incident's discovery. A follow-up report of the incident must be submitted via facsimile or mail to the member's ADvantage Case Manager within five business days after the incident. The final report must be filed with the member's ADvantage Case Manager and to the ADvantage Administration when the full investigation is complete not to exceed ten business days after the incident.

(IV) Each ALC having reasonable cause to believe that a member is suffering from abuse, neglect, exploitation, or misappropriation of member property must make a report to either the Oklahoma Department of Human Services, the office of the district attorney in the county in which the suspected abuse, neglect, exploitation, or property misappropriation occurred or the local municipal police department or sheriff's department as soon as the person is aware of the situation, in accordance with Section 10-104.A of Title 43A of Oklahoma Statutes. Reports should also be made to the OSDH, as appropriate, in accordance with the ALC's licensure rules.

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

(ix) Provision of or arrangement for necessary health services

(I) The ALC must arrange or coordinate transportation for members to and from medical appointments.

(II) The ALC must provide or coordinate with the member and the member's ADvantage Case Manager for delivery of necessary health services. The ADvantage Case Manager is responsible for monitoring that all health-related services required by the member as identified through assessment and documented on the service plan are provided in an appropriate and timely manner.

(E) Assisted Living Services are billed per diem of service for days covered by the ADvantage member's service plan and during which the Assisted Living Services provider is responsible for providing Assisted Living serviced as needed by the member. The per diem rate for the ADvantage assisted living services for a member will be one of three per diem rate levels based upon individual member's need for service - type intensity and frequency to address member ADL/IADL and health care needs. The rate level is based upon UCAT assessment by the member's ADvantage Case Manager employed by a Case Management agency that is independent of the Assisted Living Services provider.

317:35-17-3. ADvantage program services

(a) The ADvantage program is a Medicaid Home and Community Based Waiver used to finance ~~noninstitutional~~ non-institutional long-term care services for elderly and a targeted group of physically disabled adults when there is a reasonable expectation that within a 30 day period, the person's health, due to disease process or disability, would, without appropriate services, deteriorate and require nursing facility care to arrest the deterioration. ~~ADvantage program members must be SoonerCare~~

~~eligible and must not reside in an institution, room and board, licensed residential care facility, or licensed assisted living facility, unless the facility is an ADvantage Assisted Living Center.~~ Individuals may not be enrolled in ADvantage for the sole purpose of enabling them to obtain Mediciad eligibility. Eligibility for ADvantage is contingent on an individual requiring one or more of the services offered in the waiver at least monthly in order to avoid institutionalization.

(b) The number of individuals who may receive ADvantage services is limited.

(1) To receive ADvantage services, individuals must meet one of the following categories:

(A) be age 65 years or older, or

(B) be age 21 or older if physically disabled and not developmentally disabled or if age 21 or older and not physically disabled, the person has a clinically documented, progressive degenerative disease process that responds to treatment and previously has required hospital or nursing facility (NF) level of care services for treatment related to the condition and requires ADvantage services to maintain the treatment regimen to prevent health deterioration, or

(C) if developmentally disabled and between the ages of 21 and 65, not have ~~mental retardation~~ intellectual disability or a cognitive impairment related to the developmental disability.

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

(A) require nursing facility level of care [see OAC 317:35-17-2];

(B) meet service eligibility criteria [see ~~OAC 317:35-17-3(d)~~ OAC 317:35-17-3(f)]; and

(C) meet program eligibility criteria [see ~~OAC 317:35-17-3(e)~~ 317:35-17-3(g)].

(c) ADvantage members are eligible for limited types of living arrangements. The specific living arrangements are set forth below.

(1) ADvantage program members are not eligible to receive services while residing in an institutional setting, including but not limited to licensed facilities such as a hospital, a nursing facility, a licensed residential care facility, or a licensed assisted living facility, (unless the facility is an ADvantage Assisted Living Center), or in an unlicensed institutional living arrangement such as a room and board home/facility.

(2) ADvantage program members may receive services in a contracted ADvantage Assisted Living Center; an ADvantage Assisted Living Center is the only housing-with-nursing-supervised personal care services option in which a person may appropriately receive ADvantage services.

(3) Additional living arrangements in which members may receive ADvantage services are the member’s own home, apartment or independent living apartment or a family or friend’s home or apartment. A home/apartment unit is defined as a self-contained living space having a lockable entrance to the unit and including a bathroom and food storage/preparation amenities in addition to bedroom/living space.

(4) ADvantage program members may receive services in a shelter or similar temporary housing arrangement which may or may not meet the definition of home/apartment, in emergency situations, for a period not to exceed sixty (60) days during which location and transition

to permanent housing is being sought.

(5) For ADvantage members who are full-time students, a dormitory room qualifies as an allowable living arrangement in which to receive ADvantage services for the period during which the member is a student.

(6) Members may receive ADvantage respite services in a nursing facility for a continuous period not to exceed thirty (30) days.

~~(b)~~ (d) Home and Community Based Waiver Services are outside the scope of Medicaid State Plan services. The Medicaid waiver allows the OHCA to offer certain Home and Community Based services to an annually capped number of persons who are categorically needy (refer to OKDHS form 08AX001E (Appendix C-1), Schedule VIII. B. 1.) and without such services would be institutionalized. The estimated cost of providing an individual's care outside the nursing facility cannot exceed the annual cost of caring for that individual in a nursing facility. When determining the ADvantage service plan cost cap for an individual, the comparable SoonerCare cost to serve that individual in a nursing facility is estimated. If the individual has Acquired Immune Deficiency Syndrome (AIDS) or if the individual requires ventilator care, the appropriate SoonerCare enhanced nursing facility rate to serve the individual is used to estimate the ADvantage cost cap.

~~(c)~~ (e) Services provided through the ADvantage waiver are:

(1) case management;
(2) respite;
(3) adult day health care;
(4) environmental modifications;
(5) specialized medical equipment and supplies;
(6) physical therapy/occupational therapy/~~respiratory/~~speech therapy or consultation;
(7) advanced supportive/restorative assistance;
(8) ~~skilled~~ nursing;
(9) home delivered meals;
(10) hospice care;
(11) medically necessary prescription drugs within the limits of the waiver;
(12) personal care (state plan) or ADvantage personal care;
(13) Personal Emergency Response System (PERS);
(14) Consumer-Directed Personal Assistance Services and Supports (CD-PASS);
(15) Institution Transition Services;
(16) assisted living; and
(17) SoonerCare medical services for individuals age 21 and over within the scope of the State Plan.

~~(d)~~ (f) The OKDHS area nurse or nurse designee makes a determination of service eligibility prior to evaluating the UCAT assessment for nursing facility level of care. The following criteria are used to make the service eligibility determination:

(1) an open ADvantage Program waiver slot, as authorized by the waiver document approved by the Centers for Medicare and Medicaid Services (CMS), is available to assure federal participation in payment for services to the individual. If the OKDHS/ASD determines all ADvantage waiver slots are filled, the individual cannot be certified on the OKDHS computer system as eligible for ADvantage services and the individual's name is placed on a waiting list for entry as an open slot becomes available. ~~ADvantage waiver slots and corresponding waiting lists, if necessary, are maintained for~~

~~persons that have a developmental disability and those that do not have a developmental disability.~~

(2) the individual is in the ADvantage targeted service group. The target group is an individual who is frail and 65 years of age or older or age 21 or older with a physical disability and who does not have ~~mental retardation~~ intellectual disability or a cognitive impairment.

(3) the individual ~~does not pose~~ is not eligible if he/she poses a physical threat to self or others as supported by professional documentation.

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

(5) the individual is not eligible if his/her living environment poses a physical threat to self or others as supported by professional documentation where applicable, and measures to correct hazardous conditions or assist the person to move are unsuccessful or not feasible.

~~(e)~~ (g) The State, as part of the waiver program approval authorization, assures CMS that each Member's health, safety or welfare can be maintained in their home. If a member's identified needs cannot be met through provision of ADvantage program or Medicaid State Plan services and other formal or informal services are not in place or immediately available to meet those needs, the individual's health, safety or welfare in their home cannot be assured. The ~~OKDHS/ASD~~ AA determines ADvantage program eligibility through the service plan approval process. ~~The following criteria are used to make the ADvantage program eligibility determination that an individual is not eligible:~~ An individual is deemed ineligible for the ADvantage program based on the following criteria:

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

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

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

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

~~(5)~~ (4) ~~if,~~ after the service and care plan is developed, the risk to individual's health and safety is not acceptable to the individual, or to the interdisciplinary service plan team, or to the OKDHS/ASD.

(5) the individual's living environment poses a physical threat to self or others as supported by professional documentation, where applicable and measures to correct hazardous conditions or assist the person to move are unsuccessful or are not feasible.

(6) the individual's health safety or welfare in their home cannot be assured due to continued refusal of planned services.

(7) the individual does not require at least one ADvantage service monthly.

~~(f)~~ (h) The case manager provides the ~~OKDHS/ASD~~ AA with professional documentation to support the recommendation for redetermination of program eligibility. The service providers continue providing services according to the service plan as provider safety permits until the individual is removed from the ADvantage program. As a part of the procedures requesting redetermination of program eligibility, the OKDHS/ASD will provide technical assistance to the Provider for transitioning the individual to other services.

~~(g)~~ (i) Individuals determined ineligible for ADvantage program services are notified in writing by OKDHS of the determination and of their right to appeal the decision.

7.a-3 TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
Subchapter 5. Individual Providers And Specialties
Part 6. Inpatient Psychiatric Hospitals
OAC 317:30-5-95.24. [AMENDED]
OAC 317:30-5-95.25. [AMENDED]
OAC 317:30-5-95.26. [AMENDED]
OAC 317:30-5-95.27. [AMENDED]
OAC 317:30-5-95.28. [AMENDED]
OAC 317:30-5-95.29. [AMENDED]
OAC 317:30-5-95.30. [AMENDED]
OAC 317:30-5-95.31. [AMENDED]
Part 21. Outpatient Behavioral Health Services
OAC 317:30-5-240. [AMENDED]
OAC 317:30-5-240.1 [AMENEDED]
OAC 317:30-5-240.2 [AMENDED]
OAC 317:30-5-241. [AMENDED]
OAC 317:30-5-241.1. [AMENDED]
OAC 317:30-5-241.2. [AMENDED]
OAC 317:30-5-241.3. [AMENDED]
OAC 317:30-5-241.4. [AMENDED]
OAC 317:30-5-241.5. [AMENDED]
Part 25 Psychologist
OAC 317:30-5-276. [AMENDED]
Part 26 Licensed Behavioral Health Providers
OAC 317:30-5-281. [AMENDED]
Part 67. Behavioral Health Case Management Services
OAC 317:30-5-596. [AMENDED]
Part 83. Residential Behavior Management Services in Foster Care Setting
OAC 317:30-5-741. [AMENDED]
(Reference APA WF # 11-27)

SUMMARY: 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 will be 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, and Sections 5003 through 5016 of Title 63 of the Oklahoma Statutes.

PUBLIC HEARING: A public hearing was held on February 22, 2012. Written comments were received before the public hearing regarding these changes and were considered during the rulemaking process.

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
(xiv) 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.

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.a-4 TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
Subchapter 5. Individual Providers and Specialties
Part 1. Physicians
317:30-5-12. [AMENDED]
Part 49. Family Planning Centers
317:30-5-465. [REVOKED]
317:30-5-466. [REVOKED]
317:30-5-467. [REVOKED]
Part 75. Federally Qualified Health Centers
317:30-5-664.5. [AMENDED]
Part 112. Public Health Clinic Services
317:30-5-1154. [AMENDED]
CHAPTER 35. MEDICAL ASSISTANCE FOR ADULTS AND CHILDREN-ELIGIBILITY
Subchapter 5. Eligibility and Countable Income
Part 1. Determination of Qualifying Categorical Relationships
317:35-5-2. [AMENDED]
317:35-5-8. [AMENDED]
Subchapter 7. Medical Services
Part 5. Determination of Eligibility for Medical Services
317:35-7-37. [AMENDED]
317:35-7-48. [AMENDED]
Part 7. Certification, Redetermination and Notification
317:35-7-60. [AMENDED]
317:35-7-60.1. [AMENDED]
(Reference APA WF # 11-03 A & B)

SUMMARY: OHCA rules for the SoonerPlan Family Planning Program are revised to remove references to the Family Planning Waiver. Section 2303 of the Patient Protection and Affordable Care Act allows individuals receiving Family Planning Waiver services to receive those same services plus additional family planning and family planning related services under the Title XIX State Plan rather than a waiver program. In addition to a broader service package, the State Plan option allows a more efficient way of making future changes to the SoonerPlan program. If approved, the rule change will allow over 32,000 SoonerPlan members and future members to receive the enhanced package of State Plan Family Planning services. The rule revision also includes the removal of language relating to family planning centers, clarification of eligibility rules and other minor policy corrections.

BUDGET IMPACT: Agency staff has determined that the proposed changes would have a total annual budget impact of $171,887 State dollars and $1,246,000 Federal. The state share is paid by the Oklahoma State Department of Health.

MEDICAL ADVISORY COMMITTEE: The Medical Advisory Committee considered the proposed rule revisions on November 16, 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 2303 of the Patient

Protection and Affordable Care Act.

PUBLIC HEARING: A public hearing was held on February 22, 2012. One written comment was received before the public hearing and was considered during the rulemaking process.

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 1. PHYSICIANS

317:30-5-12. Family planning

~~(a) Pregnancy tests are covered.~~
~~(b) Reverse vasectomy is not covered.~~
~~(c) Reversal of sterilization procedures for the purpose of conception are not covered.~~

(a) **Adults.** Payment is made for the following family planning services:

(1) physical examination to determine the general health of the member and most suitable method of contraception;
(2) complete general history of the member and pertinent history of immediate family members;
(3) laboratory services for the determination of pregnancy, detection of certain sexually transmitted infections and detection of cancerous or pre-cancerous conditions of the reproductive anatomy;
(4) education and counseling regarding issues related to reproduction and contraception;
(5) annual supply of chosen contraceptive;
(6) insertion and removal of contraceptive devices;
(7) vasectomy and Tubal Ligation procedures; and
(8) additional visits for members experiencing difficulty with a particular contraceptive method or having concerns related to their reproductive health.

(b) **Children.** Payment is made for children as set forth in this Section for adults. However payment cannot be made for the sterilization of persons under the age of 21.

(c) **SoonerPlan Members.** Non-pregnant women and men ages 19 and older not enrolled in SoonerCare may apply for the SoonerPlan program. Eligible members receive family planning services set forth in this Section as well as family planning related services (vaccinations for the prevention of certain sexually transmitted infections and male exams). SoonerPlan eligibility requirements are found at OAC 317:35-7-48.

(d) **Individuals eligible for Part B of Medicare.** Payment is made utilizing the Medicaid allowable for comparable services. Claims for services which are not covered by Medicare should be filed directly with the Fiscal Agent for payment within the scope of the program.

PART 49. FAMILY PLANNING CENTERS [REVOKED]

317:30-5-465. Eligible providers [REVOKED]

~~In order to be eligible for participation the family planning center must meet the Oklahoma State Health Department Standards and Criteria for Family Planning Centers. The center must declare whether they will bill independently or through a computer billing arrangement with the Oklahoma State Department of Health.~~

317:30-5-466. Coverage by category [REVOKED]

~~Payment is made to family planning centers as set forth in this Section.~~

~~(1) **Adults.** Payment is made for adults on an encounter basis. Each encounter is all inclusive of the following and payment includes all services provided:~~

~~(A) **Initial examination services.** Initial examination services that are provided to new family planning patients include:~~

~~(i) Complete physical examination including assessment of height, weight, blood pressure, thyroid, extremities, heart, lungs, breasts, abdomen, pelvic examination, including visualization of the cervix, external genitalia, bimanual exam, and rectal exam as indicated. (Male clients receive examination of genitals and rectum including palpation of the prostate in lieu of pelvic exam given females.)~~

~~(ii) Complete general history of patient and pertinent history of immediate family members. This general history addresses allergies, immunizations, past illnesses, hospitalizations, surgery, review of systems, use of alcohol, tobacco and drugs. Reproductive function history in female patients includes menstrual history, sexual activity, sexually transmitted diseases, contraceptive use, pregnancies, and in utero exposure to DES. Male reproductive general history includes sexual activity, sexually transmitted diseases, fertility, and exposure to DES.~~

~~(iii) Laboratory services to include hematocrit, dip stick urinalysis, pap smear, gonorrhea culture, serologic test for syphilis and rubella screening if indicated.(iv) Education and counseling are offered to provide information regarding reproductive anatomy, range of clinic services, risks benefits and side effects of various methods of contraception, and health promotion/disease prevention topics as needed.~~

~~(v) Provision for an annual supply of chosen contraceptive method to include, but not limited to, injections (administration and medication), oral contraceptive, IUD, diaphragm, foam, condoms or natural family planning.~~

~~(vi) Treatment of minor gynecological problems, infections, and other conditions.~~

~~(vii) Referral to appropriate providers for problems or conditions which are beyond the scope of the clinic to treat.~~

~~(B) **Annual examination services.** Annual examination services are provided to continuing patients to include:~~

~~(i) Annual update physical examination to include height, weight, blood pressure, extremities, and examination of breasts and pelvic organs. If required, a complete physical examination may be provided as described under the initial visit services above.~~

~~(ii) A medical history update is taken to update the general history and includes noting the patient's adaptation to and correct use of contraceptive method, menstrual history, specific warning signs and other side effects related to the contraceptive method. If indicated, a complete general history of the patient will be taken at the annual visit.~~

~~(iii) Laboratory services to include pap smear, gonorrhea culture, hematocrit, and serologic test for syphilis.~~

(iv) Education and counseling regarding specific problems, risks and side effects of the method in use.
(v) Provision for an annual supply of chosen contraceptive method to include, but not limited to, injections (administration and medication), oral contraceptive, IUD, diaphragm, foam, condoms or natural family planning.
(vi) Treatment of minor gynecological problems, infections, and other conditions.
(vii) Referral to appropriate providers for problems or conditions which are beyond the scope of the clinic to treat.

(C) **Encounter visits.**

(i) Encounter visits covers services provided to patients which are not part of the initial/annual examinations. This may include:

(I) A follow-up visit for all new patients to insure they understand and are experiencing no problems with their particular contraceptive method.
(II) A scheduled revisit for a new or continuing patient who may have conditions which places the patient in a high risk category requiring more intensive medical management as outlined in the program medical protocol.

(ii) Encounter visits may also be scheduled at the request of the patient as they are encouraged to return to the clinic at any time they experience difficulty with a particular contraceptive method or have concerns related to their reproductive health. Pregnancy diagnosis and counseling services are also provided under this category.

(D) **Vasectomy.** For vasectomies, payment will be made as an all-inclusive rate for all services provided in connection with the surgery. Claims must have the Federally mandated consent form properly completed and attached.
(E) **Tubal ligations.** For tubal ligations, payment will be made as an all-inclusive rate for the cost of the surgeon, anesthesiologist, pre and post operative care and outpatient surgery facility. Claims must have the properly completed Federally mandated consent form attached.

(2) **Children.** Payment is made for children as set forth for adults. However payment cannot be made for the sterilization of persons under the age of 21.
(3) **Individuals eligible for Part B of Medicare.** Payment is made utilizing the Medicaid allowable for comparable services. Claims for services which are not covered by Medicare should be filed directly with the Fiscal Agent for payment within the scope of the program.

317:30-5-467. Coverage limitations [REVOKED]

(a) Sterilizations require proper consent form and are not compensable for patients under 21 years of age.
(b) The following coverage limitations apply to services provided by family planning centers:

(1) Service: Initial Examination; Unit: Completed Examination and Services; Limitation: one initial examination.
(2) Service: Annual; Unit: Completed Examination and Services; Limitation: one annual examination.
(3) Service: Encounter Visit; Unit: Completed Examination and Services; Limitation: one per day.

~~(4) Service: Vasectomy; Unit: Completed Examination and Services; Limitation: one each (required consent restricted to persons age 21 and over, at time consent form is signed).~~
~~(5) Service: Tubal Ligation; Unit: Completed Examination and Services; Limitation: one each (required consent restricted to persons age 21 and over, at time consent form is signed).~~

PART 75. FEDERALLY QUALIFIED HEALTH CENTERS

317:30-5-664.5. Health Center encounter exclusions and limitations

(a) Service limitations governing the provision of all services apply pursuant to OAC 317:30. Excluded from the definition of reimbursable encounter core services are:

(1) Services provided by an independently CLIA certified and enrolled laboratory.

(2) Radiology services including nuclear medicine and diagnostic ultrasound services.

(3) Venipuncture for lab tests is considered part of the encounter and cannot be billed separately. When a member is seen at the clinic for a lab test only, use the appropriate CPT code. A visit for "lab test only" is not considered a Center encounter.

(4) Durable medical equipment or medical supplies not generally provided during the course of a Center visit such as diabetic supplies. However, gauze, band-aids, or other disposable products used during an office visit are considered as part of the cost of an encounter and cannot be billed separately under SoonerCare.

(5) Supplies and materials that are administered to the member are considered a part of the physician's or other health care practitioner's service.

(6) Drugs or medication treatments provided during a clinic visit are included in the encounter rate. For example, a member has come into the Center with high blood pressure and is treated at the Center with a hypertensive drug or drug samples provided to the Center free of charge are not reimbursable services and are included in the cost of an encounter. Prescriptions are not included in the encounter rate and must be billed through the pharmacy program by a qualified enrolled pharmacy.

(7) Administrative medical examinations and report services;

(8) Emergency services including delivery for pregnant members that are eligible under the Non-Qualified (ineligible) provisions of OAC 317:35-5-25;

(9) ~~Family~~ SoonerPlan family planning services ~~provided to individuals enrolled in the Family Planning Waiver~~;

(10) Optometry and podiatric services other than for dual eligible for Part B of Medicare;

(11) Other services that are not defined in this rule or the State Plan.

(b) In addition, the following limitations and requirements apply to services provided by Health Centers:

(1) Physician services are not covered in a hospital.

(2) Behavioral health case management and psychosocial rehabilitation services are limited to Health Centers enrolled under the provider requirements in OAC 317:30-5-240, and 317:30-5-595 and contracted with OHCA as an outpatient behavioral health agency.

PART 112. PUBLIC HEALTH CLINIC SERVICES

317:30-5-1154. CHD/CCHD services/limitations

CHD/CCHD service limitations are:

(1) Child Guidance services (see OAC 317:30-3-65 through OAC 317:30-3-5-65.11 for specifics regarding program requirements).

(2) Dental services [OAC 317:30-3-65.4(7)].

(3) Early Periodic Screening, Diagnosis, and Treatment services (including blood lead testing and follow-up services) (see OAC 317:30-3-65 through OAC 30-3-65.11 for specific coverage).

(4) Environmental investigations.

(5) Family Planning ~~services~~ and ~~Family Planning Waiver Services~~ SoonerPlan Family Planning services (see ~~OAC 317:30-5-465 through OAC 317:30-5-467~~ OAC 317:30-5-12 for specific coverage and ~~limitations~~ guidelines).

(6) Immunizations (adult and child).

(7) Blood lead testing (see OAC 317:30-3-65.4 for specific coverage).

(8) Newborn hearing screening.

(9) Newborn metabolic screening.

(10) Maternity services (see OAC 317:30-5-22 for specific coverage).

(11) Public health nursing services.

(12) Tuberculosis case management and directly observed therapy.

(13) Laboratory services.

(14) Targeted case management.

CHAPTER 35. MEDICAL ASSISTANCE FOR ADULTS AND CHILDREN-ELIGIBILITY
SUBCHAPTER 5. ELIGIBILITY AND COUNTABLE INCOME
PART 1. DETERMINATION OF QUALIFYING CATEGORICAL RELATIONSHIPS

317:35-5-2. Categorically related programs

(a) Categorical relationship is established using the same definitions of age, disability and blindness as used by the Social Security Administration (SSA) in determining eligibility for Supplemental Security Income (SSI) or SSA benefits. If the individual is a SSA/SSI recipient in current payment status (including presumptive eligibility), a TANF recipient, or is under age 19, categorical relationship is automatically established. Categorical relationship to pregnancy-related services is established when the determination is made by medical evidence that the individual is or has been pregnant. Pregnancy-related services include all medical services provided within the scope of the program during the prenatal, delivery and postpartum periods. For an individual age 19 or over to be related to AFDC, the individual must have a minor dependent child. Categorical relationship to Refugee services is established in accordance with OAC 317:35-5-25. Categorical relationship for the Breast and Cervical Cancer Treatment program is established in accordance with OAC 317:35-21. Categorical relationship for the SoonerPlan Family Planning ~~Waiver~~ Program is established in accordance with OAC 317:35-5-8. Categorical relationship for pregnancy related benefits covered under Title XXI is established in accordance with OAC 317:35-22. Benefits for pregnancies covered under Title XXI medical services are provided within the scope of the program during the prenatal, delivery and postpartum care when included in the global delivery payment. To be eligible for SoonerCare benefits, an individual must be related to one of the following:

(1) Aged

(2) Disabled

(3) Blind
(4) Pregnancy
(5) Aid to Families with Dependent Children
(6) Refugee
(7) Breast and Cervical Cancer Treatment program
(8) SoonerPlan Family Planning ~~Waiver~~ Program
(9) Benefits for pregnancies covered under Title XXI.

(b) The Authority may provide SoonerCare to reasonable categories of individuals under age 21 who are not receiving cash assistance under any program but who meet the income requirement of the State's approved AFDC plan.

(1) Individuals eligible for SoonerCare benefits include individuals between the ages of 19 and 21:

(A) for whom a public agency is assuming full or partial financial responsibility who are in custody as reported by the Oklahoma Department of Human Services (OKDHS) and in foster homes, private institutions or public facilities; or

(B) in adoptions subsidized in full or in part by a public agency; or

(C) individuals under age 21 receiving active treatment as inpatients in public psychiatric facilities or programs if inpatient psychiatric services for individuals under age 21 are provided under the State Plan and the individuals are supported in full or in part by a public agency; or

(2) Individuals eligible for SoonerCare benefits include individuals between the ages of 18 and 21 if they are in custody as reported by OKDHS on their 18th birthday and living in an out of home placement.

317:35-5-8. Determining categorical relationship for the SoonerPlan Family Planning ~~Waiver~~ Program

All ~~uninsured~~ non-pregnant women and men ages 19 and older, ~~who have not undergone a sterilization procedure~~, regardless of pregnancy or paternity history, with family income at or below 185% of the federal poverty level and who are otherwise ineligible for SoonerCare ~~benefits~~ are categorically related to the SoonerPlan Family Planning ~~Waiver~~ Program. If eligible for SoonerCare benefits, the individual can choose to enroll only in ~~the Family Planning Waiver Program~~ SoonerPlan with the option of applying for SoonerCare at any time.

SUBCHAPTER 7. MEDICAL SERVICES
PART 5. DETERMINATION OF ELIGIBILITY FOR MEDICAL SERVICES

317:35-7-37. Financial eligibility of individuals categorically related to AFDC, or pregnancy-related services ~~or Family Planning Waiver Program~~

~~(a)~~ AFDC and/or pregnancy-related services.

(1) In determining financial eligibility for an individual related to AFDC or pregnancy-related services, the income of the following persons (if living together or if living apart as long as there has been no break in the family relationship) are considered. These persons include:

(A) the individual;

(B) the spouse of the individual;

(C) the biological or adoptive parent(s) of the individual who is a minor dependent child. Income of the stepparent of the minor dependent child is determined according to OAC 35-10-

26(a)(8);

(D) minor dependent children of the individual if the children are being included in the case for Medicaid. If the individual is 19 years or older and not pregnant, at least one minor dependent child must be living in the home and included in the case for the individual to be categorically related to AFDC;

(E) blood related siblings, of the individual who is a minor child, if they are included in the case for Medicaid;

(F) a caretaker relative and spouse (if any) and minor dependent children when the caretaker relative is to be included for coverage.

(2) The family has the option to exclude minor dependent children or blood related siblings see [OAC 317:35-7-37(1)(D) and (E)] and their income from the eligibility process. However, for the adult to be eligible, at least one minor child and his/her income [see OAC 317:35-7-37(a)(4)] must be included in the case. ~~The worker has the responsibility to inform the family of the most advantageous consideration in regard to coverage and income.~~ When determining financial eligibility for an individual related to AFDC or pregnancy-related services, consideration is not given to income of any person who is aged, blind or disabled and is determined to be categorically needy.

(3) An individual categorized as aged, blind, or disabled who is not an SSI recipient has an option to be categorically related to either AFDC or ABD. The individual may be included in the AFDC related benefit group pending determination of eligibility for ABD or SSI if all eligibility requirements are met.

(4) An individual who receives SSI cannot be included in the AFDC related benefit group. When the only dependent child is receiving SSI, the natural or adoptive parent(s) or caretaker relative may be related to AFDC if all other factors of eligibility are met. The benefit group will consist of the adult(s) only. Applicants and ~~recipients~~ members are informed of their responsibility to report to the OKDHS if any member of the benefit group makes application for SSI or becomes eligible for SSI.

~~(b) **Family Planning Program.** In determining financial eligibility for the FPW program the income of the individual and spouse (if any) is considered. The individual has the option to include or exclude minor dependent children and their income in the eligibility process. The worker has the responsibility to inform the individual of the most advantageous consideration in regard to coverage and income.~~

317:35-7-48. Eligibility for the SoonerPlan Family Planning ~~Waiver~~ Program

(a) ~~Women~~ Non-pregnant women and men ages 19 and above are eligible to receive family planning services if they meet all of the conditions of eligibility in paragraphs (1), (2), (3), and (4) of this Subsection. This is regardless of pregnancy or paternity history and includes women who gain eligibility for SoonerCare family planning services due to a pregnancy, but whose eligibility ends 60 days postpartum.

(1) The countable income is at or below 185% of the federal poverty level. The standard deduction for work related expenses such as income tax payments, Social Security taxes, and transportation to and from work, is $240 per each full-time or part-time employed member of the benefit group. Deductions for work related expenses for self-employed individuals are found at OAC 317:35-10-26(b)(1).

(2) In determining financial eligibility for the SoonerPlan Family Planning program the income of the individual and spouse (if any) is considered. The individual has the option to include or exclude minor dependent children and their income in the eligibility process.

(3) SoonerPlan members with minor dependent children and a parent absent from the home are required to cooperate with the Oklahoma Department of Human Services, Child Support Services Division (OCSS) in the collection of child support payments. Federal regulations provide a waiver of this requirement when cooperation is not in the best interest of the child.

~~(2)~~ (4) Individuals eligible for SoonerCare can choose to enroll only in the SoonerPlan Family Planning ~~Waiver~~ Program with the option of applying for SoonerCare at any time.

~~(3)~~ (5) ~~The individual is uninsured~~. Persons who have Medicare or creditable health insurance coverage are not ~~eligible~~ precluded from applying for the SoonerPlan Family Planning ~~Waiver~~ program. ~~A stand alone policy such as dental, vision or pharmacy is not considered creditable health insurance coverage.~~

~~(4) The individual has not undergone a sterilization procedure.~~

(b) All health insurance is listed on the OKDHS computer system in order for OHCA Third Party Liability Unit to verify insurance coverage. The OHCA is the payer of last resort.

(c) Income for the SoonerPlan Family Planning ~~Waiver~~ Program does not require verification, unless questionable. If the income is questionable the worker must verify the income.

(d) There is not an asset test for the SoonerPlan Family Planning ~~Waiver~~ Program.

PART 7. CERTIFICATION, REDETERMINATION AND NOTIFICATION

317:35-7-60. Certification for ~~Medical Services~~ SoonerCare

(a) The rules in this Section apply to all categories of eligibles **EXCEPT**:

(1) categorically needy SoonerCare ~~Health Benefit recipients~~ members who are categorically related to AFDC or Pregnancy Related Services, AND

(2) who if eligible, would be enrolled in SoonerCare, or

(3) individuals categorically related to the Family Planning ~~Waiver~~ Program.

(b) An individual determined eligible for ~~Medical Services~~ SoonerCare may be certified for a medical service provided on or after the first day of the third month prior to the month of application if all eligibility criteria are met during the three month period. The certification period is determined beginning with the month the medical service was received or expected to be received or the month of application for categorically needy cases in which a medical service has not been received. The period of certification may cover retroactive or future months. ~~Assignment of the certification period is dependent on the categorical relationship. Form MA-2, Medical Assistance Computation Work Sheet, is used to determine the certification period. The certification period in family cases is assigned for the shortest period of eligibility determined for any individual in the case.~~

(1) **Certification as categorically needy**. A categorically needy individual who is categorically related to ABD is assigned a

certification period of 12 months. A categorically needy individual who is determined eligible for a State Supplemental Payment (SSP) is certified effective the month of application. If the individual is also eligible for payment for medical services received during the three months preceding the month of application, the ~~Medicaid~~ SoonerCare benefit is certified for the appropriate months. If the individual is not eligible for SSP, the first month of certification is the month that a medical service was provided or, if no medical service was provided, the month of application.

(A) **Certification of individuals categorically needy and categorically related to ABD**. The certification period for the individual categorically related to ABD can be assigned for up to 12 months. The individual must be determined as categorically needy for each month of the certification period. The certification period is 12 months unless the individual:

(i) is certified as eligible in a money payment case during the 12 month period;

(ii) is certified for long-term care during the 12 month period;

(iii) becomes ineligible for medical assistance after the initial month;

(iv) becomes ineligible as categorically needy; or

(v) is deceased.

(B) **Certification period**. If any of the situations listed in subparagraph (A) of this paragraph occur after the initial month, the case is closed by the worker.

(i) If income and/or resources change after certification causing the case to exceed the categorically needy maximums, the case is closed.

(ii) A pregnant individual included in an ABD case which closes continues to be eligible for pregnancy related services through the postpartum period.

(2) **Certification of individuals categorically related to ABD and eligible as Qualified Medicare Beneficiaries Plus**. The ~~Medicaid~~ SoonerCare benefit may be certified on the first day of the third month prior to the month of application or later. If the individual receives Medicare and is eligible for SSP, the effective date of certification for the Medicare Part B premium buy-in is the month of certification for SSP. If the individual receives Medicare and is not eligible for SSP, the effective date of certification for the Medicare Part B premium buy-in is the first day of the month following the month in which the eligibility determination is made (regardless of when application was made).

(A) An individual determined eligible for QMBP benefits is assigned a certification period of 12 months. At any time during the certification period that the individual becomes ineligible, the case is closed using regular negative action procedures.

(B) At the end of the certification period a redetermination of QMBP eligibility is required, using the same forms and procedures as for ABD categorically needy individuals.

(3) **Certification of individuals categorically related to ABD and eligible as Qualified Disabled and Working Individual**. The Social Security Administration is responsible for referrals of individuals potentially eligible for QDWI. Eligibility factors verified by the SSA are Medicare Part A eligibility and discontinuation of

disability benefits due to excessive earnings. When the OKDHS State Office receives referrals from SSA the county will be notified and is responsible for obtaining an application and establishing other factors of eligibility. If an individual contacts the county office stating he/she has been advised by SSA that ~~they are~~ he/she is a potential QDWI, the county takes a ~~Medicaid~~ SoonerCare application. ~~If the individual does not have verification of eligibility factors determined by SSA, the county contacts OKDHS, FSSD, State Office, for assistance in verifying those factors. The verification will be obtained by OKDHS State Office and sent to the county office.~~ The effective date of certification for QDWI benefits is based on the date of application and the date all eligibility criteria, including enrollment for Medicare Part A, are met. For example, if an individual applies for benefits in October and is already enrolled in Medicare Part A, eligibility can be effective October 1 (or up to three months prior to October 1, if all eligibility criteria are met during the three month period). However, if in the example, the individual's enrollment for Part A is not effective until November 1, eligibility cannot be effective until that date. Eligibility can never be effective prior to July 1, 1990, the effective date of this provision. These cases will be certified for a period of 12 months. At the end of the 12-month period, eligibility redetermination is required. If the individual becomes ineligible at any time during the certification period, the case is closed. ~~The reason for closure is 69, and the worker completes the Notice to Client form.~~

(4) **Certification of individuals categorically related to ABD and eligible as Specified Low-Income Medicare Beneficiary (SLMB).** The effective date of certification of SLMB benefits may begin on the first day of the third month prior to the month of application or later. A certification can never be earlier than the date of entitlement of Medicare Part A. An individual determined eligible for SLMB benefits is assigned a certification period of 12 months. At any time during the certification period the individual becomes ineligible, the case is closed using standard negative action procedures. At the end of the certification period a redetermination of SLMB eligibility is required. A redetermination of SLMB eligibility must also be done at the same time a dually eligible individual has a redetermination of eligibility for other ~~Medicaid~~ SoonerCare benefits such as long-term care.

(5) **Certification of individuals categorically related to disability and eligible for TB related services.**

(A) An individual determined eligible for TB related services may be certified the first day of the third month prior to the month of application or later, but no earlier than the first day of the month the ~~as long as verification is received of a diagnosis of~~ TB infection is diagnosed.

(B) A certification period of 12 months will be assigned. At any time during the certification period that the individual becomes ineligible, the case is closed using the regular negative action procedures.

(C) At the end of the certification period a new application will be required if additional treatment is needed.

(6) **Certification of individuals categorically related to ABD and eligible as Qualifying Individuals.** The effective date of certification for the QI-1 may begin on the first day of the third month prior to the month of application or later. A certification

can never be earlier than the date of entitlement of Medicare Part A. An individual determined eligible for QI benefits is assigned a certification period of 12 months. At any time during the certification period the individual becomes ineligible, the case is closed using standard negative action procedures. At the end of the certification period, a redetermination of QI eligibility is required.

(A) Since the State's allotment to pay Medicare premiums for this group of individuals is limited, the State must limit the number of QIs so that the amount of assistance provided during the year does not exceed the State's allotment for that year.

(B) Persons selected to receive assistance are entitled to receive assistance with their Medicare premiums for the remainder of the federal fiscal year, but not beyond, as long as they continue to qualify. The fact that an individual is selected to receive assistance at any time during the year does not entitle the individual to continued assistance for any succeeding year.

(7) **Certification of individuals Related to Aid to the Disabled for TEFRA.** The certification period for individuals categorically related to the Disabled for TEFRA is 12 months.

317:35-7-60.1. Certification for the SoonerPlan Family Planning ~~Waiver~~ Program.

The effective date of certification for the SoonerPlan Family Planning ~~Waiver~~ Program is the date of application or later. The period of certification may not be for a retroactive period. An individual determined eligible for the SoonerPlan Family Planning ~~Waiver~~ Program is assigned a certification period of 12 months. At any time during the certification period the individual becomes ineligible, the case is closed using standard negative action procedures. At the end of the certification period, a redetermination of eligibility is required.

7.a-5 TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
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317:50-5-2. [AMENDED]
(Reference APA WF # 11-04 A, B, C & D)

SUMMARY: OHCA rules are revised to change language in policy that references "mental retardation" to "intellectual disabilities". Revisions are necessary to comply with Public Law 111-256 (Rosa's Law) that replaces the term mental retardation with intellectual disability, in federal education, health and labor laws

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

MEDICAL ADVISORY COMMITTEE: The Medical Advisory Committee considered the proposed rule revisions on November 16, 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 111-256

PUBLIC HEARING: A public hearing was held on February 22, 2012. Written comments were received before the public hearing regarding these changes and were considered during the rulemaking process.

SUBCHAPTER 3. GENERAL PROVIDER POLICIES
PART 3. GENERAL MEDICAL PROGRAM INFORMATION

317:30-3-40. Home and Community-Based Services Waivers for persons with <u>intellectual disabilities</u> ~~(mental retardation)~~ or certain persons with related conditions

(a) **Introduction to HCBS Waivers for ~~Persons~~ persons with intellectual disabilities.** The Medicaid Home and Community-Based Services (HCBS) Waiver programs are authorized in accordance with Section 1915(c) of the Social Security Act.

(1) Oklahoma Department of Human Services Developmental Disabilities Services Division (DDSD) operates HCBS Waiver programs for persons with ~~(mental retardation)~~ intellectual disabilities and certain persons with related conditions. Oklahoma Health Care Authority (OHCA), as the State's single Medicaid agency, retains and exercises administrative authority over all HCBS Waiver programs.

(2) Each waiver allows for the provision of specific SoonerCare-compensable services that assist members to reside in the community and avoid institutionalization.

(3) Waiver services:

(A) complement and supplement services available to members through the Medicaid State Plan or other federal, state, or local public programs, as well as informal supports provided by families and communities;

(B) can only be provided to persons who are Medicaid eligible, outside of a nursing facility, hospital, or institution; and

(C) are not intended to replace other services and supports available to members.

(4) Any waiver service must be:

(A) appropriate to the member's needs; and

(B) included in the member's Individual Plan (IP).

(i) The IP:

(I) is developed annually by the member's Personal Support Team, per OAC 340:100-5-52; and

(II) contains detailed descriptions of services provided, documentation of amount and frequency of services, and types of providers to provide services.

(ii) Services are authorized in accordance with OAC 340:100-3-33 and 340:100-3-33.1.

(5) DDSD furnishes case management, targeted case management, and services to members as a Medicaid State Plan service under Section 1915(g)(1) of the Social Security Act in accordance with OAC 317:30-5-1010 through 317:30-5-1012.

(b) **Eligible providers.** All providers must have entered into contractual agreements with OHCA to provide HCBS for persons with ~~mental retardation~~ an intellectual disability or related conditions.

(c) **Coverage.** All services must be included in the member's IP. Arrangements for services must be made with the member's case

317:30-3-42. Services in a Nursing Facility (NF)

Nursing facility services are those services furnished pursuant to a physician's orders which require the skills of technical or professional personnel, e.g., registered nurses, licensed practical nurses, physical therapists, occupational therapists, speech pathologists or audiologists. This care is provided by nursing facilities licensed under State law to provide, on a regular basis, health related care and services to individuals who do not require hospitalization but whose physical or mental condition requires care and services above the level of room and board which can be made available to them only through a nursing facility.

(1) To be eligible for nursing facility services the individual must:

(A) Require a treatment plan involving the planning and administration of services which require skills of licensed technical or professional personnel that are provided directly or under the supervision of such personnel and are prescribed by the physician;
(B) Have a physical impairment or combination of physical and mental impairments;
(C) Require professional nursing supervision (medication, hygiene and dietary assistance);
(D) Lack the ability to care for self or communicate needs to others; and
(E) Require medical care and treatment in a nursing facility to minimize physical health regression and deterioration. A physician's order and results from a standardized assessment which evaluates type and degree of disability and need for treatment must support the individual's need for NF level of care. Only standardized assessments approved by the OHCA and administered in accordance with Medicaid approved procedures shall be used to make the NF level of care determination.

(2) If the individual experiences mental illness or ~~mental retardation~~ an intellectual disability or a related condition, payment cannot be made for services in a nursing facility unless the individual has been assessed through the Preadmission Screening and Resident Review (PASRR) process and the appropriate MR or MI authority has determined that nursing facility services are required. If it is determined that the patient also requires specialized services, the state must provide or arrange for the provision of such services. These determinations must be made prior to the patient's admission to the nursing facility.

(3) Payment cannot be made for an individual who is actively psychotic or capable of imminent harm to self or others (i.e., suicidal or homicidal).

(4) Payment is made to licensed nursing facilities that have agreements with the Authority.

317:30-3-57. General SoonerCare coverage - categorically needy

The following are general SoonerCare coverage guidelines for the categorically needy:

(1) Inpatient hospital services other than those provided in an institution for mental diseases.
(A) Adult coverage for inpatient hospital stays as described at OAC 317:30-5-41.
(B) Coverage for members under 21 years of age is not limited. All admissions must be medically necessary. All psychiatric admissions require prior authorization for an approved length of stay.

(2) Emergency department services.

(3) Dialysis in an outpatient hospital or free standing dialysis facility.

(4) Outpatient therapeutic radiology or chemotherapy for proven malignancies or opportunistic infections.

(5) Outpatient surgical services - facility payment for selected outpatient surgical procedures to hospitals which have a contract with OHCA.

(6) Outpatient Mental Health Services for medical and remedial care including services provided on an outpatient basis by certified

hospital based facilities that are also qualified mental health clinics.
(7) Rural health clinic services and other ambulatory services furnished by rural health clinic.
(8) Optometrists' services - only as listed in Subchapter 5, Part 45, Optometrist specific rules of this Chapter.
(9) Maternity Clinic Services.
(10)Outpatient diagnostic x-rays and lab services. Other outpatient services provided to adults, not specifically addressed, are covered only when prior authorized by the agency's Medical Authorization Unit.
(11)Medically necessary screening mammography. Additional follow-up mammograms are covered when medically necessary.
(12)Nursing facility services (other than services in an institution for tuberculosis or mental diseases).
(13)Early and Periodic Screening, Diagnosis and Treatment Services (EPSDT) are available for members under 21 years of age to provide access to regularly scheduled examinations and evaluations of the general physical and mental health, growth, development, and nutritional status of infants, children, and youth. Federal regulations also require that diagnosis and treatment be provided for conditions identified during a screening whether or not they are covered under the State Plan, as long as federal funds are available for these services. These services must be necessary to ameliorate or correct defects and physical or mental illnesses or conditions and require prior authorization. EPSDT/OHCA Child Health services are outlined in OAC 317:30-3-65.2 through 317:30-3-65.4.

(A) Child health screening examinations for eligible children by a medical or osteopathic physician, physician assistant, or advanced practice nurse practitioner.
(B) Diagnostic x-rays, lab, and/or injections when prescribed by a provider.
(C) Immunizations.
(D) Outpatient care.
(E) Dental services as outlined in OAC 317:30-3-65.8.
(F) Optometrists' services. The EPSDT periodicity schedule provides for at least one visual screening and glasses each 12 months. In addition, payment is made for glasses for children with congenital aphakia or following cataract removal. Interperiodic screenings and glasses at intervals outside the periodicity schedule for optometrists are allowed when a visual condition is suspected.
(G) Hearing services as outlined in OAC 317:30-3-65.9.
(H) Prescribed drugs.
(I) Outpatient Psychological services as outlined in OAC 317:30-5-275 through OAC 317:30-5-278.
(J) Inpatient Psychotherapy services and psychological testing as outlined in OAC 317:30-5-95 through OAC 317:30-5-97.
(K) Transportation. Provided when necessary in connection with examination or treatment when not otherwise available.
(L) Inpatient hospital services.
(M) Medical supplies, equipment, appliances and prosthetic devices beyond the normal scope of SoonerCare.
(N) EPSDT services furnished in a qualified child health center.

(14) Family planning services and supplies for members of child-bearing age, including counseling, insertion of intrauterine device, implantation of subdermal contraceptive device, and sterilization for members 21 years of age and older who are legally competent, not institutionalized and have signed the "Consent Form" at least 30 days prior to procedure. Reversal of sterilization procedures for the purposes of conception is not covered. Reversal of sterilization procedures are covered when medically indicated and substantiating documentation is attached to the claim.
(15) Physicians' services whether furnished in the office, the member's home, a hospital, a nursing facility, ICF/MR, or elsewhere. For adults, payment is made for compensable hospital days described at OAC 317:30-5-41. Office visits for adults are limited to four per month except when in connection with conditions as specified in OAC 317:30-5-9(b).
(16) Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law. See applicable provider section for limitations to covered services for:
(A) Podiatrists' services
(B) Optometrists' services
(C) Psychologists' services
(D) Certified Registered Nurse Anesthetists
(E) Certified Nurse Midwives
(F) Advanced Practice Nurses
(G) Anesthesiologist Assistants
(17) Free-standing ambulatory surgery centers.
(18) Prescribed drugs not to exceed a total of six prescriptions with a limit of two brand name prescriptions per month. Exceptions to the six prescription limit are:
(A) unlimited medically necessary monthly prescriptions for:
(i) members under the age of 21 years; and
(ii)residents of Nursing Facilities or Intermediate Care Facilities for the Mentally Retarded.
(B) seven medically necessary generic prescriptions per month in addition to the six covered under the State Plan are allowed for adults receiving services under the 1915(c) Home and Community Based Services Waivers. These additional medically necessary prescriptions beyond the two brand name or thirteen total prescriptions are covered with prior authorization.
(19) Rental and/or purchase of durable medical equipment.
(20) Adaptive equipment, when prior authorized, for members residing in private ICF/MR's.
(21) Dental services for members residing in private ICF/MR's in accordance with the scope of dental services for members under age 21.
(22) Prosthetic devices limited to catheters and catheter accessories, colostomy and urostomy bags and accessories, tracheostomy accessories, nerve stimulators, hyperalimentation and accessories, home dialysis equipment and supplies, external breast prostheses and support accessories, oxygen/oxygen concentrator equipment and supplies, respirator or ventilator equipment and supplies, and those devices inserted during the course of a surgical procedure.
(23) Standard medical supplies.

(24) Eyeglasses under EPSDT for members under age 21. Payment is also made for glasses for children with congenital aphakia or following cataract removal.
(25) Blood and blood fractions for members when administered on an outpatient basis.
(26) Inpatient services for members age 65 or older in institutions for mental diseases, limited to those members whose Medicare, Part A benefits are exhausted for this particular service and/or those members who are not eligible for Medicare services.
(27) Nursing facility services, limited to members preauthorized and approved by OHCA for such care.
(28) Inpatient psychiatric facility admissions for members under 21 are limited to an approved length of stay effective July 1, 1992, with provision for requests for extensions.
(29) Transportation and subsistence (room and board) to and from providers of medical services to meet member's needs (ambulance or bus, etc.), to obtain medical treatment.
(30) Extended services for pregnant women including all pregnancy-related and postpartum services to continue to be provided, as though the women were pregnant, for 60 days after the pregnancy ends, beginning on the last date of pregnancy.
(31) Nursing facility services for members under 21 years of age.
(32) Personal care in a member's home, prescribed in accordance with a plan of treatment and rendered by a qualified person under supervision of a R.N.
(33) Part A deductible and Part B Medicare Coinsurance and/or deductible.
(34) Home and Community Based Waiver Services for the ~~mentally retarded~~ intellectually disabled.
(35) Home health services limited to 36 visits per year and standard supplies for 1 month in a 12-month period. The visits are limited to any combination of Registered Nurse and nurse aide visits, not to exceed 36 per year.
(36) Medically necessary solid organ and bone marrow/stem cell transplantation services for children and adults are covered services based upon the conditions listed in (A)-(D) of this paragraph:

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

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

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

(D) Finally, procedures considered experimental or investigational are not covered.

(37) Home and community-based waiver services for ~~mentally retarded~~ intellectually disabled members who were determined to be inappropriately placed in a NF (Alternative Disposition Plan - ADP).
(38) Case Management services for the chronically and/or severely mentally ill.
(39) Emergency medical services including emergency labor and delivery for illegal or ineligible aliens.
(40) Services delivered in Federally Qualified Health Centers. Payment is made on an encounter basis.

