OKLAHOMA HEALTH CARE AUTHORITY
REGULARLY SCHEDULED BOARD MEETING
February 11, 2016 at 1:00 P.M.
Oklahoma Health Care Authority
4345 N. Lincoln Blvd.
Oklahoma City, OK

A G E N D A

Items to be presented by Ed McFall, Chairman

1. Call to Order / Determination of Quorum

2. Action Item – Approval of the Approval of January 14, 2016 OHCA Board Meeting Minutes

Item to be presented by Nico Gomez, Chief Executive Officer

3. Discussion Item – Chief Executive Officer's Report

   a) All-Star Introduction

      - September 2015 All-Star – Andy Garnand, Reporting Manager (Ed Long)
      - November 2015 All-Star – Lisa Cole, Payroll Specialist (Carrie Evans)

   b) Financial Update – Carrie Evans, Chief Financial Officer

   c) Medicaid Director's Update – Becky Pasternik-Ikard, State Medicaid Director

   d) Legislative Update – Emily Shipley, Director of Government Relations

Item to be presented by Nicole Nantois, Chief of Legal Services

4. Announcements of Conflicts of Interest Panel Recommendations for All Action Items Regarding This Board Meeting.

Item to be presented by Tywanda Cox, Chief of Federal and State Policy

5. Action Item – Consideration and Vote of Agency Recommended Rulemaking Pursuant to Article I of the Administrative Procedures Act. The Agency Requests the Adoption of the Following Emergency Rules:

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

   Action Item – b) Consideration and Vote of Agency Recommended Rulemaking Pursuant to Article I of the Administrative Procedures Act. The Agency Requests the Adoption of the Following Emergency Rules:

ODMHSAS Initiated

The following permanent rules HAVE NOT previously been approved by the Board.

A. AMENDING Agency rules at OAC 317:30-5-240.3, 317:30-5-249, 317:30-5-660.3, 317:30-5-661.4, 317:30-5-664.1, 317:30-5-664.5, and 317:30-5-1043, REVOKING 317:30-5-595, 317:30-5-596, 317:30-5-599, and ADDING 317:30-5-241.6 to transfer coverage guidelines and provider requirements for case management services to another Part of rules addressing guidelines for services provided by Outpatient Behavioral Health Agencies. This change is being made to reduce provider confusion and to organize outpatient behavioral health agency service rules in a way that is more comprehensive and easily understood by SoonerCare providers and members.
ODMHSAS Budget Impact: Budget neutral

(Reference APA WF # 15-29)

B. AMENDING Agency rules at OAC 317:30-5-241.1 to allow providers more flexibility in conducting biopsychosocial assessments by removing specific required elements. This change in policy will align the assessment requirements in OHCA rules with those in the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) contract.
ODMHSAS Budget Impact: Budget neutral

(Reference APA WF # 15-30)

C. AMENDING Agency rules at OAC 317:30-5-251 and 317:30-5-252 to clean up and clarify inconsistencies between OHCA rules and Health Home Certification. SoonerCare Health Homes for adults with Serious Mental Illness (SMI) and Children with Serious Emotional Disturbances (SED) were implemented in February, 2015. Since implementation, some inconsistencies between OHCA rules and Health Home Certification rules administered by the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) have been identified, and are clarified in the revisions.
ODMHSAS Budget Impact: Budget neutral

(Reference APA WF # 15-32)

DHS Initiated

The following permanent rule HAS previously been approved by the Board and the Governor under Emergency rulemaking.

D. AMENDING Agency rules at OAC 317:35-17-5 and 317:30-5-763 to comply with federal regulation. The proposed changes adhere to the CMS conflict free case management requirements further changes adhere to Home and Community Based settings requirements for Medicaid Assisted Living Programs that are directly related to the Assisted Living Service Option in ADvantage program.
DHS Budget Impact: Budget neutral

(Reference APA WF # 15-14A&B)

OHCA Initiated

The following permanent rules HAVE previously been approved by the Board and the Governor under Emergency rulemaking. These rules HAVE NOT been revised for Permanent Rulemaking.

E. AMENDING Agency rules at OAC 317:30-3-11, 317:30-3-11.1, 317:30-5-44, 317:30-5-744, 317:30-5-893, 317:30-5-973, 317:30-5-993, and 317:30-5-1045 to restrict the timely filing of claims for reimbursement from 12 months to six months. In addition, policy regarding resubmission is revised to update the deadline from 24 months to 12 months. Changes to the timely filing restrictions are in accordance with federal authority.
Budget Impact: Budget neutral

(Reference APA WF # 15-09)

F. AMENDING Agency rules at OAC 317:35-5-41.8 to revise long-term care eligibility rules to be consistent with federal regulations. Changes include allowing the home equity resource limit to be increased annually based on the consumer price index. In addition, proposed revisions allow an individual to reduce their home equity through the use of a reverse mortgage or home equity loan. Revisions also clarify home exemption criteria for persons living in the home and update financial eligibility determination regarding how annuities are counted.
Budget Impact: Budget neutral

(Reference APA WF # 15-10)

The following permanent rule HAS previously been approved by the Board and the Governor under Emergency rulemaking. This rule has been REVISED for Permanent Rulemaking.