(41) Early Intervention services for children ages 0-3.
(42) Residential Behavior Management in therapeutic foster care setting.
(43) Birthing center services.
(44) Case management services through the Oklahoma Department of Mental Health and Substance Abuse Services.
(45) Home and Community-Based Waiver services for aged or physically disabled members.
(46) Outpatient ambulatory services for members infected with tuberculosis.
(47) Smoking and Tobacco Use Cessation Counseling for children and adults.
(48) Services delivered to American Indians/Alaskan Natives in I/T/Us. Payment is made on an encounter basis.
(49) OHCA contracts with designated agents to provide disease state management for individuals diagnosed with certain chronic conditions. Disease state management treatments are based on protocols developed using evidence-based guidelines.

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 6. INPATIENT PSYCHIATRIC HOSPITALS

317:30-5-96.2. Payments definitions

The following words and terms, when used in Sections OAC 317:30-5-96.3 through 317:30-5-96.7, shall have the following meaning, unless the context clearly indicates otherwise:

"Allowable costs" means costs necessary for the efficient delivery of member care.

"Ancillary Services" means the services for which charges are customarily made in addition to routine services. Ancillary services include, but are not limited to, physical therapy, speech therapy, laboratory, radiology and prescription drugs.

"Border Status" means a placement in a state that does not border Oklahoma but agrees to the same terms and conditions of instate or border facilities.

"Developmentally disabled child" means a child with deficits in adaptive behavior originating during the developmental period. This condition may exist concurrently with a significantly subaverage general intellectual functioning.

"Eating Disorders Programs" means acute or intensive residential behavioral, psychiatric and medical services provided in a discreet unit to individuals experiencing an eating disorder.

"Professional services" means services of a physician, psychologist or dentist legally authorized to practice medicine and/or surgery by the state in which the function is performed.

"Psychiatric Residential Treatment Facility (PRTF)" means a non-hospital with an agreement to provide inpatient psychiatric services to individuals under the age of 21.

"Routine Services" means services that are considered routine in the freestanding PRTF setting. Routine services include, but are not limited to:

(A) room and board;
(B) treatment program components;
(C) psychiatric treatment;
(D) professional consultation;
(E) medical management;

(F) crisis intervention;
(G) transportation;
(H) rehabilitative services;
(I) case management;
(J) interpreter services (if applicable);
(K) routine health care for individuals in good physical health; and
(L) laboratory services for a substance abuse/detoxification program.

"Specialty treatment program/specialty unit" means acute or intensive residential behavioral, psychiatric and medical services that provide care to a population with a special need or issues such as developmentally disabled, ~~mentally retarded~~ intellectually disabled, autistic/Asperger's, eating disorders, sexual offenders, or reactive attachment disorders. These members require a higher level of care and staffing ratio than a standard PRTF and typically have multiple problems.

"Treatment Program Components" means therapies, activities of daily living and rehabilitative services furnished by physician/psychologist or other licensed mental health professionals.

"Usual and customary charges" refers to the uniform charges listed in a provider's established charge schedule which is in effect and applied consistently to most members and recognized for program reimbursement. To be considered "customary" for reimbursement, a provider's charges for like services must be imposed on most members regardless of the type of member treated or the party responsible for payment of such services.

PART 9. LONG TERM CARE FACILITIES

317:30-5-122. Levels of care

(a) This rule sets forth the criteria used to determine whether an individual who is seeking SoonerCare payment for long term care services needs services at the level of Skilled Nursing Facility, or Intermediate Care Facility for People with Mental Retardation (ICF/MR). The criteria set forth in this Section must be used when determining level of care for individuals seeking SoonerCare coverage of either facility-based institutional long term care services or Home and Community Based Services (HCBS) Waivers.

(b) The level of care provided by a long term care facility or through a HCBS Waiver is based on the nature of the person's needs and the care, services, and treatment required from appropriately qualified personnel. The level of care review is a determination of an individual's physical, mental and social/emotional status to determine the appropriate level of care required. In addition to level of care requirements, other applicable eligibility criteria must be met.

(1) **Skilled Nursing facility.** When total payments from all other payers are less than the Medicaid rate, payment is made for the Part A coinsurance for Medicare covered skilled nursing facility care for dually eligible, categorically needy individuals.

(2) **Nursing Facility.** Care provided by a nursing facility to patients who require professional nursing supervision and a maximum amount of nonprofessional nursing care due to physical conditions or a combination of physical and mental conditions.

(3) **Intermediate Care Facility for the Mentally Retarded.** Care for persons with ~~mental retardation~~ intellectual disabilities or related

conditions to provide health and/or habilitative services in a protected residential setting. To qualify for ICF/MR level of care, persons must have substantial functional limitations in three or more of the following areas of major life activity:

(A) Self-care. The individual requires assistance, training or supervision to eat, dress, groom, bathe, or use the toilet.

(B) Understanding and use of language. The individual lacks functional communication skills, requires the use of assistive devices to communicate, does not demonstrate an understanding of request or is unable to follow two-step instructions.

(C) Learning. The individual has a valid diagnosis of intellectual disability ~~(mental retardation)~~ as defined in the Diagnostic and Statistical Manual of Mental Disorders.

(D) Mobility. The individual requires the use of assistive devices to be mobile and cannot physically self-evacuate from a building during an emergency without assistive device.

(E) Self-direction. The individual is 7 years old or older and significantly at risk in making age appropriate decisions or an adult who is unable to provide informed consent for medical care, personal safety or for legal, financial, habilitative or residential issues and/or has been declared legally incompetent. The individual is a danger to himself or others without supervision.

(F) Capacity for independent living. The individual who is 7 years old or older and is unable to locate and use a telephone, cross the street safely or understand that it is unsafe to accept rides, food or money from strangers or an adult who lacks basic skills in the areas of shopping, preparing food, housekeeping or paying bills.

PART 39. SKILLED NURSING SERVICES

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

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

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

(A) direct nursing care;

(B) assessment and documentation of health changes;

(C) documentation of significant observations;

(D) maintenance of nursing plans of care;

(E) medication administration;

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

(G) preventive and health care procedures; and

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

(2) The first 36 visits provided by the home health care agency are covered by the Medicaid State Plan.

(b) **Eligible providers**. Skilled nursing services providers must enter into contractual agreements with the Oklahoma Health Care Authority to

provide HCBS for adults with ~~mental retardation~~ an intellectual disability or certain adults with related conditions.

(1) Individual providers must be currently licensed in Oklahoma as a:

(A) registered nurse; or

(B) licensed practical nurse.

(2) Agency providers must:

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

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

PART 41. FAMILY SUPPORT SERVICES

317:30-5-410. Home and Community-Based Services Waivers for persons with ~~mental retardation~~ an intellectual disability or certain persons with related conditions

(a) The Oklahoma Health Care Authority (OHCA) administers Home and Community-Based Services (HCBS) Waivers for persons with ~~mental retardation~~ an intellectual disability and certain persons with related conditions that are operated by the Oklahoma Department of Human Services (OKDHS) Developmental Disabilities Services Division (DDSD). Each waiver allows payment for family support services as defined in the waiver approved by the Centers for Medicare and Medicaid Services (CMS). Waiver services:

(1) when utilized with services normally covered by SoonerCare, other generic services, and natural supports provide for health and developmental needs of members who otherwise would not be able to live in a home or community setting;

(2) are provided with the goal of promoting independence through strengthening the member's capacity for self-care and self-sufficiency;

(3) are centered on the needs and preferences of the member and support the integration of the member within his/her community; and

(4) do not include room and board. The costs associated with room and board must be met by the member.

(b) The DDSD case manager develops the Individual Plan (IP) and Plan of Care (Plan) per OAC 340:100-5-53. The IP contains descriptions of the services provided, documentation of the amount, frequency and duration of the services, and types of service providers.

(1) Services:

(A) are authorized per OAC 340:100-3-33 and 100-3-33.1.

(B) provided prior to the development of the IP or not included in the IP are not compensable. The Plan may not be backdated;

(C) may be provided on an emergency basis when approved by the area manager or designee. The plan must be revised to reflect the additional services; and

(D) are provided by qualified provider entities contracted with the OHCA.

(2) Members have freedom of choice of providers and in the selection of HCBS or institutional services.

PART 43. AGENCY COMPANION, SPECIALIZED FOSTER CARE, DAILY LIVING SUPPORTS, GROUP HOMES, AND COMMUNITY TRANSITION SERVICES

317:30-5-420. Home and Community-Based Services Waivers for persons with ~~mental retardation~~ an intellectual disability or certain persons with related conditions

The Oklahoma Health Care Authority (OHCA) administers Home and Community-Based Services (HCBS) Waivers for persons with ~~mental retardation~~ an intellectual disability and certain persons with related conditions that are operated by the Oklahoma Department of Human Services Developmental Disabilities Services Division (DDSD). The Community Waiver and Homeward Bound Waiver allow payment for residential supports as defined in the waiver approved by the Centers for Medicare and Medicaid Services (CMS).

317:30-5-423. Coverage limitations

(a) Coverage limitations for residential supports for members with ~~mental retardation~~ an intellectual disability are:

(1) Description: agency companion services (ACS); Unit: one day; Limitation: 366 units per year;

(2) Description: specialized foster care (SFC); Unit: one day; Limitation: 366 units per year;

(3) Description: daily living supports (DLS); Unit: one day; Limitation: 366 units per year; and

(4) Description: group home services; Unit: one day; Limitation: 366 units per year.

(b) Members may not receive ACS, SFC, DLS and group home services at the same time.

(c) Community transition services (CTS) are limited to $2,400 per eligible member.

(1) CTS is limited to one transition over the member's lifetime. If the member's situation changes after receipt of CTS and hospitalization or readmission to an intermediate care facility for the mentally retarded (ICF/MR) is necessary, CTS is not authorized upon transition back into the community.

(2) Members moving into a group home, SFC, or ACS arrangement in the companion's home are not eligible to receive CTS.

PART 51. HABILITATION SERVICES

317:30-5-480. Home and Community-Based Services for persons with ~~mental retardation~~ an intellectual disability or certain persons with related conditions

The Oklahoma Health Care Authority (OHCA) administers Home and Community-Based Services (HCBS) Waivers for persons with ~~mental retardation~~ intellectual disabilities or certain persons with related conditions that are operated by the Oklahoma Department of Human Services Developmental Disabilities Services Division (DDSD). Each waiver allows Medicaid compensable services provided to persons who are:

(1) medically and financially eligible; and

(2) not covered through the OHCA's SoonerCare program.

PART 53. SPECIALIZED FOSTER CARE

317:30-5-495. Home and Community-Based Services Waivers for persons with ~~mental retardation~~ an intellectual disability or certain persons with related conditions

(a) **Introduction to waiver services**. The Oklahoma Health Care Authority (OHCA) administers Home and Community-Based Services (HCBS) Waivers for persons with ~~mental retardation~~ an intellectual disability or certain persons with related conditions that are operated by Oklahoma Department of Human Services (OKDHS) Developmental Disabilities Services Division (DDSD). The Community Waiver and Homeward Bound Waiver allow payment for specialized foster care (SFC), also known as specialized family care, as defined in the waiver approved by Centers for Medicare and Medicaid Services.

(b) **Eligible providers**. All SFC providers must:

(1) enter into contractual agreements with the OHCA to provide HCBS for persons with ~~mental retardation~~ an intellectual disability or certain persons with related conditions;

(2) have an approved home profile per OAC 317:40-5-40;

(3) complete training per OAC 340:100-3-38;

(4) have the ability to implement the member's Individual Plan (IP); and

(5) be emotionally and financially stable, in good health, and of reputable character.

PART 55. RESPITE CARE

317:30-5-515. Home and Community-Based Services Waivers for persons with ~~mental retardation~~ an intellectual disability or certain persons with related conditions

The Oklahoma Health Care Authority administers Home and Community-Based Services (HCBS) Waivers for persons with ~~mental retardation~~ an intellectual disability or certain persons with related conditions that are operated by the Oklahoma Department of Human Services Developmental Disabilities Services Division. Each waiver allows payment for respite care as defined in the waiver approved by the Centers for Medicare and Medicaid Services.

PART 59. HOMEMAKER SERVICES

317:30-5-535. Home and Community-Based Services Waiver for persons with ~~mental retardation~~ an intellectual disability or certain persons with related conditions

(a) **Introduction to waiver services.** The Oklahoma Health Care Authority (OHCA) administers Home and Community-Based Services (HCBS) Waivers for persons with ~~mental retardation~~ an intellectual disability or certain persons with related conditions that are operated by the Oklahoma Department of Human Services Developmental Disabilities Services Division. Each waiver allows payment for homemaker or homemaker respite services as defined in the waiver approved by the Centers for Medicare and Medicaid Services.

(b) **Eligible providers**. All homemaker services providers must enter into contractual agreements with the OHCA to provide HCBS for persons with ~~mental retardation~~ an intellectual disability or related conditions.

PART 85. ADVANTAGE PROGRAM WAIVER SERVICES

317:30-5-760. ADvantage program

The ADvantage Program is a Medicaid Home and Community Based Services (HCBS) Waiver used to finance noninstitutional long-term care

services through Oklahoma's Medicaid program for elderly and disabled individuals. To receive ADvantage Program services, individuals must meet the nursing facility (NF) level of care (LOC) criteria, be age 65 years or older, or age 21 or older if physically disabled and not developmentally disabled, or if developmentally disabled and between the ages of 21 and 65, not have ~~mental retardation~~ an intellectual disability or a cognitive impairment related to the developmental disability. ADvantage Program recipients must be Medicaid eligible. The number of recipients of ADvantage services is limited.

PART 101. TARGETED CASE MANAGEMENT SERVICES FOR PERSONS WITH ~~MENTAL RETARDATION~~ AN INTELLECTUAL DISABILITY AND/OR RELATED CONDITIONS

317:30-5-1011. Coverage by category

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

(1) **Adults.** Payment is made for services to persons with ~~mental retardation~~ an intellectual disability and/or related conditions as follows:

(A) The target group for Developmental Disabilities Services Division Targeted Case Management (DDSDTCM) services are Medicaid eligible individuals:

(i) served by the Home and Community Based Waivers operated by the Department of Human Services/Developmental Disabilities Services Division (DHS/DDSD); or

(ii) residing in institutions who:

(I) have requested Home and Community Based Waiver services operated by DHS/DDSD, and

(II) receive targeted case management services during a transition period not to exceed 180 consecutive days immediately prior to entering the Waiver; or

(iii) who are being assessed for admission to the Home and Community Based Waiver operated by DHS/DDSD.

(B) Targeted case management services may be provided when the client, the client's family as appropriate, the client's legal representative and case manager have worked together to achieve a plan.

(2) **Children.** Services for children are the same as for adults.

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

317:30-5-1076. Coverage by category

Payment is made for Nutritional Services as set forth in this section.

(1) **Adults.** Payment is made for six hours of medically necessary nutritional counseling per year by a licensed registered dietician. All services must be prescribed by a physician, physician assistant, advanced practice nurse, or nurse midwife and be face to face encounters between a licensed registered dietitian and the member. Services must be expressly for diagnosing, treating or preventing, or minimizing the effects of illness. Nutritional services for the treatment of obesity is not covered unless there is documentation that the obesity is a contributing factor in another illness.

(2) **Children.** Payment is made for medically necessary nutritional counseling as described above for adults. Nutritional services for the treatment of obesity may be covered for children as part of the EPSDT benefit. Additional services which are deemed medically necessary and allowable under federal regulations may be covered by the EPSDT benefit found at 317:30-3-65 and 317:30-3-65.11.

(3) **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 OHCA to provide Nutrition Services under this program. All services are specified in the individual's plan of care.

(4) **Individuals eligible for Part B of Medicare.** Payment is made utilizing the Medicaid allowable for comparable services. Services which are not covered under Medicare should be billed directly to OHCA.

(5) **Obstetrical patients.** Payment is made for a maximum of six hours of medically necessary nutritional counseling per year by a licensed registered dietitian for members at risk for or those who have been recently diagnosed with gestational diabetes. The initial consultation may be in a group setting for a maximum of two hours of class time. Thereafter, four hours of nutritional counseling by a licensed registered dietitian may be provided to the individual if deemed medically necessary, which may include a post-partum visit, typically done at 6 weeks after delivery. All services must be prescribed by a physician, physician assistant, advanced practice nurse or a nurse midwife and be face-to-face between a licensed registered dietitian and the member(s). Services must be solely for the prevention, diagnosis, or treatment of gestational diabetes.

CHAPTER 35. MEDICAL ASSISTANCE FOR ADULTS AND CHILDREN-ELIGIBILITY

SUBCHAPTER 9. ICF/MR, HCBW/MR, AND INDIVIDUALS AGE 65 OR OLDER IN MENTAL HEALTH HOSPITALS

PART 1. SERVICES

317:35-9-1. Overview of long-term medical care services; relationship to QMB, SLMB, and other Medicaid services eligibility, and spenddown calculation

(a) **Long Term Medical Care Services**. Long-term medical care for the categorically needy includes care in a nursing facility (refer to OAC 317:35-19), public and private intermediate care facility for the mentally retarded (refer to this subchapter), persons age 65 years or older in mental health hospitals (refer to this subchapter), Home and Community Based Waiver Services for the ~~Mentally Retarded~~ Intellectually Disabled (refer to this subchapter), and Home and Community Based Waiver Services for frail elderly and a targeted group of adults with physical disabilities age 21 and over who have not been determined to have a developmental disability, ~~mental retardation~~ an intellectual disability or a related condition (refer to OAC 317:35-17). Personal Care provides services in the own home for categorically needy individuals (refer to OAC 317:35-15). Any time an individual is certified as eligible for Medicaid coverage of long-term care, the individual is also eligible for other Medicaid services. Another application or additional spenddown computation is not required. Spenddown is applied to the first long-term care claim filed. Any time

an aged, blind or disabled individual is determined eligible for long-term care, a separate determination must be made to see if eligibility conditions as a Qualified Medicare Beneficiary (QMB) or Specified Low-Income Medicare Beneficiary (SLMB) are met. Another application for QMB or SLMB benefits is not required. Any spenddown computed for long-term care is not applicable to QMB or SLMB coverage.
(b) **Medicaid recovery.** The State of Oklahoma operates a Medicaid Recovery program to recover for services identified in OAC 317:35-9-15. Recovery can be accomplished in two ways: liens against real property or claims made against estates.

317:35-9-5. Home and Community - Based Services (HCBS) Waivers for persons with intellectual disabilities ~~(mental retardation)~~ or certain persons with related conditions
(a) Home and Community Based Services (HCBS) Waivers for persons with intellectual disabilities ~~(mental retardation)~~ or certain persons with related conditions are operated by the Oklahoma Department of Human Services (OKDHS) Developmental Disabilities Services Division (DDSD) per OAC 317:40-1-1. Oklahoma's Medicaid agency, the Oklahoma Health Care Authority (OHCA), provides oversight of Waiver operation. HCBS Waivers allow the OHCA to offer certain home and community based services to categorically needy members who, without such services, would be eligible for care in an Intermediate Care Facility for persons with Mental Retardation (ICF/MR).
(b) Members receiving HCBS Waiver services per OAC 317:40-1-1 are subject to HCBS Waiver service conditions (1)-(11) of this subsection. The rules in this subsection shall not be construed as a limitation of the rights of class members set forth in the Second Amended Permanent Injunction in Homeward Bound vs. The Hissom Memorial Center.
(1) HCBS Waiver services are subject to annual appropriations by the Oklahoma Legislature.
(2) DDSD must limit the utilization of the HCBS Waiver services based on:
(A) the federally-approved member capacity for the individual HCBS Waivers; and
(B) the cost effectiveness of the individual HCBS Waivers as determined according to federal requirements; and
(3) DDSD must limit enrollment when utilization of services under the HCBS Waiver programs is projected to exceed the spending authority.
(4) Members receiving Waiver services must have full access to State plan services for which they are eligible including Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services when children participate in a Waiver.
(5) A member's room and board expenses may not be paid through a Waiver. Room and board expenses must be met from member resources or through other sources.
(6) A member must require at least one Waiver service per month or monthly case management monitoring in order to function in the community.
(7) Waiver services required by a member must be documented in advance of service delivery in a written plan of care.
(8) Members exercise freedom of choice by choosing Waiver services instead of institutional services.
(9) Members have the right to freely select from among any willing and qualified provider of Waiver services.

(10) The average costs of providing Waiver and non-Waiver SoonerCare services must be no more costly than the average costs of furnishing institutional (and other SoonerCare state plan) services to persons who require the same level of care.

(11) Members approved for services provided in a specific Waiver must be afforded access to all necessary services offered in the specific Waiver if the member requires the service.

PART 3. APPLICATION PROCEDURES

317:35-9-25. Application for ICF/MR, ~~HCBW/MR~~ HCBW/ID, and persons aged 65 or over in mental health hospitals.

(a) **Application procedures for long-term medical care**. An application for these types of services consists of the Medical Assistance Application. The Medical Assistance Application is signed by the patient, parent, spouse, guardian or someone else acting on the patient's behalf.

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

(2) At the request of an individual in an ICF/MR or receiving Home and Community Based Waiver Services for the ~~Mentally Retarded~~ Intellectually Disabled or the community spouse, if application for Medicaid is not being made, an assessment of the resources available to each spouse is made by use of DHS Form MA-11, Assessment of Assets. Documentation of resources must be provided by the individual and/or spouse. This assessment reflects all countable resources of the couple (owned individually or as a couple) and establishes the spousal share to be protected when subsequent determination of Medicaid eligibility is made. A copy of Form MA-11 is provided to each spouse for planning in regard to future eligibility. A copy is retained in the county office in case of subsequent application.

(3) If assessment by Form MA-11 was not done at the time of entry into the ICF/MR or ~~HCBW/MR~~ HCBW/ID services, assessment by use of Form MA-11 must be done at the time of application for Medicaid. The spousal share of resources is determined in either instance for the month of entry into the ICF/MR or ~~HCBW/MR~~ HCBW/ID services. If the individual applies for Medicaid at the time of entry into the ICF/MR or ~~HCBW/MR~~ HCBW/ID services, Form MA-11 is not appropriate. However, the spousal share must be determined using the resource information provided on the Medicaid application form and computed using DHS Form MA-12, Title XIX Worksheet.

(b) **Date of application**. When application is made in the county office the date of application is the date the applicant or someone acting on his/her behalf signs the application form. When the application is initiated outside the county office, the date of application is the date the application is stamped into the county office. When a request for Medicaid is first made by an oral request, and the application form is signed later, the date of the oral request is entered in "red" above the date the form is signed. The date of the oral request is the date of application.

PART 5. DETERMINATION OF MEDICAL ELIGIBILITY FOR ICF/MR, HCBW/MR, AND INDIVIDUALS AGE 65 OR OLDER IN MENTAL HEALTH HOSPITALS

317:35-9-45. Determination of medical eligibility for care in a private Intermediate Care Facility for Persons with Mental Retardation

(a) **Pre-approval of medical eligibility**. Pre-approval of medical eligibility for private ICF/MR care is based on level of care requirements per OAC 317:30-5-122. Pre-approval is not necessary for individuals with a severe or profound intellectual disability ~~(mental retardation)~~. Pre-approval is made by Oklahoma Health Care Authority (OHCA) Level of Care Evaluation Unit (LOCEU) analysts.

(b) **Application for ICF/MR services.** Within 30 calendar days after services begin, the facility must submit:

(1) the original of the ICF/MR Level of Care Assessment form (LTC-300) to LOCEU. Required attachments include:

(A) Current (within 90 days of requested approval date) medical information signed by a physician.

(B) A current (within 12 months of requested approval date) psychological evaluation by a licensed Psychologist or State staff supervised by a licensed Psychologist. The evaluation must include intelligence testing that yields a full-scale intelligence quotient, a full-scale functional or adaptive assessment, as well as the age of onset.

(C) A copy of the pertinent section of the Individual Plan or other appropriate documentation relative to the ICF/MR admission and the need for ICF/MR level of care.

(D) A statement that the member is not an imminent threat of harm to self or others (i.e., suicidal or homicidal).

(2) If pre-approval was determined by LOCEU and the above information is received, medical approval will be entered on an electronic medical case list known as MEDATS. Pre-approval is not needed for individuals with a severe or profound intellectual disability ~~(mental retardation)~~.

(c) **Categorical relationship**. Categorical relationship must be established for determination of eligibility for long-term medical care. If categorical relationship has not already been established, the proper forms and medical information are submitted to LOCEU. (Refer to OAC 317:35-5-4). In such instances LOCEU will render a decision on categorical relationship using the same definition as used by the with SSA. A follow-up is required by the OKDHS social worker with the SSA to be sure that their disability decision agrees with the decision of LOCEU.

(d) **Medical eligibility for ICF/MR services.**

(1) Individuals must require active treatment per 42 CFR 483.440.

(2) Individuals must have a diagnosis of intellectual disability ~~(mental retardation)~~ or a related condition based on level of care requirements per OAC 317:30-5-122 and results of a current comprehensive psychological evaluation by a licensed Psychologist or State staff supervised by a licensed Psychologist.

(A) Per the Diagnostic and Statistical Manual of Mental Disorders, intellectual disability ~~(mental retardation)~~ is a condition characterized by a significantly sub-average general intellectual functioning existing concurrently with deficits in adaptive behavior and originating before 18 years of age.

(B) Per 42 CFR 435.1010, persons with related conditions means individuals who have a severe, chronic disability that meets the following conditions:

(i) It is attributable to cerebral palsy or epilepsy; or

(ii) it is attributable to any other condition, other than mental illness, found to be closely related to intellectual disability ~~(mental retardation)~~ because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of persons with intellectual disability ~~(mental retardation)~~ and requires treatment or services similar to those required for these persons.

(iii) It is manifested before the person reaches age 22.

(iv) It is likely to continue indefinitely.

(v) It results in substantial functional limitations in three or more areas of major life activity per OAC 317:30-5-122.

(C) Conditions closely related to intellectual disability ~~(mental retardation)~~ include, but are not limited to the following:

(i) autism or autistic disorder, childhood disintegrative disorder, Rett syndrome and pervasive developmental disorder, not otherwise specified (only if "typical autism");

(ii)severe brain injury (acquired brain injury, traumatic brain injury, stroke, anoxia, meningitis);

(iii) fetal alcohol syndrome;

(iv) chromosomal disorders (Down syndrome, fragile x syndrome, Prader-Willi syndrome);and

(v) other genetic disorders (Williams syndrome, spina bifida, phenylketonuria).

(D) The following diagnoses do not qualify as conditions related to intellectual disability.~~(mental retardation)~~ Nevertheless, a person with any of these conditions is not disqualified if there is a simultaneous occurrence of a qualifying condition:

(i) learning disability;

(ii) behavior or conduct disorders;

(iii) substance abuse;

(iv) hearing impairment or vision impairment;

(v) mental illness that includes psychotic disorders, adjustment disorders, reactive attachment disorders, impulse control disorders, and paraphilias;

(vi) borderline intellectual functioning, developmental disability that does not result in an intellectual impairment, developmental delay or "at risk" designations;

(vii) physical problems (such as multiple sclerosis, muscular dystrophy, spinal cord injuries and amputations);

(viii) medical health problems (such as cancer, acquired immune deficiency syndrome and terminal illnesses);

(ix) milder autism spectrum disorders (such as Asperger's disorder and pervasive developmental disorder not otherwise specified if not "atypical autism");

(x) neurological problems not associated with intellectual deficits (such as Tourette's syndrome, fetal alcohol effects and non-verbal learning disability);or

(xi) mild traumatic brain injury (such as minimal brain injury and post-concussion syndrome).

317:35-9-48.1 Determining ICF/MR institutional level of care for TEFRA children

In order to determine level of care for TEFRA children:

(1) The child must be age 18 years or younger and expected to meet the following criteria for at least 30 days.

(A) Applicants under age three must:

(i) have a diagnosis of a developmental disability; and

(ii) have been evaluated by the SoonerStart Early Intervention Program and found to have severe dysfunctional deficiencies with findings of at least two standard deviations in at least two developmental areas.

(B) Applicants age three years and older must:

(i) have a diagnosis of ~~mental retardation~~ an intellectual disability or a developmental disability; and

(ii) have received a psychological evaluation by a licensed psychologist or school psychologist certified by the Oklahoma Department of Education (ODE) within the last 12 months. The evaluation must include intelligence testing that yields a full-scale intelligence quotient, and a full-scale functional or adaptive assessment that yields a composite functional age. Eligibility for TEFRA ICF/MR level of institutional care requires an IQ of 75 or less, and a full-scale functional assessment (Vineland or Battelle) indicating a functional age composite that does not exceed 50% of the child's chronological age. In no case shall eligibility be granted for a functional age greater than eight years.

(2) Psychological evaluations required for children who are approved for TEFRA under ICF/MR level of care. Children under age six will be required to undergo a full psychological evaluation, including both intelligence testing and adaptive/functional assessment, by a licensed psychologist or school psychologist certified by the ODE, at age three and again at age six to ascertain continued eligibility for TEFRA under the ICF/MR level of institutional care. The psychological evaluation must be completed and submitted to the LOCEU no later than 90 days following the child's third and sixth birthday.

317:35-9-49. Determination of medical eligibility for Home and Community Based Waiver Services for the ~~Mentally Retarded~~ Intellectually Disabled

Determinations of medical eligibility for Home and Community Based Waiver Services for the ~~Mentally Retarded (HCBW/MR)~~ Intellectually Disabled (HCBW/ID) is made through referral to the DHS DDSD case manager.

(1) **Referral**. If the county receives an application, Form K-13 is forwarded to the DDSD case manager, who is responsible for securing a ~~HCBW/MR~~ HCBW/ID medical determination and a disability decision, if needed.

(2) **Initial request**. If the initial request is through DDSD, Form K-13 is forwarded to the county for completing the application process.

(3) **Plan of care packet**. The DDSD case manager submits the necessary information to LOCEU for medical determination and a disability decision if needed.

(4) **County notification**. LOCEU notifies the county and DDSD case manager of determination by updating the MEDATS file.

(5) **Procedures for an individual returning home**. If referral is from a public ICF/MR for an individual returning to the home, the DDSD case manager forwards to the worker the medical eligibility determination for ~~HCBW/MR~~ HCBW/ID along with the latest application form and redetermination of eligibility form used to determine eligibility for institutional care. A new application will not be required. A case number will be assigned retaining the application date, certification date and redetermination of eligibility date.

(6) **Determination of continued eligibility for ~~HCBW/MR~~** HCBW/ID. The case manager is responsible for assuring that the individual's needs are re-evaluated and that recertification is established annually. Determination of continued medical eligibility is not necessary unless there is a significant change in the client=s condition. The DDSD cases manager will notify LOCEU if this is the case.

PART 11. PAYMENT, BILLING, AND OTHER ADMINISTRATIVE PROCEDURES

317:35-9-97. Payment for Home and Community Based Waiver services for the ~~Mentally Retarded (HCBW/MR)~~ Intellectually Disabled (HCBW/ID)

Payment is made to ~~HCBW/MR~~ HCBW/ID providers who have been certified as eligible to provide such services by the DHS Developmental Disabilities Services Division (DDSD). Certification is made after the provider has completed required training or meets the State licensing requirements for that medical discipline. Each provider must enter into a contract to provide ~~HCBW/MR~~ HCBW/ID services. Payment is made on a procedure-based reimbursement methodology for each service. All services must be preauthorized before payment can be made.

SUBCHAPTER 10. OTHER ELIGIBILITY FACTORS FOR FAMILIES WITH CHILDREN AND PREGNANT WOMEN
PART 5. INCOME

317:35-10-38. Temporary absence from the home.

An individual who is temporarily absent from the home for the purpose of receiving training or education for employment, certain medical services, etc., may be considered part of the benefit group.

(1) Individuals temporarily absent from the home, receiving training or education for employment are considered part of the benefit group during the period of time the training or educational activities are taking place.

(2) Children temporarily absent from the home to attend boarding school are considered part of the benefit group during the school term.

(3) Individuals temporarily absent from the home because of entrance into a private facility for counseling, rehabilitation, behavioral problems or special training, etc., are considered part of the benefit group. If care is projected for a period exceeding 90 days, the absence is not considered temporary. At any time an absence is determined as not temporary or no longer temporary, the needs of the individual cannot be included in the benefit group.

(4) Individuals temporarily absent from the home for medical services, other than institutionalization for treatment of mental illness, ~~mental retardation~~ intellectual disability, or tuberculosis, are considered part of the benefit group for up to six months. Six-month extensions may be allowed when the worker's

verification indicates the individual may return to the home within the next six months.

SUBCHAPTER 15. PERSONAL CARE SERVICES

317:35-15-1. Overview of long-term medical care services; relationship to QMB, SLMB and other SoonerCare service eligibility and spenddown calculation

Long-term medical care for the categorically needy includes care in a nursing facility (refer to OAC 317:35-19), public and private intermediate care facility for the mentally retarded (refer to OAC 317:35-9), persons age 65 years or older in mental health hospitals (refer to OAC 317:35-9), Home and Community Based Waiver Services for the ~~Mentally Retarded~~ Intellectually Disabled (refer to OAC 317:35-9), Home and Community Based Waiver Services for the ADvantage program (refer to OAC 317:35-17), and Personal Care services (refer to this subchapter). Personal Care provides services in the member's own home. Any time an individual is certified as eligible for SoonerCare coverage of long-term care, the individual is also eligible for other SoonerCare services. Another application is not required. Any time an aged, blind or disabled individual is determined eligible for long-term care, a separate determination must be made to see if eligibility conditions as a Qualified Medicare Beneficiary (QMB) or Specified Low-Income Medicare Beneficiary (SLMB) are met. Another application for QMB or SLMB benefits is not required.

SUBCHAPTER 19. NURSING FACILITY SERVICES

317:35-19-3. Services in a Nursing Facility (NF)

(a) Nursing facility services are those services furnished pursuant to a physician's orders which require the skills of technical or professional personnel, e.g., registered nurses, licensed practical nurses, physical therapists, occupational therapists, speech pathologists or audiologists. The care is provided by nursing facilities licensed under state law to provide, on a regular basis, health related care and services to individuals who do not require hospitalization but whose physical or mental condition requires care and services above the level of room and board which can be made available to them only through a nursing facility. To be eligible for nursing facility services, the UCAT demonstrates the individual must:

(1) require a treatment plan involving the planning and administration of services which require skills of licensed technical or professional personnel that are provided directly or under the supervision of such personnel and are prescribed by the physician;

(2) have a physical impairment or combination of physical and mental impairments;

(3) require professional nursing supervision (medication, hygiene and dietary assistance);

(4) lack the ability to care for self or communicate needs to others; and

(5) require medical care and treatment in a nursing facility to minimize physical health regression and deterioration. A physician’s order and results from a standardized assessment which evaluates type and degree of disability and need for treatment must support the individual’s need for NF level of care. Only

standardized assessments approved by the OHCA and administered in accordance with Medicaid approved procedures shall be used to make the NF level of care determination.

(b) If the individual experiences mental illness or ~~mental retardation~~ an intellectual disability or a related condition, payment cannot be made for services in a nursing facility unless the individual has been assessed through the PASRR process and the appropriate MR or MI authority has determined that nursing facility services are required. If it is determined that the client also requires specialized services, the state must provide or arrange for the provision of such services. These determinations must be made prior to the patient's admission to the nursing facility. Payment cannot be made for an individual who is in imminent danger of harm to self or others.

(c) Payment is made to licensed nursing facilities that have agreements with the OHCA.

(d) Nursing facility clients are eligible for ADvantage waiver services and must be informed by the LTC nurse of the ADvantage waiver and given the option to apply for ADvantage services.

317:35-19-8. Pre-admission screening and resident review

(a) Federal Regulations govern the State's responsibility for Preadmission Screening and Resident Review (PASRR) of individuals with mental illness and ~~mental retardation~~ intellectual disabilities. PASRR applies to the screening or reviewing of all individuals for mental illness or ~~mental retardation~~ intellectual disability or related conditions who apply to or reside in Medicaid certified nursing facilities regardless of the source of payment for the nursing facility services and regardless of the individual's or resident's known diagnoses. The NF must independently evaluate the Level I PASRR Screen regardless of who completes the form and determine whether or not to admit an individual to the facility. If an individual is admitted to the NF inappropriately, the NF is subject to recoupment of Medicaid funds and penalties imposed by CMS. Federal financial participation (FFP) may not be paid until results of any needed PASRR Level II evaluations are received. PASRR is a requirement for nursing facilities with dually certified (both Medicare and Medicaid) beds. There are no PASRR requirements for Medicare skilled beds that are not dually certified, nor is PASRR required for individuals seeking residency in an intermediate care facility for the mentally retarded (ICF/MR).

(b) For Medicaid applicants, medical and financial eligibility determinations are also required.

317:35-19-9. PASRR screening process

(a) **Level I screen for PASRR**.

(1) OHCA Form LTC-300R, Nursing Facility Level of Care Assessment, must be completed by an authorized NF official or designee. An authorized NF official or designee must consist of one of the following:

(A) The nursing facility administrator or co-administrator;

(B) A licensed nurse, social service director, or social worker from the nursing facility; or

(C) A licensed nurse, social service director, or social worker from the hospital.

(2) Prior to admission, the authorized NF official must evaluate the properly completed OHCA Form LTC-300R and the Minimum Data Set

(MDS), if available, as well as all other readily available medical and social information, to determine if there currently exists any indication of mental illness (MI), ~~mental retardation (MR)~~ intellectual disability (ID), or other related condition, or if such condition existed in the applicant's past history. Form LTC-300R constitutes the Level I PASRR Screen and is utilized in determining whether or not a Level II is necessary prior to allowing the patient to be admitted.

(3) The nursing facility is responsible for determining from the evaluation whether or not the patient can be admitted to the facility. A "yes" response to any question from Form LTC-300R, Section E, will require the nursing facility to contact the Level of Care Evaluation Unit (LOCEU) for a consultation to determine if a Level II assessment is needed. The NF is also responsible for consulting with the LOCEU regarding any ~~MI/MR~~ MI/ID /related condition information that becomes known either from completion of the MDS or throughout the resident's stay. The original Form LTC-300R must be submitted to the LOCEU by mail within 10 days of the resident's admission. SoonerCare payment may not be made for a resident whose LTC-300R requirements have not been satisfied in a timely manner.

(4) Upon receipt and review of the PASRR eligibility information packet, the LOCEU may, in coordination with the Oklahoma Department of Human Services (OKHDS) area nurse, re-evaluate whether a Level II PASRR assessment may be required. If a Level II assessment is not required, as determined by the LOCEU, the area nurse, or nurse designee, documents this and continues with the process of determining medical eligibility. If a Level II is required, a medical decision is not made until the area nurse is notified of the outcome of the Level II assessment. The results of the Level II assessment are considered in the medical eligibility decision. The area nurse, or nurse designee, makes the medical eligibility decision within ten working days of receipt of the medical information when a Level II assessment is not required. If a Level II assessment is required, the area nurse makes the decision within five working days if appropriate.

(b) **Pre-admission Level II assessment for PASRR**. The authorized official is responsible for consulting with the OHCA LOCEU in determining whether a Level II assessment is necessary. The decision for Level II assessment is made by the LOCEU.

(1) Any one of the following three circumstances will allow a patient to enter the nursing facility without being subjected to a Level II PASRR assessment:

(A) The patient has no current indication of mental illness or ~~mental retardation~~ an intellectual disability or other related condition and there is no history of such condition in the patient's past;

(B) The patient does not have a diagnosis of ~~mental retardation~~ an intellectual disability or related condition; or

(C) The patient has indications of mental illness or ~~mental retardation~~ an intellectual disability or other related condition, but is not a danger to self and/or others, and is being released from an acute care hospital as part of a medically prescribed period of recovery (Exempted Hospital Discharge). If an individual is admitted to an NF based on Exempted Hospital Discharge, it is the responsibility of the NF

to ensure that the individual is either discharged by the 30th day or that a Level II has been requested and is in process. Exempted Hospital Discharge is allowed only if all of the following three conditions are met:

(i) The individual must be admitted to the NF directly from a hospital after receiving acute inpatient care at the hospital (not including psychiatric facilities);

(ii) The individual must require NF services for the condition for which he/she received care in the hospital; and

(iii) The attending physician must certify before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. The nursing facility will be required to furnish documentation to the OHCA upon request.

(2) If the patient has current indications of mental illness or ~~mental retardation~~ an intellectual disability or other related condition, or if there is a history of such condition in the patient's past, the patient cannot be admitted to the nursing facility until the LOCEU is contacted to determine if a Level II PASRR assessment must be performed. Results of any Level II PASRR assessment ordered must indicate that nursing facility care is appropriate prior to allowing the patient to be admitted.

(3) The OHCA Level of Care Evaluation Unit authorizes Advance Group Determinations for the MI and MR Authorities in the categories listed in the following categories listed in (A) through (C) of this paragraph. Preliminary screening by the LOCEU should indicate eligibility for nursing facility level of care prior to consideration of the provisional admission.

(A) **Provisional admission in cases of delirium**. Any person with mental illness, ~~mental retardation~~ an intellectual disability or related condition who is not a danger to self and/or others, may be admitted to a Medicaid certified NF if the individual is experiencing a condition that precludes screening, i.e., effects of anesthesia, medication, unfamiliar environment, severity of illness, or electrolyte imbalance.

(i) A Level II evaluation is completed immediately after the delirium clears. LOCEU must be provided with written documentation by a physician that supports the individual's condition which allows provisional admission as defined in (i) of this subparagraph.

(ii) Payment for NF services will not be made after the provisional admission ending date. If an individual is determined to need a longer stay, the individual must receive a Level II evaluation before continuation of the stay may be permitted and payment made for days beyond the ending date.

(B) **Provisional admission in emergency situations**. Any person with a mental illness, ~~mental retardation~~ an intellectual disability or related condition, who is not a danger to self and/or others, may be admitted to a Medicaid certified nursing facility for a period not to exceed seven days pending further assessment in emergency situations requiring protective services. The request for Level II evaluation must be made immediately upon admission to the NF if a longer stay is anticipated. LOCEU must be provided with written documentation from Adult Protective Services or the nursing facility which supports the individual's emergency admission. Payment for NF

services will not be made beyond the emergency admission ending date.

(C) **Respite care admission**. Any person with mental illness, ~~mental retardation~~ an intellectual disability or related condition, who is not a danger to self and/or others, may be admitted to a Medicaid certified nursing facility to provide respite to in-home caregivers to whom the individual is expected to return following the brief NF stay. Respite care may be granted up to 15 consecutive days per stay, not to exceed 30 days per calendar year.

(i) In rare instances, such as illness of the caregiver, an exception may be granted to allow 30 consecutive days of respite care. However, in no instance can respite care exceed 30 days per calendar year.

(ii) Respite care must be approved by LOCEU staff prior to the individual's admission to the NF. The NF provides the LOCEU with written documentation concerning circumstances surrounding the need for respite care, the date the individual wishes to be admitted to the facility, and the date the individual is expected to return to the caregiver. Payment for NF services will not be made after the respite care ending date.

(c) **PASRR Level II resident review**. The resident review is used primarily as a follow-up to the pre-admission assessment.

(1) The nursing facility's routine resident assessment will identify those individuals previously undiagnosed as ~~MR~~ intellectually disabled or MI. A new condition of ~~MR~~ intellectual disabilities or MI must be referred to LOCEU by the NF for determination of the need for the Level II. The facility's failure to refer such individuals for a Level II assessment may result in recoupment of funds and/or penalties from CMS.

(2) A Level II resident review may be conducted the following year for each resident of a nursing facility who was found to experience a serious mental illness with no primary diagnosis of dementia on his or her pre-admission Level II to determine whether, because of the resident's physical and mental condition, the resident requires specialized services.

(3) A Level II resident review may be conducted for each resident of a nursing facility who has mental illness or ~~mental retardation~~ an intellectual disability or other related condition when there is a significant change in the resident's mental condition. If such a change should occur in a resident's condition, it is the responsibility of the nursing facility to have a consultation with the LOCEU concerning the need to conduct a resident review.

(4) Individuals who were determined to have a serious mental illness (as defined by CMS) on their last PASRR Level II evaluation will receive a resident review at least within one year of the previous evaluation.

(d) **Results of pre-admission Level II assessment and Resident Review**. Through contractual arrangements between the Oklahoma Health Care Authority and the Mental Illness/Mental Retardation Authorities/Community Mental Health Centers, individualized assessments are conducted and findings presented in written evaluative reports. The reports recommend if nursing facility services are needed, if specialized services or less than specialized services are needed, and if the individual meets the federal PASRR definition of mental illness

or ~~mental retardation~~ intellectual disability or related conditions. Evaluative reports are delivered to the OHCA's LOCEU within federal regulatory and state contractual timelines to allow the LOCEU to process formal, written notification to patient, guardian, NF and significant others.

(e) **Evaluation of pre-admission Level II or Resident Review assessment to determine Medicaid medical eligibility for long term care**. The determination of medical eligibility for care in a nursing facility is made by the area nurse (or nurse designee) unless the individual has ~~mental retardation~~ an intellectual disability or related condition or a serious mental illness (as defined by CMS). The procedures for obtaining and submitting information required for a decision are outlined in this subsection. When an active long term care patient enters the facility and nursing care is being requested:

(1) The pre-admission screening process must be performed and must allow the patient to be admitted.

(2) The facility will notify the local county office by the OKDHS Form 08MA083E, Notification Regarding Patient in a Nursing Facility, Intermediate Care Facility for the Mentally Retarded or Hospice and Form 08MA084E, Management of Recipient's Funds, of the member's admission.

(3) The local county office will send the NF the OKDHS Form 08MA038E, Notice Regarding Financial Eligibility, indicating actions that are needed or have been taken regarding the member.

CHAPTER 40. DEVELOPMENTAL DISABILITIES SERVICES
SUBCHAPTER 1. GENERAL PROVISIONS

317:40-1-1. Home and Community-Based Services (HCBS) Waivers for persons with intellectual disabilities ~~(mental retardation)~~ or certain persons with related conditions

(a) **Applicability.** The rules in this Section apply to services funded through Medicaid HCBS Waivers per OAC 317:35-9-5 and as defined in Section 1915(c) of the Social Security Act. The specific waivers are the In-Home Supports Waiver (IHSW) for Adults, the In-Home Supports Waiver (IHSW) for Children, the Community Waiver, and the Homeward Bound Waiver.

(b) **Program provisions.** Each individual requesting services provided through a HCBS Waiver and his or her family or guardian are responsible for:

(1) accessing, with the assistance of OKDHS staff, all benefits available under Oklahoma's Medicaid State Plan or other payment sources prior to accessing funding for those same services under a HCBS Waiver program;

(2) cooperating in the determination of medical and financial eligibility, including prompt reporting of changes in income or resources; and

(3) choosing between services provided through a HCBS Waiver and institutional care.

(c) **Waiver Eligibility.** To be eligible for Waiver services, an applicant must meet the criteria established in paragraph (1) of this Subsection and the criteria for one of the Waivers established in Subparagraph (A), (B), or (C) of this Subsection.

(1) Services provided through a HCBS Waiver are available to Oklahoma residents meeting SoonerCare eligibility requirements established by law, regulatory authority, and policy within funding

available through State or Federal resources. To be eligible for and receive services funded through any of the Waivers listed in subsection (a) of this Section, a person must meet conditions per OAC 317:35-9-5. The individual must be determined financially eligible for SoonerCare per OAC 317:35-9-68. The SoonerCare eligible individual may not simultaneously be enrolled in any other Medicaid Waiver program or receiving services in an institution including a hospital, rehabilitation facility, mental health facility, nursing facility, residential care facility as described in Section 1-819 of Title 63 of Oklahoma Statutes, or Intermediate Care facility for persons with mental retardation (ICF/MR). The individual may not be receiving DDSD state-funded services such as the Family Support Assistance Payment, Respite Voucher Program, sheltered workshop services, community integrated employment services, or assisted living without waiver supports per OAC 340:100-5-22.2. The individual must also meet other Waiver-specific eligibility criteria.

(A) **In-Home Supports Waivers.** To be eligible for services funded through the In-Home Supports Waiver (IHSW), a person must:

(i) meet all criteria given in subsection (c) of this Section; and

(ii) be determined to have a disability and a diagnosis of intellectual disability ~~(mental retardation)~~ by the Social Security Administration (SSA); or

(iii) be determined to have a disability, and a diagnosis of intellectual disability ~~(mental retardation)~~ as defined in the Diagnostic and Statistical Manual of Mental Disorders by the OHCA Level of Care Evaluation Unit (LOCEU);

(iv) be three years of age or older;

(v) be determined by the OHCA/LOCEU to meet the ICF/MR Institutional Level of Care requirements per OAC 317:30-5-122;

(vi) reside in:

(I) the home of a family member or friend;

(II) his or her own home;

(III) an OKDHS Children and Family Services Division (CFSD) foster home; or

(IV) a CFSD group home; and

(vii) have critical support needs that can be met through a combination of non-paid, non-Waiver, and SoonerCare resources available to the individual, and with HCBS Waiver resources that are within the annual per capita Waiver limit agreed between the State of Oklahoma and the Centers for Medicare and Medicaid Services (CMS).

(B) **Community Waiver.** To be eligible for services funded through the Community Waiver, the person must:

(i) meet all criteria given in subsection (c) of this Section;

(ii) be determined to have a disability and a diagnosis of intellectual disability ~~(mental retardation)~~ by the SSA; or

(iii) have intellectual disability ~~(mental retardation)~~ as defined in the Diagnostic and Statistical Manual of Mental Disorders or a related condition by the DDSD and to be covered under the State's alternative disposition plan

adopted under Section 1919(e)(7)(E) of the Social Security Act; or

(iv) be determined to have a disability and a diagnosis of intellectual disability ~~(mental retardation)~~ as defined in the Diagnostic and Statistical Manual of Mental Disorders or the OHCA/LOCEU; and

(v) be three years of age or older; and

(vi) be determined by the OHCA/LOCEU, to meet the ICF/MR Institutional Level of Care requirements per OAC 317:30-5-122; and

(vii) have critical support needs that can be met by the Community Waiver and cannot be met by IHSW services or other service alternatives, as determined by the DDSD Division Director or designee.

(C) **Homeward Bound Waiver.** To be eligible for services funded through the Homeward Bound Waiver, the person must:

(i) be certified by the United States District Court for the Northern District of Oklahoma as a member of the plaintiff class in *Homeward Bound et al. v. The Hissom Memorial Center*, Case No. 85-C-437-E;

(ii) meet all criteria for HCBS Waiver services given in subsection (c) of this Section; and

(iii) be determined to have a disability and a diagnosis of intellectual disability ~~(mental retardation)~~ by SSA; or

(iv) have an intellectual disability ~~(mental retardation)~~ as defined in the Diagnostic and Statistical Manual o Mental Disorders or a related condition per OAC 317:35-9-45 by DDSD and to be covered under the State's alternative disposition plan adopted under Section 1919(e)(7)(E) of the Social Security Act; or

(v) have a disability ~~(mental retardation)~~ as defined in the Diagnostic and Statistical Manual of Mental Disorders by the OHCA/LOCEU; and

(vi) meet the ICF/MR Institutional Level of Care requirements per OAC 317:30-5-122 by the OHCA/LOCEU.

(2) The person desiring services through any of the Waivers listed in subsection (a) of this Section participates in diagnostic evaluations and provides information necessary to determine HCBS Waiver services eligibility, including:

(A) a psychological evaluation, by a licensed Psychologist or State staff supervised by a licensed Psychologist, current within 12 months of requested approval date, that includes:

(i) a full scale functional and/or adaptive assessment; and

(ii) a statement of age of onset of the disability; and

(iii) intelligence testing that yields a full scale intelligence quotient.