G. AMENDING Agency rules at OAC 317:30-5-41 and 317:30-5-47 to clarify reimbursement methodology for diagnosis-related group (DRG) hospitals. Rules state that covered inpatient services provided to eligible members admitted to acute care and critical access hospitals will be reimbursed the lesser of the billed charges or the DRG amount. The aforementioned changes were approved during promulgation of the emergency rule. Elimination of certain DRG outlier payments, also approved in the emergency rule, is restored in the permanent rule. Certain DRG outlier payments will continue to be paid in the case of a qualifying transfer.
Budget Impact: Budget neutral

(Reference APA WF # 15-03)

The following permanent rules HAVE NOT previously been approved by the Board.

H. ADDING Agency rules at OAC 317:35-6-37, 317:35-6-39, 317:35-6-64.1, and 317:35-7-48 to clean up language where policy references Appendix C-1 (Maximum Income, Resource, and Payment Standards) which is a Department of Human Services (DHS) document. The language Appendix C-1 will be replaced with SoonerCare Income Guidelines when referencing eligibility groups for which the Oklahoma Health Care Authority (OHCA) now determines eligibility. AMENDING Agency rules at OAC 317:35-6-64.1 and 317:35-7-48 to update Transitional Medical Assistance (TMA) policy to mirror Federal regulations on MAGI eligibility determinations. Policy states that health benefits are continued when SoonerCare case closure is due to the receipt of new or increased child support. However, under MAGI rules, a case would never be closed due to child support income because child support income is not counted for determining income eligibility.
Budget Impact: Budget neutral

(Reference APA WF # 15-02)

I. AMENDING Agency rules at OAC 317:30-5-9 to allow payment for a joint injection and office visit if the claim is billed appropriately and medical documentation supports separate payments. Further, current policy states that payment is made for joint injections without a global coverage designation; however, all joint injection codes have a global coverage designation.
Budget Impact: Budget neutral

(Reference APA WF # 15-13)

J. AMENDING Agency rules at OAC 317:30-5-72.1 to reflect guidance in federal law regarding included and excluded prescription drug coverage and to update the list of covered over-the-counter drugs. This proposal will also update items within the State Plan to reflect most recent federal guidance.
Budget Impact: Budget Neutral

(Reference APA WF # 15-15)

K. AMENDING Agency rules at OAC 317:30-3-4.1, 317:30-3-15, 317:30-3-30, and 317:30-5-3 to specify electronic and paper based medical records must be authenticated on the same day the record is completed or, if completed by someone else, the record must be signed within three business days. Current rules only address signature requirements for edits of a medical record.
Budget Impact: Budget neutral

(Reference APA WF # 15-22)

L. AMENDING Agency rules at OAC 317:25-7-5 and 317:30-5-660.5 to remove language identifying medical residents as Primary Care Providers (PCP). Cleanup of language would accurately reflect OHCA practices and requirements for all facility types.
Budget Impact: Budget neutral

(Reference APA WF # 15-27A&B)

M. AMENDING Agency rules at OAC 317:35-9-95 and 317:35-19-26 to remove language allowing reimbursement for hospital leave, which was eliminated during the 2014 rulemaking process. Cleanup of language will clarify OHCA policy on reimbursement for hospital leave and accurately reflect current practices.
Budget Impact: Budget neutral

(Reference APA WF # 15-40)

Item to be presented by Nancy Nesser, Pharmacy Director

6. 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 **Daklinza™ (Daclatasvir) and Technivie™ (Ombitasvir/Paritaprevir/Ritonavir)** to the utilization and scope prior authorization program under OAC 317:30-5-77.2(e).

   b) Consideration and vote to add **Noxafil® (Posaconazole) and Cresemba® (Isavuconazonium Sulfate)** to the utilization and scope prior authorization program under OAC 317:30-5-77.2(e).

   c) Consideration and vote to add **Neulasta® (Pegfilgrastim), Granix® (Tbo-filgrastim), and Zarxio™ (Filgrastim-sndz)** to the utilization and scope prior authorization program under OAC 317:30-5-77.2(e).

   d) Consideration and vote to add **Aggrenox® (Aspirin/Dipyridamole Extended-Release)** to the utilization and scope prior authorization program under OAC 317:30-5-77.2(e).

   e) Consideration and vote to add **Nucala® (Mepolizumab)** to the utilization and scope prior authorization program under OAC 317:30-5-77.2(e).