(B) a social service summary, current within 12 months of requested approval date, that includes a developmental history; and

(C) a medical evaluation current within 90 days of requested approval date; and

(D) a completed ICF/MR Level of Care Assessment form (LTC-300); and

(E) proof of disability according to SSA guidelines. If a disability determination had not been made by SSA, the

OHCA/LOCEU may make a disability determination using the same guidelines as SSA.

(3) The OHCA reviews the diagnostic reports listed in paragraph (2) of this subsection and makes a determination of eligibility for DDSD HCBS Waivers.

(4) For individuals who are determined to have intellectual disability ~~(mental retardation)~~ or a related condition by DDSD in accordance with the State's alternative disposition plan adopted under Section 1919(e)(7)(E) of the Social Security Act, DDSD reviews the diagnostic reports listed in paragraph (2) of this subsection and, on behalf of the OHCA, makes a determination of eligibility for DDSD HCBS Waiver services and ICF/MR level of care.

(5) A determination of need for ICF/MR Institutional Level of Care does not limit the opportunities of the person receiving services to participate in community services. Individuals are assured of the opportunity to exercise informed choice in the selection of services.

(d) **Request list.** When State DDSD resources are unavailable for new persons to be added to services funded through a HCBS Waiver, persons are placed on a statewide Request for Waiver Services List.

(1) The Request for Waiver Services List is maintained in chronological order based on the date of receipt of a written request for services.

(2) The Request for Waiver Services List for persons requesting services provided through a HCBS Waiver is administered by DDSD uniformly throughout the state.

(3) An individual is removed from the Request for Waiver Services List if the individual:

(A) is found to be ineligible for services;

(B) cannot be located by OKDHS;

(C) does not provide required information to OKDHS;

(D) is not a resident of the state of Oklahoma at the time of requested Waiver approval date; or

(E) declines an offer of Waiver services

(e) **Applications.** When resources are sufficient for initiation of HCBS Waiver services, DDSD ensures action regarding a request for services occurs within 45 days. If action is not taken within the required 45 days, the applicant may seek resolution as described in OAC 340:2-5.

(1) Applicants are allowed 60 days to provide information requested by DDSD to determine eligibility for services.

(2) If requested information is not provided within 60 days, the applicant is notified that the request has been denied, and the individual is removed from the Request for Waiver Services List.

(f) **Admission protocol.** Initiation of services funded through a HCBS Waiver occurs in chronological order from the Request for Waiver Services List in accordance with subsection (d) of this Section based on the date of DDSD receipt of a completed request for services, as a result of the informed choice of the person requesting services or his or her legal guardian, and upon determination of eligibility, in accordance with subsection (c) of this Section. Exceptions to the chronological requirement may be made when:

(1) an emergency situation exists in which the health or safety of the person needing services, or of others, is endangered, and there is no other resolution to the emergency. An emergency exists when:

(A) the person is unable to care for himself or herself and:

(i) the person's caretaker, as defined in Section 10-103 of Title 43A of the Oklahoma Statutes:
(I) is hospitalized;
(II) has moved into a nursing facility;
(III) is permanently incapacitated; or
(IV) has died; and
(ii) there is no caretaker to provide needed care to the individual; or
(iii) an eligible person is living at a homeless shelter or on the street;
(B) the OKDHS finds that the person needs protective services due to experiencing ongoing physical, sexual, or emotional abuse or neglect in his or her present living situation, resulting in serious jeopardy to the person's health or safety;
(C) the behavior or condition of the person needing services is such that others in the home are at risk of being seriously harmed by the person. For example, the person is routinely physically assaultive to the caretaker or others living in the home and sufficient supervision cannot be provided to ensure the safety of those in the home or community; or
(D) the person's medical, psychiatric, or behavioral challenges are such that the person is seriously injuring or harming himself or herself, or is in imminent danger of doing so.
(2) the Legislature has appropriated special funds with which to serve a specific group or a specific class of individuals under the provisions of a HCBS Waiver;
(3) Waiver services are required for people who transition to the community from a public or ICF/MR who are children in the State's custody receiving services from OKDHS. Under some circumstances Waiver services related to accessibility may be authorized in advance of transition, but may not be billed until the day the member leaves the ICF/MR and enters the Waiver;
(4) individuals subject to the provisions of Public Law 100-203 residing in nursing facilities for at least 30 continuous months prior to January 1, 1989,and who are determined by Preadmission Screening and Resident Review (PASRR) evaluation conducted pursuant to the provisions of 42 CFR 483.100 et seq to have intellectual disability ~~(mental retardation)~~ or a related condition, who are covered under the State's alternative disposition plan adopted under Section 1919(e)(7)(E) of the Social Security Act, choose to receive services funded through the Community or Homeward Bound Waiver.

(g) **Movement between DDSD HCBS Waiver programs.** A person's movement from services funded through one HCBS Waiver to services funded through another DDSD-administered HCBS Waiver is explained in this subsection.
(1) When a member receiving services funded through the IHSW for children becomes 18 years of age, services through the IHSW for adults become effective.
(2) Change to services funded through the Community Waiver from services funded through the IHSW occurs only when:
(A) a member has critical support needs that cannot be met by IHSW services, non-Waiver services, or other resources as determined by the DDSD Director or designee; and
(B) funding is available per OAC 317:35-9-5..
(3) Change to services funded through the IHSW from services funded through the Community Waiver may only occur when a member's history

of annual service utilization has been within the per capita allowance of the IHSW.

(4) When a member served through the Community Waiver has support needs that can be met within the per capita Waiver allowance of the applicable IHSW and through a combination of non-Waiver resources, the individual may choose to receive services through the IHSW.

(h) **Continued eligibility for HCBS Waiver services.** Eligibility for members receiving services provided through the HCBS Waiver is re-determined by the OHCA/LOCEU when a determination of disability has not been made by the Social Security Administration. The OHCA/LOCEU determines categorical relationship to the SoonerCare disabled category according to Social Security Administration guidelines. OHCA/LOCEU also approves level of care per OAC 317:30-5-122 and confirms a diagnosis of intellectual disability ~~(mental retardation)~~ as defined in the Diagnostic and Statistical Manual of Mental Disorders. DDSD may require a new diagnostic evaluation in accordance with paragraph (c)(2) of this subsection and re-determination of eligibility at any time when a significant change of condition, disability, or psychological status determined under paragraph (c)(2) of this Section has been noted.

(i) **HCBS Waiver services case closure.** Services provided through a HCBS Waiver are terminated:

(1) when a member or the member's legal guardian chooses to no longer receive Waiver services;

(2) when a member is incarcerated;

(3) when a member is financially ineligible to receive Waiver services;

(4) when a member is determined by the Social Security Administration to no longer have a disability qualifying the individual for services under these Waivers;

(5) when a member is determined by the OHCA/LOCEU to no longer be eligible;

(6) when a member moves out of state, or the custodial parent or guardian of a member who is a minor moves out of state;

(7) when a member is admitted to a nursing facility, ICF/MR, residential care facility, hospital, rehabilitation facility, or mental health facility for more than 30 consecutive days;

(8) when the guardian of a member who is a minor or adjudicated adult fails to cooperate during the annual review process as described in OAC 340:100-5-50 through 340:100-5-58;

(9) when the guardian of a member who is a minor or adjudicated adult fails to cooperate in the implementation of OKDHS policy or service delivery in a manner that places the health or welfare of the member at risk, after efforts to remedy the situation through Adult Protective Services or Child Protective Services have not been effective;

(10) when the member is determined to no longer be SoonerCare eligible; or

(11) when there is sufficient evidence that the member or his/her legal representative has engaged in fraud or misrepresentation, failed to use resources as agreed on in the Individual Plan, or knowingly misused public funds associated with these services;

(12) when the member or his/her legal representative either cannot be located, has not responded to, or has not allowed case management to complete plan development or monitoring activities as required by policy and the member or his/her legal representative:

(A) does not respond to the notice of intent to terminate; or

(B) the response prohibits case management (the case manager) from being able to complete plan development or monitoring activities as required by policy;

(13) when the member or his/her legal representative fails to cooperate with the case manager to implement a Fair Hearing decision;

(14) when it is determined that services provided through a HCBS Waiver are no longer necessary to meet the member's needs and professional documentation provides assurance that the member's health, safety, and welfare can be maintained without Waiver supports;

(15) when the member or his/her legal representative fails to cooperate with service delivery;

(16) when a family member, authorized representative, other individual in the member's household or persons who routinely visit, pose a threat of harm or injury to provider staff or official representatives of OKDHS; or

(17) when a member no longer receives a minimum of one Waiver service per month and DDSD is unable to monitor member on a monthly basis.

(j) **Reinstatement of services.** Waiver services are reinstated when:

(1) the situation resulting in case closure of a Hissom class member is resolved;

(2) a member is incarcerated for 90 days or less;

(3) a member is admitted to a nursing facility, ICF/MR, residential care facility, hospital, rehabilitation facility, or mental health facility for 90 days or less; or

(4) a member's SoonerCare eligibility is re-established within 90 days of the date of SoonerCare ineligibility.

SUBCHAPTER 5. MEMEBER SERVICES
PART 11. OTHER COMMUNITY RESIDENTIAL SUPPORTS

317:40-5-152. Group home services for persons with ~~mental retardation~~ an intellectual disability or certain persons with related conditions

(a) **General Information.** Group homes provide a congregate living arrangement offering up to 24-hour per day supervision, supportive assistance, and training in daily living skills to persons who are eligible 18 years of age or older. Upon approval of the Oklahoma Department of Human Services (OKDHS) Developmental Disabilities Services Division (DDSD) director or designee, persons younger than 18 may be served.

(1) Group homes ensure members reside and participate in the community. Services are provided in homes located in close proximity to generic community services and activities.

(2) Group homes must be licensed by DDSD in accordance with Section 1430.1 et seq. of Title 10 of the Oklahoma Statutes.

(3) Residents of group homes receive no other form of residential supports.

(4) Habilitation training specialist (HTS) services or homemaker services for residents of group homes may be approved only by the DDSD director or designee to resolve a temporary emergency when no other resolution exists.

(b) **Minimum provider qualifications.** Approved providers must have a current contract with the Oklahoma Health Care Authority (OHCA) to provide DDSD Home and Community-Based Services (HCBS) Waiver for

persons with ~~mental retardation~~ an intellectual disability or related conditions.

(1) Group home providers must have a completed and approved application to provide DDSD group home services.

(2) Group home staff must:

(A) complete the OKDHS DDSD-sanctioned training curriculum per OAC 340:100-3-38; and

(B) fulfill requirements for pre-employment screening per OAC 340:100-3-39.

(c) **Description of services.**

(1) Group home services:

(A) meet all applicable requirements of OAC 340:100; and

(B) are provided in accordance with each member's Individual Plan (IP) developed per OAC 340:100-5-50 through 340:100-5-58.

(i) Health care services are secured for each member per OAC 340:100-5-26.

(ii) Members are offered recreational and leisure activities maximizing the use of generic programs and resources, including individual and group activities.

(2) Group home providers:

(A) follow protective intervention practices per OAC 340:100-5-57 and 340:100-5-58;

(B) in addition to the documentation required per OAC 340:100-3-40, must maintain:

(i) staff time sheets that document the hours each staff was present and on duty in the group home; and

(ii) documentation of each member's presence or absence on the daily attendance form provided by DDSD; and

(C) ensure program coordination staff (PCS) meet staff qualifications and supervise, guide, and oversee all aspects of group home services per OAC 340:100-5-22.6 and 340:100-6, as applicable.

(d) **Coverage limitations.** Group home services are provided up to 366 days per year.

(e) **Types of group home services.** There are three types of group home services provided through HCBS Waivers.

(1) **Traditional group homes.** Traditional group homes serve no more than 12 members per OAC 340:100-6.

(2) **Community living homes.** Community living homes serve no more than 12 members.

(A) Members who receive community living home services have:

(i) needs that cannot be met in a less structured setting; and

(ii) a diagnosis of a severe or profound ~~mental retardation~~ intellectual disability requiring frequent assistance in the performance of activities necessary for daily living or continual supervision to ensure the member's health and safety; or

(iii) complex needs requiring frequent:

(I) assistance in the performance of activities necessary for daily living, such as frequent assistance of staff for positioning, bathing, or other necessary movement; or

(II) supervision and training in appropriate social and interactive skills in order to remain included in the community.

(B) Services offered in a community living home include:

(i) 24-hour awake supervision when a member's IP indicates it is necessary; and

(ii) program supervision and oversight including hands-on assistance in performing activities of daily living, transferring, positioning, skill-building, and training.

(3) **Alternative group homes.** Alternative group homes serve no more than four members who have evidence of behavioral or emotional challenges in addition to ~~mental retardation~~ an intellectual disability and require extensive supervision and assistance in order to remain in the community.

(A) Members who receive alternative group home services must meet criteria per in OAC 340:100-5-22.6.

(B) A determination must be made by the DDSD Community Services Unit that alternative group home services are appropriate.

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

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

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

(b) Types of Waiver Employment Services offered include:

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

(2) Employment Training Specialist (ETS);

(3) Center-Based Services;

(4) Community-Based Services;

(5) Enhanced Community-Based Services;

(6) Job Coaching;

(7) Enhanced Job Coaching; and

(8) Stabilization Services.

(c) State-funded services described in OAC 340:100-17-30 may supplement Employment Services funded through the Community Waiver.

CHAPTER 50. HOME AND COMMUNITY BASED SERVICES WAIVERS
SUBCHAPTER 1. MEDICALLY FRAGILE WAIVER SERVICES

317:50-1-2. Definitions

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

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

(A) bathing,

(B) eating,

(C) dressing,

(D) grooming,

(E) transferring (includes getting in and out of a tub, bed to chair, etc.)

(F) mobility,

(G) toileting, and

(H) bowel/bladder control.

"Cognitive Impairment" means that the person, as determined by the clinical judgment of the LTC Nurse or the AA, does not have the capability to think, reason, remember or learn required for self-care,

communicating needs, directing care givers and/or using appropriate judgment for maintenance of their own health or safety. The clinical judgment of cognitive impairment is based on MSQ performance in combination with a more general evaluation of cognitive function from interaction with the person during the UCAT assessment.

"Developmental Disability" means a severe, chronic disability of an individual that:

(A) is attributable to a mental or physical impairment or combination of mental and physical impairments;

(B) is manifested before the individual attains age 22;

(C) is likely to continue indefinitely;

(D) results in substantial functional limitations in three or more of the following areas of major life activity:

(i) self-care;

(ii) receptive and expressive language;

(iii) learning;

(iv) mobility;

(v) self-direction;

(vi) capacity for independent living; and

(vii) economic self-sufficiency; and

(E) reflects the individual=s need for a combination and sequence of special, interdisciplinary, or generic services, supports, or other assistance that is of lifelong or extended duration and is individually planned and coordinated.

"IADL" means the instrumental activities of daily living.

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

(A) shopping,

(B) cooking,

(C) cleaning,

(D) managing money,

(E) using a telephone,

(F) doing laundry,

(G) taking medication, and

(H) accessing transportation.

"Level of Care Services**"** To be eligible for level of care services, meeting the minimum UCAT criteria established for SNF or hospital level of care demonstrates the individual must:

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

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

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

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

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

(F) require care that is not available through family and friends, Medicare, Veterans Administration, or other federal

entitlement program with the exception of Indian Health Services; and

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

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

"MSQ" means the mental status questionnaire.

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

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

(a) The Medically Fragile Waiver program is a Medicaid Home and Community Based Services Waiver used to finance non-institutional long-term care services for a targeted group of physically disabled adults when there is a reasonable expectation that the person's health, due to disease process or disability, would, without appropriate services, deteriorate and require skilled nursing facility or hospital level of care to arrest the deterioration. Medically Fragile Waiver program members must be SoonerCare eligible and must not reside in an institution, room and board licensed residential care facility, or licensed assisted living facility. The number of members who may receive Medically Fragile Waiver services is limited.

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

(A) be 19 years of age or older;

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

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

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

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

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

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

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

(b) Home and Community Based Waiver Services are outside the scope of state plan Medicaid services. The Medicaid waiver allows the OHCA to offer certain Home and Community Based services to an annually capped number of persons who are categorically needy (refer to OKDHS form

08AX001E, Schedule VIII. B. 1) and without such services would be institutionalized.

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

(1) case management;

(2) respite;

(3) adult day health care;

(4) environmental modifications;

(5) specialized medical equipment and supplies;

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

(7) advanced supportive/restorative assistance;

(8) skilled nursing;

(9) home delivered meals;

(10) hospice care;

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

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

(13) Personal Emergency Response System (PERS);

(14) Self Direction; and

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

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

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

(2) the member is in the Medically Fragile Waiver targeted service group. The target group is an individual who is age 19 or older with a physical disability and may also have ~~mental retardation~~ an intellectual disability or a cognitive impairment.

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

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

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

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

(2) if the individual poses a physical threat to self or others as supported by professional documentation.
(3) if other members of the household or persons who routinely visit the household who, as supported by professional documentation, pose a threat of harm or injury to the individual or other household visitors.
(4) if the individual's needs are being met, or do not require Medically Fragile Waiver services to be met, or if the individual would not require institutionalization if needs are not met.
(5) if, after the service and care plan is developed, the risk to individual health and safety is not acceptable to the individual, or to the interdisciplinary service plan team, or to the OHCA.

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

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

SUBCHAPTER 3. MY LIFE, MY CHOICE

317:50-3-2. Definitions

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

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

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

"ADLs score in high risk range" means the member's total weighted UCAT ADL score is 10 or more which indicates the member needs some help with 5 ADLs or that the member cannot do 3 ADLs at all plus the member needs some help with 1 other ADL.

"ADLs score at the high end of the moderate risk range" means member's total weighted UCAT ADL score is 8 or 9 which indicates the member needs help with 4 ADLs or the member cannot do 3 ADLs at all.

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

more general evaluation of cognitive function from interaction with the person during the UCAT assessment.

"Developmental Disability" means a severe, chronic disability of an individual that:

(A) is attributable to a mental or physical impairment or combination of mental and physical impairments;

(B) is manifested before the individual attains age 22;

(C) is likely to continue indefinitely;

(D) results in substantial functional limitations in three or more of the following areas of major life activity:

(E) self-care;

(F) receptive and expressive language;

(G) learning;

(H) mobility;

(I) self-direction;

(J) capacity for independent living;

(K) economic self-sufficiency; and

(L) reflects the individual=s need for a combination and sequence of special, interdisciplinary, or generic services, supports, or other assistance that is of lifelong or extended duration and is individually planned and coordinated.

"Environment high risk" means member's UCAT Environment score is 25 which indicates in the UCAT assessor's clinical judgment, the physical environment is strongly negative or hazardous.

"Environment moderate risk" means member's UCAT Environment score is 15 which indicates in the UCAT assessor's clinical judgment, many aspects of the physical environment are substandard or hazardous.

"Health Assessment high risk" means member's UCAT health assessment score is 25 which indicates in the UCAT assessor's clinical judgment, the member has one or more chronic health conditions, whose symptoms are rapidly deteriorating, uncontrolled, or not well controlled and requiring a high frequency or intensity of medical care/oversight to bring under control and whose functional capacity is so limited as to require full time assistance or care performed daily, by, or under the supervision of professional personnel and has multiple unmet needs for services available only through the My Life, My Choice program or a Nursing Facility (NF) and requires NF placement immediately if these needs cannot be met by other means.

"Health Assessment low risk" means member's health assessment score is 5 which indicates, in the UCAT assessor's clinical judgment, the member has one or more chronic, stable, health conditions, whose symptoms are controlled or nearly controlled, which benefit from available, or usually available, medical treatment or corrective measures, and may have an unmet need for a service available only through the My Life, My Choice program or a Nursing Facility (NF) but is not likely to enter a NF if these needs are not met.

"Health Assessment moderate risk" means member's UCAT Health Assessment score is 15 which indicates in the UCAT assessor's clinical judgment, the member has one or more chronic changing health conditions, whose symptoms are fragile or worsening and require medical care/oversight, to bring under control or to maintain in a stable, controlled state and has multiple unmet needs for services available only through the My Life, My Choice program or a Nursing Facility (NF) and is likely to enter a NF if these needs are not met.

"IADL" means the instrumental activities of daily living.

"IADLs score in high risk range" means member's total weighted UCAT IADL score is 12 or more which indicates the member needs some help with 6 IADLs or cannot do 4 IADLs at all.

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

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

"Member Support high risk" means member's UCAT Member Support score is 25 which indicates in the UCAT assessor's clinical judgment, excluding from consideration existing Ryan White CARE Act, Indian Health Service, Medicaid NF, My Life, My Choice and/or State Plan Personal Care services, very little or no support is available from informal and formal sources and the member requires additional care that is not available through Medicare, Veterans Administration, or other Federal entitlement programs.

"Member Support moderate risk" means member's UCAT Member Support score is 15 which indicates in the UCAT assessor's clinical judgment, excluding from consideration existing Ryan White CARE Act, Indian Health Service, Medicaid NF, My Life, My Choice and/or State Plan Personal Care services, support from informal and formal sources is available, but overall, it is inadequate, changing, fragile or otherwise problematic and the member requires additional care that is not available through Medicare, Veterans Administration, or other federal entitlement programs.

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

"MSQ" means the mental status questionnaire.

"MSQ score in high risk range" means the member's total weighted UCAT MSQ score is 12 or more which indicates a severe orientation-memory-concentration impairment, or a severe memory impairment.

"MSQ score at the high end of the moderate risk range" means the member's total weighted UCAT MSQ score is (10) or (11) which indicates an orientation-memory-concentration impairment, or a significant memory impairment.

"Nutrition high risk" means a total weighted UCAT Nutrition score is 12 or more which indicates the member has significant eating difficulties combined with poor appetite, weight loss, and/or special diet requirements.

"Progressive degenerative disease process that responds to treatment" means a process such as, but not limited to, Multiple Sclerosis (MS), Parkinson's Disease, Human Immunodeficiency Virus (HIV), or Acquired Immunodeficiency Syndrome (AIDS), that, untreated, systematically impairs normal body function which leads to acute illness and/or disability but that reacts positively to a medically

prescribed treatment intervention (usually medication) which arrests or significantly delays the destructive action of the process.

"Social Resources high risk" means a total weighted UCAT Social Resources score is 15 or more, which indicates the member lives alone, combined within this subchapter, shall have the following meaning, unless the context clearly indicates otherwise:

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

(A) bathing,
(B) eating,
(C) dressing,
(D) grooming,
(E) transferring (includes getting in and out of a tub, bed to chair, etc.), none or very few social contacts and no supports in times of need.

SUBCHAPTER 5. SOONER SENIORS

317:50-5-2. Definitions

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

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

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

"ADLs score in high risk range" means the member's total weighted UCAT ADL score is 10 or more which indicates the member needs some help with 5 ADLs or that the member cannot do 3 ADLs at all plus the member needs some help with 1 other ADL.

"ADLs score at the high end of the moderate risk range" means member's total weighted UCAT ADL score is 8 or 9 which indicates the member needs help with 4 ADLs or the member cannot do 3 ADLs at all.

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

"Environment high risk" means member's UCAT Environment score is 25 which indicates in the UCAT assessor's clinical judgment, the physical environment is strongly negative or hazardous.

"Environment moderate risk" means member's UCAT Environment score is 15 which indicates in the UCAT assessor's clinical judgment, many aspects of the physical environment are substandard or hazardous.

"Health Assessment high risk" means member's UCAT health assessment score is 25 which indicates in the UCAT assessor's clinical judgment, the member has one or more chronic health conditions, whose symptoms are rapidly deteriorating, uncontrolled, or not well controlled and requiring a high frequency or intensity of medical care/oversight to bring under control and whose functional capacity is so limited as to require full time assistance or care performed daily, by, or under the supervision of professional personnel and has multiple unmet needs for services available only through the Sooner Seniors program or a Nursing Facility (NF) and requires NF placement immediately if these needs cannot be met by other means.

"Health Assessment low risk" means member's health assessment score is 5 which indicates, in the UCAT assessor's clinical judgment, the member has one or more chronic, stable, health conditions, whose symptoms are controlled or nearly controlled, which benefit from available, or usually available, medical treatment or corrective measures, and may have an unmet need for a service available only through the Sooner Seniors program or a Nursing Facility (NF) but is not likely to enter a NF if these needs are not met.

"Health Assessment moderate risk" means member's UCAT Health Assessment score is 15 which indicates in the UCAT assessor's clinical judgment, the member has one or more chronic changing health conditions, whose symptoms are fragile or worsening and require medical care/oversight, to bring under control or to maintain in a stable, controlled state and has multiple unmet needs for services available only through the Sooner Seniors program or a Nursing Facility (NF) and is likely to enter a NF if these needs are not met.

"IADL" means the instrumental activities of daily living.

"IADLs score in high risk range" means member's total weighted UCAT IADL score is 12 or more which indicates the member needs some help with 6 IADLs or cannot do 4 IADLs at all.

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

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

"Member Support high risk" means member's UCAT Member Support score is 25 which indicates in the UCAT assessor's clinical judgment, excluding from consideration existing Ryan White CARE Act, Indian Health Service, Medicaid NF, Sooner Seniors and/or State Plan Personal Care services, very little or no support is available from informal and formal sources and the member requires additional care that is not available through Medicare, Veterans Administration, or other Federal entitlement programs.

"Member Support moderate risk" means member's UCAT Member Support score is 15 which indicates in the UCAT assessor's clinical judgment, excluding from consideration existing Ryan White CARE Act, Indian Health Service, Medicaid NF, Sooner Seniors and/or State Plan Personal Care services, support from informal and formal sources is available,

but overall, it is inadequate, changing, fragile or otherwise problematic and the member requires additional care that is not available through Medicare, Veterans Administration, or other federal entitlement programs.

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

"MSQ" means the mental status questionnaire.

"MSQ score in high risk range" means the member's total weighted UCAT MSQ score is 12 or more which indicates a severe orientation-memory-concentration impairment, or a severe memory impairment.

"MSQ score at the high end of the moderate risk range" means the member's total weighted UCAT MSQ score is (10) or (11) which indicates an orientation-memory-concentration impairment, or a significant memory impairment.

"Nutrition high risk" means a total weighted UCAT Nutrition score is 12 or more which indicates the member has significant eating difficulties combined with poor appetite, weight loss, and/or special diet requirements.

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

"Social Resources high risk" means a total weighted UCAT Social Resources score is 15 or more, which indicates the member lives alone, combined with none or very few social contacts and no supports in times of need.

7.a-6 TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 35. MEDICAL ASSISTANCE FOR ADULTS AND CHILDREN-ELIGIBILITY
Subchapter 6. SoonerCare for Pregnant Women and Families with Children
Part 3. Application Procedures
317:35-6-15. [AMENDED]
Subchapter 7. Medical Services
Part 3. Application Procedures
317:35-7-15. [AMENDED]
(Reference APA WF # 11-08)

SUMMARY: Eligibility rules are revised to provide clarification regarding dates of application for SoonerCare services. Current rules are difficult to interpret and, in some instances, obsolete. The revisions will make interpreting rules easier for OHCA staff, contracted agency partners, and applicants to understand when an application is considered received and completed. Rules are further amended to add the Notification of Date of Service feature for hospitals in official agency policy.

BUDGET IMPACT: Agency staff has determined that these revisions will be 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, Section 5003 through 5016 of Title 63 of Oklahoma Statutes

PUBLIC HEARING: A public hearing was held on February 22, 2012. No comments were received before or during the public hearing regarding these changes.

SUBCHAPTER 6. SOONERCARE FOR PREGNANT WOMEN AND FAMILIES WITH CHILDREN
PART 3. APPLICATION PROCEDURES

317:35-6-15. Application for SoonerCare for Pregnant Women and Families with Children; forms

(a) **Application**. An application for categorically needy pregnant women and families with children consists of the SoonerCare application. The application form is signed by the individual, parent, spouse, guardian, or someone else acting on the individual's behalf. A categorically needy individual does not have to have received a medical service nor expect to receive one to be certified for SoonerCare.

(1) An application may be made in a variety of locations, for example, a physician's office, a hospital or other medical facility, Health Department, in the county OKDHS office, or online. A face to face interview is not required. Applications are mailed to the OHCA Eligibility Unit. When an individual indicates a need for SoonerCare, the physician or facility may forward an application to the OHCA Eligibility Unit for processing. If the applicant is

unable to sign the application, someone acting on his/her behalf may sign the application.

(2) OKDHS form 08MA005E, Notification of Needed Medical Services, is required only for preauthorization of medical services. Although not required, the form may be submitted by the physician or facility as notification for a need for medical service. The form also may be accepted as medical verification of pregnancy.

(3) Receipt of the SoonerCare Application form or OKDHS form 08MA005E constitutes an application for SoonerCare.

(4) If OKDHS form 08MA005E is received and a SoonerCare application cannot be completed, receipt of OKDHS form 08MA005E constitutes an application which must be registered and subsequently denied. The applicant and provider are notified by computer-generated notice.

(5) A hospital providing services may file an electronic Notification of Date of Service (NODOS) form with OHCA up to five days from the date services are rendered. The hospital, applicant, or someone acting on the applicant's behalf has fifteen days from the date the NODOS form was received by OHCA to submit a completed SoonerCare application. Filing a Notification of Date of Service does not guarantee coverage and if a completed application is not submitted within fifteen days, the NODOS is void.

(b) **Date of application**. When an application is made online, the date of application is the date the application is submitted online. ~~When application is made in the county office, the date of application is the date the applicant or someone acting on his/her behalf signs the application form. When the application is initiated outside the county office, the date of application is the date the application or OKDHS form 08MA005E is stamped with the date the application was received into the OHCA Eligibility Unit. When a request for SoonerCare is first made by an oral request to the county office, and the application form is signed later, the date of the oral request is entered in "red" on the application form above the date the form is signed. The date of the oral request is the date of application to be used. When OKDHS form 08MA005E is received in the OHCA Eligibility Unit prior to the completion of the application form, the date that OKDHS form 08MA005E is received is considered as the date of application and must be registered as an application. Certain providers may take applications and then forward them to the OHCA Eligibility Unit for SoonerCare eligibility determination. Under this circumstance, the application date is the date the applicant signed the application form for the provider.~~ The date of application for a paper application is the date a signed application is received and stamped in by contracted agency partners or OHCA. When a request for SoonerCare is made orally, and that request is followed within 20 days by a signed application, the documented date of the oral request is the date of application. When OKDHS form 08MA005E is received by OKDHS, or received by OHCA and forwarded to OKDHS, the earliest of the date stamps is considered the date of request and should be honored when followed within 20 days by a signed application for SoonerCare.

SUBCHAPTER 7. MEDICAL SERVICES
PART 3. APPLICATION PROCEDURES

317:35-7-15. Application for Medical Services; forms

(a) **Application**. An application for Medical Services consists of the Medical Assistance Application. The application form is signed by the

individual, parent, spouse, guardian or someone else acting on the individual's behalf. A individual does not have to have received a medical service nor expect to receive one to be certified for SoonerCare.

(1) An application may be made in a variety of locations, for example, a physician's office, a hospital or other medical facility or in the county OKDHS office. An application may be made online by individuals who are pregnant, have children or are applying for family planning services only. A face to face interview is not required. SoonerCare applications for women who are pregnant, families with children and for family planning services only are mailed to the OHCA Eligibility Unit. Applications for other medical services may be mailed or faxed to the local county OKDHS office. If faxed, it is not necessary to send the original application. When an individual indicates a need for health benefits, the physician or facility may forward an application or 08MA005E to the OKDHS county office of the patient's residence for processing. The physician or facility may forward an application or 08MA005E for individuals who are pregnant, have children or are applying for family planning services only to the OHCA Eligibility Unit for processing. If the applicant is unable to sign the application, someone acting on his/her behalf may sign the application.

(2) OKDHS form 08MA005E, Notification of Needed Medical Services, is required only for preauthorization of medical services. Although not required, the form may be submitted by the physician or facility as notification for a need for medical service. The form also may be accepted as medical verification of pregnancy.

(3) Receipt of the SoonerCare Application form or OKDHS form 08MA005E constitutes an application for SoonerCare.

(4) If OKDHS form 08MA005E is received and an application cannot be completed, receipt of OKDHS form 08MA005E constitutes an application which must be registered and subsequently denied. The applicant and provider are notified by computer-generated notice.

(5) If the applicant also wishes to apply for a State Supplemental Payment, either the applicant or his/her guardian must sign the Medical Assistance Application form.

(b) **Date of application**. When an application is made online, the date of application is the date the application is submitted online. ~~When application is made in the county office, the date of application is the date the applicant or someone acting on his/her behalf signs the application form. When the application is initiated outside the county office, the date of application is the date the application or OKDHS form 08MA005E is stamped into the OHCA Eligibility Unit. When an application is faxed, the application date is the date the fax is received. When a request for SoonerCare is first made by an oral request to the county office, and the application form is signed later, the date of the oral request is entered in "red" on the application form above the date the form is signed. The date of the oral request is the date of application to be used. When OKDHS form 08MA005E is received in the county office or the OHCA Eligibility Unit prior to the completion of the application form, the date that OKDHS form 08MA005E is received is considered as the date of application and must be registered as an application. Certain providers may take applications and then forward them to the OKDHS county office or the OHCA Eligibility Unit for SoonerCare eligibility determination. Under this circumstance, the application date is the date the member signed the~~

~~application form for the provider.~~ The date of application for a paper application is the date a signed application is received and stamped in by contracted agency partners or OHCA. When a request for SoonerCare is made orally, and that request is followed within 20 days by a signed application, the documented date of the oral request is the date of application. When OKDHS form 08MA005E is received by OKDHS, or received by OHCA and forwarded to OKDHS, the earliest of the date stamps is considered the date of request and should be honored when followed within 20 days by a signed application for SoonerCare.

7.a-7 TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 50. HOME AND COMMUNITY BASED SERVICES WAIVER
Subchapter 3. My Life, My Choice Waiver Services
317:50-3-4. [AMENDED]
(Reference APA WF # 11-13)

SUMMARY: OHCA rules for the My Life, My Choice Waiver are revised to clarify waiting list procedures for individuals who apply for services but cannot enter the waiver due to capacity limitations. The rules clarify that individuals applying for the waiver but unable receive services due to capacity limitations are placed on a waiting list and enter the waiver on a first on first off basis.

BUDGET IMPACT: Agency staff has determined that these revisions will be 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, Section 5003 through 5016 of Title 63 of the Oklahoma Statutes; Medically Fragile 1915(c) Home and Community Based Services (HCBS) Waiver program as approved by The Centers for Medicare and Medicaid Services (CMS).

PUBLIC HEARING: A public hearing was held on February 22, 2012. No comments were received before or during the public hearing regarding these changes.

SUBCHAPTER 3. MY LIFE, MY CHOICE

317:50-3-4. Application for My Life, My Choice Waiver services
(a) Within 60 days of completion of the Living Choice demonstration program, members choosing to stay in a home and community based setting may apply for transition into the My Life, My Choice Waiver. In order to transition from the Living Choice demonstration program to the My Life, My Choice Waiver, a recertification of eligibility is required. The member must meet all financial and medical eligibility requirements for recertification. The same application and eligibility processes used to certify members for SoonerCare long term care and Living Choice services will be reviewed to ensure any changes in member status will not affect eligibility for the My Life, My Choice Waiver. The original application and eligibility processes are set forth in 317:50-3-4(a)(1) through 317:50-3-6 below.

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

(A) All conditions of financial eligibility must be verified and documented in the case record. When current information is

already available that establishes financial eligibility, such information may be used by recording source and date of information. If the applicant also wishes to apply for a State Supplemental Payment, either the applicant or his/her guardian must sign the application form.

(B) An individual requesting waiver services, or the individual's community spouse may request an assessment of resources available to each spouse by using OKDHS form MA-11, Assessment of Assets, when SoonerCare application is not being made. The individual and/or spouse must provide documentation of resources. The assessment reflects all countable resources of the couple (owned individually or as a couple) and establishes the spousal share to be protected when subsequent determination of SoonerCare long-term care eligibility is made.

(C) When SoonerCare application is being made, an assessment of resources must be completed if it was not completed when the individual entered the NF or began receiving home and community based services. For applicants of the My Life, My Choice waiver, those resources owned by the couple the month the application was made determines the spousal share of resources. If the individual applied for SoonerCare at the time of entry into the Living Choice Program, Form MA-11 is not appropriate. However, the spousal share must be determined using the resource information provided on the SoonerCare application form and computed using OKDHS form MA-12, Title XIX Worksheet.

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

(b) **My Life, My Choice Waiver waiting list procedures.** My Life, My Choice Waiver Program ~~"available capacity in the month"~~ capacity is the number of ~~additional~~ members that may be enrolled in the Program ~~in a given month~~ without exceeding, on an annualized basis, the maximum number authorized by the waiver to be served in the waiver year. If available waiver capacity has been realized, requests for services are not processed as applications, but placed on a waiting list. As available capacity permits, the OHCA selects in chronological order (first on, first off) requests for services from the waiting list to forward for application processing. When waiver capacity exceeds the number on the waiting list and after all persons on the waiting list have been processed, waiting list procedures are suspended.

7.a-8 TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 50. HOME AND COMMUNITY BASED SERVICES WAIVER
Subchapter 5. Sooner Seniors Waiver Services
317:50-5-4. [AMENDED]
(Reference APA WF # 11-14)

SUMMARY: OHCA rules for the Sooner Seniors Waiver are revised to clarify waiting list procedures for individuals who apply for services but cannot enter the waiver due to capacity limitations. The rules clarify that individuals applying for the waiver but unable receive services due to capacity limitations are placed on a waiting list and enter the waiver on a first on first off basis.

BUDGET IMPACT: Agency staff has determined that these revisions will be 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, Section 5003 through 5016 of Title 63 of the Oklahoma Statutes; Medically Fragile 1915(c) Home and Community Based Services (HCBS) Waiver program as approved by The Centers for Medicare and Medicaid Services (CMS)

PUBLIC HEARING: A public hearing was held on February 22, 2012. No comments were received before or during the public hearing regarding these changes.

SUBCHAPTER 5. SOONER SENIORS

317:50-5-4. Application for Sooner Seniors Waiver services
(a) Within 60 days of completion of the Living Choice demonstration program, members choosing to stay in a home and community based setting may apply for transition into the Sooner Seniors Waiver. In order to transition from the Living Choice demonstration program to the Sooner Seniors Waiver, a recertification of eligibility is required. The member must meet all financial and medical eligibility requirements for recertification. The same application and eligibility processes used to certify members for SoonerCare long term care and Living Choice services will be reviewed to ensure any changes in member status will not affect eligibility for the Sooner Seniors Waiver. The original application and eligibility processes are set forth in 317:50-5-4(a)(1) through 317:50-5-6 below.

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

(A) All conditions of financial eligibility must be verified and documented in the case record. When current information is already available that establishes financial eligibility, such

information may be used by recording source and date of information. If the applicant also wishes to apply for a State Supplemental Payment, either the applicant or his/her guardian must sign the application form.

(B) An individual requesting waiver services, or the individual's community spouse may request an assessment of resources available to each spouse by using OKDHS form MA-11, Assessment of Assets, when SoonerCare application is not being made. The individual and/or spouse must provide documentation of resources. The assessment reflects all countable resources of the couple (owned individually or as a couple) and establishes the spousal share to be protected when subsequent determination of SoonerCare long-term care eligibility is made.

(C) When SoonerCare application is being made, an assessment of resources must be completed if it was not completed when the individual entered the NF or began receiving home and community based services. For applicants of the Sooner Seniors waiver, those resources owned by the couple the month the application was made determines the spousal share of resources. If the individual applied for SoonerCare at the time of entry into the Living Choice Program, Form MA-11 is not appropriate. However, the spousal share must be determined using the resource information provided on the SoonerCare application form and computed using OKDHS form MA-12, Title XIX Worksheet.

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

(b) **Sooner Seniors Waiver waiting list procedures.** Sooner Seniors Waiver Program ~~"available capacity in the month"~~ capacity is the number of ~~additional~~ members that may be enrolled in the Program ~~in a given month~~ without exceeding, on an annualized basis, the maximum number authorized by the waiver to be served in the waiver year. If available waiver capacity has been realized, requests for services are not processed as applications, but placed on a waiting list. As available capacity permits, the OHCA selects in chronological order (first on, first off) requests for services from the waiting list to forward for application processing. When waiver capacity exceeds the number on the waiting list and after all persons on the waiting list have been processed, waiting list procedures are suspended.

7.a-9 TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 35. MEDICAL ASSISTANCE FOR ADULTS AND CHILDREN-ELIGIBILITY
Subchapter 5. Eligibility and Countable Income
Part 5. Countable Income and Resources
317:35-5-41.8 [AMENDED]
(Reference APA WF # 11-15)

SUMMARY: Oklahoma Health Care Authority long-term care eligibility rules are revised to include a brief description of the Long-term Care Partnership program. The Long-term Care Partnership program (LTCP) allows individuals with qualified LTCP insurance policies the opportunity to protect certain assets in determining eligibility for SoonerCare long term care services.

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

MEDICAL ADVISORY COMMITTEE: The Medical Advisory Committee considered the proposed rule revisions on November 16, 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; Oklahoma Long-term Care Partnership Act, 63 O.S. § 1-1955.1, et seq.

PUBLIC HEARING: A public hearing was held on February 22, 2012. No comments were received before or during the public hearing regarding these changes.

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

317:35-5-41.8. Eligibility regarding long-term care services
(a) **Home Property**. In determining eligibility for long-term care services for applications filed on or after January 1, 2006, home property is excluded from resources unless the individual's equity interest in his or her home exceeds $500,000.

(1) Long-term care services include nursing facility services and other long-term care services. For purposes of this Section, other long-term care services include services detailed in (A) through (B) of this paragraph.

(A) A level of care in any institution equivalent to nursing facility services; and

(B) Home and community-based services furnished under a waiver.

(2) An individual whose equity interest exceeds $500,000 is not eligible for long-term care services unless one of the following circumstances applies:

(A) The individual has a spouse who is lawfully residing in the individual's home;

(B) The individual has a child under the age of twenty-one who is lawfully residing in the individual's home;

(C) The individual has a child of any age who is blind or permanently and totally disabled who is lawfully residing in the

individual's home; or

(D) The denial would result in undue hardship. Undue hardship exists when denial of SoonerCare long-term care services based on an individual's home equity exceeding $500,000 would deprive the individual of medical care such that the individual's health or life would be endangered; or of food, clothing, shelter, or other necessities of life.

(3) Absence from home due to nursing facility care does not affect the home exclusion as long as the individual intends to return home within 12 months from the time he/she entered the facility. The OKDHS Form 08MA010E, Acknowledgment of Temporary Absence/Home Property Policy, is completed at the time of application for nursing facility care when the applicant has home property. After explanation of temporary absence, the member, guardian or responsible person indicates whether there is or is not intent to return to the home and signs the form.

(A) If at the time of application the applicant states he/she does not have plans to return to the home, the home property is considered a countable resource. For members in nursing facilities, a lien may be filed in accordance with OAC 317:35-9-15 and OAC 317:35-19-4 on any real property owned by the member when it has been determined, after notice and opportunity for a hearing, that the member cannot reasonably be expected to be discharged and return home. However, a lien is not filed on the home property of the member while any of the persons described in OAC 317:35-9-15(b)(1) and OAC 317:35-19-4(b)(1) are lawfully residing in the home:

(B) If the individual intends to return home, he/she is advised that:

(i) the 12 months of home exemption begins effective with the date of entry into the nursing home regardless of when application is made for SoonerCare benefits, and

(ii) after 12 months of nursing care, it is assumed there is no reasonable expectation the member will be discharged from the facility and return home and a lien may be filed against real property owned by the member for the cost of medical services received.

(C) "Intent" in regard to absence from the home is defined as a clear statement of plans in addition to other evidence and/or corroborative statements of others.

(D) At the end of the 12-month period the home property becomes a countable resource unless medical evidence is provided to support the feasibility of the member to return to the home within a reasonable period of time (90 days). This 90-day period is allowed only if sufficient medical evidence is presented with an actual date for return to the home.

(E) A member who leaves the nursing facility must remain in the home at least three months for the home exemption to apply if he/she has to re-enter the facility.

(F) However, if the spouse, minor child(ren) under 18, or relative who is aged, blind or disabled or a recipient of TANF resides in the home during the individual's absence, the home continues to be exempt as a resource so long as the spouse or relative lives there (regardless of whether the absence is temporary).

(G) For purpose of this reference a relative is defined as:

son, daughter, grandson, granddaughter, stepson, stepdaughter, in-laws, mother, father, stepmother, stepfather, half-sister, half-brother, niece, nephew, grandmother, grandfather, aunt, uncle, sister, brother, stepbrother, or stepsister.

(H) Once a lien has been filed against the property of an NF resident, the property is no longer considered as a countable resource.

(b) **Promissory notes, loans, or mortgages**. The rules regarding the treatment of funds used to purchase a promissory note, loan, or mortgage on or after February 8, 2006, are found in (1) through (2) of this subsection.

(1) Funds used to purchase a promissory note, loan, or mortgage on or after February 8, 2006, are treated as assets transferred for less than fair market value in the amount of the outstanding balance due on the note, loan, or mortgage as of the date of the individual's application for medical assistance unless the note, loan, or mortgage meets all of the conditions in paragraphs (A) through (C) of this paragraph.

(A) The note, loan, or mortgage has a repayment term that is actuarially sound (as determined in accordance with actuarial publications of the Office of the Chief Actuary of the United States Social Security Administration).

(B) The note, loan, or mortgage provides for payments to be made in equal amounts during the term of the loan, with no deferral and no balloon payments made.

(C) The note, loan, or mortgage prohibits the cancellation of the balance upon the death of the lender.

(2) Funds used to purchase a promissory note, loan, or mortgage for less than its fair market value are treated as assets transferred for less than fair market value regardless of whether:

(A) The note, loan, or mortgage was purchased before February 8, 2006; or

(B) The note, loan, or mortgage was purchased on or after February 8, 2006, and the conditions described in paragraph (1) of this subsection were met.

(c) **Annuities**. Treatment of annuities purchased on or after February 8, 2006.

(1) The entire amount used to purchase an annuity on or after February 8, 2006, is treated as assets transferred for less than fair market value unless the annuity meets one of the conditions described in (A) through (C) of this paragraph.

(A) The annuity is an annuity described in subsection (b) or (q) of Section 408 of the United States Internal Revenue Code of 1986.

(B) The annuity is purchased with proceeds from:

(i) An account or trust described in subsection (a), (c), or (p) of Section 408 of the United States Internal Revenue Code of 1986;

(ii) A simplified employee pension as defined in Section 408(k) of the United States Internal Revenue Code of 1986;

(iii) A Roth IRA described in Section 408A of the United States Internal Revenue Code of 1986.

(C) The annuity:

(i) is irrevocable and nonassignable;

(ii) is actuarially sound as determined in accordance with actuarial publications of the Office of the Chief Actuary of

the United States Social Security Administration; and

(iii) provides for payments in equal amounts during the term of the annuity, with no deferral and no balloon payments made.

(2) In addition, the entire amount used to purchase an annuity on or after February 8, 2006, is treated as a transfer of assets unless the Oklahoma Health Care Authority is named as the remainder beneficiary either:

(A) in the first position for at least the total amount of medical assistance paid on behalf of the institutionalized individual; or

(B) in the second position after the community spouse, child under 21 years of age, or disabled child and in the first position if the spouse or a representative of the child disposes of any of the remainder for less than fair market value.

(d) **Life Estates**. This subsection pertains to the purchase of a life estate in another individual's home.

(1) The entire amount used to purchase a life estate in another individual's home on or after February 8, 2006, is treated as assets transferred for less than fair market value, unless the purchaser resides in the home for at least one year after the date of the purchase.

(2) Funds used to purchase a life estate in another individual's home for less than its fair market value are treated as assets transferred for less than fair market value regardless of whether:

(A) The life estate was purchased before February 8, 2006; or

(B) The life estate was purchased on or after February, 8, 2006, and the purchaser resided in the home for one year after the date of purchase.

(e) **Oklahoma Long-Term Care Partnership (LTCP) Program.** This subsection pertains to individuals with Oklahoma Long-Term Care Partnership policies. The Oklahoma Insurance Department approves long-term care insurance policies as Long-term Care Partnership Program policies. The face page of the policy document will indicate if the insurance qualifies as a Long Term Care Partnership Program policy.

(1) Benefits from the LTCP policy must be exhausted before the individual can be eligible for long term care under the SoonerCare program.

(2) Assets in an amount equal to the amount paid out under the LTCP policy can be protected for the insured individual once the LTCP policy benefits are exhausted. Protected assets are disregarded when determining eligibility for the SoonerCare program per 317:35-5-41.9(26). A record of the amount paid on behalf of the policy holder is available through the OHCA or insurance company holding the LTCP policy.

(A) At the time of application for SoonerCare the individual must determine the asset(s) to be protected. The protected asset(s) cannot be changed. If the value of the protected asset(s) decreases, the individual does not have the option to select additional assets to bring the total up to the protected amount.

(B) If the protected asset(s) are income-producing, the income earned while on SoonerCare is counted in accordance with 317:35-5-42.

(C) The individual can choose to transfer the protected asset without incurring a transfer of assets penalty.

(D) When determining resource eligibility for a couple when one of them enters the nursing home or applies for a HCBS waiver, the LTCP protected asset(s) are disregarded in determining the total amount of the couple's resources.

7.a-10 TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
Subchapter 5. Individual Providers and Specialties
Part 3. Hospitals
317:30-5-42.6. [AMENDED]
Part 29. Renal Dialysis Facilities
317:30-5-306. [AMENDED]
317:30-5-307. [AMENDED]
(Reference APA WF # 11-19)

SUMMARY: Policy, the State Plan, and reimbursement methodology will be updated to correspond to new Medicare guidelines regarding payment to End Stage Renal Disease (ESRD) facilities. Currently policy and methodology utilizes Medicare's old composite rate for a defined set of ESRD items and services, while paying separately for services not included in the composite rate, such as drugs and laboratory tests. This payment system is replaced with a new bundled prospective payment system (PPS), in which a single bundled payment to the ESRD facility for each treatment will cover all renal dialysis services. If the change is not made, OHCA will be out of line with Medicare reimbursement rates for this provider type.

BUDGET IMPACT: Agency staff has determined that these revisions will have an estimated annual budget impact of $949,000 total dollars; $344,000 State share.

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, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; Public Law 110-275, Section 153; 42 CFR Parts 410, 413, and 414; CMS-1418-F (Federal Register Vol. 75, No. 155)

PUBLIC HEARING: A public hearing was held on February 22, 2012. No comments were received before or during the public hearing regarding these changes.

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 3. HOSPITALS

317:30-5-42.6. Dialysis

Payment for dialysis is made at the ~~all-inclusive~~ Medicare ~~allowable composite~~ prospective payment system wage adjusted base rate. This rate includes all services which Medicare has established as an integral part of the dialysis procedure~~, such as routine medical supplies, certain laboratory procedures, oxygen, etc. Payment is made separately for injections of Epoetin Alfa (EPO or Epogen)~~. The physician is reimbursed separately.

PART 29. RENAL DIALYSIS FACILITIES

317:30-5-306. Coverage by category

Payment is made to renal dialysis facilities as set forth in this Section.

(1) **Adults.** Payment is made for outpatient renal dialysis for adults at the ~~composite~~ PPS rate.

(2) **Children.** Coverage for children is the same as for adults.

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

317:30-5-307. Payment methodology

Payment of in-facility dialysis treatments and home dialysis treatment is made under the ~~composite~~ PPS rate reimbursement system ~~as established by Medicare~~.

(1) All items and services included under the ~~composite~~ PPS rate must be furnished by the facility, either directly or under arrangements, to all of its dialysis patients. If the facility fails to furnish (either directly or under arrangements) any part of the items and services covered under the rate, then the facility cannot be paid any amount for the part of the items and services that the facility does furnish. These items and services include:

(A) medically necessary dialysis equipment and dialysis support equipment;

(B) home dialysis support services including the delivery, installation, maintenance, repair, and testing of home dialysis equipment, and home support equipment;

(C) purchase and delivery of all necessary dialysis supplies;

(D) routine ESRD related laboratory tests~~,~~; and

(E) all dialysis services furnished by the facility's staff.

(2) Some examples (but not an all-inclusive list) of items and services that are included in the ~~composite~~ PPS rate and may not be billed separately when furnished by a dialysis facility are:

(A) staff time used to administer blood;

(B) declotting of shunts and any supplies used to declot shunts;

(C) oxygen and the administration of oxygen; and

(D) staff time used to administer nonroutine peritoneal items.

7.a-11 TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
Subchapter 3. General Provider Policies
Part 1. General Scope and Administration
317:30-3-2. [AMENDED]
(Reference APA WF # 11-20)

SUMMARY: Provider agreement rules are revised to ensure clarity. Revisions are made to reflect language in 42 CFR 455.414; that provider agreements must be renewed at least every five years. Additionally, revisions are made to revise the contact information for the OHCA Provider Contracting Unit.

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

MEDICAL ADVISORY COMMITTEE: The Medical Advisory Committee considered the proposed rule revisions on November 16, 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 455.414

PUBLIC HEARING: A public hearing was held on February 22, 2012. No comments were received before or during the public hearing regarding these changes.

SUBCHAPTER 3. GENERAL PROVIDER POLICIES
PART 1. GENERAL SCOPE AND ADMINISTRATION

317:30-3-2. Provider agreements

In order to be eligible for payment, providers must have on file with OHCA, an approved Provider Agreement. Through this agreement, the provider certifies all information submitted on claims is accurate and complete, assures that the State Agency's requirements are met and assures compliance with all applicable Federal and State regulations. These agreements are renewed ~~annually~~ at least every 5 years with each provider.

(1) The provider further assures compliance with Section 1352, Title 31 of the U.S. Code and implemented at 45 CFR Part 93 which provides that if payments pursuant to services provided under Medicaid are expected to exceed $100,000.00, the provider certifies federal funds have not been used nor will they be used to influence the making or continuation of the agreement to provide services under Medicaid. Upon request, the Authority will furnish a standard form to the provider for the purpose of reporting any non-federal funds used for influencing agreements.

(2) The provider assures in accordance with 31 ~~USCA~~ USC 6101, Executive Order 12549, that they are not presently or have not in the last three years been debarred, suspended, proposed for debarment or declared ineligible by any Federal department or agency.

(3) For information regarding ~~annual~~ Provider Agreements or for problems related to a current agreement, contact the Oklahoma Health Care Authority, Provider Enrollment, ~~P.O. Box 18299, Oklahoma City, Oklahoma 73154-0299, or call 1-800-871-9347 for out-of-state or~~

~~405-525-1092 from within the state.~~ P.O. Box 54015, Oklahoma City, Oklahoma 73154, or call 1-800-522-0114 option 5 toll free or 405-522-6205 for the Oklahoma City area.

7.a-12 TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
Subchapter 5. Individual Providers and Specialties
Part 113. Living Choice Program
317:30-5-1201. [AMENDED]
CHAPTER 35. MEDICAL ASSISTANCE FOR ADULTS AND CHILDREN-ELIGIBILITY
Subchapter 23. Living Choice Program
317:35-23-2. [AMENDED]
317:35-23-3. [AMENDED]
317:35-23-4. [AMENDED]
(Reference APA WF # 11-21 A & B)

SUMMARY: Living Choice Program rules are revised to add Assisted Living services as a compensable service under the Living Choice demonstration program for the elderly and those with physical disabilities. Assisted Living services are personal care and supportive services that are furnished to Living Choice members who reside in an OHCA certified assisted living center. Additionally, rules are revised to add Private Duty Nursing as an allowable service and revise the re-enrollment policy to allow members who have been in Living Choice for the maximum 365 days, and have been re-institutionalized for a minimum of 90 consecutive days, the opportunity to re-enroll in the Living Choice program for an additional 365 days. Finally, rules are revised to include coverage for people who have transitioned to the community from institutions for mental disease.

BUDGET IMPACT: Agency staff has determined that these revisions will have an estimated annual budget impact of $14,866 State dollars and $112,908 Federal.

MEDICAL ADVISORY COMMITTEE: The Medical Advisory Committee considered the proposed rule revisions on March 7, 2012 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 6071 of the Deficit Reduction Act of 2005, Section 2403 of the Affordable Care Act, June 1, 2011 CMS guidance correspondence

PUBLIC HEARING: A public hearing was held on February 22, 2012. No comments were received before or during the public hearing regarding these changes.

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 113. LIVING CHOICE PROGRAM

317:30-5-1201. Benefits for members with ~~mental retardation~~ intellectual disabilities
(a) Living Choice program participants with ~~mental retardation~~ intellectual disabilities may receive a range of necessary medical and home and community based services for one year after moving from the institution. The one year period begins the day the member occupies a qualified residence in the community. Once this transition period is complete, the member receives services through the Community waiver.

(b) Services must be billed using the appropriate HCPCS or CPT codes and must be medically necessary.
(c) All services must be necessary for the individual to live in the community, require prior authorization, and must be documented in the individual transition plan. The number of units of services the member is eligible to receive is limited to the amounts approved in the transition plan. The transition plan may be amended as the member's needs change.
(d) Services that may be provided to members with ~~mental retardation~~ intellectual disabilities are listed in paragraphs (1) through (28) of this subsection:

(1) assistive technology;
(2) adult day health care;
(3) architectural modifications;
(4) audiology evaluation and treatment;
(5) community transition;
(6) daily living support;
(7) dental services;
(8) family counseling;
(9) family training;
(10) group home;
(11) respite care;
(12) homemaker services;
(13) habilitation training services;
(14) home health care;
(15) intensive personal support;
(16) extended duty nursing;
(17) skilled nursing;
(18) nutrition services;
(19) therapy services including physical, occupational, and speech;
(20) psychiatry services;
(21) psychological services;
(22) agency companion services;
(23) non-emergency transportation;
(24) pre-vocational services;
(25) supported employment services;
(26) specialized foster care;
(27) specialized medical equipment and supplies; and
(28) SoonerCare compensable medical services.

CHAPTER 35. MEDICAL ASSISTANCE FOR ADULTS AND CHILDREN-ELIGIBILITY
SUBCHAPTER 23. LIVING CHOICE PROGRAM

317:35-23-2. Eligibility criteria

Adults with disabilities or long-term illnesses, members with ~~mental retardation~~ intellectual disabilities and members with physical disabilities are eligible to transition into the community through the Living Choice program if they meet all of the criteria in paragraphs (1) through (7) of this subsection.
(1) He/she must be at least 19 years of age.
(2) He/she must reside in an institution (nursing facility or public ICF/MR) for at least 90 consecutive days prior to the proposed transition date. If any portion of the 90 days includes time in a skilled nursing facility, those days cannot be counted toward the 90 day requirement, if the member received Medicare post-hospital extended care rehabilitative services.

(3) He/she must have at least one day of Medicaid paid long-term care services prior to transition.
(4) If transitioning from an out of state institution, he/she must be SoonerCare eligible.
(5) He/she requires at least the same level of care that necessitated admission to the institution.
(6) He/she must reside in a qualified residence after leaving the institution. A qualified residence is defined in (A) through (C) of this paragraph.
(A) a home owned or leased by the individual or the individual's family member;
(B) an apartment with an individual lease, with a locking entrance/exit, and which includes living, sleeping, bathing, and cooking areas over which the individual or the individual's family has domain and control; and
(C) a residence, in a community-based residential setting, in which no more than four unrelated individuals reside.
(7) His/her needs can be met by the Living Choice program while living in the community.
(8) He/she must not be a resident of a nursing facility or ICF/MR in lieu of incarceration.

317:35-23-3. Participant disenrollment

(a) ~~Members are~~ A member is disenrolled from the program if he/she:
(1) is admitted to a hospital, nursing facility, ICF/MR, residential care facility or behavioral health facility for more than 30 consecutive days;
(2) is incarcerated;
(3) is determined to no longer meet SoonerCare financial eligibility for home and community based services;
(4) determined by the Social Security Administration or OHCA Level of Care Evaluation Unit to no longer have a disability that qualifies for services under the Living Choice program; or
(5) moves out of state.

(b) Payment cannot be made for an individual who is in imminent danger of harm to self or others.

317:35-23-4. Re-enrollment

(a) **Members in the Living Choice Program.**
(1) The member remains eligible during periods of institutionalization as long as the stay does not exceed 30 days.
~~(a)~~ (2) A member with an institutional stay longer than 30 days may re-enroll in the program without ~~residing in an institution for the six months prior~~ re-establishing the 90 day institutional residency requirement if:
~~(1)~~ (A) the necessity for the institutionalization is documented in the revised individual transition plan; and
~~(2)~~ (B) the member can safely return to the community as determined by the transition coordinator, the member and the transition planning team.
(3) The re-enrolled member is eligible to receive services for any remaining days up to the 365 day limit.

~~(b) The member remains eligible during hospitalization and convalescent care periods as long as the stay does not exceed six months~~.

(b) **Members no longer in the Living Choice Program.**
(1) Members who have completed 365 days in the Living Choice Program

and have been re-institutionalized for a minimum of 90 consecutive days may be eligible for re-enrollment in the Living Choice Program. Before re-enrollment of a former member, a re-evaluation of the former member's plan of care must be completed and a determination made if the plan of care could not be carried out as a result of:

(A) medical and/or behavioral changes resulting in the necessity of readmission into the inpatient facility;

(B) the lack of community services to support the member that were identified in the original plan of care; or

(C) the plan of care was not supported by the delivery of quality services.

(2) After determining the basis for re-institutionalization and creation of a new plan of care that ensures the health and safety of the former member, he/she may be re-enrolled for an additional 365 days.

7.a-13 TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
Subchapter 5. Individual Providers and Specialties
Part 32. SoonerRide Non-Emergency Transportation
317:30-5-326.1. [AMENDED]
317:30-5-327. [AMENDED]
317:30-5-327.1. [AMENDED]
317:30-5-327.2. [REVOKED]
317:30-5-328. [NEW]
CHAPTER 35. MEDICAL ASSISTANCE FOR ADULTS AND CHILDREN-ELIGIBILITY
Subchapter 3. Coverage and Exclusions
317:35-3-2. [AMENDED]
(Reference APA WF # 11-25 A & B)

SUMMARY: SoonerCare non-emergency transportation rules are revised to clarify OHCA's current policy concerning meals and lodging, travel distance, and eligibility. This rule will assist with future cost savings and prevent abuse of services. This rule will also ensure services for current and future SoonerCare members.

BUDGET IMPACT: Agency staff has determined that these revisions will be 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, and Sections 5003 through 5016 of Title 63 of the Oklahoma Statutes.

PUBLIC HEARING: A public hearing was held on February 22, 2012. Written comments were received before or during the public hearing regarding these changes and were incorporated into the rulemaking process.

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 32. SOONERRIDE NON-EMERGENCY TRANSPORTATION

317:30-5-326.1. Definitions

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

"Attendant" means an employee of the nursing facility who is provided by and trained by the nursing facility at the nursing facility's expense.

"Emergency" means a serious situation or occurrence that happens unexpectedly and demands immediate action such as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected, by a reasonable and prudent layperson, to result in placing the members' health in serious jeopardy, serious impairment to bodily function, or serious dysfunction of any bodily organ or part.

"~~Escort~~Medical escort" means a family member, ~~or~~ legal guardian, or volunteer whose presence is required and medically necessary to assist

a member during transport and while at the place of treatment. ~~An~~ A medical escort voluntarily accompanies the member during transport and leaves the vehicle at its destination and remains with the member. ~~An~~ A medical escort must be of an age of legal majority recognized under State law.

"Member/eligible member" means any person eligible for SoonerCare ~~with the exception of~~ and individuals considered to be Medicare/SoonerCare full dually eligible. This does not include those individuals who are categorized only as Qualified Medicare Beneficiaries ~~Plus (QMBP)~~ (QMB), Specified Low Income Medicare Beneficiaries (SLMB), Qualifying Individuals-1 (QI-1), individuals who are in an institution for mental disease (IMD), inpatient, institutionalized, Home and Community Based Waiver members, with the exception of the In-home Supports Waiver for Children ~~and~~, the Advantage Waiver, the Living Choice demonstration, the Sooner Seniors Waiver, the My Life; My Choice Waiver and the Medically Fragile Waiver.

"Nearest appropriate facility" means a medical facility that is generally equipped and legally permitted to provide the needed care for the illness or injury involved that is the closest in geographical proximity to the members' residence with exceptions. In the case of approved hospital services, it also means that a physician or physician specialist is available to provide the necessary care required to treat the member's condition. The fact that a particular physician does or does not have staff privileges in a hospital is not a consideration in determining whether the hospital has appropriate facilities. Thus, non-emergency transportation service to a more distant hospital, clinic, practitioner or physicians' office solely to avail a member of the service of a specific physician or physician specialist does not make the institution in which the physician has staff privileges the nearest institution with appropriate facilities.

"Non-ambulance" means a carrier that is not an ambulance.

"Non-emergency" means all reasons for transportation that are not an emergency as defined above.

"SoonerRide Non-Emergency Transportation (NET)" means non-emergency non-ambulance transportation provided statewide within the geographical boundaries of the State of Oklahoma.

317:30-5-327. Eligibility for SoonerRide ~~non-emergency non-ambulance transportation eligibility~~ NET

Transportation ~~must be for medically necessary treatment~~ is provided when medically necessary in connection with examination and treatment to the nearest appropriate facility in accordance with 42 CFR 441.170. As the Medicaid Agency, OHCA is the payer of last resort, with few exceptions. When other resources are available, those resources must first be utilized. Exceptions to this policy are those receiving medical treatment through Indian Health Services and those eligible for the Crime Victims Compensation Act. Individuals considered fully dual eligible qualify for SoonerRide. However, SoonerRide excludes those individuals who are categorized as:

(1) Qualified Medicare Beneficiaries ~~Plus (QMBP)~~ (QMB);
(2) Specified Low Income Medicare Beneficiaries (SLMB);
(3) Qualifying Individuals-1 and individuals who are in an institution for mental disease (IMD);
(4) inpatient;
(5) institutionalized (i.e. long-term care facility);

(6) Home and Community Based Waiver members, with the exception of the In-home Supports Waiver for Children ~~and~~, the Advantage Waiver, the Living Choice demonstration, the Sooner Seniors Waiver, the My Life; My Choice Waiver and the Medically Fragile Waiver.

317:30-5-327.1. ~~Access to non-emergency non-ambulance transportation through SoonerRide~~ SoonerRide NET Coverage

(a) SoonerRide NET is available for SoonerCare covered admission and discharge into inpatient hospital care, outpatient hospital care, services from physicians/approved practitioners, diagnostic services, clinic services, pharmacy services, eye care and dental care under the following conditions:

(1) Transportation is to the nearest appropriate facility or medical provider capable of providing the necessary services.

(A) The nearest appropriate facility or provider is not considered appropriate if the member's condition requires a higher level of care or specialized services available at the more distant facility. However, a legal impediment barring a member's admission would mean that the institution did not have "appropriate facilities". For example, the nearest transplant center may be in another state and that state's law precludes admission of nonresidents.

(B) The nearest appropriate facility is not considered appropriate if no bed or provider is available. However, the medical records must be properly documented.

(C) Services should be available within 45 miles of the members' residence with exceptions. The OHCA has discretion and the final authority to approve or deny travel greater than 45 miles to access services.

(i) Members seeking self-referred services are limited to the 45 mile radius.

(ii) Native Americans seeking services at a tribal or I.H.S facility may be transported to any facility within a 45 mile radius equipped for their medical needs with exceptions. Trips to out-of-state facilities require prior approval.

(iii) Veterans may be transported to the nearest Veterans Affairs (VA) facility equipped for their medical needs. Trips to out-of-state VA facilities require prior approval.

(iv) Duals may be transported to any facility within a 45 mile radius equipped for their medical needs with exceptions. Trips to out-of-state facilities require prior approval.

(2) The service provided must be a SoonerCare covered service provided by a medical provider who is enrolled in the SoonerCare program; and

(3) Services requiring prior authorization must have been authorized (e.g. travel that exceeds the 45 mile radius, out-of-state travel, meals and lodging services).

~~(a)~~(b) ~~Non-emergency, non-ambulance transportation services are available through the state's SoonerRide Non-Emergency Transportation (NET) program.~~ SoonerRide NET is available on a statewide basis to all eligible members.

~~(b)~~(c) ~~SoonerRide NET includes non-emergency, non-ambulance transportation for members to and from SoonerCare providers of health care services. Eligible providers are providers who have valid OHCA contracts. The NET must be to access medically necessary covered services for which a member has available benefits. Additionally,~~

SoonerRide NET may also be provided for eligible members to providers other than SoonerCare providers if the transportation is to access medically necessary services covered by SoonerCare.
~~(c)~~(d) ~~The use of SoonerCare funded transportation for any other purpose is fraudulent activity and subject to criminal prosecution and civil and administrative sanctions.~~ SoonerRide NET is available if a member is being discharged from a facility to their home. The facility is responsible for scheduling the transportation.
~~(d) The SoonerRide broker assures that NET transportation services are provided:~~

~~(1) in a manner consistent with the best interest of the member;~~
~~(2) similar in scope and duration state-wide, although there will be some variation based on available resources in a particular geographical area of the state;~~
~~(3) appropriate to available services; and~~
~~(4) appropriate for the limitations of the member.~~

(e) In documented medically necessary instances, a medical escort may accompany the member.

(1) SoonerRide NET is not required to transport any additional individuals other than the one approved individual providing the escort services. In the event that additional individuals request transportation, the SoonerRide broker may charge those family members according to the SoonerRide broker's policies which have been approved by the OHCA.
(2) A medical escort is not eligible for direct compensation by the SoonerRide broker or SoonerCare.

317:30-5-327.2. Service availability [REVOKED]

~~(a) SoonerRide NET is available for SoonerCare covered admission and discharge into inpatient hospital care, outpatient hospital care, services from physicians, diagnostic devices, clinic services, pharmacy services, eye care and dental care.~~
~~(b) SoonerRide NET is available if a member is being discharged from a facility to home. The facility is responsible for scheduling the transportation.~~
~~(c) In documented medically necessary instances, may wish to accompany the member for health care services. In such instances, the family member or legal guardian may accompany the member.~~

~~(1) SoonerRide is not required to transport any additional family members other than the one family member providing escort services. In the event that additional family members request transportation, the SoonerRide broker may charge those family members according to the SoonerRide broker's policies which have been approved by the OHCA.~~
~~(2) A escort is not eligible for direct compensation by the SoonerRide broker or SoonerCare.~~

317:30-5-328. Subsistence (sleeping accommodations and meals)

(a) Lodging and meals assistance for eligible members is provided only when medically necessary in connection with transportation to and from SoonerCare compensable services. All efforts to secure a temporary place to stay either by the hospital or a nonprofit organization must be exhausted prior to seeking reimbursement for lodging.

(1) Lodging and/or meals are reimbursable when prior authorized. The following factors may be considered by OHCA when authorizing reimbursement:

(A) travel is to obtain specialty care; and
(B) the trip cannot be completed during SoonerRide operating hours;
(C) the trip is more than 100 miles from the member's city of residence; or
(D) the treatment requires an overnight stay.

(2) When a member is not required to have a PCP or when a PCP referral is not required to obtain a SoonerCare covered service, a member may go to any provider they choose but SoonerCare will not reimburse for transportation, lodging, or meals if the distance is beyond what is considered the nearest appropriate facility.

(3) Meals will be reimbursed only if an overnight stay occurs and the stay meets the lodging criteria.

(4) Reimbursement for meals is based on a daily per diem and may be used for breakfast, lunch or dinner, or all three meals, whichever is required. A member may not receive reimbursement for lodging and meals for days the member is an inpatient in a hospital or medical facility.

(5) During inpatient or outpatient medical stays, meals and lodging are limited to 14 days for each medical stay unless the OHCA prior authorizes additional days. A member may not receive reimbursement for lodging and meals for days the member is an inpatient in a hospital or medical facility.

(b) A member who needs lodging and/or meals assistance must first seek services with a contracted lodging provider. If the lodging provider provides meals the member may not be reimbursed for services billable by the contracted lodging provider. If lodging and/or meals assistance with contracted lodging providers are not available, the member may request reimbursement assistance by submitting a travel reimbursement form. The travel reimbursement form may be obtained by contacting SoonerCare Care Management division. Any lodging and/or meal expenses claimed on the travel reimbursement form must be documented with receipts, and reimbursement must not exceed state per diem amounts. The OHCA has discretion and the final authority to approve or deny meals and lodging reimbursement.

CHAPTER 35. MEDICAL ASSISTANCE FOR ADULTS AND CHILDREN-ELIGIBILITY
SUBCHAPTER 3. COVERAGE AND EXCLUSIONS

317:35-3-2. SoonerCare transportation and subsistence

(a) The Oklahoma Health Care Authority (OHCA) is responsible for assuring that necessary transportation is available to all eligible SoonerCare members who are in need of SoonerCare medical services in accordance with 42 CFR 431.53. The agency contracts with a broker to provide statewide curb to curb coverage for non-emergency transportation under the SoonerRide program. The broker provides the most appropriate and least costly mode of transportation necessary to meet the individual needs of SoonerCare members. ~~Payment for covered services to the broker is reimbursed under a capitated methodology based on per member per month.~~ As the Medicaid Agency, OHCA is the payer of last resort, with few exceptions. When other resources are available, those resources must first be utilized. Exceptions to this policy are those receiving medical treatment through Indian Health Services and those eligible for the Crime Victims Compensation Act. The agency contracts directly with ambulance and air providers for all

other transportation needs for eligible members not provided by SoonerRide. SoonerRide excludes those individuals who are categorized as:

(1) Qualified Medicare Beneficiaries ~~Plus~~ ~~(QMBP)~~ (QMB)when SoonerCare pays only the Medicare premium, deductible, and co-pay;
(2) Specified Low Income Medicare Beneficiaries (SLMB);
(3) Qualifying Individuals-1;
(4) individuals who are in an institution for mental disease (IMD), ~~inpatient;~~
(5) inpatient;
~~(5)~~(6) institutionalized (i.e. long-term care facility);
~~(6)~~(7) Home and Community Based Waiver members with the exception of the In-home Supports Waiver for Children ~~and~~, the ADvantage Waiver, the Living Choice demonstration, the Sooner Seniors Waiver, the My Life; My Choice Waiver and the Medically Fragile Waiver.

(b) Members seeking medically necessary non-emergency transportation will be required to contact the SoonerRide reservation center. Contact will be made via a toll-free phone number which is answered Monday through Saturday, 8 a.m. to 6 p.m. Whenever possible, the member is required to notify SoonerRide at least 72 hours prior to the appointment. The member is asked to furnish the SoonerRide reservation center their SoonerCare member number, home address, the time and date of the medical appointment, the address and phone number of the medical provider, and any physical/mental limitations which will impact the type of transportation needed. SoonerRide makes arrangements for the most appropriate, least costly transportation. SoonerRide verifies appointments when appropriate. If the member disagrees with the transportation arranged or denied by SoonerRide, an appeal must be filed with OHCA according to OAC 317:2-1-2. The appropriateness of transportation may be appealed only to the extent that the transportation does not meet the medical needs of the member. Dissatisfaction with the use of public transportation, shared rides, type of vehicle, etc., is not appropriate grounds for appeal. The Oklahoma Health Care Authority's decision is final.

(1) **Authorization for transportation by private vehicle or bus.** Transportation by private vehicle or bus is administered through the broker when it is necessary for an eligible member to receive medical services.
(2) **Authorization for transportation by taxi.** Taxi service may be authorized at the discretion of the broker.
(3) **Transportation by ambulance (ground, air ambulance or helicopter).** Transportation by ambulance is compensable for individuals eligible for SoonerCare benefits when other available transportation does not meet the medical needs of the individual. Payment is made for ambulance transportation to and/or from a medical facility for medical care compensable under SoonerCare.
(4) **Transportation by airplane.** When an individual's medical condition is such that transportation out-of-state by a commercial airline is required, approval for airfare must be secured by telephoning the OHCA who will make the necessary flight arrangements.
(5) **Subsistence (sleeping accommodations and meals).** ~~An individual who is eligible for transportation to or from a medical facility to obtain medical services may receive assistance with the necessary expenses of lodging and meals from SoonerCare funds. If the individual needs assistance with necessary expenses of lodging and~~

~~meals, the member may pay for the lodging and meals and then submit a travel reimbursement form for reimbursement; if the member does not have the funds for the necessary subsistence, authorization is made by the local office on the Room and Board Order form. The travel reimbursement form may be obtained by contacting OHCA or the local OKDHS office. Any subsistence expense claimed on the travel reimbursement form must be documented with receipts, and reimbursement cannot state per diem amounts. Payment for meals is only provided for overnight stays that are more than 50 miles from the home and are based on a daily per diem and may be used for breakfast, lunch or dinner, or all three meals, whichever is required.~~ Lodging and meals assistance for eligible members is provided only when medically necessary in connection with transportation to and from SoonerCare compensable services. All efforts to secure a temporary place to stay either by the hospital or a nonprofit organization must be exhausted prior to seeking reimbursement for lodging.

(A) Lodging and/or meals are reimbursable when prior authorized. The following factors may be considered by OHCA when authorizing reimbursement:

(i) travel is to obtain specialty care; and

(ii)the trip cannot be completed during SoonerRide operating hours;

(iii) the trip is more than 100 miles from the member's city of residence; or

(iv) the treatment requires an overnight stay.

(B) When a member is not required to have a PCP or when a PCP referral is not required to obtain a SoonerCare covered service, a member may go to any provider they choose but SoonerCare will not reimburse for transportation, lodging, or meals if the distance is beyond what is considered the nearest appropriate facility.

(C) Meals will be reimbursed only if an overnight stay occurs and the stay meets the lodging criteria.

(D) Reimbursement for meals is based on a daily per diem and may be used for breakfast, lunch or dinner, or all three meals, whichever is required.

(E) During inpatient or outpatient medical stays, meals and lodging are limited to 14 days for each medical stay unless the OHCA prior authorizes additional days. A member may not receive reimbursement for lodging and meals for days the member is an inpatient in a hospital or medical facility.

(F) A member who needs lodging and/or meal assistance must first seek services with an OHCA contracted lodging provider. If the lodging provider provides meals the member is not eligible for separate reimbursement and may not seek assistance for meals obtained outside of the contracted lodging facility. If lodging and/or meal assistance with contracted lodging providers is not available, the member may request reimbursement assistance by submitting a travel reimbursement form. The travel reimbursement form may be obtained by contacting SoonerCare Care Management division. Any lodging and/or meal expenses claimed on the travel reimbursement form must be documented with receipts, and reimbursement will not exceed established state per diem amounts. The OHCA has discretion and the final authority to approve or deny meals and lodging reimbursement.

(6) **Escort assistance required.** Payment for transportation and subsistence of one escort may be authorized if the service is required. Only one escort may be authorized. It is the responsibility of the OHCA to determine this necessity. The decision should be based on the following circumstances:

(A) when the individual's health or disability does not permit traveling alone; and

(B) when the individual seeking medical services is a minor child.

7.a-14 TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
Subchapter 3. General Provider Policies
Part 1. General Scope and Administration
317:30-3-19.1. [NEW]
(Reference APA WF # 11-26)

SUMMARY: OHCA's provider agreements policy is expanded to explain situations in which a provider agreement and billing privileges may be revoked for improper actions. These situations include noncompliance with enrollment requirements, provider misconduct, and felony convictions, among others. These rules will assist the agency in provider integrity determinations and will align agency policy with CMS's Medicare regulations on provider agreements.

BUDGET IMPACT: Agency staff has determined that these revisions will be 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, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; 42 U.S.C § 1396a; 42 CFR 424.535

PUBLIC HEARING: A public hearing was held on February 22, 2012. No comments were received before or during the public hearing regarding these changes.

SUBCHAPTER 3. GENERAL PROVIDER POLICIES
PART 1. GENERAL SCOPE AND ADMINISTRATION

317:30-3-19.1. Revocation of enrollment and billing privileges in the Medicaid Program.

OHCA and providers have the right to terminate or suspend contracts with each other. Remedies are provided in this Section that may be used by the agency in addition to a formal contract action against the provider. When the use of these remedies results in a contract action, appropriate due process protections will be afforded to the provider for that contract action. Subsections (1) through (10) are additional remedies under which OHCA may revoke a currently enrolled provider or supplier's SoonerCare billing privileges and any corresponding provider agreement or supplier agreement.

(1) **Noncompliance**. The provider or supplier is determined not to be in compliance with the enrollment requirements described in OAC 317:30-3-2, or in the enrollment application applicable for its provider or supplier type. All providers and suppliers are granted an opportunity to correct the deficient compliance requirement before a final determination to revoke billing privileges, except for those imposed under subsections (2), (3), (5), or (7) of this Section.

(A) OHCA may request additional documentation from the provider or supplier to determine compliance if adverse information is received or otherwise found concerning the provider or supplier.

(B) Requested additional documentation must be submitted within 60 calendar days of request.

(2) **Provider or supplier conduct**. The provider or supplier, or any owner, managing employee, authorized or delegated official, medical director, supervising physician, or other health care personnel of the provider or supplier is:

(A) Excluded from the Medicare, Medicaid, or any other Federal health care program, as defined in 42 CFR 1001.2; or

(B) Is debarred, suspended, or otherwise excluded from participating in any other Federal procurement or nonprocurement program or activity.

(3) **Felonies**. The provider, supplier, or any owner of the provider or supplier, within the 10 years preceding enrollment or revalidation of enrollment, was convicted of a Federal or State felony offense that OHCA has determined to be detrimental to the best interests of the program and its beneficiaries. Denials based on felony convictions are for a period to be determined by the OHCA, but not less than 10 years from the date of conviction if the individual has been convicted on one previous occasion for one or more offenses. Offenses include but are not limited to:

(A) Felony crimes against persons, such as murder, rape, assault, and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pretrial diversions;

(B) Financial crimes, such as extortion, embezzlement, income tax evasion, insurance fraud and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pretrial diversions;

(C) Any felony that placed the Medicaid program or its beneficiaries at immediate risk, such as a malpractice suit that results in a conviction of criminal neglect or misconduct; and

(D) Any felonies that would result in mandatory exclusion under 42 U.S.C. § 1320a-7a of the Social Security Act.

(4) **False or misleading information.** The provider or supplier certified as "true" misleading or false information on the enrollment application to be enrolled or maintain enrollment in the SoonerCare program. Offenders may be subject to either fines or imprisonment, or both, in accordance with current law and regulations.

(5) **On-site review**. OHCA determines, upon on-site review, that the provider or supplier is no longer operational to furnish SoonerCare covered items or services, or is not meeting SoonerCare enrollment requirements under statute or regulation to supervise treatment of, or to provide SoonerCare covered items or services for, SoonerCare members.

(6) **Provider and supplier screening requirements.**

(A) A provider does not submit an application fee that meets the requirements set forth in 42 CFR 455.460.

(B) Either of the following occurs:

(i) OHCA is not able to deposit the full application amount.

(ii) The funds are not able to be credited to the State of Oklahoma.

(C) The provider or supplier lacks sufficient funds in the account at the banking institution whose name is imprinted on the check or other banking instrument to pay the application fee; or

(D) There is any other reason why OHCA is unable to deposit the application fee.

(7) **Misuse of billing number**. The provider or supplier knowingly sells to or allows another individual or entity to use its billing number. This does not include those providers or suppliers who enter into a valid reassignment of benefits as specified in 42 U.S.C. § 1396a (a)(32) or a change of ownership as outlined in 42 CFR 455.104(c) (within 35 days of a change in ownership).

(8) **Abuse of billing privileges**. The provider or supplier submits a claim or claims for services that could not have been furnished to a specific individual on the date of service. These instances include but are not limited to situations where the beneficiary is deceased, the directing physician or beneficiary is not in the State or country when services were furnished, or when the equipment necessary for testing is not present where the testing is said to have occurred.

(9) **Failure to report**. The provider or supplier did not comply with the reporting requirements specified in the SoonerCare provider agreement or regulations.

(10) **Failure to document or provide OHCA access to documentation.**

(A) The provider or supplier did not comply with the documentation or OHCA access requirements specified in the SoonerCare Provider Agreement.

(B) A provider or supplier that meets the revocation criteria specified in (10)(A) of this subsection is subject to revocation for a period of not more than 1 year for each act of noncompliance.

7.a-15 TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 50. HOME AND COMMUNITY BASED SERVICES WAIVER
Subchapter 1. Medically Fragile Waiver Services
317:50-1-4. [AMENDED]
(Reference APA WF # 11-29)

SUMMARY: OHCA rules for the Medically Fragile Waiver are revised to clarify waiting list procedures for individuals who apply for services but cannot enter the waiver due to capacity limitations. The rules clarify that individuals applying for the waiver but unable receive services due to capacity limitations are placed on a waiting list and enter the waiver on a first on first off basis.

BUDGET IMPACT: Agency staff has determined that these revisions will be 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, Section 5003 through 5016 of Title 63 of the Oklahoma Statutes; Medically Fragile 1915(c) Home and Community Based Services (HCBS) Waiver program as approved by The Centers for Medicare and Medicaid Services (CMS)

PUBLIC HEARING: A public hearing was held on February 22, 2012. No comments were received before or during the public hearing regarding these changes.

SUBCHAPTER 1. MEDICALLY FRAGILE WAIVER SERVICES

317:50-1-4. Application for Medically Fragile Waiver services
(a) If waiver slots are available, the application process is initiated by the receipt of a UCAT, Part I or by an oral request for services. A written financial application is not required for an individual who is a SoonerCare member at the time of application. A financial application for Medically Fragile Waiver services consists of the Medical Assistance Application form. The form is signed by the applicant, parent, spouse, guardian or someone else acting on the applicant's behalf.

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

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

spousal share to be protected when subsequent determination of SoonerCare long-term care eligibility is made.

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

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

(c) **Medically Fragile Waiver waiting list procedures.** Medically Fragile Waiver Program ~~"available capacity in the month"~~ capacity is the number of ~~additional~~ members that may be enrolled in the Program ~~in a given month~~ without exceeding, on an annualized basis, the maximum number authorized by the waiver to be served in the waiver year. If available waiver capacity has been realized, requests for services are not processed as applications, but placed on a waiting list. As available capacity permits, the OHCA selects in chronological order (first on, first off) requests for services from the waiting list to forward for application processing. When waiver capacity exceeds the number on the waiting list and after all persons on the waiting list have been processed, waiting list procedures are suspended.

7.a-16 TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
Subchapter 5. Individual Providers and Specialties
Part 103. Qualified Schools as Providers of Health Related Services
317:30-5-1023. [AMENDED]
317:30-5-1027. [AMENDED]
(Reference APA WF # 11-30)

SUMMARY: Agency rules are currently being revised to align policy with Current Procedural Terminology (CPT) coding and guidelines. Proposed revisions will correct references to units of service and include additional clarification for guidelines associated with the codes in a school setting. In addition, rules are revised to remove Dental Screenings for clarification as dental services are included in the Child Health Encounter and are not considered a separate screening. Rules are also revised to remove references to psychological services as these services are covered under the scope of psychotherapy services. Rules will remove references to IEP School Based and School Based billing, as the billing codes and rates are the same for both IEP and non-IEP services.

BUDGET IMPACT: Agency staff has determined that these revisions will be 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, and Sections 5003 through 5016 of Title 63 of the Oklahoma Statutes.

PUBLIC HEARING: A public hearing was held on February 22, 2012. No comments were received before or during the public hearing regarding these changes.

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 103. QUALIFIED SCHOOLS AS PROVIDERS OF HEALTH RELATED SERVICES

317:30-5-1023. Coverage by category

(a) **Adults.** There is no coverage for services rendered to adults.

(b) **Children.** Payment is made for compensable services rendered by local, regional, and state educational services agencies as defined by IDEA:

(1) **Child health screening ~~examination~~.** An initial screening may be requested by an eligible individual at any time and must be provided without regard to whether the individual's age coincides with the established periodicity schedule. Coordination referral is made to the SoonerCare provider to assure at a minimum, that periodic screens are scheduled and provided in accordance with the periodicity schedule following the initial screening.

(2) **Child health encounter.** The child health encounter may include a diagnosis and treatment encounter, a follow-up health encounter, or a home visit. A Child Health Encounter may include ~~a child~~

~~health history, physical examination, developmental assessment, nutrition assessment and counseling, social assessment and counseling, genetic evaluation and counseling, indicated laboratory and screening tests, screening for appropriate immunizations, health counseling and treatment of childhood illness and conditions.~~ any of the following:

(A) vision

(B) hearing

(C) dental

(D) a child health history

(E) physical examination

(F) developmental assessment

(G) physical examination

(H) developmental assessment

(I) nutrition assessment and counseling

(J) social assessment and counseling

(K) genetic evaluation and counseling

(L) indicated laboratory and screening tests

(M) screening for appropriate immunizations

(N) health counseling and treatment of childhood illness and conditions

(3) **Diagnostic encounters.** Diagnostic encounters are defined as those services necessary to fully evaluate defects, physical or behavioral health illnesses or conditions discovered by the screening. Approved diagnostic encounters may include the following:

~~(3)~~(A) **Hearing and Hearing Aid evaluation.** Hearing evaluation includes pure tone air, bone and speech audiometry provided by a state licensed audiologist who:

~~(A)~~(i) holds a certificate of clinical competence from the American Speech and Hearing Association; or

~~(B)~~(ii) has completed the equivalent educational requirements and work experience necessary for the certificate; or

~~(C)~~(iii) has completed the academic program and is acquiring supervised work experience to qualify for the certificate.

~~(4)~~(B) **Audiometry test.** Audiometric test (Immittance [Impedance] audiometry or tympanometry) includes bilateral assessment of middle ear status and reflex studies (when appropriate) provided by a state licensed audiologist who:

~~(A)~~(i) holds a certificate of clinical competence from the American Speech and Hearing Association; or

~~(B)~~(ii) has completed the equivalent educational requirements and work experience necessary for the certificate; or

~~(C)~~(iii) has completed the academic program and is acquiring supervised work experience to qualify for the certificate.

~~(5)~~(C) **Ear impression (for earmold).** Ear impression (for earmold) includes taking impression of a member's ear and providing a finished earmold which is used with the member's hearing aid provided by a state licensed audiologist who:

~~(A)~~(i) holds a certificate of clinical competence from the American Speech and Hearing Association; or

~~(B)~~(ii) has completed the equivalent educational requirements and work experience necessary for the certificate; or

~~(C)~~(iii) has completed the academic program and is acquiring supervised work experience to qualify for the certificate.

~~(6)~~(D) **Vision Screening**. Vision screening ~~examination~~ in school children includes application of tests and examinations to

identify visual defects or vision disorders and must be provided by a state licensed Doctor of Optometry (O.D.) or licensed physician specializing in ophthalmology (M.D. or D.O.). At a minimum, vision services include diagnosis and treatment for defects in vision.

~~(7)~~(E) **Speech Language evaluation.** Speech Language evaluation is for the purpose of identification of children with speech or language disorders and the diagnosis and appraisal of specific speech and language services and must be provided by state licensed speech language pathologist who:

~~(A)~~(i) holds a certificate of clinical competence from the American Speech and Hearing Association; or

~~(B)~~(ii) has completed the equivalent educational requirements and work experience necessary for the certificate; or

~~(C)~~(iii) has completed the academic program and is acquiring supervised work experience to qualify for the certificate.

~~(8)~~(F) **Physical Therapy evaluation**. Physical Therapy evaluation includes evaluating the student's ability to move throughout the school and to participate in classroom activities and the identification of movement dysfunction and related functional problems and must be provided by a state licensed physical therapist.

~~(9)~~(G) **Occupational Therapy evaluation**. Occupational Therapy evaluation services include determining what therapeutic services, assistive technology, and environmental modifications a student requires for participation in the special education program and must be provided by a state licensed occupational therapist.

~~(10)~~(H)**Psychological Evaluation and Testing.** Psychological Evaluation and Testing are for the purpose of diagnosing and determining if emotional, behavioral, neurological, or developmental issues are affecting academic performance and for determining recommended treatment protocol. Evaluation/testing for the sole purpose of academic placement (e.g. diagnosis of learning disorders) is not a compensable service. Psychological Evaluation and Testing must be provided by state licensed, Board Certified, Psychologist or School Psychologist certified by State Department of Education (SDE).

~~(11) **Dental Screening Examination.** Screening for dental disease by a state licensed dentist. The child may be referred directly to a dentist for further screening and/or treatment.~~

~~(12)~~(4) **Child guidance treatment encounter.** A child guidance treatment encounter may occur through the provision of individual, family, or group treatment services to children who are identified as having specific disorders or delays in development, emotional, or behavioral problems, or disorders of speech, language or hearing. These types of encounters are initiated following the completion of a diagnostic encounter and subsequent development of a treatment plan, or as a result of an IEP or IFSP and may include the following:

(A) **Hearing and Vision Services.** Hearing and vision services may include provision of habilitation activities, such as auditory training, aural and visual habilitation training, including Braille, and communication management, orientation and mobility, counseling for vision and hearing losses and disorders. Services must be provided by:

(i) state licensed, Master's Degree Audiologist who:

(I) holds a certificate of clinical competence from the American Speech and Hearing Association; or

(II) has completed the equivalent educational requirements and work experience necessary for the certificate; or

(III) has completed the academic program and is acquiring supervised work experience to qualify for the certificate;

(ii) state licensed, Master's Degree Speech Language Pathologist who:

(I) holds a certificate of clinical competence from the American Speech and Hearing Association; or

(II) has completed the equivalent educational requirements and work experience necessary for the certificate; or

(III) has completed the academic program and is acquiring supervised work experience to qualify for the certificate;

(iii) state certified Speech Therapist working under the direction of a state licensed Speech Language Pathologist;

(iv) state certified deaf education teacher;

(v) certified orientation and mobility specialists; and

(vi) state certified vision impairment teachers.

(B) **Speech Language Therapy Services.** Speech Language Therapy Services include provisions of speech and language services for the habilitation or prevention of communicative disorders and must be provided by a state licensed Speech Language Pathologist who:

(i) holds a certificate of clinical competence from the American Speech and Hearing Association; or

(ii) has completed the equivalent educational requirements and work experience necessary for the certificate; or

(iii) has completed the academic program and is acquiring supervised work experience to qualify for the certificate; or

(iv) a Speech Therapy Assistant who has been authorized by the Board of Examiners, working under the direction of a state licensed speech language pathologist. The licensed Speech Language Pathologist may not supervise more ~~that~~ than two Speech Therapy assistants, and must be on site.

(C) **Physical Therapy Services.** Physical Therapy Services are provided for the purpose of preventing or alleviating movement dysfunction and related functional problems that adversely affects the child's education and must be provided by state licensed physical therapist or a Physical Therapy Assistant who has been authorized by the Board of Examiners working under the supervision of a licensed Physical Therapist. The licensed Physical Therapist may not supervise more than three Physical Therapy Assistants.

(D) **Occupational Therapy Services**. Occupational therapy may include provision of services to improve, develop or restore impaired ability to function independently and must be provided by a state licensed Occupational Therapist or an Occupational Therapy Assistant who has been authorized by the Board of Examiners, working under the supervision of a licensed Occupational Therapist.

(E) **Nursing Services.** Nursing Services may include provision of services to protect the health status of children, correct health problems and assist in removing or modifying health related barriers and must be provided by a registered nurse or licensed practical nurse under supervision of a registered nurse. Services include medically necessary procedures rendered at the school site, such as catheterization, suctioning, administration and monitoring of medication.

~~(F) **Psychological Services.** Psychological services are planning and managing a program of psychological services, including the provision of counseling for children and parents, consulting on management of severe behavioral and emotional concerns in school and home. All services must be for the direct benefit of the child. Psychological services must be provided by a state licensed Psychologist, or School Psychologist certified by SDE.~~

~~(G)~~(F) **Psychotherapy ~~Counseling~~ Services.** Psychotherapy ~~counseling~~ services are the provision of counseling for children and parents. All services must be for the direct benefit of the child. Psychotherapy ~~counseling~~ services must be provided by a state licensed Social Worker, a state Licensed Professional Counselor, a State licensed Psychologist or School Psychologist certified by the SDE, a State licensed Marriage and Family Therapist or a State licensed Behavioral Practitioner, or under Board supervision to be licensed in one of the above stated areas.

~~(H)~~(G) **Assistive Technology.** Assistive technology are the provision of services that help to select a device and assist a student with disability(ies) to use an Assistive technology device including coordination with other therapies and training of child and caregiver. Services must be provided by a:

(i) state licensed, Speech Language Pathologist who:

(I) holds a certificate of clinical competence from the American Speech and Hearing Association; or

(II) has completed the equivalent educational requirements and work experience necessary for the certificate; or

(III) has completed the academic program and is acquiring supervised work experience to qualify for the certificate;

(ii) state licensed Physical Therapist; or

(iii) state licensed Occupational Therapist.

~~(13)~~(H) **Personal Care.** Provision of personal care services allow students with disabilities to safely attend school; includes, but is not limited to assistance with toileting, feeding, positioning, hygiene, and riding school bus to handle medical or physical emergencies. Services must be provided by registered paraprofessionals/assistants ~~who~~ that have completed training approved or provided by SDE, or Personal Care Assistants, including Licensed Practical Nurses, who have completed on-the-job training specific to their duties.

~~(14)~~(I) **Therapeutic Behavioral Services**. Therapeutic behavioral services ~~is~~ are an intervention to modify the non-adaptive behavior necessary to improve the student's ability to function in the community as identified on the plan of care. Medical necessity must be identified and documented through assessment and evaluation. Services encompass behavioral management,

redirection, and assistance in acquiring, retaining, improving, and generalizing socialization, communication and adaptive skills. This service must be provided by a Behavioral Health School Aide (BHSA) who has a high school diploma or equivalent and has successfully completed the paraprofessional training approved by the State Department of Education and a training curriculum in behavioral interventions for Pervasive Developmental Disorders as recognized by OHCA. BHSA must be supervised by a bachelors level individual with a special education certification. BHSA must have CPR and First Aid certification. Six additional hours of related continuing education are required per year.

~~(15)~~(J) **Immunization.** Immunizations must be coordinated with the Primary Care Physician for ~~those Medicaid eligible~~ children enrolled in SoonerCare. An administration fee, only, can be paid for immunizations provided by the schools.

(c) **Individuals eligible for Part B of Medicare.** EPSDT school health related services provided to Medicare eligible ~~recipients~~ members are billed directly to the fiscal agent.

317:30-5-1027. Billing

(a) Each service has a specified unit of service (unit) for billing purposes which represents the actual time spent providing a direct service. Direct service must be face-to face with the child. There is no reimbursement for time reviewing/completing paperwork and/or documentation related to the service or for staff travel to/from the site of service, unless otherwise specified.

(1) Most units of service are time-based, meaning that the service must be of a minimum duration in order to be billed. A unit of service that is time-based is continuous minutes; the time cannot be aggregated throughout the day.

(2)There are no minimum time requirements for evaluation services, for which the unit of service is generally a completed evaluation. The only exception is the Psychological Evaluation, which is billed in hourly increments.

(b) The following units of service are billed on the appropriate claim form:

(1) Service: Child Health Screening; Unit: Completed comprehensive screening.

(2) Service: Interperiodic Child Health Screening; Unit: Completed interperiodic screening.

(3) Service: Child Health Encounter; ~~Unit: 5-10 minutes equals 1 unit; 11-20 minutes equals 2 units; over 21 minutes equals 3 units;~~ Unit: per encounter; limited to ~~30 units per year, additional units must be prior authorized~~ 3 encounters per day.

(4) Service: Individual Treatment Encounter ~~for IEP School Based and School Based~~; Unit: 15 minutes, unless otherwise specified.

(A) Hearing and Vision Services~~, IEP School Based~~.

~~(B) Hearing and Vision Services, School Based.~~

~~(C)~~(B) Speech Language Therapy~~, IEP School Based~~; Unit: per session, limited to one per day.

~~(D) Speech Language Therapy, School Based~~

~~(E)~~(C) Physical Therapy~~, IEP School Based~~.

~~(F) Physical Therapy, School Based.~~

~~(G)~~(D) Occupational Therapy~~, IEP School Based~~.

~~(H) Occupational Therapy, School Based.~~

~~(I)~~(E) Nursing Services~~, IEP School Based~~; ~~Unit: 5 minutes equals 1 unit; limited to 24 per day~~Unit: up to 15 minutes; maximum 32 units per day.

~~(J) Nursing Services, School Based; Unit: 5 minutes equals 1 unit; limited to 24 per day~~

~~(K) Psychological Services, IEP School Based~~.

~~(L) Psychological Services, School Based.~~

~~(M)~~(F) Psychotherapy ~~Counseling~~ Services~~, IEP School Based~~; maximum 8 units per day.

~~(N) Psychotherapy Counseling Services, School Based.~~

~~(O)~~(G) Assistive Technology~~, IEP School Based~~.

~~(P) Assistive Technology, School Based.~~

~~(Q) Dental Screening, IEP School Based.~~

~~(R) Dental Screening, School Based.~~

~~(S)~~(H) Therapeutic Behavioral Services~~, IEP School Based; limited to 12 units per day~~.

(5) Service: Group Treatment Encounter ~~for IEP School Based and School Based~~; No more than 5 ~~recipients~~ members per group, Unit: 15 minutes, unless otherwise specified.

(A) Hearing and Vision Services~~, IEP School Based~~.

~~(B) Hearing and Vision Services, School Based.~~

~~(C)~~(B) Speech Language Therapy~~, IEP School Based~~; Unit: per session, limited to one per day.

~~(D) Speech Language Therapy, School Based.~~

~~(E)~~(C) Physical Therapy~~, IEP School Based~~.

~~(F) Physical Therapy, School Based.~~

~~(G)~~(D) Occupational Therapy~~, IEP School Based~~.