Item to be presented by Ed McFall, Chairman

7. New Business

8. ADJOURNMENT

NEXT BOARD MEETING
March 24, 2016
Oklahoma Health Care Authority
Charles Ed McFall Boardroom
4345 N. Lincoln Blvd.
Oklahoma City, OK

MINUTES OF A REGULARLY SCHEDULED BOARD MEETING
OF THE HEALTH CARE AUTHORITY BOARD
January 14, 2016
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 January 13, 2016 at 10:30 a.m. Advance public meeting notice was provided to the Oklahoma Secretary of State. In addition to the posting of the statutory public notice, the agency placed its agenda on its website on January 13, 2016 at 11:00 a.m.

Pursuant to a roll call of the members, a quorum was declared to be present, and Chairman McFall called the meeting to order at 1:03 p.m.

BOARD MEMBERS PRESENT: Chairman McFall, Member Case, Member Bryant, Member Robison

BOARD MEMBERS ABSENT: Vice-Chairman Armstrong, Member Nuttle, Member McVay

OTHERS PRESENT:
Jim Claflin, OHCA
Andrew Ronson, OHCA
Virginia Ragan, SOFS
Tyler Tuley, eCapitol
Brenda Teel, Chickasaw Nation
Jim Fowler, AZ
Tiffany Lyon, OHCA
Nichole Burland, OHCA
Ashley, OMES
Darla Koone, OHCA
Jaclyn Mullen, OHCA
Kristin Florer, OHCA
Karen Beam, OHCA
Renee Spratt, OHCA
Brent Wilborn, OKPCA
Greg Reid, OKAMA
Melanie Lawrence, OHCA

OTHERS PRESENT:
Charles Brodt, HPE
Becky Moore, OAHCP
Jean Ann Ingram, SOFS
Rick Snyder, OHA
David Dude, American Cancer Society
Lekenya Antwine, OHCA
Tony Cothran, OUCOP
Melissa Pratt, OHCA
Jimmy John, OKAMA
Mike Herndon, OHCA
Kara Kearns, OHCA
Randy Curry, SWOSU College of Pharmacy
Jean Krieske, OHCA
Lori Alexander, OHCA
Rebecca Williamson, OKAMA
Sherris H Ososanya, OHCA

DISCUSSION AND POSSIBLE VOTE ON APPROVAL OF BOARD MINUTES OF THE REGULARY SCHEDULED BOARD MEETING HELD NOVEMBER 12, 2015.

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 Bryant moved for approval of the December 10, 2015 board meeting minutes as published. The motion was seconded by Member Case.

FOR THE MOTION: Chairman McFall

ABSTAINED: Member Robison

ABSENT: Vice-Chairman Armstrong, Member Nuttle, Member McVay

NICO GOMEZ, CHIEF EXECUTIVE OFFICER'S REPORT

ITEM 3a / ALL STARS INTRODUCTION
Nico Gomez, Chief Executive Officer

The following OHCA All-Stars were recognized.

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- October 2015 All-Star – Darla Koone, QA/QI SoonerCare Compliance Analyst (Sylvia Lopez presented)

ITEM 3b / FINANCIAL UPDATE
Carrie Evans, Chief Financial Officer

Ms. Evans reported on the final financial transactions through the month of November 2015. She stated that we continue to run under budget with a $15.9 million state dollar positive variance and are under budget in program spending by $11.4 million state dollars and $1.6 million in administration. Ms. Evans reported that we are under budget in drug rebate collections by $1.6 million state dollars and $1.9 million in taxes and fees as well as under budget in settlements and overpayments by $.6 million. She predicted that OHCA will continue to be under budget for December. For more detailed information, see Item 3b in the board packet.

ITEM 3c / MEDICAID DIRECTOR'S UPDATE
Becky Pasternik-Ikard, State Medicaid Director

Ms. Ikard provided an update for November 2015 data that included a report on the number of SoonerCare enrollees in different areas of the Medicaid program. She discussed the charts provided for the total in-state contracted providers. Ms. Ikard mentioned that in December our tier 1 SoonerCare helpline had about 70,000 incoming calls and our member services area had another 25,000 calls for members. She discussed the chart for data regarding prescription opioid analgesics. For more detailed information, see Item 3c in the board packet.

ITEM 3c.1 / PAIN MANAGEMENT PROGRAM PRESENTATION
Dr. Mike Herndon, Sr. Medical Director

Dr. Herndon presented the SoonerCare Pain Management Program explaining the provider toolkit, practice facilitation and substance use resource specialists. For more detailed information, see Item 3c.1 in the board packet.

ITEM 3d / LEGISLATIVE UPDATE
Emily Shipley, Director of Government Relations

Ms. Shipley updated the board members on the number of bills, upcoming legislative dates and impacts to OHCA appropriations. For more detailed information, see Item 3d in the in the board packet.