~~(H) Occupational Therapy, School Based.~~

~~(I) Psychological Services, IEP School Based.~~

~~(J) Psychological Services, School Based.~~

~~(K)~~(E) Psychotherapy ~~Counseling~~ Services~~, IEP School Based~~; maximum 8 units per day.

~~(L) Psychotherapy Counseling Services, School Based.~~

(6) Service: Administration only, Immunization; Unit: one administration.

(7) Service: Hearing Evaluation; Unit: Completed Evaluation.

(8) Service: Hearing Aid Evaluation; Unit: Completed Evaluation.

(9) Service: Audiometric Test (Impedance); Unit: Completed Test (Both Ears).

(10) Service: Tympanometry and acoustic reflexes.

(11) Service: Ear Impression Mold; Unit: 2 molds (one per ear).

(12) Service: Vision Screening; Unit: one examination, by state licensed O.D., M.D., or D.O.

(13) Service: Speech Language Evaluation; Unit: one evaluation.

(14) Service: Physical Therapy Evaluation; Unit: one evaluation.

(15) Service: Occupational Therapy Evaluation; Unit: one evaluation.

(16) Service: Psychological Evaluation and Testing; Unit: one hour ~~(with written report)~~.

(17) Service: Personal Care Services; Unit: 10 minutes.

(18) Service: Nursing Assessment/Evaluation (Acute episodic care); Unit: one assessment/evaluation, 18 yearly.

(19) Service: Psychological Evaluation and Testing; Unit: per hour of psychologist time, 8 hours yearly.

7.a-17 TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 10. PURCHASING
317:10-1-1. [AMENDED]
317:10-1-12. [AMENDED]
(Reference APA WF # 11-31)

SUMMARY: Purchasing rules are revised to align policy with Department of Central Services (DCS) rules. Rules refer to sections that are not valid; therefore rules need to be revised to reflect new numbering for DCS policy.

BUDGET IMPACT: Agency staff has determined that these revisions will be 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, and Sections 5003 through 5016 of Title 63 of the Oklahoma Statutes.

PUBLIC HEARING: A public hearing was held on February 22, 2012. No comments were received before or during the public hearing regarding these changes.

317:10-1-1. Purpose
(a) The purpose of this Chapter is to describe the rules governing the contracting and purchasing requirements of the Oklahoma Health Care Authority (OHCA). The Contracts and Purchasing Divisions are internal divisions of the OHCA. These divisions provide the mechanism for the acquisition of goods, equipment, non-professional and professional services for the operation of the OHCA. These rules are superseded by the Oklahoma Department of Central Services (DCS) Purchasing rules ~~(OAC 580:15)~~ (OAC 580:16) whenever DCS has final authority on an acquisition.
(b) Different rules apply depending on which of the above three entities is making the acquisition and whether the purchase is for professional services or non-professional services and products. When an acquisition is made by DCS, the DCS Purchasing rules at OAC ~~580:15~~ 580:16 apply. When an acquisition is made by OHCA, these rules must be read in conjunction with the DCS rules.

317:10-1-12. Protest of award
(a) Protests of awards made by the Authority under 74 Okla. Stat. ' 85.5T are addressed at OAC 317:2-1-1 et seq.
(b) Bidders who wish to protest any other award shall follow the process outlined in the Oklahoma Department of Central Services rules at OAC ~~580:15-4-13~~ 580:16-3-21.

7.a-18 TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
Subchapter 5. Individual Providers and Specialties
Part 9. Long Term Care Facilities
317:30-5-123. [AMENDED]
Part 51. Habilitation Services
317:30-5-482. [AMENDED]
Part 101. Targeted Case Management Services for Persons With ~~Mental Retardation~~ Intellectual Disability and/or Related Conditions
317:30-5-1012. [AMENDED]
317:30-5-1014. [AMENDED]
CHAPTER 40. DEVELOPMENTAL DISABILITIES SERVICES
Subchapter 5. Member Services
Part 1. Agency Companion Services
317:40-5-3. [AMENDED]
317:40-5-5. [AMENDED]
317:40-5-8. [REVOKED]
317:40-5-9. [AMENDED]
317:40-5-13. [AMENDED]
Part 5. Specialized Foster Care
317:40-5-59. [AMENDED]
Part 9. Service Provisions
317:40-5-101. [AMENDED]
317:40-5-113. [AMENDED]
Subchapter 7. Employment Services Through Home and Community Based Services Waiver
317:40-7-12. [AMENDED]
317:40-7-15. [AMENDED]
317:40-7-21. [AMENDED]
(Reference APA WF # 11-32 A & B)

SUMMARY: Permanent rule revisions are proposed by the OKDHS Developmental Disability Services Division (DDSD) pertaining to clarification of policy for the termination of Agency Companion providers based on certain background check information and to provide clarification on the limits of background search information for Specialized Foster Care providers regarding involvement in a court action. Additionally policy is revised to require architectural modification contractors to provide evidence of a lead based paint safety certificate; the addition of Adult Day Services for members in the Homeward Bound Waiver; Targeted Case Management to be billed weekly rather than monthly; removal of the Physical Status Review score as one of criteria for determining the enhanced rate for Community Based Group services and Job Coaching Services, and removal of Adult Day Services as an option to the member's required employment hours. Other minor policy revisions are also included.

BUDGET IMPACT: Agency staff has determined that these revisions will be 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, Section 5003 through 5016 of Title 63 of the Oklahoma Statutes; Medically Fragile 1915(c) Home and Community Based Services (HCBS) Waiver program as approved by The Centers for Medicare and Medicaid Services (CMS)

PUBLIC HEARING: A public hearing was held on February 22, 2012. No comments were received before or during the public hearing regarding these changes.

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 9. LONG TERM CARE FACILIIES

317:30-5-123. Patient certification for long term care

(a) **Medical eligibility**. Initial approval of medical eligibility for long-term care is determined by the Oklahoma Department of Human Services (OKDHS) area nurse, or nurse designee. The certification is obtained by the facility at the time of admission.

(1) **Pre-admission screening**. Federal Regulations govern the State's responsibility for Preadmission Screening and Resident Review (PASRR) for individuals with mental illness and ~~mental retardation~~ intellectual disability. PASRR applies to the screening or reviewing of all individuals for mental illness or ~~mental retardation~~ intellectual disability or related conditions who apply to or reside in Title XIX certified nursing facilities regardless of the source of payment for the nursing facility services and regardless of the individual's or resident's known diagnoses. The nursing facility (NF) must independently evaluate the Level I PASRR Screen regardless of who completes the form and determine whether or not to admit an individual to the facility. Nursing facilities which inappropriately admit a person without a PASRR Screen are subject to recoupment of funds. PASRR is a requirement for nursing facilities with dually certified (both Medicare and Medicaid) beds. There are no PASRR requirements for Medicare skilled beds that are not dually certified, nor is PASRR required for individuals seeking residency in an intermediate care facility for the mentally retarded (ICF/MR).

(2) **PASRR Level I screen**.

(A) Form ~~LTC-300R~~ LTC-300, Nursing Facility Level of Care Assessment, must be completed by an authorized NF official or designee. An authorized NF official or designee must consist of one of the following:

(i) The nursing facility administrator or co-administrator;

(ii) A licensed nurse, social service director, or social worker from the nursing facility; or

(iii) A licensed nurse, social service director, or social worker from the hospital.

(B) Prior to admission, the authorized NF official must evaluate the properly completed OHCA Form ~~LTC-300R~~ LTC-300 and the Minimum Data Set (MDS), if available. Any other readily available medical and social information is also used to determine if there currently exists any indication of mental illness (MI), ~~mental retardation (MR)~~, intellectual disability or other related condition, or if such condition existed in the applicant's past history. Form ~~LTC-300R~~ LTC-300 constitutes the Level I PASRR Screen and is utilized in determining whether or not a Level II Assessment is necessary prior to allowing the

patient to be admitted. The NF is also responsible for consulting with the Level of Care Evaluation Unit (LOCEU) regarding any ~~MI/MR~~ mental illness/intellectual disability related condition information that becomes known either from completion of the MDS or throughout the resident's stay.

(C) The nursing facility is responsible for determining from the evaluation whether or not the patient can be admitted to the facility. A "yes" response to any question from Form ~~LTC-300R~~ LTC-300, Section E, will require the nursing facility to contact the LOCEU for a consultation to determine if a Level II Assessment is needed. If there is any question as to whether or not there is evidence of ~~MI, MR,~~ mental illness, intellectual disability or related condition, LOCEU should be contacted prior to admission. The original Form ~~LTC-300R~~ LTC-300 must be submitted by mail to the LOCEU within 10 days of the resident admission. SoonerCare payment may not be made for a resident whose ~~LTC-300R~~ LTC-300 requirements have not been satisfied in a timely manner.

(D) Upon receipt and review of the Form ~~LTC-300R~~ LTC-300, the LOCEU may, in coordination with the OKDHS area nurse, re-evaluate whether a Level II PASRR assessment may be required. If a Level II Assessment is not required, the process of determining medical eligibility continues. If a Level II is required, a medical decision is not made until the results of the Level II Assessment are known.

(3) **Level II Assessment for PASRR.**

(A) Any one of the following three circumstances will allow a patient to enter the nursing facility without being subjected to a Level II PASRR Assessment.

(i) The patient has no current indication of mental illness or ~~mental retardation~~ intellectual disability or other related condition and there is no history of such condition in the patient's past.

(ii) The patient does not have a diagnosis of ~~mental retardation~~ intellectual disability or related condition.

(iii) An individual may be admitted to an NF if he/she has indications of mental illness or ~~mental retardation~~ intellectual disability or other related condition, but is not a danger to self and/or others, and is being released from an acute care hospital as part of a medically prescribed period of recovery (Exempted Hospital Discharge). If an individual is admitted to an NF based on Exempted Hospital Discharge, it is the responsibility of the NF to ensure that the individual is either discharged by the 30th day or that a Level II has been requested and is in process. Exempted Hospital Discharge is allowed only if all three of the following conditions are met:

(I) The individual must be admitted to the NF directly from a hospital after receiving acute inpatient care at the hospital (not including psychiatric facilities);

(II) The individual must require NF services for the condition for which he/she received care in the hospital; and

(III) The attending physician must certify in writing before admission to the facility that the individual is likely to require less than 30 days of nursing facility

services. The NF will be required to furnish this documentation to OHCA upon request.

(B) If the patient has current indications of mental illness or ~~mental retardation~~ intellectual disability or other related condition, or if there is a history of such condition in the patient's past, the patient cannot be admitted to the nursing facility until the LOCEU is contacted for consultation to determine if a Level II PASRR Assessment must be performed. Results of any Level II PASRR Assessment ordered must indicate that nursing facility care is appropriate prior to allowing the patient to be admitted.

(C) The OHCA, LOCEU, authorizes Advance Group Determinations for the ~~MI and MR~~ mental illness and intellectual disability Authorities in the following categories listed in (i) through (iii) of this subparagraph. Preliminary screening by the LOCEU may indicate eligibility for nursing facility level of care prior to consideration of the provisional admission.

(i) **Provisional admission in cases of delirium**. Any person with mental illness, ~~mental retardation~~ intellectual disability or related condition that is not a danger to self and or others, may be admitted to a Title XIX certified NF if the individual is experiencing a condition that precludes screening, i.e., effects of anesthesia, medication, unfamiliar environment, severity of illness, or electrolyte imbalance.

(I) A Level II evaluation is completed immediately after the delirium clears. The LOCEU must be provided with written documentation by a physician that supports the individual's condition which allows provisional admission as defined in (i) of this subparagraph.

(II) Payment for NF services will not be made after the provisional admission ending date. If an individual is determined to need a longer stay, the individual must receive a Level II evaluation before continuation of the stay may be permitted and payment made for days beyond the ending date.

(ii) **Provisional admission in emergency situations**. Any person with a mental illness, ~~mental retardation~~ intellectual disability or related condition, who is not a danger to self and/or others, may be admitted to a Title XIX certified nursing facility for a period not to exceed seven days pending further assessment in emergency situations requiring protective services. The request for Level II evaluation must be made immediately upon admission to the NF if a longer stay is anticipated. The LOCEU must be provided with written documentation from OKDHS Adult Protective Services which supports the individual's emergency admission. Payment for NF services will not be made beyond the emergency admission ending date.

(iii) **Respite care admission**. Any person with mental illness, ~~mental retardation~~ intellectual disability or related condition, who is not a danger to self and/or others, may be admitted to a Title XIX certified nursing facility to provide respite to in-home caregivers to whom the individual is expected to return following the brief NF stay. Respite care may be granted up to 15 consecutive days per stay, not

to exceed 30 days per calendar year.

(I) In rare instances, such as illness of the caregiver, an exception may be granted to allow 30 consecutive days of respite care. However, in no instance can respite care exceed 30 days per calendar year.

(II) Respite care must be approved by LOCEU staff prior to the individual's admission to the NF. The NF provides the LOCEU with written documentation concerning circumstances surrounding the need for respite care, the date the individual wishes to be admitted to the facility, and the date the individual is expected to return to the caregiver. Payment for NF services will not be made after the respite care ending date.

(4) **Resident Review**.

(A) The nursing facility's routine resident assessment will identify those individuals previously undiagnosed as ~~MR or MI~~ intellectally disaled or mentally ill. A new condition of ~~MR or MI~~ intellectual disability or mental illness must be referred to LOCEU by the NF for determination of the need for the Level II Assessment. The facility's failure to refer such individuals for a Level II Assessment may result in recoupment of funds.

(B) A Level II Resident Review may be conducted the following year for each resident of a nursing facility who was found to experience a serious mental illness with no primary diagnosis of dementia on his or her pre-admission Level II, to determine whether, because of the resident's physical and mental condition, the resident requires the level of services provided by a nursing facility and whether the resident requires specialized services.

(C) A significant change in a resident's mental condition could trigger a Level II Resident Review. If such a change should occur in a resident's condition, it is the responsibility of the nursing facility to notify the LOCEU of the need to conduct a resident review.

(5) **Results of Level II Pre-Admission Assessment and Resident Review**. Through contractual arrangements between the OHCA and the ~~MI/MR~~ mental illness/intellectual disability authorities, individualized assessments are conducted and findings presented in written evaluations. The evaluations determine if nursing facility services are needed, if specialized services or less than specialized services are needed, and if the individual meets the federal PASRR definition of mental illness or ~~mental retardation~~ intellectual disability or related conditions. Evaluations are delivered to the LOCEU to process formal, written notification to patient, guardian, NF and interested parties.

(6) **Readmissions, and interfacility transfers**. The Preadmission Screening process does not apply to readmission of an individual to an NF after transfer for a continuous hospital stay, and then back to the NF. There is no specific time limit on the length of absence from the nursing facility for the hospitalization. Inter-facility transfers are also subject to preadmission screening. In the case of transfer of a resident from an NF to a hospital or to another NF, the transferring NF is responsible for ensuring that copies of the resident's most recent ~~LTC-300R~~ LTC-300 and any PASRR evaluations accompany the transferring resident. The receiving NF must submit an updated ~~LTC-300R~~ LTC-300 that reflects the resident's current

status to LOCEU within 10 days of the transfer. Failure to do so could result in possible recoupment of funds. LOCEU should also be contacted prior to admitting out-of-state NF applicants with mental illness or ~~mental retardation~~ intellectual disability or related condition, so that PASRR needs can be ascertained. Any PASRR evaluations previously completed by the referring state should be forwarded to LOCEU as part of this PASRR consultation.

(7) **PASRR appeals process**.

(A) Any individual who has been adversely affected by any PASRR determination made by the State in the context of either a preadmission screening or an annual resident review may appeal that determination by requesting a fair hearing. If the individual does not consider the PASRR decision a proper one, the individual or their authorized representative must contact the local county OKDHS office to discuss a hearing. Forms for requesting a fair hearing (OKDHS Form 13MP001E, Request for a Fair Hearing), as well as assistance in completing the forms, can be obtained at the local county OKDHS office. Any request for a hearing must be made no later than 20 days following the date of written notice. Appeals of these decisions are available under OAC 317:2-1-2. All individuals seeking an appeal have the same rights, regardless of source of payment. Level I determinations are not subject to appeal.

(B) When the individual is found to experience ~~MI, MR,~~ mental illness, intellectual disability or related condition through the Level II Assessment, the PASRR determination made by the ~~MR/MI~~ intellectual disability/mental illness authorities cannot be countermanded by the Oklahoma Health Care Authority, either in the claims process or through other utilization control/review processes, or by the Oklahoma State Department of Health. Only appeals determinations made through the fair hearing process may overturn a PASRR determination made by the ~~MR/MI~~ intellectual disability /mental illness authorities.

(b) **Determination of Title XIX medical eligibility for long term care.** The determination of medical eligibility for care in a nursing facility is made by the OKDHS area nurse, or nurse designee. The procedures for determining Nursing Facility (NF) program medical eligibility are found in OAC 317:35-19. Determination of ICF/MR medical eligibility is made by LOCEU. The procedures for obtaining and submitting information required for a decision are outlined below.

(1) **Pre-approval of medical eligibility.** Pre-approval of medical eligibility for private ICF/MR care is based on results of a current comprehensive psychological evaluation by a licensed psychologist or state staff psychologist, documentation of ~~MR~~ intellectual disability or related condition prior to age 22, and the need for active treatment according to federal standards. Pre-approval is made by LOCEU analysts.

(2) **Medical eligibility for ICF/MR services.** Within ~~10~~ 30 calendar days after services begin, the facility must submit the original of the Nursing Facility Level of Care Assessment ~~(Form LTC-300R)~~ (Form LTC-300) to LOCEU. Required attachments include current (within 90 days of requested approval date) medical information signed by a physician, a current (within 12 months of requested approval date) psychological evaluation, a copy of the pertinent section of the Individual Developmental Plan or other appropriate documentation relative to discharge planning and the need for ICF/MR

level of care, and a statement that the member is not an imminent threat of harm to self or others (i.e., suicidal or homicidal). If pre-approval was determined by LOCEU and the above information is received, medical approval will be entered on MEDATS.

(3) **Categorical relationship.** Categorical relationship must be established for determination of eligibility for long-term medical care. If categorical relationship to disability has not already been established, the proper forms and medical information are submitted to LOCEU. (Refer to OAC 317:35-5-4). In such instances, LOCEU will render a decision on categorical relationship using the same definition as used by the Social Security Administration (SSA). A follow-up is required by the OKDHS worker with SSA to be sure that their disability decision agrees with the decision of LOCEU.

PART 51. HABILITATION SERVICES

317:30-5-482. Description of services

Habilitation services include the services identified in (1) through (15). Providers of any habilitation service must have an applicable agreement with the Oklahoma Health Care Authority (OHCA) to provide Developmental Disabilities Services Division (DDSD) Home and Community Based Services (HCBS).

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

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

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

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

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

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

(3) **Occupational therapy services.**

(A) **Minimum qualifications.** Occupational therapists and occupational therapy assistants must have current non-restrictive licensure by the Oklahoma State Board of Medical Licensure and Supervision. Occupational therapy assistants must be employed by the occupational therapist.

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

(i) Services are:

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

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

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

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

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

(4) **Physical therapy services.**

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

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

(i) Services are intended to help the member achieve greater independence to reside and participate in the community. Services are provided in any community setting as specified in the member's IP. The IP must include a ~~physician's~~ practitioner's prescription.

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

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

(C) **Coverage limitations.** Payment is made for compensable services to individual physical therapists for direct services

or for services provided by a qualified physical ~~therapy~~ therapist assistant within their employment. Payment is made in 15-minute units with a limit of 480 units per Plan of Care year. Payment is not allowed solely for written reports or record documentation.

(5) **Psychological services.**

(A) **Minimum qualifications.** Qualification as a provider of psychological services requires non-restrictive licensure as a psychologist by the Oklahoma Psychologist Board of Examiners, or licensing board in the state in which service is provided.

(B) **Description of services.** Psychological services include evaluation, psychotherapy, consultation, and behavioral treatment. Service is provided in any community setting as specified in the member's IP.

(i) Services are:

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

(II) provided in individual and group, six person maximum, formats.

(ii) A minimum of 15 minutes for each individual encounter and 15 minutes for each group encounter and record documentation of each treatment session is included and required.

(C) **Coverage limitations.**

(i) Limitations for psychological services are:

(I) Description: Psychotherapy services and behavior treatment services (individual): Unit: 15 minutes; and

(II) Description: Cognitive/behavioral treatment (group): Unit: 15 minutes.

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

(I) Initial authorization is through the Developmental Disabilities Services Division (DDSD) case manager, with review and approval by the DDSD case management supervisor.

(II) Initial authorization must not exceed 192 units (48 hours of service).

(III) Monthly progress notes must include a statement of hours and type of service provided, and an empirical measure of member status as it relates to each objective in the member's IP.

(IV) If progress notes are not submitted to the DDSD case manager for each month of service provision, authorization for payment must be withdrawn until such time as progress notes are completed.

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

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

(II) When revising a protective intervention plan (PIP) to accommodate recommendations of a required committee review or an Oklahoma Department of Human Services

(OKDHS) audit, the provider may bill for only one revision. The time for preparing the revision must be clearly documented and must not exceed four hours.

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

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

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

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

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

(6) **Psychiatric services.**

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

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

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

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

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

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

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

(B) **Description of services.** Speech therapy includes evaluation, treatment, and consultation in communication and oral motor/feeding activities provided to members who are eligible. Services are intended to maximize the member's community living skills and may be provided in any community setting as specified in the member's IP. The IP must include a ~~physician's~~ practitioner's prescription.

(i) For purposes of this Section, a ~~physician~~ practitioner is defined as all licensed medical and osteopathic physicians, and physician assistants and other licensed professionals with prescriptive authority to order speech/language services in accordance with rules and regulations covering the OHCA's SoonerCare program.

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

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

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

(A) **Minimum qualifications.** Providers must complete the OKDHS DDSD sanctioned training curriculum. Residential habilitation providers:

(i) are at least 18 years of age;

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

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

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

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

(i) Payment will not be made for:

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

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

(ii) Family members who provide HTS services must meet the same standards as providers who are unrelated to the member. HTS staff residing in the same household as the member may not provide services in excess of 40 hours per week. Members who require more than 40 hours per week of HTS must use staff members who do not reside in the household and are employed by the member's chosen provider agency to deliver the balance of any necessary support staff hours.

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

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

(v) DDSD case management supervisor review and approval is required.

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

(I) provider will receive oversight from DDSD area staff; and

(II) must be pre-approved by the DDSD director or designee.

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

(i) A unit is 15 minutes.

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

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

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

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

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

(9) **Self Directed HTS (SD HTS).**

SD HTS are provided per 317:40-9-1.

(10) **Self Directed Goods and Services (SD GS).**

SD GS are provided per 317:40-9-1.

(11) **Audiology services.**

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

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

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

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

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

(12) **Prevocational services.**

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

(i) are at least 18 years of age;

(ii) complete the OKDHS DDSD sanctioned training curriculum;

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

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

(B) **Description of services.** Prevocational services are not available to persons who can be served under a program funded per Section 110 of the Rehabilitation Act of 1973 or Section 602(16) and (17) of the Individuals with Disabilities Education Act (IDEA). Services are aimed at preparing a member for

employment, but are not job-task oriented. Services include teaching concepts, such as compliance, attendance, task completion, problem solving, and safety.

(i) Prevocational services are provided to members who are not expected to:

(I) join the general work force; or

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

(ii) When compensated, members are paid at less than 50 percent of the minimum wage. Activities included in this service are not primarily directed at teaching specific job skills, but at underlying habilitative goals, such as attention span and motor skills.

(iii) All prevocational services will be reflected in the member's IP as habilitative, rather than explicit employment objectives.

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

(v) Services include:

(I) center-based prevocational services as specified in OAC 317:40-7-6;

(II) community-based prevocational services as specified in OAC 317:40-7-5;

(III) enhanced community-based prevocational services as specified in OAC 317:40-7-12; and

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

(C) **Coverage limitations.** A unit of center-based or community-based prevocational services is one hour and payment is based upon the number of hours the member participates in the service. All prevocational services and supported employment services combined may not exceed $25,000 per Plan of Care year. The following services may not be provided to the same member at the same time as prevocational services:

(i) HTS;

(ii) Intensive Personal Supports;

(iii) Adult Day Services;

(iv) Daily Living Supports;

(v) Homemaker; or

(vi) therapy services such as occupational therapy, physical therapy, nutrition, speech, psychological services, family counseling, or family training except to allow the therapist to assess the individual's needs at the workplace or to provide staff training and as allowed per 317:40-7-6.

(13) **Supported employment.**

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

(i) are at least 18 years of age;

(ii) complete the OKDHS DDSD sanctioned training curriculum;

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

(iv) receive supervision and oversight by a person with a minimum of four years of any combination of college level

education or full-time equivalent experience in serving persons with disabilities.

(B) **Description of services.** Supported employment is conducted in a variety of settings, particularly work sites in which persons without disabilities are employed, and includes activities that are outcome based and needed to sustain paid work by members receiving services through HCBS Waiver, including supervision and training.

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

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

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

(ii) Services include:

(I) job coaching as specified in OAC 317:40-7-7;

(II) enhanced job coaching as specified in OAC 317:40-7-12;

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

(IV) stabilization as specified in OAC 317:40-7-11.

(iii) Supported employment services furnished under HCBS Waiver are not available under a program funded by the Rehabilitation Act of 1973 or IDEA.

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

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

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

(II) payments that are passed through to users of supported employment programs; or

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

(C) **Coverage limitations.** A unit is 15 minutes and payment is made in accordance with OAC 317:40-7-1 through 317:40-7-21. All prevocational services and supported employment services combined cannot exceed $25,000 per Plan of Care year. The DDSD case manager assists the member to identify other alternatives to meet identified needs above the limit. The following services may not be provided to the same member at the same time as supported employment services:

(i) HTS;

(ii) Intensive Personal Supports;

(iii) Adult Day Services;

(iv) Daily Living Supports;

(v) Homemaker; or

(vi) Therapy services such as occupational therapy, physical

therapy, nutrition, speech, psychological services, family counseling, or family training except to allow the therapist to assess the individual's needs at the workplace or to provide staff training.

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

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

(i) are at least 18 years of age;

(ii) complete the OKDHS DDSD sanctioned training curriculum;

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

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

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

(B) **Description of services.**

(i) IPS:

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

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

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

(iii) DDSD case management supervisor review and approval is required.

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

(15) **Adult day services.**

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

(i) meet the licensing requirements set forth in 63 O.S. ' 1-873 *et seq*. and comply with OAC 310:605; and

(ii) be approved by the OKDHS DDSD and have a valid OHCA contract for adult day services.

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

(C) **Coverage limitations.** Adult day services are typically furnished four or more hours per day on a regularly scheduled basis, for one or more days per week. A unit is 15 minutes for

up to a maximum of six hours daily, at which point a unit is one day. All services must be authorized in the member's IP.

PART 101. TARGETED CASE MANAGEMENT SERVICES FOR PERSONS WITH ~~MENTAL RETARDATION~~ INTELLECTUAL DISABILITY AND/OR RELATED CONDITIONS

317:30-5-1012. Reimbursement

(a) Reimbursement for DDSDTCM services is a unit rate based on the ~~monthly~~ weekly cost per case for documented DDSDTCM services. The cost base consists of the annualized cost of case management staff including all applicable overhead and indirect service cost in accordance with the approved DHS cost allocation plan. A first year interim rate is computed by dividing the annual cost base by the projected number of units. Subsequent annual rates will include an adjustment based on previous years cost versus total billable amount. A unit of service is defined as one calendar ~~month~~ week of targeted case management, provided that a minimum of one contact which meets the description of a targeted case management activity with or on behalf of the ~~recipient~~ member has been documented during the ~~month~~ week claimed. Payment is made on the basis of claims submitted for payment. The provider bills at the ~~monthly~~ weekly unit rate for a documented unit of ~~Medicaid~~ SoonerCare DDSDTCM services provided to each ~~Medicaid~~ SoonerCare eligible ~~recipient~~ member during the calendar ~~month~~ week.

(b) Only one unit of DDSDTCM services may be billed for each ~~Medicaid~~ SoonerCare eligible ~~recipient~~ member per ~~month~~ week while the ~~recipient~~ member is receiving services under a DHS/DDSD HCBS Waiver or is in the transition process to receive those services. No more than twenty-six units of DDSDTCM may be provided and billed for each eligible ~~Medicaid~~ SoonerCare ~~recipient~~ member during their transition period from the institution. DHS/DDSD must provide documentation of all such transitional DDSDTCM services provided, indicating the date performed for each unit billed. In no case may DHS/DDSD bill for transitional and regular DDSDTCM services provided during the same ~~month~~ week (i.e., if DDSD bills transitional DDSDTCM for the third week in June and the ~~recipient~~ member is deinstitutionalized into the particular Waiver during the third week in June, DDSD cannot also bill for regular DDSDTCM for the third week in June). If DDSDTCM has been provided to an individual during such a transitional period but that individual dies before the placement into the community is made, decides to refuse the placement or the placement falls through, reimbursement is available.

(c) the billing week for DDSDTCM is Monday through Sunday.

317:30-5-1014. Documentation of records

All case management services rendered must be reflected by documentation in the records. All units of ~~Medicaid~~ SoonerCare DDSDTCM services provided are documented by the case manager ~~on the monthly Record of Contact form~~ weekly in Client Contact Manager. The following conditions must be met in order for case management services to reimbursed under ~~Medicaid~~ SoonerCare.

(1) The case manager must conduct a face-to-face interview with the ~~client~~ member in order to determine ~~client~~ member needs and develop approaches to meet these needs.

(2) The case manager with a team including the ~~client~~ member or ~~client's~~ member's representative, must develop a plan of care which is

documented in the case record.
(3) The case manager must reassess the plan of care when necessary but at a minimum annually.
(4) The case manager must provide documentation to supplement the plan of care which includes:
(A) information supporting the selection of outcomes;
(B) information supporting the approaches selected;
(C) information supporting case management decisions and actions;
(D) documentation of communication with the ~~client~~ member and, as appropriate, his/her representative;
(E) documentation of linkages with resources;
(F) documentation of follow-up and monitoring of the plan; and
(G) other factual information relevant to the case.

CHAPTER 40. DEVELOPMENTAL DISABILITIES SERVICES
SUBCHAPTER 5. MEMBER SERVICES
PART 1. AGENCY COMPANION SERVICES

317:40-5-3. Agency companion services

(a) Agency companion services (ACS):
(1) are provided by agencies that have a provider agreement with the Oklahoma Health Care Authority (OHCA);
(2) provide a living arrangement developed to meet the specific needs of the member that includes a live-in companion providing supervision, supportive assistance, and training in daily living skills provided in a shared home owned or rented by the member, companion, or in a mutually rented or owned home;
(3) are available to members 18 years of age or older who are eligible for services through Community or Homeward Bound Waivers. Persons under the age of 18 years may be served with approval from the DDSD director or designee;
(4) are based on the member's need for residential services per OAC 340:100-5-22 and support as described in the member's Individual Plan ~~(IP)~~ (Plan), per OAC 340:100-5-50 through 340:100-5-58.

(b) An agency companion:
(1) must be employed by or contract with a provider agency approved by the Oklahoma Department of Human Services Developmental Disabilities Services Division (DDSD);
(2) may provide companion services for one member. Exceptions to serve as companion for two members may be ~~granted only upon~~ approved by the DDSD director or designee. Exceptions may be approved when members have an existing relationship and to separate them would be detrimental to their well being and the companion demonstrates the skill and ability required to serve as companion for two members;
(3) household is limited to one individual companion provider. Exceptions for two individual companion providers in a household who each provide companion services to different members may be approved by the DDSD director or designee;
(4) may not provide companion services to more than two members at any time;
(5) household may not serve more than three members through any combination of companion or respite services;
(6) may not have employment, volunteer activities, or personal commitments that prevent the companion from fulfilling his or her responsibilities to the member per OAC 317:40-5.

(A) Employment as an agency companion is the companion's primary employment.
(B) The companion may not have other employment when approved to serve two members regardless of the levels of support required by the members.
(C) The companion may have other employment when:
(i) the ~~personal support~~ Team documents and addresses all related concerns in the member's ~~IP~~ Plan;
(ii) the other employment is approved in advance by the DDSD area manager or designee; and
(iii) the companion's employment does not require on-call duties and occurs during time the member is engaged in outside activities such as school, employment or other routine scheduled meaningful activities; and
(iv) the companion provides assurance the employment is such that the member's needs will be met by the companion should the member's outside activities be disrupted.
(D) If, after receiving approval for other employment, authorized DDSD staff determines the other employment interferes with the care, training, or supervision needed by the member, the companion must terminate, within 30 days:
(i) the other employment; or
(ii) his or her employment as an agency companion.
(E) Homemaker, habilitation training specialist, and respite services are not provided ~~in order~~ for the companion to ~~perform~~ maintain other employment.
(c) Each member may receive up to 60 days per year of therapeutic leave without reduction in the agency companion's salary.
(1) Therapeutic leave:
(A) is a SoonerCare payment made to the contract provider to enable the member to retain services; and
(B) is claimed when:
(i) the member does not receive ACS for 24 consecutive hours due to:
(I) a visit with family or friends without the companion;
(II) vacation without the companion; or
(III) hospitalization, regardless of whether the companion is present; or
(ii) the companion uses authorized respite time;
(C) is limited to no more than 14 consecutive days per event, not to exceed 60 days per Plan of Care (POC) year; and
(D) cannot be accrued from one Plan of Care (POC) year to the next.
(2) The therapeutic leave daily rate is the same amount as the ACS per diem rate except for the pervasive rate which is paid at the enhanced agency companion per diem rate.
(3) The provider agency pays the agency companion the salary that he or she would earn if the member were not on therapeutic leave.
(d) The companion may receive a combination of hourly or daily respite per POC year equal to 660 hours for respite for the companion.
(e) Habilitation Training Specialist (HTS) services:
(1) may be approved by the DDSD director or designee when providing ACS with additional support represents the most cost-effective placement for the member when there is an ongoing pattern of not:
(A) sleeping at night; or

(B) working or attending employment, educational, or day services with documented and continuing efforts by the Team;

(2) may be approved when a time-limited situation exists in which the ACS provider is unable to provide ACS, and the provision of HTS will maintain the placement or provide needed stability for the member, and must be reduced when the situation changes;

(3) must be reviewed annually or more frequently as needed, which includes a change in agencies or individual companion providers.

(f) The agency receives a provider rate based on the agency's service model. The AC rate for the:

(1) employer model includes funding for the provider agency for the provision of benefits to the companion; or

(2) contractor model does not include funding for the provider agency for the provision of benefits to the companion.

~~(d)~~(g) The agency receives a provider rate based on the member's level of support. Levels of support for the member and corresponding payment are:

(1) determined by authorized DDSD staff in accordance with levels described in (A) through(D); and

(2) re-evaluated when the member has a change in agency companion providers which includes a change in agencies or individual companion providers.

(A) **Intermittent level of support**. Intermittent level of support is authorized when the member:

(i) requires minimal physical assistance with basic daily living skills, such as bathing, dressing, and eating;

(ii) may be able to spend short periods of time unsupervised inside and outside the home; and

(iii) requires assistance with medication administration, money management, shopping, housekeeping, meal preparation, scheduling appointments, arranging transportation or other activities.

(B) **Close level of support**. Close level of support is authorized when the member:

(i) requires regular, frequent and sometimes constant physical assistance and support to complete daily living skills, such as bathing, dressing, eating, and toileting;

(ii) requires extensive assistance with medication administration, money management, shopping, housekeeping, meal preparation, scheduling appointments, arranging transportation or other activities; and

(iii) requires assistance with health, medication, or behavior interventions that may include the need for specialized training, equipment, and diet.

(C) **Enhanced level of support**. Enhanced level of support is authorized when the member:

(i) is totally dependent on others for:

(I) completion of daily living skills, such as bathing, dressing, eating, and toileting; and

(II) medication administration, money management, shopping, housekeeping, meal preparation, scheduling appointments, and arranging transportation or other activities;

(ii) demonstrates ongoing complex medical issues requiring specialized training courses per OAC 340:100-5-26; or

(iii) has behavioral issues that requires a protective intervention plan (PIP) with a restrictive or intrusive procedure as defined in OAC 340:100-1-2. The PIP must:

(I) be approved by the Statewide Behavior Review Committee (SBRC), per OAC 340:100-3-14;

(II) be reviewed by the Human Rights Committee (HRC), per OAC 340:100-3-6, or

(III) have received expedited approval per OAC 340:100-5-57.

(D) **Pervasive level of support.** Pervasive level of support is authorized when the member:

(i) requires additional professional level support to remain in an agency companion setting due to pervasive behavioral or emotional challenges. The support must be provided:

(I) by a licensed professional counselor (LPC) or professional with a minimum of Masters of Social Work (MSW) degree; and

(II) as ongoing support and training to the companion, offering best practice approaches in dealing with specific members; and

(ii) does not have an available personal support system. The need for this service level:

(I) must be identified by the grand staffing committee, per OAC 340:75-8-40; and

(II) requires the provider to market, recruit, screen, and train potential companions for the member identified.

(h) The Plan reflects the amount of room and board the member pays to the companion. If the amount exceeds $450, the additional amount must be:

(1) agreed upon by the member and, if applicable, legal guardian;

(2) recommended by the Team; and

(3) approved by the DDSD area manager or designee.

317:40-5-5. Agency Companion Services provider responsibilities

(a) Providers of Agency Companion Services (ACS) are required to meet all applicable standards outlined in this subchapter and competency-based training described in OAC 340:100-3-38. The provider agency ensures that all companions meet the criteria in this Section.

(b) Failure to follow any rules or standards, failure to promote the independence of the member, or failure to follow recommendation(s) of the personal support team (Team) results in problem resolution, ~~as described in subsection (b) of~~ per OAC 340:100-3-27, for the companion, and if warranted, revocation of approval of the companion.

(c) In addition to the criteria given in OAC 317:40-5-4, the companion:

(1) ensures no other adult or child is cared for in the home on a regular or part-time basis including other Oklahoma Department of Human Services (OKDHS) placements, family members, ~~and~~ or friends without prior written authorization from the OKDHS Developmental Disabilities Services Division (DDSD) area manager or designee;

(2) meets the requirements of OAC 317:40-5-103, Transportation. Neither the companion nor the provider agency may claim transportation reimbursement for vacation travel;

(3) transports or arranges transportation for the member to and from school, employment programs, recreational activities, medical appointments, and therapy appointments;

(4) delivers services in a manner that contributes to the member's

enhanced independence, self sufficiency, community inclusion, and well-being;
(5) participates as a member of the member's Team and assists in the development of the member's Individual Plan (Plan) for service provision;
(6) with assistance from the DDSD case manager and the provider agency program coordination staff, develops, implements, evaluates, and revises the training strategies corresponding to the relevant outcomes for which the companion is responsible, as identified in the ~~Individual~~ Plan;
(A) The companion documents and provides monthly data and health care summaries to the provider agency program coordination staff.
(B) The agency staff provides monthly reports to the DDSD case manager or nurse.
(7) delivers services at appropriate times as directed in the ~~Individual~~ Plan;
(8) does not deliver services that duplicate the services mandated to be provided by the public school district pursuant to the Individuals with Disabilities Education Act (IDEA);
(9) is sensitive to and assists the member in participating in the member's chosen religious faith. No member is expected to attend any religious service against his or her wishes;
(10) participates in and supports visitation and contact with the member's natural family, guardian, and friends, provided this visitation is desired by the member;
(11) obtains permission from the member's legal guardian, if a guardian is assigned, and notifies the family, the provider agency program coordination staff, and the case manager prior to:
(A) traveling out of state;
(B) overnight visits; or
(C) involvement of the member in any publicity;
(12) serves as the member's health care coordinator ~~in accordance with~~ per OAC 340:100-5-26;
(13) ensures the monthly room and board contribution received from the member ~~as reflected on OKDHS Form 06AC074E, Service Authorization Budget (SAB),~~ is used toward the cost of operating the household;
(14) assists the member in accessing entitlement programs for which the member may be eligible and maintains records required for the member's ongoing eligibility;
(15) works closely with the provider agency program coordination staff and the DDSD case manager to ensure all aspects of the member's program are implemented to the satisfaction of the member, the member's family or legal guardian, when appropriate, and the member's Team;
(16) assists the member in achieving the member's maximum level of independence;
(17) submits, in a timely manner, to the provider agency program coordination staff all necessary information regarding the member;
(18) ensures that the member's confidentiality is maintained ~~in accordance with~~ per OAC 340:100-3-2;
(19) supports the member in forming and maintaining friendships with neighbors, co-workers, and peers, including people who do not have disabilities;
(20) implements training and provides supports that enable the

member to actively join in community life;
(21) does not serve as representative payee for the member without a written exception ~~approval~~ from the DDSD area manager or designee;
(A) The written ~~approval~~ exception is retained in the member's home record.
(B) When serving as payee, the companion complies with the requirements of OAC 340:100-3-4.
(22) ensures the member's funds are properly safeguarded.
(23) ~~must obtain~~ obtains prior approval from the provider agency when making a purchase of over $50.00 with the member's funds;
(24) allows the provider agency staff and DDSD staff to make announced and unannounced visits to the home;
(25) develops an Evacuation Plan, using OKDHS Form 06AC020E, for the home and conducts training with the member;
(26) conducts fire and weather drills at least quarterly and ~~maintains~~ documents the ~~Fire and Weather Drill Record, OKDHS~~ fire and weather drills using Form 06AC021E~~, available for review:~~ ;
(27) develops and maintains a ~~Personal Possession Inventory~~ personal possession inventory for personal possessions and adaptive equipment, ~~OKDHS~~ using Form 06AC022E~~, documenting the member's possessions and adaptive equipment~~;
(28) supports the member's employment program by:
(A) assisting the member to wear appropriate work attire; and
(B) contacting the member's employer ~~only~~ as outlined by the Team and in the ~~Individual~~ Plan; and
(29) is responsible for the cost of their meals and entertainment during recreational and leisure activities. Activities must be affordable to the member. Concerns about affordability are presented to the Team for resolution.
~~(29)~~ (30) follows all applicable rules promulgated by the Oklahoma Health Care Authority ~~or~~ and DDSD, including:
(A) OAC 340:100-3-40;
(B) OAC 340:100-5-50 through 100-5-58;
(C) OAC 340:100-5-26;
(D) OAC 340:100-5-34;
(E) OAC 340:100-5-32;
(F) OAC 340:100-5-22.1;
(G) OAC 340:100-3-27; and
(H) OAC 340:100-3-38.

317:40-5-8. Agency companion services service authorization budget [REVOKED]

~~Upon approval of the home profile per OAC 317:40-5-40, the companion, provider agency, the Oklahoma Department of Human Services (OKDHS) Developmental Disabilities Services Division (DDSD) case manager, agency companion services (ACS) staff, and others as appropriate meet to develop a service authorization budget. The service authorization budget form is used to develop the individual service budget for the member's program and is updated annually by the member's Personal Support Team (Team).~~
~~(1) The companion receives:~~
~~(A) a salary based on the level of support needed by the member. The level of support is determined by authorized DDSD staff per OAC 317:40-5-3. The ACS rate for the:~~
~~(i) employer model includes funding for the provider agency for the provision of benefits to the companion; and~~

(ii) contractor model does not include funding for the provider agency for the provision of benefits to the companion.

(B) any combination of hourly or daily respite per Plan of Care year to equal 660 hours in order to provide respite to the companion as reflected on the service authorization budget form.

(C) Habilitation training specialist (HTS) services:

(i) may be approved by the DDSD director or designee when providing ACS with additional support represents the most cost-effective placement for the member and the member has an ongoing pattern of not:

(I) sleeping at night; or

(II) working or attending employment services, with documented and continuing efforts by the Team.

(ii) may be approved when a time limited situation exists in which the ACS provider is unable to provide ACS and the provision of HTS will maintain the placement or provide needed stability to the member; and must be reduced when the situation changes.

(iii) must be reviewed annually or more often if needed, which includes a change in agencies or individual companion providers.

(2) The service authorization budget form reflects the amount of room and board the member pays to the companion. If the amount exceeds $450, the increase must be:

(A) agreed to by the member and, if applicable, legal guardian;

(B) recommended by the Team; and

(C) submitted with written justification attached to the service authorization budget form to the DDSD area manager or designee for approval.

(3) A back-up plan identifying respite staff is developed by the provider agency program coordination staff and companion, prior to the meeting to discuss the service authorization budget.

(A) The back-up plan:

(i) is submitted to the DDSD case manager for review and approval;

(ii) describes expected and emergency back-up support and program monitoring for the home; and

(iii) is reviewed initially and annually by the SFC specialist.

(B) The companion and provider agency program coordination staff equally share the responsibility to identify approved respite providers who are:

(i) knowledgeable about the member;

(ii) trained to implement the member's Individual Plan (Plan);

(iii) trained per OAC 340:100-3-38; and

(iv) when possible, involved in the member's daily life.

(C) The spouse or other adult residing in the home may provide ACS in the absence of the companion, when trained per OAC 340:100-3-38.

(D) The spouse or other adult residing in the home cannot serve as paid respite staff.

(4) The companion and respite staff are responsible for the cost of their meals and entertainment during recreation and leisure activities. Activities selected must be affordable to the member

~~and respite staff. Concerns about affordability are presented to the Team for resolution.~~

~~(5) The member is allowed therapeutic leave per OAC 317:40-5-3.~~

317:40-5-9. Payment authorization for Agency Companion Services

Authorization for payment of Agency Companion Services (ACS) is ~~made~~ contingent upon ~~the completion~~ receipt of:

(1) ~~the letter that approves~~ the ~~applicant~~ applicant's approval letter authorizing ~~to provide~~ ACS for the identified ~~service recipient~~ member;

~~(2) an approved service authorization budget (SAB) in accordance with OAC 317:40-5-8;~~

~~(3)~~ (2) ~~an~~ approved relief and emergency back-up plan;

~~(4)~~ (3) ~~revision of the~~ revised Individual Plan;

~~(5)~~ (4) ~~revision of the service recipient's~~ revised Plan of Care; and

~~(6)~~ (5) ~~the~~ placement of the ~~service recipient~~ member in the ACS home.

317:40-5-13. Agency Companion Services provider agency responsibilities

(a) The agency providing Agency Companion Services (ACS) complies with Oklahoma Health Care Authority and Oklahoma Department of Human Services policies and procedures governing all aspects of service provision.

(b) The provider agency is responsible for all employee or contract provider related activities detailed in this Subchapter.

(c) In the event the provider agency wishes to discontinue services immediately due to an emergency, the provider agency cooperates with the Developmental Disabilities Services Division (DDSD) to secure alternative services in the least restrictive environment.

(d) The provider agency ensures that services provided meet requirements of OAC 340:100-5-22.1, unless different requirements are stated in this Section.

(e) If the agency serves as the ~~service recipient's~~ member's representative payee, the agency must adhere to the requirements of OAC 340:100-3-4.1.

(f) The provider agency acts immediately to remedy any situation posing a risk to the health, well-being, or provision of specified services to the ~~service recipient~~ member.

(1) In the event of such a risk, the provider agency immediately notifies DDSD of the nature of the situation and notifies DDSD upon the resolution of the threatening situation.

(2) The provider agency's program coordination staff contacts and informs the DDSD case manager within 24 hours of an incident or injury. The provider agency completes and submits incident and injury reports to DDSD in accordance with OAC 340:100-3-34.

(3) A companion is immediately terminated when a provider agency becomes aware that a companion's name appears on the Community Services Worker Registry per OAC 340:100-3-39.

(g) The provider agency ensures that only one ~~service recipient~~ member is served in a provider home. Exceptions may be approved by the DDSD area manager or designee.

(h) When the provider agency has knowledge of problems occurring in the placement, the provider agency's program coordination staff immediately schedules a meeting with the companion, the ~~service recipient~~ member, the ~~service recipient's~~ member's legal guardian or advocate, the DDSD

case manager and other appropriate DDSD staff to resolve the issues involved. If resolution of the issues does not occur at the meeting, any participant is to contact the DDSD area manager or designee and the provider agency for resolution.
(i) When a change in the provider agency is requested by the ~~service recipient~~ member or the companion, all participants attempt to resolve the issues. No change in the provider agency occurs unless the DDSD area manager or designee agrees that all issues have been discussed.
(j) The decision to remain or terminate services with the provider agency is the choice of the ~~service recipient~~ member or his or her legal guardian.
(k) When a ~~service recipient~~ member transfers from a provider agency, the provider agency ensures that the ~~service recipient~~ member has a 30-day supply of medication and a seven-day supply of food, household supplies, and personal supplies.
(l) The responsibilities of the provider agency's program coordination staff are:
(1) to visit the provider home daily during the first week of placement;
(2) to visit the home a minimum of three times per month ~~in accordance with~~ per OAC 340:100-5-22.1;
(3) to allow the needs of the ~~service recipient~~ member to determine the frequency of all other visits;
(4) to coordinate and submit ~~monthly~~ quarterly reports to the provider agency for submission to the DDSD area office; and
(5) to communicate regularly with the DDSD case manager regarding any changes in the household or any other program issues or concerns.
(m) The provider agency works with the companion, member, and guardian to develop a back-up plan identifying respite staff. The back-up plan:
(1) is submitted to the DDSD case manager for approval;
(2) describes expected and emergency back-up support and program monitoring for the home; and
(3) is incorporated into the member's Individual Plan (Plan).
(n) The respite provider is:
(1) knowledgeable about the member;
(2) trained to implement the member's Plan;
(3) trained per OAC 340:100-3-38;
(4) responsible for the cost of their meals and entertainment during recreation and leisure activities. Activities selected must be affordable to the member and respite staff. Concerns about affordability are presented to the Team for resolution.
(o) The spouse or other adult residing in the home is considered a natural support and may provide ACS in the absence of the companion, when trained per OAC 340:100-3-38.12.
(p) The spouse or other adult residing in the home cannot serve as paid respite staff.

PART 5. SPECIALIZED FOSTER CARE

317:40-5-59. Back-up Plan for persons receiving Specialized Foster Care
Prior to a member moving into Specialized Foster Care (SFC), the SFC provider and the SFC specialist develop a Back-up Plan. The SFC specialist communicates the Back-Up Plan in writing to the DDSD case manager for incorporation into the Individual Plan.
(1) The Back-up Plan identifies the person(s) who provides emergency

back-up supports.
(2) The member's natural family is considered as the first resource for the Back-up Plan at no cost to OKDHS, unless the member is in the custody of the Oklahoma Department of Human Services.
(3) The Back-up Plan contains the name(s) and current telephone number(s) of the person(s) providing back-up service.
(4) When paid providers are necessary, the Back-up Plan explains specifically where the service is to be provided.
(A) If back-up service is to be provided outside the SFC home, a Home Profile must be completed for the back-up staff per OAC 317:40-5-40.
(B) If back-up service is to be provided in the SFC home, the person providing this service must have completed all necessary requirements to become a paid provider, including:
(i)an Oklahoma State Bureau of Investigation (OSBI) name and criminal records history search , including the Department of Public Safety (DPS), Sex Offender, and Mary Rippy Violent Offender Registries;
(ii) a Federal Bureau of Investigation (FBI) national criminal history search, based on the fingerprints of the applicant;
(iii) a search of any involvement as a party in a court action~~;~~ that may impact the safety or stability of the member that includes: victims protective order; or bankruptcy;
(iv) a search of all Oklahoma Department of Human Services (OKDHS) records, including child welfare (CW) records;
(v) a search of all applicable out-of-state child abuse and neglect registries for any applicant who has not lived continuously in Oklahoma for the past five years. The applicant is not approved without the results of the out-of-state maintained child abuse and neglect registry checks, if a registry is maintained in the applicable state;
(vi) Community Services Worker registry check;
(vii) Oklahoma statutorily mandated liability insurance coverage, and a valid driver license; and
(viii) completion of required DDSD training per OAC 340:100-3-38.4.
(C) The Back-up Plan details where the member and provider will stay if the provider's home is not habitable. If there is a fee to stay in the alternate location, the fee is paid by the provider and not reimbursed by DDSD.
(5) The Back-up Plan is jointly reviewed at least monthly by the SFC specialist and the SFC provider to ensure the Back-up Plan continues to be appropriate and current.
(6) The SFC provider is responsible to report any needed changes in the Back-up Plan to the SFC specialist.
(7) The SFC specialist will report any changes in the Back-up Plan to the case manager.

PART 9. SERVICE PROVISIONS

317:40-5-101. Architectural modifications

(a) **Applicability.** The rules in this Section apply to architectural modification (AM) services authorized by the Oklahoma Department of Human Services (OKDHS) Developmental Disabilities Services Division (DDSD) through Home and Community Based Services (HCBS) Waivers.

(b) **General information.** Architectural Modification services:

(1) are provided by building contractors who have contractual agreements with the Oklahoma Health Care Authority to provide Home and community Based Services. Providers must meet requirements of the International Code Council (ICC), formerly the Building Official and Code Administrators (BOCA), for building, electrical, plumbing and mechanical inspections;

(2) include the installation of ramps, grab-bars, widening of doorways, modification of a bathroom or kitchen facilities, specialized safety adaptations such as scald protection devices, stove guards, and modifications required for the installation of specialized equipment, which are necessary to ensure the health, welfare and safety of the member or that enable the member to function with greater independence in the home;

(3) must be recommended by the member's Team and included in the member's IP. Arrangements for this service must be made through the member's case manager;

(4) are performed on homes of eligible members who have disabilities that limit accessibility or require modifications to ensure health and safety;

(5) are provided based on the:

(A) assessment and Personal Support Team (Team) consideration of the member's unique needs per OAC 317:40-5-101(b);

(B) scope of architectural modifications per OAC 317:40-5-101;

(C) most appropriate and cost effective bid, if applicable, ensuring the quality of materials and workmanship;

(D) lack of a less expensive equivalent, such as assistive technology, that meets the member's needs; and

(E) safety and suitability of the home.

(6) are limited to modifications of two different residences within any seven year period beginning with the member's first request for an approved architectural modification service;

(7) are provided with assurance of plans for the member to remain in the residence for at least five years;

(8) may be denied when DDSD determines the home is unsafe or otherwise unsuitable for architectural modifications.

(A) DDSD area office resource development staff with architectural modification experience screens a home for safety and suitability for architectural modifications prior to home acquisition.

(B) Members needing home modification services and provider agencies assisting members to locate rental property identify several homes, when possible, for screening in order to select a home with the fewest or most cost effective modifications;

(9) are provided to eligible members with the homeowner's signed permission;

(10) are not authorized to modify homes solely for family or staff convenience or for cosmetic preference;

(11) are provided on finished rooms complete with wiring and plumbing;

(12) services that do not meet the requirements of OAC 317:40-5-101 may be approved by the DDSD division administrator or designee in exceptional circumstances; and

(13) are authorized in accordance with requirements of The Oklahoma Central Purchasing Act 74 O.S., ' 85.1 et. Seq., Chapter 15 of Title 580 of the Department of Central Services, and other applicable

statutory provisions.

(c) **Assessment and Team process.**

(1) Architectural modification assessments are performed by:

(A) DDSD area office resource development staff with architectural modification experience, when the requested architectural modification complies with minimum applicable national standards for persons with physical disabilities as applicable to private homes; or

(B) a licensed occupational therapist or physical therapist, at the request of designated DDSD area office resource development staff or area program supervisory staff, when the requested architectural modification exceeds or requires a variance to applicable national standards for persons with physical disabilities, or when such expertise is deemed necessary by DDSD area office resource development staff or area program supervisory staff.

(2) The Team considers the most appropriate architectural modifications based on the:

(A) member's needs;

(B) member's ability to access his or her environment; and

(C) possible use of assistive technology instead of architectural modification.

(3) The Team considers architectural modifications that:

(A) are necessary to ensure the health, welfare, and safety of the member; and

(B) provide the member increased access to the home to reduce dependence on others for assistance in daily living activities.

(d) **Requirements and standards for architectural modification contractors and construction.** All contractors must meet applicable federal, state and local requirements.

(1) Contractors are responsible for:

(A) obtaining all permits required by the municipality where construction is performed;

(B) following all applicable building codes; and

(C) taking and providing pictures to area office resource development staff of each completed architectural modification project within five working days of project completion and prior to payment of the architectural modification claim. Area office resource development staff may take pictures of the completed architectural modification projects when requested by the contractor.

(2) Any penalties assessed for failure to comply with requirements of the municipality are the sole responsibility of the contractor.

(3) New contractors must provide three references of previous work completed.

(4) Contractors must provide evidence of:

(A) liability insurance;

(B) vehicle insurance; ~~and~~

(C) worker's compensation insurance or affidavit of exemption~~.~~ ; and

(D) lead paint safety certificate.

(5) All modifications meet national standards for persons with physical disabilities as applicable to private homes unless a variance is required by the assessment.

(6) Contractors complete construction in compliance with written assessment recommendations from the:

(A) DDSD area office resource development staff with architectural modification experience; or

(B) a licensed professional.

(7) All architectural modifications must be completed by using high standard materials and workmanship, in accordance with industry standard.

(8) Ramps are constructed using the standards in (A) through (G) of this paragraph.

(A) All exterior wooden ramps are constructed of number two pressure treated wood.

(B) Surface of the ramp has a rough, non-skid texture.

(C) Ramps are assembled by the use of deck screws.

(D) Hand rails on ramps, if required, are sanded and smooth.

(E) Ramps can be constructed of stamped steel.

(F) Support legs on ramps are no more than six feet apart.

(G) Posts on ramps must be set or anchored in concrete.

(9) Roll-in showers are constructed to meet standards in (A) through (E) of this paragraph.

(A) The roll-in shower includes a new floor that slopes uniformly to the drain at not less than one-fourth nor more than one-half inch per foot.

(B) The material around the drain is flush, without an edge on which water can catch before going into the drain.

(C) Duro-rock, rather than sheet rock, is installed around the shower area, at least 24 inches up from the floor, with green board above the duro-rock.

(D) Tile, shower insert, or other appropriate water resistant material is installed to cover the duro-rock and green board.

(E) The roll-in shower includes a shower pan, or liner if applicable.

(F) Roll in showers may also be constructed with a one piece pre-formed material.

(10) DDSD area office resource development staff inspect any or all architectural modification work, prior to payment of an architectural modifications claim, to ensure:

(A) architectural modifications are completed in accordance with assessments; and

(B) quality of workmanship and materials used comply with requirements of OAC 317:40-5-101.

(e) **Architectural modifications when members change residences.**

(1) When two or more members share a home that has been modified and the member will no longer be sharing the home, the member whose Plan of Care authorized the modifications is given the first option of remaining in the residence.

(2) Restoration of architectural modifications is performed only for members of the Homeward Bound class when a written agreement between the homeowner and DDSD director, negotiated before any architectural modifications begin, describes in full the extent of the restoration. If no written agreement exists between the DDSD director and homeowner, OKDHS is not responsible to provide, pay for, or authorize any restorative services.

(f) **Services not covered under architectural modifications.** Architectural modifications do not include adaptations or improvements to the home which are of general utility and are not of direct medical or remedial benefit to the member, construction, reconstruction, or remodeling of any existing construction in the home, such as floors,

sub-floors, foundation work, roof, or major plumbing.

(1) Square footage is not added to the home as part of an architectural modification.

(2) Architectural modifications are not performed during construction or remodeling of a home.

(3) Modifications not authorized by the OKDHS include, but are not limited to:

(A) roofs;
(B) installation of heating or air conditioning units;
(C) humidifiers;
(D) water softener units;
(E) fences;
(F) sun rooms;
(G) porches;
(H) decks;
(I) canopies;
(J) covered walkways;
(K) driveways;
(L) sewer lateral lines or septic tanks;
(M) foundation work;
(N) room additions;
(O) carports;
(P) concrete for any type of ramp, deck, or surface other than a five by five landing pad at the end of a ramp, as described in applicable national standards for persons with physical disabilities as applicable to private homes;
(Q) non-adapted home appliances;
(R) carpet or floor covering that is not part of an approved architectural modification that requires and includes a portion of the floor to be re-covered such as a roll in shower, a door widening; or
(S) a second ramp or roll in shower in a home.

(4) A sidewalk is not authorized unless needed by the member to move between the house and vehicle.

(g) **Approval or denial of architectural modification services.** DDSD approval or denial of an architectural modification service is determined in accordance with (1) through (3) of this subsection.

(1) The architectural modification request provided by the DDSD case manager to DDSD area office resource development staff includes:

(A) documentation from the member's Team confirming the need and basis for architectural modification, including the architectural modification assessment;
(B) documentation of current Team consensus, including consideration of issues per OAC 317:40-5-101;
(C) lease, proof of home ownership, or other evidence that the member is able to live in the modified residence for at least 12 months; and
(D) an assurance by the member or legal guardian, if applicable, that the member plans to reside in the residence for five years.

(2) The DDSD area office:

(A) authorizes architectural modification services less than $2500 when the plan of care is less than the state office reviewer limit; and
(B) provides all required information to the DDSD State Office architectural modification programs manager for authorization of services when the plan of care is more than the area office

limit or is $2500 or more.

(3) Architectural modifications may be denied when the requirements of OAC 317:40-5-101 are not met.

(h) **Appeals**. The denial of acquisition of an architectural modification request may be appealed per OAC 340:2-5.

(i) **Resolving problems with services.** If the member, family member, or legal guardian, or Team is dissatisfied with the architectural modification, the problem resolution process per OAC 340:100-3-27 is initiated.

317:40-5-113. Adult Day Services

(a) **Introduction.** Adult Day Services are provided by agencies approved by the Developmental Disabilities Services Division (DDSD) of the Oklahoma Department of Human Services (OKDHS) that have a valid Oklahoma Health Care Authority contract for providing Adult Day Services. This service is available through the Community Waiver, Homeward Bound Waiver and through the In-Home Supports Waiver for Adults. Adult Day Services is a structured, comprehensive program that provides a variety of health, social, and related support services in a protective environment for some portion of a day. Individuals who participate in adult day services receive these services on a planned basis during specified hours. Adult day services are designed to work toward the goals of:

(1) promoting the member's maximum level of independence;

(2) maintaining the member's present level of functioning as long as possible, preventing or delaying further deterioration;

(3) assisting the member in achieving the highest level of functioning possible;

(4) providing support, respite, and education for families and other caregivers; and

(5) fostering socialization and peer interaction.

(b) **Eligibility requirements.** Adult Day Services are provided to eligible members whose teams have determined the service is appropriate to meet their needs. Members must:

(1) require ongoing support and supervision in a safe environment when away from their own residence;

(2) be 18 years of age or older; and

(3) not pose a threat to others.

(c) **Provider requirements.** Provider agencies must:

(1) meet the licensing requirements set forth by Section 1-873 et seq of Title 63 of the Oklahoma Statutes;

(2) comply with OAC 310:605, Adult Day Care Centers;

(3) allow DDSD staff to make announced and unannounced visits to the facility during the hours of operation;

(4) provide the DDSD case manager a copy of the individualized plan of care;

(5) submit incident reports per OAC 340:100-3-34;

(6) maintain a copy of the member's Individual Plan (Plan);

(7) submit Oklahoma Department of Human Services (OKDHS) Adult Day Services Progress Report Form 06WP046E to the DDSD case manager ~~by the tenth of each month for the previous month's services~~ per OAC 340:100-5-52, for each member receiving services; and

(8) serve as a member of the Personal Support Team and meet the Personal Support Team requirements per OAC 340:100-5-52.

(d) **Coverage.** The member's Plan contains detailed descriptions of services to be provided and documentation of hours of services. All

services must be authorized in the Plan and reflected in the approved plan of care. Arrangements for care must be made with the member's case manager.

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

317:40-7-12. Enhanced rates

An Enhanced Rate is available for both Community-Based Group Services and Group Job Coaching Services when necessary to meet a member's intensive personal needs in the employment setting(s). The need for the enhanced rate is identified through the Team process and is supported by documentation in the Individual Plan (Plan) with consideration of risk assessment per OAC 340:100-5-56 and assessment of medical, nutritional, and mobility needs and:

(1) Team assessment per OAC 340:100-5-51, OAC 340:100-5-56, OAC 340:100-5-57, and OAC 340:100-5-26 of the member's needs.

(2) the member must:

(A) have a protective intervention plan that:

(i) contains a restrictive or intrusive procedure as defined in OAC 340:100-1-2 implemented in the employment setting;

(ii) has been approved by the State Behavior Review Committee (SBRC) in accordance with OAC 340:100-3-14 or by the Developmental Disabilities Services Division (DDSD) staff per OAC 340:100-5-57; and

(iii) has been reviewed by the Human Rights Committee (HRC) per OAC 340:100-3-6;

(B) have procedures included in the Individual Plan which address dangerous behavior that places the member or others at risk of serious physical harm but are neither restrictive or intrusive procedures as defined in OAC 340:100-1-2. The Team submits documentation of this risk and the procedures to the positive support field specialist to assure that positive approaches are being used to manage dangerous behavior;

(C) have a visual impairment that requires assistance for mobility or safety;

~~(D) have two or more of the circumstances given in this subparagraph.~~

~~(i) The member has medical support needs which are rated at Level 4, Level 5, or Level 6 on the Physical Status Review (PSR), explained in OAC 340:100-5-26 or a comparable level of high medical needs as documented in the Plan.~~

~~(ii)~~ (D) ~~The member has~~ have nutritional needs requiring tube feeding or other dependency for food intake which must occur in the employment setting.

~~(iii)~~ (E) ~~The member has~~ have mobility needs, such that he or she requires two or more people for lifts, transfers, and personal care. Use of a mechanical lift or other assistive technology has been evaluated for the current employment program and determined not feasible by the DDSD division director or designee; or

~~(E)~~ (F) reside in alternative group home as described in OAC 317:40-5-152.

(3) The enhanced rate can be claimed only if the person providing services fulfills all applicable training criteria specified in OAC 340:100-3-38.

(4) There are no exceptions for the enhanced rate other than as allowed in this Section.

317:40-7-15. Service requirements for employment services through Home and Community-Based Services Waivers

(a) The Developmental Disabilities Services Division (DDSD) case manager, member, a member's family or, if applicable, legal guardian, and provider develop a preliminary plan of services including:

(1) site and amount of the services to be offered;

(2) types of services to be delivered; and

(3) expected outcomes.

(b) To promote community integration and inclusion, employment services are only delivered in non-residential sites.

(1) Employment services through Home and Community-Based Services (HCBS) Waivers cannot be reimbursed if those services occur in the residence or property of the member or provider-paid staff, including garages and sheds, whether or not the garage or shed is attached to the home.

(2) No exceptions to OAC 317:40-7-15(b) are authorized.

~~(c) Providers of HCBS employment services comply with OAC 340:100-17.~~

~~(d)~~ (c) The service provider is required to notify the DDSD case manager in writing when the member:

(1) is placed in a new job;

(2) loses his or her job. A Personal Support Team (Team) meeting must be held if the member loses the job;

(3) experiences significant changes in the community-based schedule or employment schedule; or

(4) experiences other circumstances, per OAC 340:100-3-34.

~~(e)~~ (d) The provider submits Oklahoma Department of Human Services (OKDHS) Provider Progress Report per OAC 340:100-5-52, for each member receiving services.

~~(f)~~ (e) The cost of a member's employment services, excluding transportation and state-funded services per OAC 340:100-17-30, cannot exceed $25,000 per Plan of Care year.

~~(g)~~ (f) Each member receiving residential supports per OAC 340:100-5-22.1 or group home services is employed for 30 hours per week or receives a minimum of 30 hours of employment services, ~~adult day services per OAC 317:40-5-113, or a combination of both,~~ each week, excluding transportation to and from the member's residence.

(1) Thirty hours of employment service each week can be a combination of community-based services, center-based services, employment training specialist (ETS) intensive training services, stabilization services, and job coaching services. Center-based services cannot exceed 15 hours per week for members receiving services through the Homeward Bound Waiver.

(2) Less than 30 hours of employment activities per week requires approval per OAC 317:40-7-21.

317:40-7-21. Exception process for employment services through Home and Community-Based Services Waivers

(a) All exceptions to rules in OAC 317:40-7 are:

(1) approved per OAC 317:40-7-21 prior to service implementation;

(2) intended to result in the Personal Support Team (Team) development of an employment plan tailored to meet the member's needs;

(3) identified in the Individual Plan (Plan) process per OAC

340:100-5-50 through 340:100-5-58; and

(4) documented and recorded in the Individual Plan by the Developmental Disabilities Services Division (DDSD) case manager after Team approval.

(b) A request for an exception to the minimum of 30 hours per week of employment services, ~~adult day services per OAC 317:40-5-113, or a combination of both,~~ per OAC 317:40-7-15, includes documentation of the Team's:

(1) discussion of:

(A) current specific situation that requires an exception;

(B) all employment efforts, successful and unsuccessful, made by the member and Team in the past year; and

(C) progress toward previous exception strategies or plans;

(2) plan with specific steps and target dates to address the situation throughout the Plan of Care year so the exception may be lessened or no longer necessary at the end of the Plan of Care year; and

(3) specific residential schedule to provide integrated activities outside the home while the plan to increase to 30 hours is implemented.

(c) A request for an exception to the maximum limit of 15 hours per week for center-based services, per OAC 317:40-7-6, or continuous supplemental supports, per OAC 317:40-7-13, for a member receiving services through the Homeward Bound Waiver includes documentation of the Team's:

(1) discussion of:

(A) current specific situation that requires an exception;

(B) all employment efforts, successful and unsuccessful, made by the member and Team in the past year; and

(C) progress toward previous exception strategies or plans; and

(2) plan with specific steps and target dates to address the situation throughout the Plan of Care year so the exception may be lessened or no longer necessary at the end of the Plan of Care year.

(d) A request for an alternative to required community-based activities per OAC 317:40-7-5 includes documentation of the Team's:

(1) discussion of:

(A) current specific situation that requires an exception;

(B) all employment efforts, successful and unsuccessful, made by the member and Team in the past year; and

(C) progress toward previous exception strategies or plans; and

(2) plan with specific steps and target dates to address the situation throughout the Plan of Care year so the exception may be lessened or no longer necessary at the end of the Plan of Care year.

(e) Exception requests per OAC 340:40-7-21(f) are documented by the DDSD case manager after Team consensus and submitted to the DDSD area manager or designee within ten working days after the annual IP or interim Team meeting. The area manager approves or denies the request with a copy to the DDSD area office claims staff and case manager based on the thoroughness of the Team's discussion of possible alternatives and reasons for rejection of the other possible alternatives.

(1) State dollar reimbursement for absences of a member receiving services through the Community Waiver in excess of 10% of authorized units up to 150 units is approved for medical reasons only. The request includes:

(A) Team's discussion of current specific situation that requires an exception;

(B) specific medical issues necessitating the exception request; and

(C) a projection of units needed to complete the State fiscal year.

(2) A request for any other exception to rules in OAC 317:40-7-21 requires documentation of the Team's discussion of:

(A) current specific situation that requires an exception;

(B) all employment efforts, successful and unsuccessful, made by the member and Team in the past year; and

(C) progress toward previous exception strategies or plans.

(f) The DDSD director or designee may review exceptions granted per OAC 317:40-7-21, directing the Team to provide additional information, if necessary, to comply with OAC 340:100-3-33.1 and other applicable rules.

7.a-19 TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 45. INSURE OKLAHOMA
Subchapter 1. General Provisions
317:45-1-3. [AMENDED]
317:45-1-4. [AMENDED]
(Reference APA WF # 11-33)

SUMMARY: Insure Oklahoma rules are revised to clarify in-network is defined as the highest percentage reimbursement network approved by OHCA. The rules are also revised to clarify that OHCA will only reimburse expenses related to the highest percentage network.

BUDGET IMPACT: Agency staff has determined that these revisions will be 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, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; Sections 1009.2 and 1010.1 of Title 56 of Oklahoma Statutes

PUBLIC HEARING: A public hearing was held on February 22, 2012. No comments were received before or during the public hearing regarding these changes.

SUBCHAPTER 1. GENERAL PROVISIONS

317:45-1-3. Definitions

The following words or terms, when used in this Chapter, will have the following meanings unless the context clearly indicates otherwise:

"Carrier" means:

(A) an insurance company, insurance service, insurance organization, or group health service, which is licensed to engage in the business of insurance in the State of Oklahoma and is subject to State law which regulates insurance, or Health Maintenance Organization (HMO) which provides or arranges for the delivery of basic health care services to enrollees on a prepaid basis, except for copayments or deductibles for which the enrollee is responsible, or both and is subject to State law which regulates Health Maintenance Organizations (HMOs);

(B) a Multiple Employer Welfare Arrangement (MEWA) licensed by the Oklahoma Insurance Department;

(C) a domestic MEWA exempt from licensing pursuant to Title 36 O.S., Section 634(B) that otherwise meets or exceeds all of the licensing and financial requirements of MEWAs as set out in Article 6A of Title 36; or

(D) any entity organized pursuant to the Interlocal Cooperation Act, Section 1001 et seq. of Title 74 of the Oklahoma Statutes as authorized by Title 36 Section 607.1 of the Oklahoma Statutes and which is eligible to qualify for and hold a certificate of authority to transact insurance in this State and annually submits on or before March 1st a financial statement to the

Oklahoma Insurance Department in a form acceptable to the Insurance Commissioner covering the period ending December 31st of the immediately preceding fiscal year.

"Child Care Center" means a facility licensed by OKDHS which provides care and supervision of children and meets all the requirements in OAC 340:110-3-1 through OAC 340:110-3-33.3.

"College Student" means an Oklahoma resident between the age of 19 through 22 that is a full-time student at an Oklahoma accredited University or College.

"Dependent" means the spouse of the approved applicant and/or child under 19 years of age or his or her child 19 years through 22 years of age who is attending an Oklahoma qualified institution of higher education and relying upon the insured employee or member for financial support.

"Eligibility period" means the period of eligibility extending from an approval date to an end date.

"Employee" means a person who works for an employer in exchange for earned income. This includes the owners of a business.

"Employer" means the business entity that pays earned income to employees.

"Employer Sponsored Insurance" means the program that provides premium assistance to qualified businesses for approved applicants.

"EOB" means an Explanation of Benefits.

"Explanation of Benefit" means a statement issued by a carrier that indicates services rendered and financial responsibilities for the carrier and Insure Oklahoma member.

"Full-time Employment" means a normal work week of 24 or more hours.

"Full-time Employer" means the employer who employs an employee for 24 hours or more per week to perform work in exchange for wages or salary.

"Gross Household Income" or "Annual Gross Household Income" means the countable income (earned or unearned) that is computed pursuant to OHCA's waiver and/or state plan using rules found in OAC 317:35.

"Individual Plan" means the safety net program for those qualified individuals who do not have access to Insure Oklahoma ESI.

"In-network" means providers or health care facilities that are part of a health plan's network of providers with which it has negotiated a discount, and services provided by a physician or other health care provider with a contractual agreement with the insurance company paid at the highest benefit level.

"Insure Oklahoma" means a health plan purchasing strategy in which the State uses public funds to pay for a portion of the costs of health plan coverage for eligible populations.

"Insure Oklahoma IP" means the Individual Plan program.

"Insure Oklahoma ESI" means the Employer Sponsored Insurance program.

"Member" means an individual enrolled in the Insure Oklahoma ESI or IP program.

"OESC" means the Oklahoma Employment Security Commission.

"OHCA" means the Oklahoma Health Care Authority.

"OKDHS" means the Oklahoma Department of Human Services.

"PCP" means Primary Care Provider.

"PEO" or "Professional Employer Organization" means any person engaged in the business of providing professional employer services. A person engaged in the business of providing professional employer services shall be subject to registration under the Oklahoma

Professional Employer Organization Recognition and Registration Act as provided in Title 40, Chapter 16 of Oklahoma Statutes, Section 600.1 et.seq.

"Primary Care Provider" means a provider under contract with the Oklahoma Health Care Authority to provide primary care services, including all medically necessary referrals.

"Premium" means a monthly payment to a carrier for health plan coverage.

"Qualified Health Plan (QHP)" means a health plan that has been approved by the OHCA for participation in the Insure Oklahoma program.

"Qualifying Event" means the occurrence of an event that permits individuals to join a group health plan outside of the "open enrollment period" and/or that allows individuals to modify the coverage they have had in effect. Qualifying events are defined by the employer's health plan and meet federal requirements under Public Law 104-191 (HIPAA), and 42 U.S.C. 300bb-3.

"State" means the State of Oklahoma, acting by and through the Oklahoma Health Care Authority.

317:45-1-4. Reimbursement for out-of-pocket medical expenses

(a) Out-of-pocket medical expenses for all approved and eligible members (and/or their approved and eligible dependents) will be limited to 5 percent of their annual gross household income. The OHCA will provide reimbursement for out-of-pocket medical expenses in excess of the 5 percent annual gross household income. A medical expense must be for an allowed and covered service by a qualified health plan (QHP) to be eligible for reimbursement. For the purpose of this Section, an allowed and covered service is defined as an in-network service covered in accordance with a qualified health plan's benefit summary and policies. For instance, if a QHP has multiple in-network reimbursement percentage methodologies (80% for level 1 provider and 70% for level 2 provider) the OHCA will only reimburse expenses related to the highest percentage network.

(b) For all eligible medical expenses as defined above in OAC 317:45-1-4(a), the member must submit the OHCA required form and all OHCA required documentation to support that the member incurred and paid the out-of-pocket medical expense. The required documentation must be submitted no later than 90 days after the close of the member's eligibility period. The OHCA required documentation must substantiate that the member actually incurred and paid the eligible out-of-pocket expense. The OHCA may request additional documentation at any time to support a member's request for reimbursement of eligible out-of-pocket medical expenses.

7.a-20 TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 35. MEDICAL ASSISTANCE FOR ADULTS AND CHILDREN-ELIGIBILITY
Subchapter 18. Programs of All-Inclusive Care for the Elderly
317:35-18-1. [AMENDED]
317:35-18-2. [AMENDED]
317:35-18-3. [AMENDED]
317:35-18-4. [AMENDED]
317:35-18-5. [AMENDED]
317:35-18-6. [AMENDED]
317:35-18-7. [AMENDED]
317:35-18-9. [AMENDED]
317:35-18-10. [AMENDED]
317:35-18-11. [AMENDED]
(Reference APA WF # 11-35)

SUMMARY: PACE rules are revised to remove pilot specific requirements and replace with language that is applicable to all PACE providers. Additional revisions include revising the Nursing Facility Level of Care criteria to be more specific to PACE eligibility criteria and cleaning up rules for clarity.

BUDGET IMPACT: Agency staff has determined that these revisions will be 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, and Sections 5003 through 5016 of Title 63 of the Oklahoma Statutes.

PUBLIC HEARING: A public hearing was held on February 22, 2012. No comments were received before or during the public hearing regarding these changes.

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

317:35-18-1. Programs of All-Inclusive Care for the Elderly (PACE)

This chapter establishes the requirements for ~~the Cherokee Nation Pilot Program~~ approved SoonerCare contracted Program of All-Inclusive Care for the Elderly (PACE) providers to provide services to eligible elderly ~~clients~~ individuals through the Oklahoma Health Care Authority's (OHCA) ~~Programs of All-Inclusive Care for the Elderly (PACE)~~ PACE program.

317:35-18-2. Introduction

(a) Programs of All-Inclusive Care for the Elderly (PACE) provide home and community-based acute and long-term care services to eligible individuals who meet the medical requirements for nursing facility care and can be served safely and appropriately in the community. PACE is optional in a State Medicaid program. PACE is jointly funded and administered by the Centers for Medicare and Medicaid Services and the state of Oklahoma. The PACE provider receives a monthly capitation payment and is at full risk for the delivery of all medically necessary

services for the ~~recipient~~ individual. For eligible individuals who elect to participate in the PACE program, the OHCA will make capitation payments for individuals who are only eligible for Medicaid or who are dually eligible for Medicaid and Medicare. OHCA will contract with ~~the Cherokee Nation~~ providers for ~~a~~ the PACE ~~pilot~~ program in the geographic areas as specified and approved in the ~~Cherokee Nation~~ provider PACE application. ~~The Cherokee Nation PACE pilot~~ The PACE program will provide medically necessary services to both American Indian/Alaska Native (AI/AN) and non-Indian Medicaid eligible ~~recipients~~ individuals.

(b) Rules applicable to the operation of the PACE program are contained in 42 Code of Federal Regulations (CFR), Part 460. These regulations, as currently written or amended in the future, are incorporated by reference as the rule base for operating the PACE program in Oklahoma.

317:35-18-3. Definitions

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

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

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

(3) **"Interdisciplinary Team (IDT)"** means the team of persons who interact and collaborate to assess PACE ~~clients~~ participants and plan for their care as set forth in 42 CFR ~~460:102~~ 460.102. The IDT may also include the PACE ~~client's~~ participant's personal representative or advocate.

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

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

(6) **"Provider"** means the non-profit entity ~~established by the Cherokee Nation~~ that delivers required PACE services under an agreement with OHCA and CMS.

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

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

317:35-18-4. Provider regulations

(a) The provider must comply with provisions of this Subchapter, and the regulations in 42 CFR, Part 460.

(b) The provider agency must be licensed by the State of Oklahoma as an adult day care center.

(c) The provider must meet all applicable local, state, and federal regulations.

(d) The provider must maintain an inquiry log of all individuals requesting Programs of All-Inclusive Care for the Elderly (PACE) services. This log will be available to the OHCA at all times. The log must include:

(1) type of contact;

(2) date of contact;

(3) name and phone number of the individual requesting services;

(4) name and address of the potential ~~client~~ participant; and

(5) date of enrollment, or reason for denial if the individual is not enrolled.

317:35-18-5. Eligibility criteria

(a) To be eligible for participation in PACE, the applicant must:

(1) meet categorical relationship to disability (reference OAC 317:35-5-4);

(2) meet medical and financial criteria for the ADvantage program (reference OAC 317:35-17-2, 317:35-17-10, and 317:35-17-11);

(3) be age 55 years or older

(4) live in a PACE service area;

(5) be determined by the PACE Interdisciplinary team as able to be safely served in the community. If the PACE provider denies enrollment because the IDT determines that the applicant cannot be served safely in the community, the PACE provider must:

(A) notify the applicant in writing of the reason for the denial;

(B) refer the ~~individual~~ applicant to alternative services as appropriate;

(C) maintain supporting documentation for the denial and notify CMS and OHCA of the denial and make the supporting documentation available for review; and

(D) advise the ~~client~~ applicant orally and in writing of the grievance and appeals process.

(b) To be eligible for ~~Medicaid~~ SoonerCare capitated payments, the ~~participant~~ individual must:

(1) be eligible for Title XIX services if institutionalized as determined by the Oklahoma Department of Human Services;

(2) be eligible for ~~Medicaid~~ SoonerCare State Plan services;

(3) be eligible for the ~~Medicaid~~ SoonerCare ADvantage program per OAC 317:35-17-3 and 317:35-17-5.

(c) To obtain and maintain eligibility, the ~~participant~~ individual must agree to accept the PACE providers and its contractors as the ~~participant's~~ individual's only service provider. The ~~participant~~ individual may be held financially liable for services received without prior authorization except for emergency medical care.

317:35-18-6. Program benefits

(a) A provider agency must provide a participant all the services listed in 42 CFR 460.92 that are approved by the IDT. The PACE benefit package for all participants, regardless of the source of payment, must include but is not limited to the following:

(1) All ~~Medicaid-covered~~ SoonerCare-covered services, as specified in the State's approved ~~Medicaid~~ SoonerCare plan.

(2) Interdisciplinary assessment and treatment planning.

(3) Primary care, including physician and nursing services.

(4) Social work services.

(5) Restorative therapies, including physical therapy, occupational therapy, and speech-language pathology services.

(6) Personal care and supportive services.

(7) Nutritional counseling.

(8) Recreational therapy.

(9) Transportation.

(10) Meals.

(11) Medical specialty services including, but not limited to the following:

(A) Anesthesiology.
(B) Audiology.
(C) Cardiology.
(D) Dentistry.
(E) Dermatology.
(F) Gastroenterology.
(G) Gynecology.
(H) Internal medicine.
(I) Nephrology.
(J) Neurosurgery.
(K) Oncology.
(L) Ophthalmology.
(M) Oral surgery.
(N) Orthopedic surgery.
(O) Otorhinolaryngology.
(P) Plastic surgery.
(Q) Pharmacy consulting services.
(R) Podiatry.
(S) Psychiatry.
(T) Pulmonary disease.
(U) Radiology.
(V) Rheumatology.
(W) General surgery.
(X) Thoracic and vascular surgery.
(Y) Urology.

(12) Laboratory tests, x-rays and other diagnostic procedures.

(13) Drugs and biologicals.

(14) Prosthetics, orthotics, durable medical equipment, corrective vision devices, such as eyeglasses and lenses, hearing aids, dentures, and repair and maintenance of these items.

(15) Acute inpatient care, including the following:
(A) Ambulance.
(B) Emergency room care and treatment room services.
(C) Semi-private room and board.
(D) General medical and nursing services.
(E) Medical surgical/intensive care/coronary care unit.
(F) Laboratory tests, x-rays and other diagnostic procedures.
(G) Drugs and biologicals.
(H) Blood and blood derivatives.
(I) Surgical care, including the use of anesthesia.
(J) Use of oxygen.
(K) Physical, occupational, respiratory therapies, and speech-language pathology services.
(L) Social services.

(16) Nursing facility care including:
(A) Semi-private room and board;
(B) Physician and skilled nursing services;
(C) Custodial care;
(D) Personal care and assistance;
(E) Drugs and biologicals;
(F) Physical, occupational, recreational therapies, and speech-language pathology, if necessary;
(G) Social services; and
(H) Medical supplies and appliances.

(17) Other services determined necessary by the interdisciplinary team to improve and maintain the participant's overall health status.

(b) The following services are excluded from coverage under PACE:

(1) Any service that is not authorized by the interdisciplinary team, even if it is a required service, unless it is an emergency service.

(2) In an inpatient facility, private room and private duty nursing services (unless medically necessary), and non-medical items for personal convenience such as telephone charges and radio or television rental (unless specifically authorized by the interdisciplinary team as part of the participant's plan of care).

(3) Cosmetic surgery, which does not include surgery that is required for improved functioning of a malformed part of the body resulting ~~fran~~ from an accidental injury or for reconstruction following mastectomy.

(4) Experimental medical, surgical, or other health procedures.

(5) Services furnished outside of the United States, except as follows:

(A) in accordance with 42 CFR 424.122 through 42 CFR 424.124, and

(B) as permitted under the State's approved Medicaid plan.

317:35-18-7. Appeals process

(a) Internal appeals

(1) Any ~~client~~ individual who is denied program services is entitled to an appeal through the provider.

(2) If the ~~client~~ individual also chooses to file an external appeal, the provider must assist the ~~client~~ individual in filing an external appeal.

(b) External appeals may be filed by any ~~client~~ individual covered by:

(1) ~~Medicaid~~ SoonerCare through the OHCA legal division.

(2) Medicare but not ~~Medicaid~~ SoonerCare through the Centers for Medicare and Medicaid Services hearing process.

317:35-18-9. Continuation of enrollment

(a) At least annually, OHCA must reevaluate whether a participant needs the level of care for nursing facility services.

(b) At least annually, OKDHS will reevaluate the participant's financial eligibility for ~~Medicaid~~ SoonerCare.

(c) If the individual meets the state's medical eligibility criteria and the individual has an irreversible or progressive diagnosis or a terminal illness that could ~~reasonable~~ reasonably be expected to result in death in the next six months, and OHCA determines that there is no reasonable expectation of improvement or significant change in the condition because of severity of a chronic condition or the degree of impairment of functional capacity, OHCA will permanently waive the annual recertification requirement and the ~~client~~ participant ~~may~~ will be deemed to be continually eligible for PACE. The assessment form must have sufficient documentation to substantiate the participant's prognosis and functional capacity.

(d) If OHCA determines that a PACE participant no longer meets the medical criteria for nursing facility level of care, the participant ~~may~~ will be deemed to continue to be eligible for PACE until the next annual reassessment, if, in the absence of PACE services, it is

reasonable to expect that the ~~client~~ participant would meet the nursing facility level of care criteria within the next six months.
(e) Participant enrollment continues when OHCA in consultation with the PACE organization, makes a determination of continued eligibility based on a review of the participant's medical record and plan of care. The participant's medical record and plan of care must support deemed continued eligibility.

317:35-18-10. Disenrollment (voluntary and involuntary)
(a) ~~The member~~ A participant may voluntarily disenroll from PACE at any time without cause ~~but~~ however, the effective date of disenrollment must be the last day of the month that the participant elects to disenroll.
(b) A participant may be involuntarily disenrolled for any of the following reasons:
(1) The participant/caregiver or guardian fails to pay, or to make satisfactory arrangements to pay, any premium due the PACE organization after a 30-day grace period.
(2) The participant/caregiver or guardian engages in disruptive or threatening behavior, as described in subsection (c) of this section.
(3) The participant moves out of the PACE program service area or is out of the service area for more than 30 consecutive days, unless the PACE organization agrees to a longer absence due to extenuating circumstances.
(4) The participant is determined to no longer meet the ~~State Medicaid~~ SoonerCare nursing facility level of care requirements and is not deemed eligible.
(5) The PACE program agreement with CMS and ~~the State administering agency~~ OHCA is not renewed or is terminated.
(6) The PACE organization is unable to offer health care services due to the loss of State licenses or contracts with outside providers.
(c) A participant may be involuntarily disenrolled for disruptive or threatening behavior. For purposes of this section, a participant who engages in disruptive or threatening behavior refers to a participant who exhibits either of the following:
(1) A participant whose behavior jeopardizes his or her health or safety, or the safety of others; or
(2) A participant with decision-making capacity who consistently refuses to comply with his or her individual plan of care or the terms of the PACE enrollment agreement.
(d) If a PACE organization proposes to disenroll a participant who is disruptive or threatening, the organization must document the following information in the participant's medical record:
(1) The reasons for proposing to disenroll the participant.
(2) All efforts to remedy the situation.
(e) A participant may be disenrolled involuntarily for noncompliant behavior.
(1) PACE organization may not disenroll a PACE participant on the grounds that the participant has engaged in noncompliant behavior if the behavior is related to a mental or physical condition of the participant, unless the participant's behavior jeopardizes his or her health or safety, or the safety of others.

(2) For purposes of this section, noncompliant behavior includes repeated noncompliance with medical advice and repeated failure to keep appointments.

(f) Before an involuntary disenrollment is effective, ~~the State administering agency must~~ OHCA will review ~~it~~ the participant's medical record and determine in a timely manner that the PACE organization has adequately documented acceptable grounds for disenrollment.

317:35-18-11. Data collection and reporting

The PACE provider must:

(1) collect ~~and enter~~ data to comply with reporting requirements in provider application ~~into the DATA PACE system.~~;

(2) generate and maintain monthly reports from ~~the DATA PACE system.~~ collected data;

(3) make the reports available to the OHCA~~.~~; and

(4) comply with all data requests as specified by the OHCA within 30 days of such requests.

7.a-21 TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
Subchapter 5. Individual Providers and Specialties
Part 79. Dentists
317:30-5-696. [AMENDED]
317:30-5-698. [AMENDED]
(Reference APA WF # 11-36)

SUMMARY: Agency dental policy is revised to allow for permanent restoration of a tooth when done as part of a Cvek Pulpotomy. The Cvek Pulpotomy is a procedure that better maintains the vitality of exposed pulps, especially in young patients. Allowing permanent restoration with the Cvek Pulpotomy will reduce the need for root canals. Finally, rules are revised to allow dentists to choose the proper type of crown that best serves the member's oral environment.

BUDGET IMPACT: Agency staff has determined that these revisions will be 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, and Sections 5003 through 5016 of Title 63 of the Oklahoma Statutes.

PUBLIC HEARING: A public hearing was held on February 22, 2012. Written comments were received before the public hearing regarding these changes and were considered during the rulemaking process.

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 79. DENTISTS

317:30-5-696. Coverage by category
Payment is made for dental services as set forth in this Section.
(1) **Adults.**
(A) Dental coverage for adults is limited to:
(i) emergency extractions;
(ii) Smoking and Tobacco Use Cessation Counseling; and
(iii) medical and surgical services performed by a dentist, to the extent such services may be performed under State law either by a doctor of dental surgery or dental medicine, when those services would be covered if performed by a physician.
(B) Payment is made for dental care for adults residing in private Intermediate Care Facilities for the Mentally Retarded (ICF/MR) and who have been approved for ICF/MR level of care, similar to the scope of services available to individuals under age 21.
(C) Pregnant women are covered under a limited dental benefit plan (Refer to (a)(4)of this Section).
(2) **Home and community based waiver services (HCBWS) for the ~~mentally retarded~~ intellectually disabled.** All providers participating in the HCBWS must have a separate contract with the

OHCA to provide services under the HCBWS. Dental services are defined in each waiver and must be prior authorized.

(3) **Children.** The OHCA Dental Program provides the basic medically necessary treatment. The services listed below are compensable for members under 21 years of age without prior authorization. ALL OTHER DENTAL SERVICES MUST BE PRIOR AUTHORIZED. Anesthesia services are covered for children in the same manner as adults. All providers performing preventive services must be available to perform needed restorative services for those members receiving any evaluation and preventive services.

(A) **Comprehensive oral evaluation.** This procedure is performed for any member not seen by any dentist for more than 12 months.

(B) **Periodic oral evaluation.** This procedure may be provided for a member of record if she or he has not been seen for more than six months.

(C) **Emergency examination/limited oral evaluation.** This procedure is not compensable within two months of a periodic oral examination or if the member is involved in active treatment unless trauma or acute infection is the presenting complaint.

(D) **Radiographs (x-rays).** To be SoonerCare compensable, x-rays must be of diagnostic quality and medically necessary. A clinical examination must precede any radiographs, and chart documentation must include member history, prior radiographs, caries risk assessment and both dental and general health needs of the member. The referring dentist is responsible for providing properly identified x-rays of acceptable quality with a referral, if that provider chooses to expose and submit for reimbursement prior to referral. Panoramic films are allowable once in a three year period and must be of diagnostic quality. Panoramic films are only compensable when chart documentation clearly indicates the test is being performed to rule out or evaluate non-caries related pathology. Prior authorization and a detailed medical need narrative are required for additional panoramic films taken within three years of the original set.

(E) **Dental sealants.** Tooth numbers 2, 3, 14, 15, 18, 19, 30 and 31 must be caries free on the interproximal and occlusal surfaces to be eligible for this service. This service is available through 18 years of age and is compensable only once per lifetime. Replacement of sealants is not a covered service under the SoonerCare program.

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

(G) **Composite restorations.**

(i) This procedure is compensable for primary incisors as follows:

(I) tooth numbers O and P to age 4 years;

(II) tooth numbers E and F to age 6 years;

(III) tooth numbers N and Q to 5 years; and

(IV) tooth numbers D and G to 6 years.

(ii) The procedure is also allowed for use in all vital and successfully treated non-vital permanent anterior teeth.

(iii) Class I and II composite restorations are allowed in posterior teeth; however, the OHCA has certain restrictions for the use of this restorative material. (See OAC 317:30-5-699).

(H) **Amalgam.** Amalgam restorations are allowed in:

(i) posterior primary teeth when:

(I) 50 percent or more root structure is remaining;

(II) the teeth have no mobility; or

(III) the procedure is provided more than 12 months prior to normal exfoliation.

(ii) any permanent tooth, determined as medically necessary by the treating dentist.

(I) **Stainless steel crowns.** The use of any stainless steel crowns is allowed as follows:

(i) Stainless steel crowns are allowed if:

(I) the child is five years of age or under;

(II) 70 percent or more of the root structure remains; or

(III) the procedure is provided more than 12 months prior to normal exfoliation.

(ii) Stainless steel crowns are treatment of choice for:

(I) primary teeth with pulpotomies or pulpectomies, if the above conditions exist;

(II) primary teeth where three surfaces of extensive decay exist; or

(III) primary teeth where cuspal occlusion is lost due to decay or accident.

(iii) Stainless steel crowns are the treatment of choice on posterior permanent teeth that have completed endodontic therapy, if more than three surfaces of extensive decay exist or where cuspal occlusion are lost due to decay prior to age 16 years.

(iv) Preoperative periapical x-rays and/or written documentation explaining the extent of decay must be available for review, if requested.

(v) Placement of a stainless steel crown includes all related follow up service for a period of two years. No other prosthetic procedure on that tooth is compensable during that period of time. A stainless steel crown is not a temporizing treatment to be used while a permanent crown is being fabricated.

(J) **Pulpotomies and pulpectomies.**

(i) Therapeutic pulpotomies are allowable for molars and teeth numbers listed below. Pre and post operative periapical x-rays must be available for review, if requested.

(I) Primary molars having at least 70 percent or more of their root structure remaining or more than 12 months prior to normal exfoliation;

(II) Tooth numbers O and P before age 5 years;

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

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

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

(ii) Pulpectomies are allowed for primary teeth if exfoliation of the teeth is not expected to occur for at least one year or if 70 percent or more of root structure is remaining.

(K) **Anterior root canals.** Payment is made for the services provided in accordance with the following:

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

(ii) Acceptable ADA filling materials must be used.

(iii) Preauthorization is required if the member's treatment plan involves more than four anterior root canals.

(iv) Teeth with less than 50 percent of clinical crown should not be treatment-planned for root canal therapy.

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

(vi) Pulpotomy may be performed for the relief of pain while waiting for the decision from the OHCA.

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

(viii) Endodontic treated teeth should be restored to limited occlusal function and all contours should be replaced. These teeth are not automatically approved for any type of crown.

(ix) If there are three or more missing teeth in the arch that requires replacement, root therapy will not be allowed.

(L) **Space maintainers.** Certain limitations apply with regard to this procedure. Providers are responsible for recementation of any maintainer placed by them for six months post insertion.

(i) **Band and loop type space maintenance.** This procedure must be provided in accordance with the following guidelines:

(I) This procedure is compensable for all primary molars where permanent successor is missing or where succedaneous tooth is more than 5mm below the crest of the alveolar ridge or where the successor tooth would not normally erupt in the next 12 months.

(II) First primary molars are not allowed space maintenance if the second primary and first permanent molars are present and in cuspal interlocking occlusion regardless of the presence or absence of normal relationship.

(III) If there are missing teeth bilaterally in the same arch, under the above guidelines, bilateral space maintainer is the treatment of choice.

(IV) The teeth numbers shown on the claim should be those of the missing teeth.

(V) Post operative bitewing x-rays must be available for review.

(VI) Bilateral band and loop space maintainer is allowed if member does not have eruption of the four mandibular anterior teeth in position or if sedation case that presents limitations to fabricate other space maintenance appliances.

(ii) **Lingual arch bar.** Payment is made for the services provided in accordance with the following:

(I) Lingual arch bar is used when permanent incisors are erupted and multiple missing teeth exist in the same arch.

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

(III) Multiple missing upper anterior primary incisors may be replaced with the appliance to age 6 years to prevent abnormal swallowing habits.

(IV) Pre and post operative x-rays must be available.

(iii) **Interim partial dentures.** This service is for anterior

permanent tooth replacement or if the member is missing three or more posterior teeth to age 16 years.

(M) **Analgesia.** Analgesia services are reimbursable in accordance with the following:

(i) **Inhalation of nitrous oxide.** Use of nitrous oxide is compensable for four occurrences per year and is not separately reimbursable, if provided on the same date by the same provider as IV sedation, non-intravenous conscious sedation or general anesthesia. The need for this service must be documented in the member's record. This procedure is not covered when it is the dentist's usual practice to offer it to all patients.

(ii) **Non-intravenous conscious sedation.** Non-intravenous conscious sedation is not separately reimbursable, if provided on the same date by the same provider as analgesia, anxiolysis, inhalation of nitrous oxide, IV sedation or general anesthesia. Non-intravenous conscious sedation is reimbursable when determined to be medically necessary for documented handicapped members, uncontrollable members or justifiable medical or dental conditions. The report must detail the member's condition. No services are reimbursable when provided primarily for the convenience of the member and /or the dentist, it must be medically necessary.

(N) **Pulp caps.** Indirect and direct pulp cap must be ADA accepted materials, not a cavity liner. Indirect and direct pulp cap codes require specific narrative support addressing materials used, intent and reasons for use. Application of chemicals used for dentinal hypersensitivity is not allowed as indirect pulp cap. Utilization of these codes is verified by post payment review.

(O) **Sedative restorations.** Sedative restorations include removal of decay, if present, and direct or indirect pulp cap, if needed. These services are reimbursable for the same tooth on the same date of service. Permanent restoration of the tooth is allowed after 30 days unless the tooth becomes symptomatic and requires pain relieving treatment.

(P) **History and physical.** Payment is made for services for the purpose of admitting a patient to a hospital for dental treatment.

(Q) **Local anesthesia.** This procedure is included in the fee for all services.

(R) **Smoking and Tobacco Use Cessation Counseling.** Smoking and Tobacco Use Cessation Counseling is covered when performed utilizing the five intervention steps of asking the member to describe his/her smoking, advising the member to quit, assessing the willingness of the member to quit, assisting with referrals and plans to quit, and arranging for follow-up. Up to eight sessions are covered per year per individual who has documented tobacco use. It is a covered service when provided by physicians, physician assistants, nurse practitioners, nurse midwives, and Oklahoma State Health Department and FQHC nursing staff in addition to other appropriate services rendered. Chart documentation must include a separate note, separate signature, and the member specific information addressed in the five steps and the time spent by the practitioner performing the counseling. Anything under three minutes is considered part of

a routine visit.

(4) **Pregnant Women.** Dental coverage for this special population is provided regardless of age.

(A) Proof of pregnancy is required (Refer to OAC 317:35-5-6).

(B) Coverage is limited to a time period beginning at the diagnosis of pregnancy and ending upon 60 days post partum.

(C) In addition to dental services for adults, other services available include:

(i) Comprehensive oral evaluation must be performed and recorded for each new member, or established member not seen for more than 24 months;

(ii) Periodic oral evaluation as defined in OAC 317:30-5-696(3)(B);

(iii) Emergency examinations/limited oral evaluation. This procedure is not allowed within two months of an oral examination by the same provider for the same member, or if the member is under active treatment;

(iv) Radiographs as defined in OAC 317:30-5-696(3)(D);

(v) Dental prophylaxis as defined in OAC 317:30-5-696(3)(F);

(vi) Composite restorations:

(I) Any permanent tooth that has an opened lesion that is a food trap will be deemed medically necessary for this program and will be allowed for all anterior teeth.