ITEM 3e / BUDGET UPDATE
Nico Gomez, Chief Executive Officer

Mr. Gomez stated that the board and agency have been discussing the SFY17 budget since August 2015 and we were able to file a zero growth budget because we made a 3% across the board provider rate cut January 1, 2016. He said that it was a very difficult decision and that it was done in an effort to get our budget balanced for SFY17 with the same amount of money we received in SFY16. After the revenue failure occurred, the board did not have to take additional action because they already had and Mr. Gomez thanked them for their leadership. He stated that there will be provider cuts for SFY17, but he does not know yet on the numbers.

ITEM 4 / OHCA DASHBOARDS PRESENTATION
Connie Steffee, Reporting & Statistics Director & Adrea Hall, Research Associate

Ms. Steffee and Ms. Hall presented and explained the external and internal dashboards for data information. For more detailed information, go to www.okhca.org/dashboards.

ITEM 5 / ANNOUNCEMENTS OF CONFLICTS OF INTEREST PANEL RECOMMENDATIONS FOR ALL ACTION ITEMS
Nicole Nantois, Chief of Legal Services

There were no recommendations regarding conflicts.

ITEM 6a / CONSIDERATION AND VOTE OF AUTHORITY FOR EXPENDITURE OF FUNDS BY AN EXTERNAL QUALITY REVIEW ORGANIZATION (EQRO)
Vickie Kersey, Director of Fiscal Planning and Procurement

DRAFT

MOTION: Member Case moved for approval of item 6a as published. The motion was seconded by Member Robison.

FOR THE MOTION: Chairman McFall, Member Bryant

ABSENT: Vice-Chairman Armstrong, Member Nuttle, Member McVay

ITEM 6b / CONSIDERATION AND VOTE OF AUTHORITY FOR EXPENDITURE OF FUNDS FOR INFORMATION TECHNOLOGY SECURITY SERVICES CONTRACT
Vickie Kersey, Director of Fiscal Planning and Procurement

MOTION: Member Robison moved for approval of item 6b as published. The motion was seconded by Member Bryant.

FOR THE MOTION: Chairman McFall, Member Case

ABSENT: Vice-Chairman Armstrong, Member Nuttle, Member McVay

ITEM 7 / CONSIDERATION AND VOTE REGARDING RECOMMENDATIONS MADE BY THE DRUG UTILIZATION REVIEW BOARD UNDER 63 OKLAHOMA STATUTES §5030.3.
Nancy Nesser, Pharmacy Director

a) Consideration and vote to add **Ibrance® (Palbociclib)** to the utilization and scope prior authorization program under OAC 317:30-5-77.2(e).

b) Consideration and vote to add **Oralair® (Sweet Vernal, Orchard, Perennial Rye, Timothy, & Kentucky Blue Grass Mixed Pollens Allergen Extract)** to the utilization and scope prior authorization program under OAC 317:30-5-77.2(e).

c) Consideration and vote to add **Omidria® (Phenylephrine/ Ketorolac) Injection** to the utilization and scope prior authorization program under OAC 317:30-5-77.2(e).

d) Consideration and vote to add **Daraprim® (Pyrimethamine)** to the utilization and scope prior authorization program under OAC 317:30-5-77.2(e).

e) Consideration and vote to add **Movantik™ (Naloxegol), Viberzi™ (Eluxadoline), and Xifaxan® (Rifaximin)** to the utilization and scope prior authorization program under OAC 317:30-5-77.2(e).

f) Consideration and vote to add **Keveyis™ (Dichlorphenamide)** to the utilization and scope prior authorization program under OAC 317:30-5-77.2(e).

g) Consideration and vote to add **Cayston® (Aztreonam Inhalation) and Kitabis™ Pak (Tobramycin Inhalation)** to the utilization and scope prior authorization program under OAC 317:30-5-77.2(e).

h) Consideration and vote to add **Tetracycline Capsules, Minocycline Tablets, Ofloxacin Tablets, & Moxifloxacin Tablets** to the utilization and scope prior authorization program under OAC 317:30-5-77.2(e).

MOTION: Member Case moved for approval of item 7a-h as published. The motion was seconded by Member Bryant.

FOR THE MOTION: Chairman McFall, Member Robison

ABSENT: Vice-Chairman Armstrong, Member Nuttle, Member McVay

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ITEM 8 / NEW BUSINESS

There was no new business.