(II) Class I posterior composite resin restorations are allowed in posterior teeth that qualify;

(vii) Amalgam. Any permanent tooth that has an opened lesion that is a food trap will be deemed as medically necessary and will be allowed; and

(viii) Analgesia. Analgesia services are reimbursable in accordance with OAC 317:30-5-696(iii)(M).

(D) Services requiring prior authorization (Refer to OAC 317:30-5-698).

(E) Periodontal scaling and root planing. Required that 50% or more of six point measurements be 5 millimeters or greater. This procedure is designed for the removal of cementum and dentin that is rough, and/or permeated by calculus or contaminated with toxins and microorganism and requires anesthesia and some soft tissue removal.

(5) **Individuals eligible for Part B of Medicare.**

(A) Payment is made based on the member's coinsurance and deductibles.

(B) Services which have been denied by Medicare as non-compensable should be filed directly with the OHCA with a copy of the Medicare EOB indicating the reason for denial.

317:30-5-698. Services requiring prior authorization

(a) Providers must have prior authorization for certain specified services before delivery of that service, unless the service is provided on an emergency basis (See OAC 317:30-5-695(d)(2). Requests for dental services requiring prior authorization must be accompanied by sufficient documentation. X-rays, six point periodontal charting and comprehensive treatment plans are required. Study models and narratives may be requested by OHCA or representatives of OHCA. If the quality of the supporting material is such that a determination of authorization cannot be made, the material is returned to the provider. Any new documentation must be provided at the provider's expense.

Submitted documentation used to base a decision will not be returned.
(b) Requests for prior authorization are filed on the currently approved ADA form. OHCA notifies the provider on the determination of prior authorization using OHCA Prior Authorization Request Decision form. Prior authorized services must be billed exactly as they appear on the prior authorization. Payment is not made for any services provided prior to receiving authorization except for the relief of pain.
(c) Prosthodontic services provided to members who have become ineligible mid-treatment are covered if the member was eligible for SoonerCare on the date the final impressions were made.
(d) Listed below are examples of services requiring prior authorization for members under 21 and eligible ICF/MR residents. Minimum required records to be submitted with each request are right and left mounted bitewing x-rays and periapical films of tooth/teeth involved or the edentulous areas if not visible in the bitewings. X-rays must be submitted with x-ray film mounts and each film or print must be of good readable quality. X-rays must be identified by left and right sides with the date, member name, member ID, provider name, and provider ID. All x-rays, regardless of the media, must be placed together in the same envelope with a completed comprehensive treatment plan and a completed current ADA form requesting all treatments requiring prior authorization. The film, digital media or printout must be of sufficient quality to clearly demonstrate for the reviewer, the pathology which is the basis for the authorization request. If radiographs are not taken, provider must include in narrative sufficient information to confirm diagnosis and treatment plan.

(1) **Endodontics.** Pulpotomy may be performed for the relief of pain while waiting for the decision from the OHCA on request for endodontics. ~~A permanent restoration is not billable to the OHCA when performing pulpotomy or pulpal debridement on a permanent tooth.~~

(A) **Anterior root canals.** This procedure is for members who have a treatment plan requiring more than four anterior and/or posterior root canals. Payment is made for services provided in accordance with the following:

(i) Permanent teeth numbered 6, 7, 8, 9, 10, 11, 22, 23, 24, 25, 26 and 27 are eligible for therapy if there are no other missing teeth in the same arch requiring replacement, unless numbers 6 , 11 , 22, or 27 are abutments for prosthesis.

(ii) Accepted ADA materials must be used.

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

(iv) Providers are responsible for any follow-up treatment required by a failed endodontically treated tooth within 24 months post completion.

(v) A tooth will not be approved if it appears there is not adequate natural tooth structure remaining to establish good tooth/restorative margins or if crown to root ratio is poor.

(vi) An endodontic procedure may not be approved if the tooth requires a post and core to retain a crown.

(vii) If there are three or more missing teeth in the arch that requires replacement, root therapy will not be authorized.

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

(i) The provider documents that the member has improved oral hygiene and flossing ability in this member's records.

(ii) Teeth that would require pre-fabricated post and cores to retain a restoration due to lack of natural tooth structure should not be treatment planned for root canal therapy.

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

(iv) Providers are responsible for any follow-up treatment required by a failed endodontically treated tooth within 24 months post completion.

(v) A tooth will not be approved if it appears there is not adequate natural tooth structure remaining to establish good tooth/restorative margins or if there is a poor crown to root ratio or weakened root furcation area. Approval of second molars is contingent upon proof of medical necessity.

(vi) Only ADA accepted materials are acceptable under the OHCA policy.

(vii) Posterior endodontic procedure is limited to a maximum of five teeth. A request may not be approved if the tooth requires a post and core in order to present adequate structure to retain a crown.

(viii) Endodontics will not be considered if:

(I) there are missing teeth in the same arch requiring replacement;

(II) an opposing tooth has super erupted;

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

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

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

(ix) Endodontically treated teeth must be restored to limited occlusal function and all contours must be replaced. Core build-up code is only available for use if other restorative codes are not sufficient. These teeth will not be approved for a crown if it appears the apex is not adequately sealed.

(x) a failing root canal is determined not medically necessary for re-treatment.

(2) **~~Cast metal crowns or ceramic-based crowns.~~ Crowns for permanent teeth.** ~~These procedures~~ Crowns are compensable for restoration of natural teeth for members who are 16 years of age or older and adults residing in private Intermediate Care Facilities for the Mentally Retarded(ICF/MR) and who have been approved for (ICF/MR) level of care. Certain criteria and limitations apply.

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

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

(ii) The clinical crown is fractured or destroyed ~~by the above elements~~ by one-half or more.

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

(B) The conditions listed in (A)(i) through (A)(iii) of this paragraph should be clearly visible on the submitted x-rays when a request is made for any type of crown.

(C) Routine build-up(s) for authorized crowns are included in the fee for the crown.

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

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

~~(F) Ceramic-metal based crowns will be considered only for tooth numbers 4 through 13 and 21 through 28.~~

~~(G) Porcelain/Ceramic substrate crowns are allowed on maxillary and mandibular incisors only.~~

~~(H) Full cast metal crowns are treatment for all posterior teeth,~~

~~(I)~~ (F) Provider is responsible for replacement or repair of all ~~cast~~ crowns if ~~due to~~ failure is caused by poor laboratory processes or procedure by provider for 48 months post insertion.

(3) **Cast frame partial dentures.** This appliance is the treatment of choice for replacement of three or more missing permanent teeth in the same arch for members 16 through 20 years of age. Provider must indicate tooth number to be replaced and teeth to be clasped.

(4) **Acrylic partial.** This appliance is the treatment of choice for replacement of missing anterior permanent teeth or three or more missing teeth in the same arch for members 12 through 16 years of age and adults residing in private Intermediate Care Facilities for the Mentally Retarded (ICF/MR) and who have been approved for ICF/MR level of care. Provider must indicate tooth numbers to be replaced and teeth to be clasped. This appliance includes all necessary clasps and rests.

(5) **Occlusal guard.** Narrative of clinical findings must be sent with prior authorization request.

(6) **Fixed cast non-precious metal or porcelain/metal bridges.** Only members 17 through 20 years of age where the bite relationship precludes the use of removable partial dentures are considered. Members must have excellent oral hygiene documented in the requesting provider's records. Provider is responsible for any needed follow up for a period of five years post insertion.

(7) **Periodontal scaling and root planing.** This procedure requires that 50% or more of the six point measurements be five millimeters or greater and must involve two or more teeth per quadrant for consideration. This procedure is allowed on members 12 to 20 years of age and requires anesthesia and some soft tissue removal. The procedure is not allowed in conjunction with any other periodontal surgery. Allowance may be made for submission of required authorization data post treatment if the member has a medical or emotional problem that requires sedation.

(8) **Additional prophylaxis.** The OHCA recognizes that certain physical conditions require more than two prophylaxes. The following conditions may qualify a member for one additional prophylaxis per year:

(A) dilantin hyperplasia;

(B) cerebral palsy;

(C) ~~mental retardation~~ intellectual disabilities;

(D) juvenile periodontitis.

7.a-22 TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
Subchapter 5. Individual Providers and Specialties
Part 17. Medical Suppliers
317:30-5-211.10. [AMENDED]
(Reference APA WF # 11-38)

SUMMARY: Policy is revised to remove the requirement for a certificate of medical necessity for positive airway pressure devices (BiPAP and CPAP) as such CMNs are no longer used for authorization decisions. The agency's Medical Authorization Unit and physicians rely on documentation from sleep studies and other medical records to prior authorize.

BUDGET IMPACT: Agency staff has determined that these revisions will be 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, and Sections 5003 through 5016 of Title 63 of the Oklahoma Statutes.

PUBLIC HEARING: A public hearing was held on February 22, 2012. No comments were received before or during the public hearing regarding these changes.

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 17. MEDICAL SUPPLIERS

317:30-5-211.10. Durable medical equipment (DME)
(a) **DME**. DME includes, but is not limited to: medical supplies, orthotics and prosthetics, custom braces, therapeutic lenses, respiratory equipment and other qualifying items when acquired from a contracted DME provider.
(b) **Certificate of medical necessity**. Certain items of DME require a CMN/OHCA CMN which should be submitted with the request for prior authorization. These items include but are not limited to:
(1) hospital beds;
(2) support surfaces;
~~(3) continuous positive airway pressure devices (BiPAP and CPAP);~~
~~(4)~~ (3) patient lift devices;
~~(5)~~ (4) external infusions pumps;
~~(6)~~ (5) enteral and parenteral nutrition;
~~(7)~~ (6) osteogenesis stimulators; and
~~(8)~~ (7) pneumatic compression devices.
(c) **Prior authorization.**
(1) **Rental.** Rental of hospital beds, support surfaces, continuous positive airway pressure devices (CPAP and BiPAP), pneumatic compression devices, and lifts require prior authorization and, except for CPAP and BiPAP devices, a completed CMN/OHCA CMN; medical necessity must be documented in the member's medical record and be signed by the physician.
(2) **Purchase.** Equipment will be purchased when a member requires

the equipment for an extended period of time. During the prior authorization review the PA consultant may change the authorization from a rental to a purchase or a purchase to a rental based on the documentation submitted. The provider must indicate whether the DME item provided is new or used.

(d) **Backup equipment.** Backup equipment is considered part of the rental cost and not a covered service without prior authorization.

(e) **Home modification.** Equipment used for home modification is not a covered service.

7.a-23 TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 35. MEDICAL ASSISTANCE FOR ADULTS AND CHILDREN-ELIGIBILITY
Subchapter 17. ADvantage Waiver Services
317:35-17-1. [AMENDED]
317:35-17-2. [AMENDED]
317:35-17-3. [AMENDED]
317:35-17-4. [AMENDED]
317:35-17-5. [AMENDED]
317:35-17-11. [AMENDED]
317:35-17-12. [AMENDED]
317:35-17-14. [AMENDED]
317:35-17-15. [AMENDED]
317:35-17-16. [AMENDED]
317:35-17-17. [AMENDED]
317:35-17-18. [AMENDED]
317:35-17-19. [AMENDED]
317:35-17-21.1. [AMENDED]
317:35-17-24. [AMENDED]
(Reference APA WF # 11-39 A & B)

SUMMARY: OHCA rules for the ADvantage Waiver are revised to remove Respiratory Therapy as an allowable service within the waiver and remove Hospice when the member is in a nursing facility receiving ADvantage Facility Based Extended Respite. Both services are removed due to lack of utilization. Additionally, rules are revised to remove language allowing for reimbursement to providers of case management transition services when the member fails to transition into the ADvantage waiver program. The revisions are necessary to align OHCA policy with revised operational procedures as approved by the Centers for Medicare and Medicaid Services. Additional rule revisions include the following: removal of language requiring transportation to be provided by Adult Day Health Care Centers; clarification of family support services versus waiver services; addition of language clarifying "client support moderate risk", "client support high risk" and addition of language describing "client support low risk" and "environmental low risk"; the addition of eligibility language clarifying member reauthorization, recertification and redetermination; clarification regarding the member's level of need in order to be eligible for waiver services; clarification about the types of living arrangements allowable for ADvantage members; clarification regarding the member's health, safety and welfare; policy is revised to remove language allowing a financial eligibility assessment for individuals who are not applying for waiver services; clarification regarding when a new level of care determination is required; removal of language requiring recertification of the member by a case manager and requiring an OKDHS nurse to provide medical certification, and at a minimum annually; language added regarding plan of care documentation when more than one member of the household receives waiver services; clarification regarding the use of family members as paid providers; clarification of conditions requiring a member's service plan goals to be amended; removal of policy regarding the expedited eligibility determination process (SPEED); other

minor clean-up language.

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

MEDICAL ADVISORY COMMITTEE: The Medical Advisory Committee considered the proposed rule revisions on March 7, 2012 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 the Oklahoma Statutes; Medically Fragile 1915(c) Home and Community Based Services (HCBS) Waiver program as approved by The Centers for Medicare and Medicaid Services (CMS)

PUBLIC HEARING: A public hearing was held on February 22, 2012. No comments were received before or during the public hearing regarding these changes.

CHAPTER 35. MEDICAL ASSISTANCE FOR ADULTS AND CHILDREN-ELIGIBILITY
SUBCHAPTER 17. ADVANTAGE WAIVER SERVICES

317:35-17-1. Overview of long-term medical care services; relationship to QMBP, SLMB, and other Medicaid services eligibility

(a) Long-term medical care for the categorically needy includes:

(1) care in a nursing facility (refer to OAC 317:35-19);

(2) care in a public or private intermediate care facility for the ~~mentally retarded~~ intellectually disabled(refer to OAC 317:35-9);

(3) care of persons age 65 years or older in mental health hospitals (refer to OAC 317:35-9);

(4) Home and Community Based Services Waivers for ~~the Mentally Retarded~~ persons with intellectual disabilities (refer to OAC 317:35-9);

(5) Personal Care services (refer to OAC 317:35-15); and

(6) the Home and Community Based Services Waiver for frail elderly, and a targeted group of adults with physical disabilities age 21 and over who do not have ~~mental retardation~~ intellectual disability or a cognitive impairment (ADvantage Waiver).

(b) Any time an individual is certified as eligible for SoonerCare coverage of long-term care, the individual is also eligible for other SoonerCare services. ADvantage Waiver members do not have a copayment for ADvantage services except for prescription drugs. For members residing in an ADvantage Assisted Living Center, any income beyond 150% of the federal benefit rate is available to defray the cost of the Assisted Living services received. The member is responsible for payment to the Assisted Living Services Center provider for days of service from the first day of each full month in which services have been received until the vendor pay obligation is met. Any time an individual is aged, blind or disabled ~~individual~~ and is determined eligible for long-term care, a separate eligibility determination must be made for Qualified Medicare Beneficiary Plus (QMBP) or Specified Low-Income Medicare Beneficiary (SLMB) benefits. An ADvantage program member may reside in a licensed assisted living facility only if the assisted living center is a certified ADvantage Assisted Living Services provider from whom the member is receiving ADvantage Assisted

Living services.

317:35-17-2. Level of care medical eligibility determination

The OKDHS area nurse, or nurse designee, determines medical eligibility for ADvantage program services based on the ~~Long Term Care (LTC) nurse's~~ Uniform Comprehensive Assessment Tool (UCAT) III assessment and the determination that the ~~client~~ member has unmet care needs that require ADvantage or NF services to assure ~~client~~ member health and safety. ADvantage services are initiated to support the informal care that is being provided in the ~~client's~~ member's home, or, that based on the UCAT, can be expected to be provided in the ~~client's~~ members's home upon discharge of the ~~client~~ member from a NF or hospital. These services are not intended to take the place of regular care and general maintenance tasks or meal preparation typically shared or done for one another by spouses or other adults and who live in the same household. Additionally, services are not furnished if they principally benefit the family unit ~~provided by family members and/or by significant others~~. When there is an informal (not paid) system of care available in the home, ADvantage service provision will supplement the system within the limitations of ADvantage Program policy to enable the family and/or significant others to continue caregiving over extended periods. When the ADvantage personal care attendant and member live within the same household, personal care will only be approved by agreement of the interdisciplinary service planning team and OKDHS AA approval that the personal care tasks are consistent with plan goals and have beneficial outcomes for the member.

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

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

(i) bathing,
(ii) eating,
(iii) dressing,
(iv) grooming,
(v) transferring (includes getting in and out of a tub, bed to chair, etc.),
(vi) mobility,
(vii) toileting, and
(viii) bowel/bladder control.

(B) **"ADLs score in high risk range"** means the ~~client's~~ member's total weighted UCAT ADL score is 10 or more which indicates the ~~client~~ member needs some help with 5 ADLs or that the ~~client~~ member cannot do 3 ADLs at all plus the ~~client~~ member needs some help with 1 other ADL.

(C) **"ADLs score at the high end of the moderate risk range"** means ~~client's~~ member's total weighted UCAT ADL score is 8 or 9 which indicates the ~~client~~ member needs help with 4 ADLs or the ~~client~~ member cannot do 3 ADLs at all.

~~(D) **"CHC"** means Comprehensive Home Care.~~

~~(E)~~ (D) **"Client Support high risk"** means ~~client's~~ member's UCAT Client Support score is 25 which indicates in the UCAT assessor's clinical judgment, excluding from consideration existing Ryan White CARE Act, Indian Health Service, Medicaid

NF, ADvantage and/or State Plan Personal Care services, very little or no support is available from informal and formal sources and the overall total support is entirely inadequate to meet a high degree of medically complex needs. Functional capacity is so limited as to require full time assistance and the stability of the care system is likely to fail. The ~~client~~ member requires additional care that is not available through Medicare, Veterans Administration, or other Federal entitlement programs to prevent an imminent risk of life threatening health deterioration or institutional placement.

(E) **"Client Support low risk"** means member's UCAT Client Support score is 5 which indicates in the UCAT assessor's clinical judgment, excluding from consideration existing Ryan White CARE Act, Indian Health Service, Medicaid NF, ADvantage and/or State Plan Personal Care services, support from informal and formal sources is nearly sufficient/stable with minimal or few needs for formal services (i.e. some housekeeping only). The member/family/ informal supports are meeting most needs typically expected for family/household members to share or do for one another, i.e. general household maintenance. There is little risk of institutional placement even with a loss of current supports.

(F) **"Client Support moderate risk"** means ~~client's~~ member's UCAT Client Support score is 15 which indicates in the UCAT assessor's clinical judgment, excluding from consideration existing Ryan White CARE Act, Indian Health Service, Medicaid NF, ADvantage and/or State Plan Personal Care services, support from informal and formal sources is available, but overall, it is inadequate, changing, fragile or otherwise problematic and the ~~client~~ member requires additional care that usually includes personal care assistance with one or more activity of daily living tasks and is not available through Medicare, Veterans Administration, or other federal entitlement programs. Support provided by informal caregivers is of questionable reliability due to one or more of the following:

(i) Care/support is required continuously with no relief or backup available, or

(ii) Informal support lacks continuity due to conflicting responsibilities such as job and/or child care, or

(iii) Care/support is provided by persons with advanced age and/or disability, and

(iv) Institutional placement can reasonably be expected with any loss of existing support.

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

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

(i) is attributable to a mental or physical impairment or

combination of mental and physical impairments;
(ii) is manifested before the individual attains age 22;
(iii) is likely to continue indefinitely;
(iv) results in substantial functional limitations in three or more of the following areas of major life activity:
(I) self-care;
(II) receptive and expressive language;
(III) learning;
(IV) mobility;
(V) self-direction;
(VI) capacity for independent living; and
(VII) economic self-sufficiency; and
(v) reflects the individual?s need for a combination and sequence of special, interdisciplinary, or generic services, supports, or other assistance that is of lifelong or extended duration and is individually planned and coordinated.

(I) **"Environment high risk"** means ~~client's~~ member's UCAT Environment score is 25 which indicates in the UCAT assessor's clinical judgment, the physical environment is strongly negative or hazardous.

(J) **"Environment low risk"** means member's UCAT Environment score is 5 which indicates in the UCAT assessor's clinical judgment that, although aspects of the physical environment may need minor repair/improvement, the physical environment poses little risk to member's health and/or safety.

~~(J)~~ (K) **"Environment moderate risk"** means ~~client's~~ member's UCAT Environment score is 15 which indicates in the UCAT assessor's clinical judgment, many aspects of the physical environment are substandard or hazardous.

~~(K)~~ (L) **"Health Assessment high risk"** means ~~client's~~ member's UCAT health assessment score is 25 which indicates in the UCAT assessor's clinical judgment, the ~~client~~ member has one or more chronic health conditions, whose symptoms are rapidly deteriorating, uncontrolled, or not well controlled and requiring a high frequency or intensity of medical care/oversight to bring under control and whose functional capacity is so limited as to require full time assistance or care performed daily, by, or under the supervision of professional personnel and has multiple unmet needs for services available only through the ADvantage program or a Nursing Facility (NF) and requires NF placement immediately if these needs cannot be met by other means.

~~(L)~~ (M) **"Health Assessment low risk"** means ~~client's~~ member's health assessment score is 5 which indicates, in the UCAT assessor's clinical judgment, the ~~client~~ member has one or more chronic, stable, health conditions, whose symptoms are controlled or nearly controlled, which benefit from available, or usually available, medical treatment or corrective measures, and may have an unmet need for a service available only through the ADvantage program or a Nursing Facility (NF) but is not likely to enter a NF if these needs are not met.

~~(M)~~ (N) **"Health Assessment moderate risk"** means ~~client's~~ member's UCAT Health Assessment score is 15 which indicates in the UCAT assessor's clinical judgment, the ~~client~~ member has one or more chronic changing health conditions, whose symptoms are fragile or worsening and require medical care/oversight, to

bring under control or to maintain in a stable, controlled state and has multiple unmet needs for services available only through the ADvantage program or a Nursing Facility (NF) and is likely to enter a NF if these needs are not met.

~~(N)~~ (O) **"IADL"** means the instrumental activities of daily living~~.~~ that reflect household chores and tasks within the community essential for sustaining health and safety such as:

(i) shopping,
(ii) cooking,
(iii) cleaning,
(iv) managing money,
(v) using a telephone,
(vi) doing laundry,
(vii) taking medication, and
(viii) accessing transportation.

~~(O)~~ (P) **"IADLs score in high risk range"** means ~~client's~~ member's total weighted UCAT IADL score is 12 or more which indicates the ~~client~~ member needs some help with 6 IADLs or cannot do 4 IADLs at all.

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

~~(i) shopping,~~
~~(ii) cooking,~~
~~(iii) cleaning,~~
~~(iv) managing money,~~
~~(v) using a telephone,~~
~~(vi) doing laundry,~~
~~(vii) taking medication, and~~
~~(viii) accessing transportation.~~

(Q) ~~**"Mental Retardation"**~~ "Intellectual Disability" means that the ~~person~~ individual has, as determined by a standardized testing by trained professionals, substantial limitations in functional ability due to significantly sub-average intellectual functioning related to an event occurring before the age of 18.

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

(S) **"MSQ score in high risk range"** means the ~~client's~~ member's total weighted UCAT MSQ score is 12 or more which indicates a severe orientation-memory-concentration impairment, or a severe memory impairment.

(T) **"MSQ score at the high end of the moderate risk range"** means the ~~client's~~ member's total weighted UCAT MSQ score is (10) or (11) which indicates an orientation-memory-concentration impairment, or a significant memory impairment.

(U) **"Nutrition high risk"** means a total weighted UCAT Nutrition score is 12 or more which indicates the ~~client~~ member has significant eating difficulties combined with poor appetite, weight loss, and/or special diet requirements.

(V) **"Progressive degenerative disease process that responds to treatment"** means a process such as, but not limited to, Multiple Sclerosis (MS), Parkinson's Disease, Human Immunodeficiency Virus (HIV), or Acquired Immunodeficiency Syndrome (AIDS), that, untreated, systematically impairs normal body function which leads to acute illness and/or disability that results in rapid and/or advanced effects beyond those of regular chronic disease

degeneration but that reacts positively to a medically prescribed treatment intervention (usually medication) which arrests or significantly delays the destructive action of the process.

(W) **"Reauthorization"** means the official approval by the AA of an ADvantage member's Service Plan after the approval/authorization of the member's initial, or first year, Service Plan. At a minimum, reauthorization of an ADvantage member's Service Plan is required every 12 months.

(X) **"Recertification"** means the formal certification of medical and/or financial eligibility for an ADvantage member by OKDHS within ELDERS and IMS upon completion of the annual review.

(Y) **"Redetermination of eligibility"** means a subsequent determination of eligibility for an ADvantage member after the initial eligibility decision. Redetermination of financial and medical eligibility for ADvantage members is required at a minimum of once every 12 months. A redetermination of Program Eligibility, although not required, may occur when a significant change in the service plan is authorized or a significant change in the living arrangement occurs.

~~(W)~~ (Z) **"Social Resources high risk"** means a total weighted UCAT Social Resources score is 15 or more, which indicates the ~~client~~ member lives alone, combined with none or very few social contacts and no supports in times of need.

(2) **Minimum UCAT criteria**. The minimum UCAT criteria for NF level of care criteria are:

(A) Care need: The UCAT documents need for assistance to sustain health and safety as demonstrated by:

(i) either the ADLs or MSQ score is in the high risk range; or

(ii) any combination of two or more of the following:

(I) ADLs score is at the high end of moderate risk range; or,

(II) MSQ score is at the high end of moderate risk range; or,

(III) IADLs score is in the high risk range; or,

(IV) Nutrition score is in the high risk range; or,

(V) Health Assessment is in the moderate risk range, and, in addition;

(B) Loss of independence: The UCAT documents absence of support or adequate environment to meet the needs to sustain health and safety as demonstrated by:

(i) ~~Client~~ Member Support is moderate risk; or,

(ii) Environment is high risk; or,

(iii) Environment is moderate risk and Social Resources is in the high risk range; or, regardless of whether criteria under (A) of Care need and (B) ~~of absence of support are met~~ Loss of independence;

(C) Expanded criteria: The UCAT documents that:

(i) the ~~client~~ member has a clinically documented progressive degenerative disease process that will produce health deterioration to an extent that the ~~person~~ individual will meet OAC 317:35-17-2(2)(A) criteria if untreated; and

(ii) the ~~client~~ member previously has required Hospital or NF level of care services for treatment related to the condition; and

(iii) a medically prescribed treatment regimen exists that will significantly arrest or delay the disease process; and
(iv) only by means of ADvantage Program eligibility will the individual have access to the required treatment regimen to arrest or delay the disease process.

(3) **NF Level of Care Services**. To be eligible for NF level of care services, meeting the minimum UCAT criteria demonstrates the individual must:

(A) require a treatment plan involving the planning and administration of services that require the skills of licensed or otherwise certified technical or professional personnel, and are provided directly or under the supervision of such personnel;
(B) have a physical impairment or combination of physical, mental and/or functional impairments;
(C) require professional nursing supervision (medication, hygiene and/or dietary assistance);
(D) lack the ability to adequately and appropriately care for self or communicate needs to others;
(E) require medical care and treatment in order to minimize physical health regression or deterioration;
(F) require care that is not available through family and friends, Medicare, Veterans Administration, or other federal entitlement program with the exception of Indian Health Services; and
~~(G) require care that cannot be met through Medicaid State Plan Services, including Personal Care, if financially eligible.~~

317:35-17-3. ADvantage program services

(a) The ADvantage program is a Medicaid Home and Community Based Waiver used to finance ~~noninstitutional~~ non-institutional long-term care services for elderly and a targeted group of physically disabled adults when there is a reasonable expectation that within a 30 day period, the person's health, due to disease process or disability, would, without appropriate services, deteriorate and require nursing facility care to arrest the deterioration. ~~ADvantage program members must be SoonerCare eligible and must not reside in an institution, room and board, licensed residential care facility, or licensed assisted living facility, unless the facility is an ADvantage Assisted Living Center.~~ Individuals may not be enrolled in ADvantage for the sole purpose of enabling them to obtain Medicaid eligibility. Eligibility for ADvantage is contingent on an individual requiring one or more of the services offered in the waiver at least monthly in order to avoid institutionalization.

(b) The number of individuals who may receive ADvantage services is limited.

(1) To receive ADvantage services, individuals must meet one of the following categories:

(A) be age 65 years or older, or
(B) be age 21 or older if physically disabled and not developmentally disabled or if age 21 or older and not physically disabled, the person has a clinically documented, progressive degenerative disease process that responds to treatment and previously has required hospital or nursing facility (NF) level of care services for treatment related to the condition and requires ADvantage services to maintain the

treatment regimen to prevent health deterioration, or

(C) if developmentally disabled and between the ages of 21 and 65, not have ~~mental retardation~~ intellectual disability or a cognitive impairment related to the developmental disability.

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

(A) require nursing facility level of care [see OAC 317:35-17-2];

(B) meet service eligibility criteria [see ~~OAC 317:35-17-3(d)~~ OAC 317:35-17-3(f)]; and

(C) meet program eligibility criteria [see ~~OAC 317:35-17-3(e)~~ 317:35-17-3(g)].

(c) ADvantage members are eligible for limited types of living arrangements. The specific living arrangements are set forth below.

(1) ADvantage program members are not eligible to receive services while residing in an institutional setting, including but not limited to licensed facilities such as a hospital, a nursing facility, a licensed residential care facility, or a licensed assisted living facility, (unless the facility is an ADvantage Assisted Living Center), or in an unlicensed institutional living arrangement such as a room and board home/facility.

(2) ADvantage program members may receive services in a contracted ADvantage Assisted Living Center; an ADvantage Assisted Living Center is the only housing-with-nursing-supervised personal care services option in which a person may appropriately receive ADvantage services.

(3) Additional living arrangements in which members may receive ADvantage services are the member's own home, apartment or independent living apartment or a family or friend's home or apartment. A home/apartment unit is defined as a self-contained living space having a lockable entrance to the unit and including a bathroom and food storage/preparation amenities in addition to bedroom/living space.

(4) ADvantage program members may receive services in a shelter or similar temporary housing arrangement which may or may not meet the definition of home/apartment, in emergency situations, for a period not to exceed sixty (60) days during which location and transition to permanent housing is being sought.

(5) For ADvantage members who are full-time students, a dormitory room qualifies as an allowable living arrangement in which to receive ADvantage services for the period during which the member is a student.

(6) Members may receive ADvantage respite services in a nursing facility for a continuous period not to exceed thirty (30) days.

~~(b)~~ (d) Home and Community Based Waiver Services are outside the scope of Medicaid State Plan services. The Medicaid waiver allows the OHCA to offer certain Home and Community Based services to an annually capped number of persons who are categorically needy (refer to OKDHS form 08AX001E (Appendix C-1), Schedule VIII. B. 1.) and without such services would be institutionalized. The estimated cost of providing an individual's care outside the nursing facility cannot exceed the annual cost of caring for that individual in a nursing facility. When determining the ADvantage service plan cost cap for an individual, the comparable SoonerCare cost to serve that individual in a nursing facility is estimated. If the individual has Acquired Immune Deficiency Syndrome (AIDS) or if the individual requires ventilator care, the appropriate SoonerCare enhanced nursing facility rate to

serve the individual is used to estimate the ADvantage cost cap.

~~(c)~~ (e) Services provided through the ADvantage waiver are:

(1) case management;

(2) respite;

(3) adult day health care;

(4) environmental modifications;

(5) specialized medical equipment and supplies;

(6) physical therapy/occupational therapy/~~respiratory/~~speech therapy or consultation;

(7) advanced supportive/restorative assistance;

(8) ~~skilled~~ nursing;

(9) home delivered meals;

(10) hospice care;

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

(12) personal care (state plan) or ADvantage personal care;

(13) Personal Emergency Response System (PERS);

(14) Consumer-Directed Personal Assistance Services and Supports (CD-PASS);

(15) Institution Transition Services;

(16) assisted living; and

(17) SoonerCare medical services for individuals age 21 and over within the scope of the State Plan.

~~(d)~~ (f) The OKDHS area nurse or nurse designee makes a determination of service eligibility prior to evaluating the UCAT assessment for nursing facility level of care. The following criteria are used to make the service eligibility determination:

(1) an open ADvantage Program waiver slot, as authorized by the waiver document approved by the Centers for Medicare and Medicaid Services (CMS), is available to assure federal participation in payment for services to the individual. If the OKDHS/ASD determines all ADvantage waiver slots are filled, the individual cannot be certified on the OKDHS computer system as eligible for ADvantage services and the individual's name is placed on a waiting list for entry as an open slot becomes available. ~~ADvantage waiver slots and corresponding waiting lists, if necessary, are maintained for persons that have a developmental disability and those that do not have a developmental disability.~~

(2) the individual is in the ADvantage targeted service group. The target group is an individual who is frail and 65 years of age or older or age 21 or older with a physical disability and who does not have ~~mental retardation~~ intellectual disability or a cognitive impairment.

(3) the individual ~~does not pose~~ is not eligible if he/she poses a physical threat to self or others as supported by professional documentation.

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

(5) the individual is not eligible if his/her living environment poses a physical threat to self or others as supported by professional documentation where applicable, and measures to correct hazardous conditions or assist the person to move are unsuccessful or not feasible.

~~(e)~~ (g) The State, as part of the waiver program approval authorization, assures CMS that each member's health, safety or welfare can be maintained in their home. If a member's identified needs cannot be met through provision of ADvantage program or Medicaid State Plan services and other formal or informal services are not in place or immediately available to meet those needs, the individual's health, safety or welfare in their home cannot be assured. The ~~OKDHS/ASD~~ AA determines ADvantage program eligibility through the service plan approval process. ~~The following criteria are used to make the ADvantage program eligibility determination that an individual is not eligible:~~ An individual is deemed ineligible for the ADvantage program based on the following criteria:

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

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

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

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

~~(5)~~ (4) ~~if,~~ after the service and care plan is developed, the risk to individual's health and safety is not acceptable to the individual, or to the interdisciplinary service plan team, or to the OKDHS/ASD.

(5) the individual's living environment poses a physical threat to self or others as supported by professional documentation, where applicable and measures to correct hazardous conditions or assist the person to move are unsuccessful or are not feasible.

(6) the individual's health safety or welfare in their home cannot be assured due to continued refusal of planned services.

(7) the individual does not require at least one ADvantage service monthly.

~~(f)~~ (h) The case manager provides the ~~OKDHS/ASD~~ AA with professional documentation to support the recommendation for redetermination of program eligibility. The service providers continue providing services according to the service plan as provider safety permits until the individual is removed from the ADvantage program. As a part of the procedures requesting redetermination of program eligibility, the OKDHS/ASD will provide technical assistance to the Provider for transitioning the individual to other services.

~~(g)~~ (i) Individuals determined ineligible for ADvantage program services are notified in writing by OKDHS of the determination and of their right to appeal the decision.

317:35-17-4. Application for ADvantage services

(a) **Application procedures for ADvantage services**. If waiver slots are available, the application process is initiated by the receipt of a UCAT, Part I or by an oral request for services. A written financial application is not required for an individual who has an active Medicaid case. A financial application for ADvantage services consists of the Medical Assistance Application form. The form is signed by the applicant, parent, spouse, guardian or someone else acting on the applicant's behalf.

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

~~(2) An individual residing in an NF or requesting waiver services, or the individual's community spouse may request an assessment of resources available to each spouse by using OKDHS form MA-11, Assessment of Assets, when Medicaid application is not being made. The individual and/or spouse must provide documentation of resources. The assessment reflects all countable resources of the couple (owned individually or as a couple) and establishes the spousal share to be protected when subsequent determination of Medicaid long-term care eligibility is made.~~

~~(3)~~ (2) When Medicaid application is being made, an assessment of resources must be completed ~~if it was not completed when the individual entered the NF or began receiving waiver services~~. For applicants of the ADvantage waiver, those resources owned by the couple the month the application was made determines the spousal share of resources. ~~If the individual applies for Medicaid at the time of entry into the ADvantage waiver, Form MA-11 is not appropriate. However, the spousal share must be determined using the resource information provided on the Medicaid application form and computed using OKDHS form MA-12, Title XIX Worksheet.~~

(b) **Date of application**.

(1) The date of application is:

(A) the date the applicant or someone acting in his/her behalf signs the application in the county office; or

(B) the date the application is stamped into the county office when the application is initiated outside the county office; or

(C) the date when the request for Medicaid is made orally and the financial application form is signed later. The date of the oral request is entered in "red" above the date the form is signed.

(2) An exception is when OKDHS has contracts with certain providers to take applications and obtain documentation. After the documentation is obtained, the contracted provider forwards the application and documentation to the OKDHS county office of the ~~client's~~ applicant's county of residence for Medicaid eligibility determination. The application date is the date the ~~client~~ applicant signed the application form for the provider.

(c) **ADvantage waiting list procedures.** ADvantage Program "available capacity" is the number of ~~clients~~ members that may be enrolled in the Program without exceeding, on an annualized basis, the maximum number authorized by the waiver to be served in the waiver year. Upon

notification from the AA that 90% of the available capacity has been exceeded, OKDHS Aging Services Division (OKDHS/ASD) notifies OKDHS county offices and contract agencies approved to complete the UCAT, Parts I and II that, until further notice, requests for ADvantage services are not to be processed as applications, but referred to AA to be placed on a waiting list of requests for ADvantage services. As available capacity permits, but remaining in compliance with waiver limits of maximum capacity, and until an increase in ADvantage available capacity occurs, the AA selects in chronological order (first on, first off) requests for ADvantage from the waiting list to forward to the appropriate OKDHS county office for processing the application. When the waiver capacity exceeds the number on the waiting list and after all persons on the waiting list have been processed, waiting list procedures are suspended.

317:35-17-5. ADvantage program medical eligibility determination

The OKDHS area nurse, or nurse designee, makes the medical eligibility determination utilizing professional judgment, the Uniform Comprehensive Assessment Tool (UCAT) I, Part III, and other available medical information.

(1) When ADvantage care services are requested or the UCAT is received in the county office:

(A) the ~~LTC~~ OKDHS nurse is responsible for completing the UCAT III.

(B) the social worker is responsible for contacting the individual within three working days to initiate the financial eligibility application process.

(2) Categorical relationship must be established for determination of eligibility for ADvantage services. If categorical relationship to disability has not already been established, the local social worker submits the same information described in OAC 317:35-5-4(2) to the Level of Care Evaluation Unit (LOCEU) to request a determination of eligibility for categorical relationship. LOCEU renders a decision on categorical relationship to the disabled using the same definition used by SSA. A follow-up is required by the OKDHS social worker with the Social Security Administration to be sure their disability decision agrees with the decision of LOCEU.

(3) Community agencies complete the UCAT, Part I and forwards the form to the county office. If the UCAT, Part I indicates that the applicant does not qualify for Medicaid long-term care services, the applicant is referred to appropriate community resources.

(4) The ~~LTC~~ OKDHS nurse completes the UCAT, Part III assessment visit with the ~~client~~ member within 10 working days of receipt of the referral for ADvantage services for a client who is Medicaid eligible at the time of the request. The ~~LTC~~ OKDHS nurse completes the UCAT, Part III assessment within 20 working days of the date the Medicaid application is completed for new ~~clients~~ applicants.

(5) During the assessment visit, the ~~LTC~~ OKDHS nurse informs the ~~client~~ applicant of medical eligibility and provides information about the different long-term care service options. If there are multiple household members applying for the ADvantage program, the UCAT assessment is done for the applicant household members during the same visit. The ~~LTC~~ OKDHS nurse documents whether the ~~client~~ member chooses NF program services or ADvantage program services. In addition, the LTC nurse makes a level of care and service program recommendation.

(6) The ~~LTC~~ OKDHS nurse informs the ~~client~~ member and family of agencies certified to deliver ADvantage case management and in-home care services in the local area to obtain the client's primary and secondary informed choices.

(A) If the ~~client~~ member and/or family declines to make a provider choice, the ~~LTC~~ OKDHS nurse documents that decision on the ~~client~~ member choice form.

(B) The AA uses a rotating system to select an agency for the ~~client~~ member from a list of all local certified case management and in-home care agencies.

(7) The ~~LTC~~ OKDHS nurse documents the names of the chosen agencies and the agreement (by dated signature) of the ~~client~~ member to receive services provided by the agencies.

(8) If the needs of the ~~client~~ member require an immediate interdisciplinary team (IDT) meeting with home health agency nurse participation to develop a care plan and service plan, the ~~LTC~~ OKDHS nurse documents the need for priority processing.

(9) The ~~LTC~~ OKDHS nurse scores the UCAT, Part III. The ~~LTC~~ OKDHS nurse forwards the UCAT, Parts I and III, documentation of financial eligibility, and documentation of the ~~client's~~ member's case management and in-home care agency choices to the area nurse, or nurse designee, for medical eligibility determination.

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

(11) Within ten working days of receipt of a complete ADvantage application, the area nurse, or nurse designee, determines medical eligibility using NF level of care criteria and service eligibility criteria [refer to OAC 317:35-17-2 and OAC 317:35-17-3] and enters the medical decision on the system. ~~The original documents are sent with the MS-52 to the AA.~~

(12) Upon notification of financial eligibility from the social worker, medical eligibility (MS-52) and approval for ADvantage entry from the area nurse, or nurse designee, the AA communicates with the ~~client and~~ case management provider to begin care plan and service plan development. The AA communicates to the client's case management provider the ~~client's~~ member's name, address, case number and social security number, the units of case management and, if applicable, the number of units of home health agency nurse evaluation authorized for care plan and service plan development~~, whether the needs of the client require an immediate IDT meeting with home health agency nurse participation and the effective date for client entry into ADvantage~~. If the member requires an immediate home visit to develop a service plan within 24 hours, the AA contacts the case management provider directly to confirm availability and then sends the new case packet information to the case management provider via facsimile.

(13) If the services must be in place to ensure the health and safety of the ~~client~~ member upon discharge to the home from the NF or Hospital, ~~the AA provides administrative case management to develop and implement the care plan and service plan. For administrative case management, the AA, or~~ a nurse case manager from an ADvantage case management provider selected by the client and referred by the AA follows ADvantage Institution Transition case management procedures for care plan and service plan development and

implementation. ~~If the AA has provided transition case management services, when the client returns home, the AA begins transitioning case management to the ADvantage case management provider chosen by the client.~~

~~(14) If a client in a hospital requests ADvantage services, the hospital initiates a request for Medicaid ADvantage services by contacting the AA for intake and screening.~~

~~(A) The AA, or a nurse case manager from an ADvantage case management provider selected by the client and referred by the AA completes the UCAT, Part III assessment visit, if possible, with the hospitalized applicant. If the local OKDHS office receives the request for Medicaid ADvantage services for a client in a hospital it is referred to the AA. During the assessment visit, the AA, or ADvantage nurse case manager informs the client of financial and medical eligibility criteria and provides information about the different long-term care service options. The AA, or ADvantage nurse case manager documents the client's choice on the UCAT, Part III. The AA, or ADvantage nurse case manager will review forms documenting the selection of provider(s), agreement with the service plan and release of information with the client and obtain the client's dated signature on the forms.~~

~~(B) If the UCAT indicates the client is eligible for ADvantage services and financial eligibility has been determined, the AA, or ADvantage nurse case manager, in consultation with the hospital discharge planner provides administrative case management. The AA, or ADvantage nurse case manager develops a temporary care plan and service plan if services must be in place to ensure the health and safety of the client upon discharge from the hospital. When the client returns home, the AA, or ADvantage nurse case manager transitions case management to the ADvantage case management provider chosen by the client.~~

~~(C) The completed assessment forms are submitted to the OKDHS area nurse who makes the medical eligibility decision, enters it on the system and notifies the AA of the decision.~~

~~(D) If the applicant is determined not eligible for ADvantage, providers follow special procedures specified by the AA to bill for services provided. If authorized by the AA, case management providers may bill using an administrative case management procedure code for services delivered and not reimbursable under any other ADvantage case management procedure code.~~

~~(15)~~ (14) ~~If the client has a current certification and requests a change from Personal Care Services to ADvantage services, a new UCAT is required. The UCAT is updated when a client requests a change from ADvantage services to Personal Care services, or when a client requests a change from the nursing facility to ADvantage services. If a client is receiving ADvantage services and requests to go to a nursing facility, a new medical level of care decision is not needed.~~ A new medical level of care determination is required when a member requests any of the following changes in service program:

(A) from State Plan Personal Care to ADvantage services.

(B) from ADvantage to State Plan Personal Care services.

(C) from Nursing Facility to ADvantage services.

(D) from ADvantage to Nursing Facility services.

(15) A new medical level of care determination is not required when a member requests re-activation of ADvantage services after a short-

term stay (90 days or less) in a Nursing Facility when the member has had previous ADvantage services and the ADvantage certification period has not expired.

(16) When a UCAT assessment has been completed more than 90 days prior to submission to the area nurse or nurse designee for a medical decision, a new assessment is required.

317:35-17-11. Determining financial eligibility for ADvantage program services

Financial eligibility for individuals in ADvantage program services is determined according to whether or not a spouse remains in the home.

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

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

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

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

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

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

(C) **Vendor payment**. For individuals in the ADvantage program who live in a house, an apartment, or other independent living setting, there is not a spenddown calculation as the member does not pay a vendor payment. For individuals in the ADvantage program who reside in an ADvantage Assisted Living Services Center, a vendor payment must be computed if the income exceeds 150% of the federal benefit rate. The member is responsible for payment to the Assisted Living Services Center provider for days of service from the first day of each month in which services have been received until the vendor payment obligation is met.

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

(2) **Individual with a spouse who receives ADvantage or HCBW/MR services, or is institutionalized in a NF or ICF/MR, or is 65 or over and in a mental health hospital.** For an individual with a

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

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

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

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

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

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

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

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

(C) **Vendor payment**. For individuals in the ADvantage program who live in a house, an apartment, or other independent living setting, there is not a spenddown calculation as the member does not pay a vendor payment. For individuals in the ADvantage program who reside in an ADvantage Assisted Living Services Center, a vendor payment must be computed if the income exceeds 150% of the federal benefit rate. The member is responsible for payment to the Assisted Living Services Center provider for days of service from the first day of each month in which services have been received until the vendor payment obligation is met.

(D) **Equity in capital resources.** If the equity in the individual's capital resources is in excess of the maximum resource standards, certification is delayed up to 30 days providing plans are made for the applicant to utilize the excess resource. Certification is made at the point the excess resources have been exhausted, with the effective date of certification being shown as the date on which the resources came within the standard. If the excess capital resources can

not reasonably be expected to come within standards in one month, the application is denied.

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

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

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

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

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

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

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

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

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

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

XI.
(iii) The minimum resource standard for the community spouse, as established by the OHCA, is found on OKDHS form 08AX001E, Schedule XI. When the community spouse's share is less than the minimum standard, an amount may be deemed from the other spouse's share to ensure the minimum resource standard for the community spouse. If the community spouse's share equals or exceeds the minimum resource standard, deeming cannot be done.
(iv) If deeming is necessary to meet the minimum resource standard for the community spouse, the amount that is deemed must be legally transferred to the community spouse within one year of the effective date of certification for SoonerCare. At the first redetermination of eligibility, the worker must document that the resources have been transferred. After the first year of SoonerCare eligibility, resources of the community spouse will not be available to the other spouse and resources cannot be deemed to the community spouse.
(v) After the month in which the institutionalized spouse and community spouse have met the resource standard and the institutionalized spouse is determined eligible for benefits, no resources of the community spouse, regardless of value, will be considered available to the institutionalized spouse. If the resources of the community spouse grow to exceed the original deemed amount, the State cannot require the community spouse to apply any of these excess resources toward the cost of the care of the institutionalized spouse.
(vi) When determining eligibility for SoonerCare, the community spouse's share of resources is protected and the remainder considered available to the spouse receiving ADvantage program services.
(vii) The resources determined in (i) - (vi) of this subparagraph for the individual receiving ADvantage program services cannot exceed the maximum resource standard for an individual as shown in OKDHS form 08AX001E, Schedule VIII. D.
(viii) Once the dollar value of the community spouse's share of resources is established for the month of the other spouse's entry into the ADvantage program service, that amount is used when determining resource eligibility for a subsequent SoonerCare application for Long-Term Care for either spouse.
(ix) Once a determination of eligibility for SoonerCare is made, either spouse is entitled to a fair hearing. A fair hearing regarding the determination of the community spouse's resource allowance is held within 30 days of the date of the request for the hearing. Either spouse is entitled to a fair hearing if dissatisfied with a determination of:
(I) the community spouse's monthly income allowance;
(II) the amount of monthly income otherwise available to the community spouse;
(III) determination of the spousal share of resource;
(IV) the attribution of resources (amount deemed); or
(V) the determination of the community spouse's resource allowance.
(x) The rules on determination of income and resources are

applicable only when an individual receiving ADvantage program services is likely to remain under care for 30 consecutive days. The 30-day requirement is considered to have been met even if a hospital stay interrupts it or the individual is deceased before the 30-day period ends.

(C) **Vendor payment**. For individuals in the ADvantage program who live in a house, an apartment, or other independent living setting, there is not a spenddown calculation as the member does not pay a vendor payment. For individuals in the ADvantage program who reside in an ADvantage Assisted Living Services Center, after allowable deeming to the community spouse, a vendor payment must be computed if the income exceeds 150% of the federal benefit rate. The member is responsible for payment to the Assisted Living Services Center provider for days of service from the first day of each month in which services have been received until the vendor payment obligation is met.

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

317:35-17-12. Certification for ADvantage program services

(a) **Application date**. If the applicant is found eligible for SoonerCare, certification may be effective the date of application. The first month of the certification period must be the first month the member was determined eligible for ADvantage, both financially and medically.

(1) As soon as eligibility or ineligibility for ADvantage program services is established, the worker updates the computer form and the appropriate notice is computer generated to the member and the ADvantage Administration (AA). Notice information is retained on the notice file for county use.

(2) An applicant approved for ADvantage program services is mailed a Medical Identification Card.

(b) **Financial certification period for ADvantage program services**. The financial certification period for the ADvantage program services is 12 months. Although "medical eligibility number of months" on the computer input record will show 99 months, redetermination of eligibility is completed according to the categorical relationship.

(c) **Medical Certification period for ADvantage program services**. The medical certification period for ~~the~~ ADvantage program services is up to 12 months. ~~Reassessment and redetermination~~ Redetermination of medical eligibility is completed by OKDHS in coordination with the annual ~~recertification~~ reauthorization of the member's service plan ~~by the case manager~~. ~~In addition, an~~ An independent ~~evaluation~~ redetermination of medical eligibility is completed by the OKDHS Nurse ~~at least every third year~~ when, depending upon the needs of the member, the medical certification is determined to be less than 12 months, or, at any time~~. If~~ documentation supports a reasonable expectation that the member ~~will~~ may not continue to meet medical eligibility criteria ~~or have a need for long term care services for more than 12 months, the~~

~~OKDHS Nurse does an independent evaluation of medical eligibility before the end of the current medical certification period~~.