ITEM 9 / ADJOURNMENT

MOTION:	Member Robison moved for approval for adjournment. The motion was seconded by Member Bryant.
FOR THE MOTION:	Chairman McFall, Member Case
ABSENT:	Vice-Chairman Armstrong, Member Nuttle, Member McVay

Meeting adjourned at 2:01 p.m., 1/14/16

NEXT BOARD MEETING
February 11, 2016
Oklahoma Health Care Authority
OKC, OK

Lindsey Bateman
Board Secretary

Minutes Approved: _______________

*Initials:*______________

DRAFT

FINANCIAL REPORT

For the Six Months Ended December 31, 2015
Submitted to the CEO & Board

- Revenues for OHCA through December, accounting for receivables, were **$2,020,933,626** or **.1% under** budget.
- Expenditures for OHCA, accounting for encumbrances, were **$1,966,690,271 or .6% under** budget.
- The state dollar budget variance through December is a **positive $8,749,503.**
- The budget variance is primarily attributable to the following (in millions):

Expenditures:		
Medicaid Program Variance		2.0
Administration		2.6
Revenues:		
Drug Rebate		2.3
Taxes and Fees		2.1
Overpayments/Settlements		(.3)
Total FY 16 Variance	**$**	**8.7**

ATTACHMENTS

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

OKLAHOMA HEALTH CARE AUTHORITY
Summary of Revenues & Expenditures: OHCA
SFY 2016, For the Six Month Period Ending December 31, 2015

REVENUES	FY16 Budget YTD	FY16 Actual YTD	Variance	% Over/ (Under)
State Appropriations	$ 474,001,888	$ 474,001,888	$ -	0.0%
Federal Funds	1,159,237,308	1,153,223,779	(6,013,529)	(0.8)%
Tobacco Tax Collections	23,130,082	25,216,168	2,086,086	9.0%
Quality of Care Collections	38,529,345	38,033,383	(495,962)	(1.3)%
Prior Year Carryover	67,016,727	67,016,727	-	0.0%
Federal Deferral - Interest	152,737	152,737	-	0.0%
Drug Rebates	130,133,583	135,910,903	5,777,320	4.4%
Medical Refunds	18,521,273	17,843,043	(678,230)	(3.7)%
Supplemental Hospital Offset Payment Program	100,738,627	100,738,627	-	0.0%
Other Revenues	8,405,916	8,796,371	390,455	4.6%
TOTAL REVENUES	**$ 2,019,867,486**	**$ 2,020,933,626**	**$ 1,066,140**	**(0.1)%**

EXPENDITURES	FY16 Budget YTD	FY16 Actual YTD	Variance	% (Over)/ Under
ADMINISTRATION - OPERATING	**$ 27,168,720**	**$ 25,035,397**	**$ 2,133,323**	**7.9%**
ADMINISTRATION - CONTRACTS	**$ 48,455,129**	**$ 44,773,474**	**$ 3,681,655**	**7.6%**
MEDICAID PROGRAMS				
Managed Care:				
SoonerCare Choice	19,864,236	19,471,886	392,350	2.0%
			-	
Acute Fee for Service Payments:			-	
Hospital Services	458,215,345	457,629,154	586,191	0.7%
Behavioral Health	9,923,461	10,123,479	(200,018)	(2.0)%
Physicians	236,448,769	236,266,295	182,474	0.3%
Dentists	67,555,165	67,436,093	119,072	0.2%
Other Practitioners	22,583,470	22,501,514	81,956	0.4%
Home Health Care	9,983,190	9,983,190	-	0.0%
Lab & Radiology	31,870,392	31,493,850	376,542	1.2%
Medical Supplies	23,198,602	23,133,799	64,802	0.3%
Ambulatory/Clinics	64,344,509	65,238,212	(893,703)	(1.4)%
Prescription Drugs	261,063,430	261,063,430	-	0.0%
OHCA Therapeutic Foster Care	401,248	283,851	117,397	29.3%
			-	
Other Payments:			-	
Nursing Facilities	288,239,103	288,239,103	-	0.0%
Intermediate Care Facilities for Individuals with Intellectual Disabilities Private	30,415,250	30,415,250	-	0.0%
Medicare Buy-In	67,817,524	67,817,524	-	0.0%
Transportation	32,764,964	32,764,964	-	0.0%
Money Follows the Person-OHCA	357,438	227,711	129,727	0.0%
Electonic Health Records-Incentive Payments	3,743,987	3,743,987	-	0.0%
Part D Phase-In Contribution	40,180,721	40,179,000	1,721	0.0%
Supplemental Hospital Offset Payment Program	226,781,184	226,781,184	-	0.0%
Telligen	2,988,640	2,087,924	900,716	58.1%
Total OHCA Medical Programs	**1,898,740,627**	**1,896,881,400**	**1,859,227**	**0.4%**
OHCA Non-Title XIX Medical Payments	9,158	-	9,158	0.0%
TOTAL OHCA	**$ 1,979,373,634**	**$ 1,966,690,271**	**$ 12,683,363**	**0.6%**
REVENUES OVER/(UNDER) EXPENDITURES	**$ 45,493,852**	**$ 54,243,355**	**$ 8,749,503**	

OKLAHOMA HEALTH CARE AUTHORITY
Total Medicaid Program Expenditures
by Source of State Funds
SFY 2016, For the Six Month Period Ending December 31, 2015

Category of Service	Total	Health Care Authority		Quality of Care Fund	HEEIA	SHOPP Fund	BCC Revolving Fund	Other State Agencies
SoonerCare Choice	$ 19,539,659	$ 19,465,466	$ 19,471,886	$ -	$ 67,773	$ -	$ 6,419	$ -
Inpatient Acute Care	565,485,309	313,825,078	482,811,124	243,343	1,997,384	167,684,823	1,057,880	80,676,801
Outpatient Acute Care	189,691,715	140,739,973	187,794,765	20,802	1,896,950	45,291,912	1,742,078	
Behavioral Health - Inpatient	24,206,307	6,100,931	19,115,396	-	131,388	13,014,465	-	4,959,523
Behavioral Health - Psychiatrist	4,812,532	4,022,548	4,812,532	-	-	789,984	-	-
Behavioral Health - Outpatient	14,347,111	-	-	-	-	-	-	14,347,111
Behaviorial Health-Health Home	10,547,359	-		-	-	-	-	10,547,359
Behavioral Health Facility- Rehab	129,176,359	-	-	-	-	-	40,488	129,176,359
Behavioral Health - Case Management	9,226,035	-	-	-	-	-	-	9,226,035
Behavioral Health - PRTF	41,961,704	-	-	-	-	-	-	41,961,704
Residential Behavioral Management	10,058,388	-	-	-	-	-	-	10,058,388
Targeted Case Management	32,475,090	-	-	-	-	-	-	32,475,090
Therapeutic Foster Care	283,851	283,851	283,851	-	-	-	-	-
Physicians	266,627,027	233,449,293	236,266,295	29,050	929,369	-	2,787,952	29,431,362
Dentists	67,441,593	67,429,238	67,436,093	-	5,500	-	6,855	-
Mid Level Practitioners	1,292,182	1,284,474	1,284,808	-	7,374	-	334	-
Other Practitioners	21,258,736	20,990,642	21,216,706	223,182	42,030	-	2,882	-
Home Health Care	9,985,561	9,978,537	9,983,190	-	2,371	-	4,652	-
Lab & Radiology	32,163,582	31,284,788	31,493,850	-	669,732	-	209,062	-
Medical Supplies	23,265,166	21,759,094	23,133,799	1,355,766	131,366	-	18,939	-
Clinic Services	65,835,537	61,564,760	61,647,075	-	312,440	-	82,315	3,876,022
Ambulatory Surgery Centers	3,652,708	3,583,079	3,591,137	-	61,571	-	8,059	-
Personal Care Services	6,468,314	-		-	-	-	-	6,468,314
Nursing Facilities	288,239,103	181,780,346	288,239,103	106,435,281	-	-	23,476	-
Transportation	32,668,772	31,346,339	32,668,772	1,321,481	-	-	952	-
GME/IME/DME	61,536,864	-		-	-	-	-	61,536,864
ICF/IID Private	30,415,250	24,850,887	30,415,250	5,564,363	-	-	-	-
ICF/IID Public	18,329,923	-	-	-	-	-	-	18,329,923
CMS Payments	107,996,524	107,635,500	107,996,524	361,024	-	-	-	
Prescription Drugs	266,635,170	260,215,617	261,063,430	-	5,571,739	-	847,813	-
Miscellaneous Medical Payments	96,191	95,974	96,191	-	-	-	217	-
Home and Community Based Waiver	100,393,962	-	-	-	-	-	-	100,393,962
Homeward Bound Waiver	44,226,663	-	-	-	-	-	-	44,226,663
Money Follows the Person	3,128,516	227,711	227,711	-	-	-	-	2,900,805
In-Home Support Waiver	13,122,964	-	-	-	-	-	-	13,122,964
ADvantage Waiver	90,942,756	-	-	-	-	-	-	90,942,756
Family Planning/Family Planning Waiver	2,977,630	-	-	-	-	-	-	2,977,630
Premium Assistance*	22,667,418	-	-	-	22,667,418	-	-	-
Telligen	2,087,924	2,087,924	2,087,924	-	-	-	-	-
Electronic Health Records Incentive Payments	3,743,987	3,743,987	3,743,987	-	-	-	-	-
Total Medicaid Expenditures	**$ 2,639,011,441**	**$ 1,547,746,038**	**$ 1,896,881,400**	**$ 115,554,293**	**$ 34,494,406**	**$ 226,781,184**	**$ 6,840,373**	**$ 707,635,635**

* Includes $22,513,118 paid out of Fund 245

OKLAHOMA HEALTH CARE AUTHORITY

Summary of Revenues & Expenditures:
Other State Agencies
SFY 2016, For the Six Month Period Ending December 31, 2015