317:35-17-14. Case management services

(a) Case management services involve ongoing assessment, service planning and implementation, service monitoring and evaluation, member advocacy, and discharge planning.

(1) Within one working day of receipt of an ADvantage referral from the ADvantage Administration (AA), the case management supervisor assigns a case manager to the member. ~~Within three working days of being assigned an ADvantage member, the~~ The case manager makes a home visit to review the ADvantage program (its purpose, philosophy, and the roles and responsibilities of the member, service provider, case manager, ~~AA~~ and OKDHS in the program), ~~and~~ review, update and complete the UCAT assessment, ~~and to~~ discuss service needs and ADvantage service providers. The Case Manager notifies in writing the member's UCAT identified primary physician that the member has been determined eligible to receive ADvantage services. The notification is via a preprint form that contains the member's signed permission to release this health information and requests physician's office verification of primary and secondary diagnoses and diagnoses code obtained from the UCAT.

(2) Within 14 calendar days of the receipt of an ADvantage referral, the case manager completes and submits to the AA an individualized care plan and service plan for the member, signed by the member and the case management supervisor. The case manager completes and submits to the AA the annual reassessment service plan documents no sooner than 60 days before the existing service plan end date but sufficiently in advance of the end date to be received by the AA at least 30 calendar days before the end date of the existing service plan. Within 14 calendar days of receipt of a Service Plan Review Request (SPR) from the AA, the Case Manager provides corrected care plan and service plan documentation. Within five calendar days of assessed need, the case manager completes and submits a service plan addendum to the AA to amend current services on the care plan and service plan. The care plan and service plan are based on the member's service needs identified by the UCAT, Part III, and includes only those ADvantage services required to sustain and/or promote the health and safety of the member. The case manager uses an interdisciplinary team (IDT) planning approach for care plan and service plan development. If in-home care is the primary service, the IDT includes, at a minimum, the member, a nurse from the ADvantage in-home care provider chosen by the member, and the case manager. Otherwise, the member and case manager constitute a minimum IDT.

(3) The case manager identifies long-term goals, challenges to meeting goals, and service goals including plan objectives, actions steps and expected outcomes. The ADvantage case manager documents on the care plan the presence of two or more ADvantage members residing in the same household and/or when the member and personal care provider reside together. The case manager documents on the IVRA system in the member record any instance in which a member's health or safety would be "at risk" if even one personal care visit is missed. The case manager identifies services, service provider, funding source, units and frequency of service and service cost, cost by funding source and total cost for ADvantage services. The

member signs and indicates review/agreement with the care plan and service plan by indicating acceptance or non-acceptance of the plans. The member, the member's legal guardian or legally authorized representative shall sign the service plan in the presence of the case manager. The signatures of two witnesses are required when the member signs with a mark. If the member refuses to cooperate in development of the service plan, or, if the member refuses to sign the service plan, the case management agency refers the case to the AA for resolution. In addition, based on the UCAT and/or case progress notes that document chronic uncooperative or disruptive behaviors, the ~~LTC~~ OKDHS nurse or AA may identify members that require AA intervention.

(A) For members that are uncooperative or disruptive, the ~~AA~~ case manager develops an individualized ~~Addendum to the Rights and Responsibilities Agreement~~ plan to overcome challenges to receiving services ~~to try to modify the member's uncooperative/disruptive behavior. The Rights and Responsibilities addendum focuses~~ focusing on behaviors, both favorable and those that jeopardize the member's well-being and includes a design approach of incremental plans and addenda that allow the member to achieve stepwise successes in the modification of their behavior.

(B) The AA may implement a service plan without the member's signature ~~if the AA has developed an Addendum to the Rights and Responsibilities Agreement for the member. For~~ when, for these members, the presence of a document that "requires" their signature may itself trigger a "conflict". In these circumstances, mental health/behavioral issues may prevent the member from controlling their behavior to act in their own interest. Since the person by virtue of level of care and the IDT assessment, needs ADvantage services to assure their health and safety, the AA may ~~implement~~ authorize the service plan if the ~~AA~~ case manager demonstrates effort to work with and obtain the member's agreement ~~through an individualized Addendum to the Rights and Responsibilities Agreement~~. Should negotiations not result in agreement with the care plan and service plan, the member may withdraw their request for services or request a fair hearing.

(4) CD-PASS Planning and Supports Coordination.

(A) The ADvantage Case Management provider assigns to the CD-PASS member a Case Manager that has successfully completed training on CD-PASS, Independent Living Philosophy, ~~and~~ Person-Centered Planning and the individual budgeting process and process guidelines. Case Managers that have completed this specialized CD-PASS training are referred to as Consumer-Directed Agent/Case Managers (CDA/CM) with respect to their CD-PASS service planning and support role in working with CD-PASS members. The CDA/CM educates the member about their rights and responsibilities as well as about community resources, service choices and options available to the member to meet CD-PASS service goals and objectives.

(B) The member may designate a family member or friend as an "authorized representative" to assist in the service planning process and in executing member employer responsibilities. If the member chooses to designate an "authorized representative", the designation and agreement identifying the "willing adult" to

assume this role and responsibility is documented with dated signatures of the member, the designee and the member's Case Manager or the AA staff.

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

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

(iii) The case manager reviews the designation of Authorized Representative, Power of Attorney and Legal Guardian status on an annual basis and this is included in the reassessment packet to AA.

(C) The CDA/CM provides support to the member in the Person-Centered CD-PASS Planning process. ~~Person-Centered Planning is a process directed by the participant, with assistance as needed from an "authorized representative" or support team. The process supports the member to exercise choice and control and to assume a responsible role in developing, implementing and managing their services and supports. The process is intended to identify the strengths, capacities, preferences, needs and desired outcomes of the participant and it may enlist assistance from individuals freely chosen by the participant to serve as important contributors. The Person-Centered Planning process enables the participant to identify and access a personalized mix of paid and non-paid services and supports to help him/her achieve personally-defined outcomes in the most inclusive community setting. The focus of Person-Centered Planning is on the individual's development of personal relationships, positive roles in community activities, and self-empowerment skills. Decisions are made and outcomes controlled by the participant. Strengths, preferences and an individualized system of support are identified to assist the individual to achieve functional and meaningful goals and objectives.~~ Principles of Person-Centered Planning are as follows:

(i) The person is the center of all planning activities.

(ii) The member and their representative, or support team, are given the requisite information to assume a controlling role in the development, implementation and management of the member's services.

(iii) The individual and those who know and care about him or her are the fundamental sources of information and decision-making.

(iv) The individual directs and manages a planning process that identifies his or her strengths, capacities, preferences, desires, goals and support needs.

(v) Person-Centered Planning results in personally-defined outcomes.

(D) The CDA/CM encourages and supports the member, or as applicable their designated "authorized representative", to lead, to the extent feasible, the CD-PASS service planning process for Personal Services Assistance. The CDA/CM helps the member define support needs, service goals and service preferences including access to and use of generic community resources. Consistent with member-direction and preferences,

the CDA/CM provides information and helps the member locate and access community resources. Operating within the constraints of the Individual Budget Allocation (IBA) units, the CDA/CM assists the member in translating the assessment of member needs and preferences into an individually tailored, personalized service plan.

(E) To the extent the member prefers, the CDA/CM develops assistance to meet member needs using a combination of traditional Personal Care and CD-PASS PSA services. However, the CD-PASS IBA and the PSA unit authorization will be reduced proportional to agency Personal Care service utilization.

(F) The member determines with the PSA to be hired, a start date for PSA services. The member coordinates with the CDA/CM to finalize the service plan. The start date must be after authorization of services, after completion and approval of the background checks and after completion of the member employee packets.

(G) Based on outcomes of the planning process, the CDA/CM prepares an ADvantage service plan or plan amendment to authorize CD-PASS Personal Service Assistance units consistent with this individual plan and notifies existing duplicative Personal Care service providers of the end date for those services.

(H) If the plan requires an APSA to provide assistance with Health Maintenance activities, the CDA/CM works with the member and, as appropriate, arranges for training by a skilled nurse for the member or member's family and the APSA to ensure that the APSA performs the specific Health Maintenance tasks safely and competently;

(i) If the member's APSA has been providing Advanced Supportive Restorative Assistance to the member for the same tasks in the period immediately prior to being hired as the PSA, additional documentation of competence is not required;

(ii) If the member and APSA attest that the APSA has been performing the specific Health Maintenance tasks to the member's satisfaction on an informal basis as a friend or family member for a minimum of two months in the period immediately prior to being hired as the PSA, and no evidence contra-indicates the attestation of safe and competent performance by the APSA, additional documentation is not required.

(I) The CDA/CM monitors the member's well being and the quality of supports and services and assists the member in revising the PSA services plan as needed. If the member's need for services changes due to a change in health/disability status and/or a change in the level of support available from other sources to meet needs, the CDA/CM, based upon an updated assessment, amends the service plan to ~~increase~~ modify CD-PASS service units appropriate to meet additional member's need and forwards the plan amendment to the AA for authorization and update of the member's IBA.

(J) The CDA/CM uses the ADvantage Risk Management process the results of which are binding on all parties to resolve service planning or service delivery disagreements between members and ADvantage service providers under the following circumstances:

(i) A claim is formally registered with the CDA/CM by the

member (or the member's family or "authorized representative"), the AA, or a provider that the disagreement poses a significant risk to the member's health or safety; and

(ii) The disagreement is about a service, or about the appropriate frequency, duration or other aspect of the service; or

(iii) The disagreement is about a behavior/action of the member, or about a behavior/action of the provider.

(K) The CDA/CM and the member prepare an emergency backup/emergency response capability for CD-PASS PSA services in the event a PSA provider of services essential to the individual's health and welfare fails to deliver services. As part of the planning process, the CDA/CM and member define what failure of service or neglect of service tasks would constitute a risk to health and welfare to trigger implementation of the emergency backup. Any of the following may be used in planning for the backup:

(i) Identification of a qualified substitute provider of PSA services and preparation for their quick response to provide backup services when called upon in emergency circumstances (including execution of all qualifying background checks, training and employment processes); and/or,

(ii) Identification of one or more qualified substitute ADvantage agency service providers (Adult Day Care, Personal Care or Nursing Facility Respite provider) and preparation for their quick response to provide backup services when called upon in emergency circumstances.

(L) If the emergency backup fails, the CDA/CM is to request the AA to authorize and facilitate member access to Adult Day Care, Agency Personal Care or Nursing Facility Respite services.

(5) The case manager submits the care plan and service plan to the case management supervisor for review. The case management supervisor documents the review/approval of the plans within two working days of receipt from the case manager or returns the plans to the case manager with notations of errors, problems, and concerns to be addressed. The case manager re-submits the corrected care plan and service plan to the case management supervisor within two working days. The case management supervisor returns the approved care plan and service plan to the case manager. Within one working day of receiving supervisory approval, the case manager forwards, via postal mail, a legible copy of the care plan and service plan to the AA. Case managers are responsible for retaining all original documents for the member's file at the agency. Only priority service needs and supporting documentation may be faxed to the AA with the word, "PRIORITY" being clearly indicated and the justification attached. "Priority" service needs are defined as services needing immediate authorization to protect the health and welfare of the member and/or avoid premature admission to the nursing facility. Corrections to service conditions set by the AA are not considered to be a priority unless the health and welfare of the member would otherwise be immediately jeopardized and/or the member would otherwise require premature admission to a nursing facility.

(6) Within one working day of notification of care plan and service plan authorization, the case manager communicates with the service

plan providers and with the member to facilitate service plan implementation. Within one working day of receipt of a copy or the computer-generated authorized service plan from the AA, the case manager sends (by mail or fax) copies of the authorized service plan or computer-generated copies to providers. Within five working days of notification of an initial service plan or a new reassessment service plan authorization, the case manager visits the member, gives the member a copy of the service plan or computer-generated copy of the service plan and evaluates the progress of the service plan implementation. The case manager evaluates service plan implementation on the following minimum schedule:

(A) within 30 calendar days of the authorized effective date of the service plan or service plan addendum amendment; and

(B) monthly after the initial 30 day follow-up evaluation date.

(b) **Authorization of service plans and amendments to service plans**. The ADvantage Administration (AA) ~~certifies~~ authorizes the individual service plan and all service plan amendments for each ADvantage member. When the AA verifies member ADvantage eligibility, plan cost effectiveness, that service providers are ADvantage authorized and SoonerCare contracted, and that the delivery of ADvantage services are consistent with the member's level of care need, the service plan is authorized. ~~Except as provided by the process described in OAC 317:30-5-761(6), family members may not receive payment for providing ADvantage waiver services. A family member is defined as an individual who is legally responsible for the member (spouse or parent of a minor child).~~

(1) Except as provided by the process described in OAC 317:30-5-761(6), family members may not receive payment for providing ADvantage waiver services. A family member is defined as an individual who is legally responsible for the member (spouse or parent of a minor child).

(2) The OKDHS/ASD may under criteria described in OAC 317:35-15-13 authorize personal care service provision by an Individual PCA (an individual contracted directly with OHCA). Legally responsible family members are not eligible to serve as Individual PCA's.

~~(1)~~ (3) If the service plan authorization or amendment request packet received from case management is complete and the service plan is within cost effectiveness guidelines, the AA authorizes or denies authorization within five working days of receipt of the request. If the service plan ~~authorization or amendment request packet received from case management is complete and the service plan~~ is not within cost-effectiveness guidelines, the plan is referred for administrative review to develop an alternative cost-effective plan or assist the member to access services in an alternate setting or program. If the request packet is not complete, the AA notifies the case manager immediately and puts a "hold" on authorization until the required additional documents are received from case management.

~~(2)~~ (4) The AA authorizes the service plan by entering the authorization date and ~~signing the submitted service plan~~ assigning a control number that internally identifies the OKDHS staff completing the authorization. Notice of authorization and a computer-generated copy of the authorized plan or a computer-generated copy of the authorized plan are provided to case management. AA authorization determinations are provided to case management within one working day of the ~~certification~~ authorization

date. A service plan may be authorized and implemented with specific services temporarily denied. The AA communicates to case management the conditions for approval of temporarily denied services. The case manager submits revisions for denied services to AA for approval within 5 working days.

~~(3)~~ (5) For audit purposes (including ~~SURS~~ Program Integrity reviews), the computer-generated copy of the authorized service plan is documentation of service authorization for ADvantage waiver and State Plan Personal Care services. State or Federal quality review and audit officials may obtain a copy of specific service plans with original signatures by submitting a request to the ~~AA~~ member's case manager.

(c) **Change in service plan**. The process for initiating a change in the service plan is described in this subsection.

(1) The service provider initiates the process for an increase or decrease in service to the member's service plan. The requested changes and justification for them are documented by the service provider and, if initiated by a direct care provider, submitted to the member's case manager. If in agreement, the case manager requests the service changes on a care plan and service plan amendment submitted to the AA within five calendar days of assessed need. The AA ~~approves~~ authorizes or denies the care plan and service plan changes ~~within five calendar days of receipt of the plan~~ per 317:35-17-14.

(2) The member initiates the process for replacing Personal Care services with Consumer-Directed Personal Services and Supports (CD-PASS) in geographic areas in which CD-PASS services are available. The member may contact the AA ~~using a CD-PASS services request form provided by the Case Manager~~ or by calling the toll-free number established to process requests for CD-PASS services.

(3) A significant change in the member's physical condition or caregiver support, one that requires additional goals, deletion of goals or goal changes, or requires a four-hour or more adjustment in services per week, requires ~~a~~ an updated UCAT reassessment by the case manager. The case manager~~, in consultation with AA, makes the determination of need for reassessment. Develops~~ develops an amended or new service plan and care plan, as appropriate, and submits the new amended plans for authorization.

(4) One or more of the following changes or service requests require an Interdisciplinary Team review and service plan goals amendment:

(A) the presence of two or more ADvantage members residing in the same household, or

(B) the member and personal care provider residing together, or

(C) a request for a family member to be a paid ADvantage service provider, or

(D) a request for an Individual PCA service provider.

(5) Based on the reassessment and consultation with the AA as needed, the member may, as appropriate, be authorized for a new service plan or be eligible for a different service program. If the member is significantly improved from the previous assessment and does not require ADvantage services, the case manager obtains the member's dated signature indicating voluntary withdrawal for ADvantage program services. If unable to obtain the member's consent for voluntary closure, the case manager requests assistance from the AA. The AA requests that the OKDHS area nurse initiate a reconsideration of level of care. ~~If the member's service needs are~~

~~different or have significantly increased, the case manager develops an amended or new service plan and care plan, as appropriate, and submits the new/amended plans for authorization.~~

317:35-17-15. Redetermination of eligibility for ADvantage services

(a) The worker must complete a redetermination of financial eligibility prior to the end of the certification period. A notice is generated only if there is a change which affects the member's financial responsibility.

(b) The ADvantage case manager or the OKDHS nurse must complete ~~a~~ an annual UCAT reassessment that is reviewed for redetermination of medical eligibility prior to the end of the certification period.

317:35-17-16. Member annual level of care re-evaluation and annual re-authorization of service plan

(a) Annually, the case manager reassesses the member's needs using the UCAT Part I, III and then evaluates the current service plan, especially with respect to progress of the member toward service plan goals and objectives. Based on the reassessment, the case manager develops a new service plan with the member and service providers, as appropriate, and submits the new service plan to the AA for authorization. The case manager initiates the UCAT reassessment and development of the new service plan at least 40 days, but not more than ~~55~~ 60 days, prior to the current service plan authorization end date. The case manager provides the AA the new reassessment service plan packet no less than 30 days prior to the end date of the existing plan. The new reassessment service plan packet includes the reassessed service plan, UCAT Parts I and III, Nurse Evaluation and any supporting documentation.

(b) OKDHS reviews the ADvantage case manager UCAT for a level of care redetermination. If policy defined criteria for Nursing Facility level of care cannot be determined or cannot be justified from documentation available or via direct contact with the case manager, a UCAT is completed in the home by the local OKDHS nurse. The local OKDHS nurse submits the UCAT evaluation to the area nurse, or nurse designee, to make the medical eligibility level of care determination.

(c) If medical eligibility redetermination is not made prior to current medical eligibility expiration, the existing medical eligibility certification is automatically extended until level of care redetermination is established. If the member no longer meets medical eligibility the area nurse, or nurse designee, updates the system=s "medical eligibility end date" and simultaneously notifies AA electronically.

(d) If OKDHS determines a member no longer meets medical eligibility, the AA communicates to the member=s case manager that the member has been determined to no longer meet medical eligibility for ADvantage as of the effective date of the eligibility determination. The case manager communicates with the member and if requested, assists the member to access other services.

317:35-17-17. Supplemental process for expedited eligibility determination (SPEED) [REVOKED]

~~(a) When the ADvantage Administration (AA) determines that a person requires ADvantage services to begin immediately to prevent nursing facility admission or to ensure the person's health or safety and the UCAT, Part I documents that the person is expected to be eligible for~~

~~ADvantage, either the OKDHS nurse or the AA will complete the assessment for medical eligibility determination. The completed assessment forms are submitted to the area nurse who makes the medical eligibility decision, enters it on the system and notifies the AA of the decision.~~

~~(b) If the applicant fails to meet financial eligibility, providers follow special procedures specified by the AA to bill for services provided. If authorized by the AA, case management providers may bill using an administrative case management procedure code for SPEED services delivered and not reimbursable under any other ADvantage case management procedure code.~~

317:35-17-18. ADvantage services during hospitalization or NF placement

When the member's OKDHS social worker, ADvantage case manager, or the AA is informed (by the member, family or service provider) of a member's hospitalization or placement in a nursing facility, that party determines the date of the member's institutionalization and communicates the date, name of the institution, reason for placement and expected duration for placement, to the other ADvantage Program Administrative partners. If a member requires hospital or nursing facility services, the case manager assists the member in accessing institutional care, periodically monitors the member's progress during the institutional stay and, as appropriate, updates the service plan and prepares services to start on the date the member is discharged from the institution and returns home. All case management units for "institution transition" services to plan for and coordinate service delivery and to assist the member to safely return home, even if provided while the person is in an institution, are to be considered delivered on and billed for the date the member returns home from institutional care. ~~When the case manager is informed (by the member, family or service provider) of a member's hospitalization or placement in an NF, the case manager determines the date of the member's institutionalization and communicates the date, name of institution, reason for placement and expected duration of placement to the ADvantage Administration (AA) and the member's OKDHS worker.~~

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

(2) **NF placement of less than 30 days.** When the member returns home from a NF stay of 30 days or less or when notified of the member's anticipated discharge date the case manager notifies relevant providers, the member's OKDHS worker and the AA of the discharge and coordinates the resumption of ADvantage services in the home.

(3) **NF placement greater than 30 days.** When the member is scheduled to be discharged and return home from a NF stay that is greater than 30 days, the member's OKDHS worker, ADvantage case manager, or the AA (whoever first receives notification of the discharge), notifies other ADvantage Program Administrative partners to expedite the restart of ADvantage services for the member. In these circumstances, the SPEED process may be used to re-establish ADvantage eligibility to coincide with the date of discharge from the NF. The member's case manager provides "institution transition" case management services to assist the member to re-establish him or herself safely in the home.

317:35-17-19. Closure or termination of ADvantage services

(a) **Voluntary closure of ADvantage services**. If the ~~client~~ member requests a lower level of care than ADvantage services or if the ~~client~~ member agrees that ADvantage services are no longer needed to meet his/her needs, a medical decision by the area nurse, or nurse designee, is not needed. The closure request is completed and signed by the ~~client~~ member and the case manager and sent to the AA to be placed in the ~~client's~~ member's case record. The AA notifies the OKDHS county office of the voluntary closure and effective date of closure. The case manager documents in the case record all circumstances involving the reasons for the voluntary termination of services and alternatives for services if written request for closure cannot be secured.

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

(1) **Financial ineligibility**. Anytime the local OKDHS office determines a ~~client~~ member does not meet the financial eligibility criteria, the local OKDHS office notifies the ~~client~~, member provider, and AA of financial ineligibility. A medical eligibility redetermination is not required when a financial ineligibility period does not exceed the medical certification period.

(2) **Medical ineligibility.** Any time the local OKDHS office is notified through MEDATS of a decision that the individual is no longer medically eligible for ADvantage services, the local office notifies the individual, AA and provider of the decision.

(c) **Closure due to other reasons**. Refer to OAC 317:35-17-3(e) - (h).

(d) **Resumption of ADvantage services.** If a ~~client~~ member approved for ADvantage services has been without services for less than 90 days and has a current medical and financial eligibility determination, services may be resumed using the previously approved service plan. If a ~~client~~ member decides he/she desires to have his/her services restarted after 90 days, the ~~client~~ member must request the services as a new referral through the county office. If an individual is determined to be eligible for Advantage services and is transitioning from a hospital or a nursing facility to a community setting, an ADvantage case manager may provide Institution Transition case managemet services to assist the individual to establish or re-establish him or herself safely in the home.

317:35-17-21.1. ADvantage and agency Personal Care provider certification

~~Either Aging Services or the~~ ADvantage Administration (AA) forwards information on all certified ADvantage and Personal Care agency providers providing services in the specific OKDHS area to the area nurse and OKDHS county director. The provider information includes agency name, address, contact person for ADvantage/Personal Care programs, provider number, a list of ADvantage/Personal Care services the provider is certified to deliver, and other information as needed by OKDHS staff to achieve efficient service delivery. The AA certifies ADvantage case managers and case management supervisors. The AA maintains a master registry of certified ADvantage case management supervisors and case managers. Case manager certifications are based on successful completion of ADvantage case management training and demonstration of competency in case management and, for supervisors, case management supervision. As additional providers are certified in an OKDHS area or if a provider loses certification, ~~Aging Services or~~

~~the~~ AA provides appropriate notice to the area nurse and OKDHS county director in counties affected by the certification changes. The OHCA may execute agreements to provide care only with qualified individuals and agencies and facilities which are properly licensed or certified by the state licensing or certification agency and, as applicable, Title XIX certified. The agreement is initiated by application from the individual agency or facility. The agreement expires on a specified date, with termination of the agency license or certification, or automatically terminated on notice, with appropriate documentation, to OHCA that the individual agency or facility is not in compliance with Title XIX (or other federal long-term care) requirements. The AA certifies Title XIX providers of ADvantage services with the exception of pharmacy and medical equipment and supply providers.

317:35-17-24. Referral for social services

In many situations, social services are needed by adults who are receiving medical services through Medicaid. The ~~LTC~~ OKDHS nurse may make referrals for social services to the social worker in the local office. In addition to these referrals, a request for social services may be initiated by a ~~client~~ member or by another individual acting upon behalf of a ~~client~~ member.

(1) The social worker is responsible for providing the indicated services or for referral to the appropriate resource outside the Department if the services are not available within the Department.

(2) Among the services provided by the social worker are:

(A) Services which will enable individuals to attain and/or maintain as good physical and mental health as possible;

(B) Services to assist patients who are receiving care outside their own homes in planning for and returning to their own homes or to other alternate care;

(C) Services to encourage the development and maintenance of family and community interest and ties;

(D) Services to promote maximum independence in the management of their own affairs;

(E) Protective services, including evaluation of need for and arranging for guardianship; and

(F) Appropriate family planning services which include assisting the family in acquiring means to responsible parenthood. Services are offered in making the necessary referral and follow-up.

7.a-24 TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 35. MEDICAL ASSISTANCE FOR ADULTS AND CHILDREN-ELIGIBILITY
Subchapter 5. Eligibility and Countable Income
Part 1. Determination of Qualifying Categorical Relationships
317:35-5-4. [AMENDED]
Part 5. Countable Income and Resources
317:35-5-43. [AMENDED]
Subchapter 22. Pregnancy Related Benefits Covered Under Title XXI
317:35-22-1. [AMENDED]
(Reference APA WF # 11-40)

SUMMARY: Eligibility policy is revised for clarity and updates. All changes are minor and will not affect programs or budget. The revisions include changing a form number and altering punctuation to ensure the meaning and intention of the policy is clear.

BUDGET IMPACT: Agency staff has determined that these revisions will be 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, and Sections 5003 through 5016 of Title 63 of the Oklahoma Statutes.

PUBLIC HEARING: A public hearing was held on February 22, 2012. No comments were received before or during the public hearing regarding these changes.

SUBCHAPTER 5. ELIGIBILITY AND COUNTABLE INCOME
PART 1. DETERMINATION OF QUALIFYING CATEGORICAL RELATIONSHIPS

317:35-5-4. Determining categorical relationship to the disabled

An individual is related to disability if he/she is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death, or which has lasted (or can be expected to last) for a continuous period of not less than 12 months.

(1) **Determination of categorical relationship to the disabled by SSA.** The procedures outlined in (A) through (G) of this paragraph are applicable when determining categorical relationship based on a SSA disability decision:

(A) **Already determined eligible for Social Security disability benefits.** If the applicant states he/she is already receiving Social Security benefits on the basis of disability, the information is verified by seeing the applicant's notice of award or the Social Security benefit check. If the applicant states an award letter approving Social Security disability benefits has been received but a check has not been received, this information is verified by seeing the award letter. Such award letter or check establishes categorical relationship. The

details of the verification used are recorded in the case record.

(B) **Already determined eligible for SSI on disability.** If the applicant, under age 65, states he/she is already receiving SSI on the basis of his/her disability (or that a written notice of SSI eligibility on disability has been received but has not yet received a check) this information is verified by seeing the written notice or check. If neither are available, the county clears on the terminal system for the Supplemental Data Exchange (SDX) record. The SDX record shows, on the terminal, whether the individual has been approved or denied for SSI. If the individual has been approved for such benefits, the county uses this terminal clearance to establish disability for categorical relationship. The details of the verification used are recorded in the case record.

(C) **Pending SSI/SSA application or has never applied for SSI.** If the applicant says he/she has a pending SSI/SSA application, an SDX record may not appear on the terminal. Therefore, it is requested that the applicant bring the notice regarding the action taken on his/her SSI/SSA application to the county office as soon as it is received. The other conditions of eligibility are established while awaiting the SSI/SSA decision. When the SSI/SSA notice is presented, the details of the verification are recorded in the case record and the indicated action is taken on the Title XIX application. If the applicant says he/she has never applied for SSI/SSA but appears potentially eligible from the standpoint of unearned income and has an alleged disability which would normally be expected to last for a period of 12 months, he/she is referred to the SSA office to make SSI/SSA application immediately following the filing of the Title XIX application.

(D) **Already determined ineligible for SSI.** If the applicant says he/she has been determined ineligible for SSI, the written notice of ineligibility from SSA is requested to determine if the denial was based on failure to meet the disability definition. If the SSI notice shows ineligibility was due to not meeting the disability definition, and the applicant says the medical condition has not worsened since the SSI denial, the Title XIX application is denied for the same reason. If written notice is not available, the SDX record on the terminal system is used. This record shows whether the individual has been determined eligible or ineligible for SSI. If he/she has been determined ineligible, the payment status code for ineligibility is shown. The definition of this code is found on OKDHS Appendix Q in order to determine the reason for SSI ineligibility. If the reason for SSI ineligibility was based on failure to meet the disability definition, the Title XIX application is denied for the same reason and the details of the verification are recorded in the case record. If the reason for SSI ineligibility was based on some reason other than failure to meet the disability definition (and therefore, a determination of disability was not made), the Level of Care Evaluation Unit (LOCEU) must determine categorical relationship. In any instance in which an applicant who was denied SSI on "disability" states the medical condition has worsened since the SSI denial, he/she is referred to the SSA office to reapply for

SSI immediately following the filing of the Title XIX application.

(E) **Already determined ineligible for Social Security disability benefits.** If the applicant says he/she has been determined ineligible for Social Security disability benefits, he/she is requested to provide written notice of ineligibility to determine if the denial was based on failure to meet the disability definition. If the SSA notice shows ineligibility was due to not meeting the disability definition, and the applicant says the medical condition has not worsened since the denial, the Title XIX application is denied for the same reason. The details of the verification used are recorded in the case record. If the written notice is not available, TPQY procedure is used to verify the denial and the reason for ineligibility. If the reason for ineligibility was based on failure to meet the disability definition, the Title XIX application is denied for the same reason and the details of the verification are recorded in the case record. If the reason for ineligibility was based on some reason other than failure to meet the disability definition (and a determination of disability was, thus, not made), the LOCEU must determine categorical relationship. In any instance in which an applicant who was denied Social Security benefits on disability states the medical condition has worsened since the denial, he/she is referred to the SSA office to reapply immediately following the filing of the Title XIX application.

(F) **Determined retroactively eligible for SSA/SSI due to appeal.** If an individual becomes retroactively eligible for SSA/SSI due to a decision on an appeal, categorical relationship is established as of the effective date of the retroactive disability decision. Payment will be made for medical services only if the claim is received within 12 months from the date of medical services. If the effective date of the retroactive disability decision does not cover the period of the medical service because the SSA/SSI application was made subsequent to the service, a medical social summary with pertinent medical information is sent to the LOCEU for a categorical relationship decision for the time period of the medical service.

(G) **SSA/SSI appeal with benefits continued.** A Title XIX recipient who has filed an appeal due to SSA's determination that he/she is no longer disabled may continue to receive SSA benefits. The recipient has the option to have Title XIX benefits continued until the appeal decision has been reached. After the decision has been reached, the appropriate case action is taken. If SSA's decision is upheld, an overpayment referral is submitted for any Title XIX benefits the recipient received beginning with the month that SSA/SSI determined the recipient did not meet disability requirements.

(H) **Applicant deceased.** Categorical relationship to the disabled is automatically established if an individual dies while receiving a medical service or dies as a result of an illness for which he/she was hospitalized if death occurs within two months after hospital release. The details of the verification used are recorded in the case record.

(2) **Determination of categorical relationship to the disabled by the LOCEU.**

(A) A disability decision from the LOCEU to determine categorical relationship to the disabled is required only when SSA makes a disability decision effective after medical services were received or when the SSA will not make a disability decision. The LOCEU is advised of the basis for the referral. SSA does not make disability decisions on individuals who:

(i) have been determined ineligible by SSA on some condition of eligibility other than disability,

(ii) have unearned income in excess of the SSI standard and, therefore, are not referred to SSA, or

(iii) do not have a disability which would normally be expected to last 12 months but the applicant disagrees.

(B) A disability decision from the LOCEU is not required if the disability obviously will not last 12 months and the individual agrees with the short term duration. The case record is documented to show the individual agrees with the short term duration.

(C) The local OKDHS office is responsible for submitting a medical social summary on OKDHS form ~~ABCDM-80-B~~ ABCDM-80-D 08MA022E with pertinent medical information substantiating or explaining the individual's physical and mental condition. The medical social summary should include relevant social information such as the worker's personal observations, details of the individual's situation including date of onset of the disability, and the reason for the medical decision request. The worker indicates the beginning date for the categorical relationship to disability. Medical information submitted might include physical exam results, psychiatric, lab, and x-ray reports, hospital admission and discharge summaries, and/or doctors' notes and statements. Copies of medical and hospital bill and OKDHS Form ~~MS-MA-5~~ 08MA005E are not normally considered pertinent medical information by themselves. Current (less than 90 days old) medical information is required for the LOCEU to make a decision on the client's current disability status. If existing medical information cannot be obtained without cost to the client, the county administrator authorizes either payment for existing medical information or one general physical examination by a medical or osteopathic physician of the client's choice. The physician cannot be in an intern, residency or fellowship program of a medical facility, or in the full-time employment of Veterans Administration, Public Health Service or other Agency. Such examination is authorized by use of OKDHS form ~~ABCDM-16~~ 08MA016E, Authorization for Examination and Billing. The OKDHS worker sends the ~~ABCDM-16~~ 08MA016E and OKDHS form ~~ABCDM-80~~ 08MA080E, Report of Physician's Examination, to the physician who will be completing the exam.

(i) **Responsibility of Medical Review Team in the LOCEU.** The responsibilities of the Medical Review Team in the LOCEU include:

(I) The decision as to whether the applicant is related to Aid to the Disabled.

(II) The effective date (month and year) of eligibility from the standpoint of disability. (This date may be retroactive for any medical service provided on or after the first day of the third month prior to the month in which the application was made.)

(III) A request for additional medical and/or social information when additional information is necessary for a decision.

(IV) Authorizing specialists' examinations as needed.

(V) Setting a date for re-examination, if needed.

(ii) **Specialist's examination.** If, on receipt of the medical information from the county office, the LOCEU needs additional medical information, the LOCEU may, at their discretion, make an appointment for a specialist's examination by a physician selected by the medical member of the team and authorize it on Form M-S-32, Request to Physician for Examination and Authorization for Billing, routing the original of the form to the examining physician and a copy to the county office. As soon as the county receives a copy of Form M-S-32, the worker immediately notifies the individual of the appointment and explains that failure to keep the appointment with the specialist without good cause will result in denial of the application (or closure of the case in instances of determination of continuing disability). The worker assists the individual in keeping the appointment, if necessary.

(I) If the specialist requires additional laboratory work or X-rays, he/she should call the LOCEU for authorization. The LOCEU is responsible for making the decision regarding the request. If additional medical services are authorized, another Form M-S-32 will be completed.

(II) If the individual notifies the worker at least 24 hours prior to the date of the examination that he/she cannot keep the appointment, this constitutes good cause. In such an instance, the worker cancels the appointment, makes a new appointment, and submits information regarding the cancellation and the date of a new appointment to the LOCEU.

(III) When the individual fails to keep the appointment without advance notice, good cause must be determined. The worker determines the reasons and submits a memorandum to the LOCEU for a decision on good cause.

(IV) If the appointment was missed due to illness, the illness must be supported by a written statement from a physician. If missed for some reason other than illness, the reason must be supported by an affidavit signed by someone other than the individual or his/her representative and sworn to before a notary public or other person authorized to administer oaths. If, in the opinion of the LOCEU, good cause is established, the LOCEU and the county follow the same procedures as outlined in (2)(C)(ii) of this Section for any other specialist's examination. If, in the opinion of the LOCEU, good cause is not established, the LOCEU notifies the local office. The local office is responsible for denying the application or closing the case with notification to individual in accordance with OHCA and Department policy.

(D) When the LOCEU has made a determination of categorical relationship to disability and SSA later renders a different

decision, the county uses the effective date of the SSA approval or denial as their date of disability approval or denial. No overpayment will occur based solely on the SSA denial superseding the LOCEU approval.

(E) Public Law 97-248, the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982, provides coverage to certain disabled children living in the home if they would qualify for Medicaid as residents of nursing facilities, ICF/MRs, or inpatient acute care hospital stays expected to last not less than 60 days. In addition to disability LOCEU determines the appropriate level of care and cost effectiveness.

(3) **Determination of categorical relationship to the disabled based on TB infection.** Categorical relationship to disability is established for individuals with a diagnosis of tuberculosis (TB). An individual is related to disability for TB related services if he/she has verification of an active TB infection established by a medical practitioner.

(4) **Determination of categorical relationship to the disabled for TEFRA.** Section 134 of TEFRA allows states, at their option, to make Medicaid benefits available to children, under 19 years of age, living at home who are disabled as defined by the Social Security Administration, even though these children would not ordinarily be eligible for SSI benefits because of the deeming of parental income or resources. Under TEFRA, a child living at home who requires the level of care provided in an acute care hospital (for a minimum of 60 days), nursing facility or intermediate care facility for the mentally retarded, is determined eligible using only his/her income and resources as though he/she were institutionalized.

PART 5. COUNTABLE INCOME AND RESOURCES

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

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

(1) **Insurance.**

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

(B) **Government benefits.** Individuals requesting SoonerCare who are also eligible for Civilian Health and Medical Programs for Uniformed Services (CHAMPUS), must disclose that the coverage is available. They are considered a third party liability source.

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

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

(A) If OKDHS receives information regarding a SoonerCare member or applicant seeking medical services due to an accident, the worker submits any information available to OHCA/TPL.

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

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

(5) **Absent parent.**

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

determining SoonerCare eligibility. The rules in OAC 317:10 are used, with the following exceptions:

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

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

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

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

SUBCHAPTER 22. PREGNANCY RELATED BENEFITS COVERED UNDER TITLE XXI

317:35-22-1. Pregnancy related benefits covered under Title XXI

(a) The revision of the definition of child at 42 CFR 457.10, allows states to cover pregnancy related services under Title XXI, individuals who would not otherwise qualify for services under SoonerCare. This coverage is intended to benefit newborn children who are Oklahoma residents at birth.

(b) To receive pregnancy related services under Title XXI, the pregnant woman must:

(1) be otherwise ineligible for any other categorically SoonerCare eligibility group;

(2) reside in Oklahoma with the intent to remain, at the time services are rendered;

(3) have household income at or below 185% FPL; and

(4) not be covered by creditable insurance, the term creditable insurance means coverage under a group health plan or other health insurance as defined in the Health Insurance Portability and Accountability Act (HIPAA).

(c) All services are subject to post payment review by the OHCA or its designated agent.

7.a-25 TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 35. MEDICAL ASSISTANCE FOR ADULTS AND CHILDREN-ELIGIBILITY
Subchapter 13. Member Rights and Responsibilities
317:35-13-7. [AMENDED]
(Reference APA WF # 11-42)

SUMMARY: Eligibility policy is revised to address sanctioning of members who abuse SoonerCare benefits. For members who OHCA has determined to have abused their benefits, sanctions are put in place such that on the first violation, the member's eligibility will be suspended for up to six months; for the second violation, the member's eligibility will be suspend for up to twelve months; and for the third violation, the member's eligibility will be suspended indefinitely. All sanctions, including the length of the penalty period, are subject to administrative due process.

BUDGET IMPACT: Agency staff has determined that these revisions will be 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, and Sections 5003 through 5016 of Title 63 of the Oklahoma Statutes.

PUBLIC HEARING: A public hearing was held on February 22, 2012. One written comment was received before the public hearing regarding these changes and considered during the rulemaking process.

SUBCHAPTER 13. MEMBER RIGHTS AND RESPONSIBILITIES

317:35-13-7. Program Abuse and Administrative Sanctions
(a) **Definitions.** The following words and terms, when used in this Section, shall have the following meaning, unless the context clearly indicates otherwise.

(1) "Abuse" means ~~recipient~~ member actions that defraud the Oklahoma Health Care Authority (OHCA), cause unnecessary medical expenses to the program or over-utilize services provided by the OHCA. It shall also mean causing unnecessary or excessive claims to be submitted to the OHCA.

(2) "Conviction" or "Convicted" means a judgment of conviction has been entered by a Federal, State or local court, regardless of whether an appeal from that judgment is pending.

(3) "Exclusion" means not being able to be certified for Medicaid benefits under the State Plan or Waivered services in Oklahoma.

(4) "Fraud" means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law.

(5) "Knowingly" means that a person, with respect to information:

(A) has actual knowledge of the information;
(B) acts in deliberate ignorance of the truth or falsity of the information; or
(C) acts in reckless disregard of the truth or falsity of the information, and no proof of specific intent to defraud is required.

(6) "Medical Services Providers" means:
(A) "Practitioner" means a physician or other individual licensed under State law to practice his or her profession or a physician who meets all requirements for employment by the Federal Government as a physician and is employed by the Federal Government in an IHS facility or affiliated with a 638 Tribal facility.
(B) "Supplier" means an individual or entity, other than a provider or practitioner, who furnishes health care services under Medicaid or other medical services programs administered by the OHCA.
(C) "Provider" means:
(i) a hospital, skilled nursing facility, comprehensive outpatient rehabilitation facility, home health agency, or a hospice that has in effect an agreement to participate in Medicaid, or any other medical services program administered by the OHCA, or
(ii) a clinic, a rehabilitation agency, or a public health agency that has a similar agreement.
(D) "Laboratories" means any laboratory or place equipped for experimental study in science or for testing or analysis which has an agreement with the OHCA to receive Medicaid monies.
(E) "Pharmacy" means any pharmacy or place where medicines are compounded or dispensed or any pharmacist who has an agreement with OHCA to receive Medicaid monies for the dispensing of drugs.
(F) "Any other provider" means any provider who has an agreement with OHCA to deliver health services, medicines, or medical services for the receipt of Medicaid monies.

(7) "OIG" means the Office of Inspector General of the Department of Health and Human Services.

(8) ~~"Recipient"~~ "Member" means a beneficiary, patient or person served by the OHCA.

(9) "Sanctions" means any administrative decision by OHCA to suspend or exclude a ~~recipient~~ member from the ability to be certified for medical assistance. A sanction may include a decision to use the remedy provided in OAC 317:30-3-14(b) or to require payment by the ~~recipient~~ member of the service.

(10) "Suspension" means an administrative action to suspend temporarily the certification of a case for medical assistance.

(11) "Willfully" means proceeding from a conscious motion of the will; voluntary, intending the result which comes to pass; intentional.

(b) **Basis for sanctions.**

(1) The OHCA may sanction a ~~recipient~~ member who has or has had a certified medical assistance case with OHCA for the following reasons:
(A) Knowingly or willfully made, or causing to be made, any false statement or misrepresentation of material fact to get a case certified or causing services to be rendered to the

~~recipient~~ member;

(B) Caused or ordered services under Medicaid that are substantially in excess of the ~~recipient's~~ member's needs or that fail to meet professionally recognized standards for health care;

(C) Submitted or caused to be submitted to the Medicaid program, bills or requests for payment containing charges or costs that are substantially in excess of customary charges or costs; or

(D) Threatened harm to medical providers or state officials.

(2) The agency may base its determination that services are excessive or unnecessary based upon reports, including sanction reports, from any of the following sources:

(A) The PRO for the area served by the provider or the PRO contracted by OHCA;

(B) State or local law enforcement agencies and licensing or certification authorities;

(C) Peer review committees of fiscal agents or contractors;

(D) State or local professional societies;

(E) Surveillance and Utilization Review Section Reports done by OHCA;

(F) Medicaid Fraud Control Unit;

(G) Other sources, including internal investigations, deemed appropriate by the Medicaid agency or the OIG.

(3) OHCA must suspend from the Medicaid program any ~~recipient~~ member who has been suspended from participation in Medicare or Medicaid due to a conviction of a program related crime. This suspension must be at a minimum, the same period as the Medicare suspension.

(c) **Procedures for imposing sanctions.**

(1) Notice of proposed administrative sanction.

(A) If the OHCA proposes to sanction, it will send the ~~recipient~~ member a written notice stating:

(i) the reasons for the proposed sanction;

(ii) the date upon which the sanction will be effective;

(iii) the result of the sanction should it be imposed; and

(iv) a statement that the ~~recipient~~ member has a right to an evidentiary hearing prior to the imposition of the sanction.

(B) A copy of this section of the rules will be attached to the letter of proposed action.

(2) Notice of sanction.

(A) After an evidentiary hearing is conducted under OAC 317:2-1-2, the Agency will make a final administrative decision regarding the decision to sanction.

(B) Based upon its final decision, the Agency shall send a notice to the ~~recipient~~ member that provides:

(i) the reasons for the decision;

(ii) the effective date of the sanction;

(iii) the effect of the sanction on the party's participation in the Medicaid program;

(iv) the ~~recipient's~~ member's right to request a reconsideration of the Agency's final decision;

(v) the earliest date in which the Agency will accept a request for reinstatement;

(vi) the requirements and procedures for reinstatement; and

(vii) instructions on how to ask for reconsideration.

(d) **Effect of sanction.** OHCA will advise its eligibility agent of the closure or suspension of the case and when the ~~recipient~~ member can be

recertified. The sanctions are as follows:

(1) For the first violation in which the agency finds a member has abused SoonerCare benefits or SoonerCare waiver benefits, the member's eligibility may be suspended for a period of up to 6 months.

(2) For the second violation in which the agency finds a member has abused SoonerCare benefits or SoonerCare waiver benefits, the member's eligibility may be suspended for a period of up to 12 months.

(3) For the third violation in which the agency finds a member has abused SoonerCare benefits or SoonerCare waiver benefits, the member's eligibility may be suspended indefinitely.

(4) All members' sanctions, including the length of the penalty period, are subject to administrative due process as described in this section.

(e) **Criteria for reinstatement.**

(1) Upon the request for reinstatement made by the ~~recipient~~ member, OHCA may consider the following factors to reinstate the ~~recipient~~ member;

(A) The number and nature of the program violations and other related offenses.

(B) The nature and extent of any adverse impact the violations have had on providers or other ~~recipients~~ members;

(C) The amount of any damages;

(D) Any mitigating circumstances;

(E) Other facts bearing on the nature and seriousness of the program violations and related offenses;

(F) Convictions in a federal, state, or local court of other offenses related to participation in the Medicare or Medicaid program which were not considered during the development of the exclusion; and

(G) Whether the state or local licensing authorities have taken any adverse action against the party for offenses related to participation in the Medicare or Medicaid program which were not considered during the development of the exclusion.

(2) Regardless of the applicability of one or many of the factors in paragraph (1) of this subsection, reinstatement shall not be granted unless it is reasonably certain that the violation(s) that led to the exclusion will not be repeated.

7.a-26 TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
Subchapter 5. Individual Providers and Specialties
Part 1. Physicians
317:30-5-7. [AMENDED]
(Reference APA WF # 11-43)

SUMMARY: Agency policy on anesthesia is revised to allow reimbursement for a pain management procedure when performed during an anesthesia session.

BUDGET IMPACT: Agency staff has determined that these revisions will be 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, and Sections 5003 through 5016 of Title 63 of the Oklahoma Statutes.

PUBLIC HEARING: A public hearing was held on February 22, 2012. One comment was received during the public hearing regarding these changes and was considered during the rulemaking process.

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 1. PHYSICIANS

317:30-5-7. Anesthesia
(a) **Procedure codes.** Anesthesia codes from the Physicians' Current Procedural Terminology should be used. Payment is made only for the major procedure during an operative session.
(b) **Modifiers.** All anesthesia procedure codes must have a modifier. Without the modifier, the claim will be denied.
(c) **Qualifying circumstances.** Certain codes in the Medicine section of the CPT are used to identify extraordinary anesthesia services. The appropriate modifiers should be added to these codes. Additional payment can be made for extremes of age, total body hypothermia, and controlled hypertension.
(d) **Hypothermia.** Hypothermia total body or regional is not covered unless medical necessity is documented and approved through review by the Authority's Medical Consultants.
(e) **Anesthesia with Blood Gas Analysis**. Blood gas analysis is part of anesthesia service. Payment for anesthesia includes payment for blood gas analysis.
(f) **Steroid injections.** Steroid injections administered by an anesthesiologist are covered as nerve block. The appropriate CPT procedure code is used to bill services.
(g) **Local anesthesia**. If local anesthesia is administered by attending surgeon, payment is included in the global surgery fee, except for spinal or epidural anesthesia in conjunction with childbirth.
(h) **Stand by anesthesia**. This is not covered unless the physician is actually in the operating room administering medication, etc. If this is indicated, claim will be processed as if anesthesia was given. Use appropriate anesthesia code.

(i) **Other qualifying circumstances.** All other qualifying circumstances, i.e., physical status, emergency, etc. have been structured into the total allowable for the procedure.

(j) **Central venous catheter and anesthesia.** Payment for placement of central venous catheter, injection of anesthesia substance or similar procedures will be made only when the procedure is distinctly separate from the anesthesia procedure.

(k) **Pain management.** Pain management procedures performed during the anesthesia session will be covered when medically necessary to adequately control anticipated post-operative pain.

MIKE FOGARTY
CHIEF EXECUTIVE OFFICER

MARY FALLIN
GOVERNOR

STATE OF OKLAHOMA

OKLAHOMA HEALTH CARE AUTHORITY

RECOMMENDATIONS OF THE DRUG UTILIZATION REVIEW COMMITTEE FROM THE FEBRUARY 8, 2012 MEETING

Recommendation 1: Prior Authorize Select Prenatal Vitamins

The Drug Utilization Review (DUR) Board recommends placing a prior authorization on any prenatal vitamin with a cost per day of greater than 75 cents. All preferred products will contain 1 mg of Folic Acid and at least two products will contain DHA/Omega-3 (based on the two lowest priced products available). Products with a cost greater than 75 cents per day will require prior authorization with the following criteria for approval: *clinically significant reason why the member cannot use any available non-prior authorized product.*

Due to the transient nature of the use of prenatal vitamins during pregnancy, current members will be allowed to stay on their product for the duration of their pregnancy as long as they remain compliant.

Prior authorization requirements may be removed when a product's price is at or below the designated pricing cutoff.

Recommendation 2: Prior Authorize Soliris® (eculizumab)

The DUR Board recommends medical prior authorization of Soliris® (eculizumab) with the following approval criteria:

1. Established diagnosis of paroxysmal nocturnal hemoglobinuria or atypical hemolytic uremic syndrome via ICD-9 coding in member's medical claims.
2. An age restriction of 19 18 years and older will apply.
3. For members under 18 years of age, approval can be granted with a documented diagnosis of atypical hemolytic uremic syndrome.

Recommendation 3: Prior Authorize Onfi™ (clobazam)

The DUR Board recommends prior authorization of Onfi™ (clobazam) with the following approval criteria:

1. Diagnosis of generalized tonic, atonic or myoclonic seizures; and
2. Previous failure of at least two non-benzodiazepine anticonvulsants; and
3. Previous failure of clonazepam.
4. For continuation prescriber must include information regarding improved response/effectiveness of this medication.