	FY16
REVENUE	**Actual YTD**
Revenues from Other State Agencies	$ 294,805,092
Federal Funds	436,734,345
TOTAL REVENUES	**$ 731,539,437**

EXPENDITURES	**Actual YTD**
Department of Human Services	
Home and Community Based Waiver	$ 100,393,962
Money Follows the Person	2,900,805
Homeward Bound Waiver	44,226,663
In-Home Support Waivers	13,122,964
ADvantage Waiver	90,942,756
Intermediate Care Facilities for Individuals with Intellectual Disabilities Public	18,329,923
Personal Care	6,468,314
Residential Behavioral Management	7,997,038
Targeted Case Management	26,877,861
Total Department of Human Services	**311,260,286**
State Employees Physician Payment	
Physician Payments	29,431,362
Total State Employees Physician Payment	**29,431,362**
Education Payments	
Graduate Medical Education	24,915,759
Graduate Medical Education - Physicians Manpower Training Commission	2,436,996
Indirect Medical Education	32,248,316
Direct Medical Education	1,935,793
Total Education Payments	**61,536,864**
Office of Juvenile Affairs	
Targeted Case Management	1,606,496
Residential Behavioral Management	2,061,350
Total Office of Juvenile Affairs	**3,667,845**
Department of Mental Health	
Case Management	9,226,035
Inpatient Psychiatric Free-standing	4,959,523
Outpatient	14,347,111
Health Homes	10,547,359
Psychiatric Residential Treatment Facility	41,961,704
Rehabilitation Centers	129,176,359
Total Department of Mental Health	**210,218,092**
State Department of Health	
Children's First	895,686
Sooner Start	1,395,611
Early Intervention	2,525,364
Early and Periodic Screening, Diagnosis, and Treatment Clinic	1,163,223
Family Planning	68,555
Family Planning Waiver	2,895,219
Maternity Clinic	6,803
Total Department of Health	**8,950,461**
County Health Departments	
EPSDT Clinic	390,913
Family Planning Waiver	13,856
Total County Health Departments	**404,769**
State Department of Education	**114,265**
Public Schools	**455,418**
Medicare DRG Limit	**74,500,000**
Native American Tribal Agreements	**919,472**
Department of Corrections	**735,918**
JD McCarty	**5,440,883**
Total OSA Medicaid Programs	**$ 707,635,635**
OSA Non-Medicaid Programs	**$ 36,143,570**
Accounts Receivable from OSA	**$ 12,239,767**

OKLAHOMA HEALTH CARE AUTHORITY
SUMMARY OF REVENUES & EXPENDITURES:
Fund 205: Supplemental Hospital Offset Payment Program Fund
SFY 2016, For the Six Month Period Ending December 31, 2015

REVENUES	FY 16 Revenue
SHOPP Assessment Fee	$ 100,460,830
Federal Draws	139,785,611
Interest	69,705
Penalties	208,092
State Appropriations	(15,100,000)
TOTAL REVENUES	$ 225,424,237

EXPENDITURES	Quarter	Quarter	FY 16 Expenditures
Program Costs:	7/1/15 - 9/30/15	10/1/15 - 12/31/15	
Hospital - Inpatient Care	83,225,354	84,459,469	$ 167,684,823
Hospital -Outpatient Care	22,465,442	22,826,470	45,291,912
Psychiatric Facilities-Inpatient	6,265,547	6,748,918	13,014,465
Rehabilitation Facilities-Inpatient	392,213	397,771	789,984
Total OHCA Program Costs	112,348,555	114,432,629	$ 226,781,185
Total Expenditures			$ 226,781,185
CASH BALANCE			$ (1,356,947)

OKLAHOMA HEALTH CARE AUTHORITY
SUMMARY OF REVENUES & EXPENDITURES:
Fund 230: Nursing Facility Quality of Care Fund
SFY 2016, For the Six Month Period Ending December 31, 2015

REVENUES	Total Revenue	State Share
Quality of Care Assessment	$ 38,012,639	$ 38,012,639
Interest Earned	20,744	20,744
TOTAL REVENUES	**$ 38,033,383**	**$ 38,033,383**

EXPENDITURES	FY 16 Total $ YTD	FY 16 State $ YTD	Total State $ Cost
Program Costs			
Nursing Facility Rate Adjustment	$ 104,618,386	$ 40,131,613	
Eyeglasses and Dentures	138,534	53,142	
Personal Allowance Increase	1,678,360	643,819	
Coverage for Durable Medical Equipment and Supplies	1,355,766	520,072	
Coverage of Qualified Medicare Beneficiary	516,378	198,083	
Part D Phase-In	361,024	138,489	
ICF/IID Rate Adjustment	2,631,179	1,009,320	
Acute Services ICF/IID	2,933,184	1,125,169	
Non-emergency Transportation - Soonerride	1,321,481	506,920	
Total Program Costs	**$ 115,554,293**	**$ 44,326,627**	**$ 44,326,627**
Administration			
OHCA Administration Costs	$ 262,245	$ 131,123	
DHS-Ombudsmen	-	-	
OSDH-Nursing Facility Inspectors	-	-	
Mike Fine, CPA	-	-	
Total Administration Costs	**$ 262,245**	**$ 131,123**	**$ 131,123**
Total Quality of Care Fee Costs	**$ 115,816,538**	**$ 44,457,749**	
TOTAL STATE SHARE OF COSTS			**$ 44,457,749**

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

OKLAHOMA HEALTH CARE AUTHORITY
SUMMARY OF REVENUES & EXPENDITURES:
Fund 245: Health Employee and Economy Improvement Act Revolving Fund
SFY 2016, For the Six Month Period Ending December 31, 2015

REVENUES	FY 15 Carryover	FY 16 Revenue	Total Revenue
Prior Year Balance	$ 27,746,235	$ -	$ 1,498,834
State Appropriations	(25,000,000)	-	-
Tobacco Tax Collections	-	20,740,186	20,740,186
Interest Income	-	109,610	109,610
Federal Draws	235,637	14,880,181	14,880,181
TOTAL REVENUES	**$ 2,981,872**	**$ 35,729,976**	**$ 37,228,811**

EXPENDITURES		FY 15 Expenditures	FY 16 Expenditures	Total $ YTD
Program Costs:				
	Employer Sponsored Insurance		$ 22,513,118	$ 22,513,118
	College Students		154,300	59,190
Individual Plan				
	SoonerCare Choice		$ 64,815	$ 24,863
	Inpatient Hospital		1,983,502	760,872
	Outpatient Hospital		1,870,131	717,382
	BH - Inpatient Services-DRG		128,164	49,164
	BH -Psychiatrist		-	-
	Physicians		907,269	348,029
	Dentists		4,516	1,732
	Mid Level Practitioner		7,275	2,791
	Other Practitioners		41,494	15,917
	Home Health		2,371	909
	Lab and Radiology		657,311	252,144
	Medical Supplies		125,654	48,201
	Clinic Services		308,351	118,284
	Ambulatory Surgery Center		61,571	23,619
	Prescription Drugs		5,498,113	2,109,076
	Miscellaneous Medical		-	-
	Premiums Collected		-	(219,075)
Total Individual Plan			**$ 11,660,538**	**$ 4,253,907**
	College Students-Service Costs		**$ 166,450**	**$ 63,850**
Total OHCA Program Costs			**$ 34,494,406**	**$ 26,890,065**
Administrative Costs				
	Salaries	$ 73,467	$ 1,071,261	$ 1,144,728
	Operating Costs	60,069	449,565	509,633
	Health Dept-Postponing	-	-	-
	Contract - HP	1,349,503	4,827,177	6,176,679
Total Administrative Costs		**$ 1,483,038**	**$ 6,348,003**	**$ 7,831,041**
Total Expenditures				**$ 34,721,106**
NET CASH BALANCE		**$ 1,498,834**		**$ 2,507,705**

OKLAHOMA HEALTH CARE AUTHORITY
SUMMARY OF REVENUES & EXPENDITURES:
Fund 250: Belle Maxine Hilliard Breast and Cervical Cancer Treatment Revolving Fund
SFY 2016, For the Six Month Period Ending December 31, 2015

REVENUES	FY 16 Revenue	State Share
Tobacco Tax Collections	$ 413,789	$ 413,789
TOTAL REVENUES	**$ 413,789**	**$ 413,789**

EXPENDITURES	FY 16 Total $ YTD	FY 16 State $ YTD	Total State $ Cost
Program Costs			
SoonerCare Choice	$ 6,419	$ 985	
Inpatient Hospital	1,057,880	162,385	
Outpatient Hospital	1,742,078	267,409	
Inpatient Services-DRG	-	-	
Psychiatrist	-	-	
TFC-OHCA	-	-	
Nursing Facility	3,113	478	
Physicians	2,787,952	427,951	
Dentists	6,855	1,052	
Mid-level Practitioner	334	51	
Other Practitioners	2,882	442	
Home Health	4,652	714	
Lab & Radiology	209,062	32,091	
Medical Supplies	18,939	2,907	
Clinic Services	82,315	12,635	
Ambulatory Surgery Center	8,059	1,237	
Prescription Drugs	847,813	130,139	
Transportation	21,316	3,272	
Miscellaneous Medical	217	33	
Total OHCA Program Costs	**$ 6,799,885**	**$ 1,043,782**	
OSA DMHSAS Rehab	$ 40,488	$ 10,685	
Total Medicaid Program Costs	**$ 6,840,373**	**$ 1,054,467**	
TOTAL STATE SHARE OF COSTS			**$ 1,054,467**

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.

OHCA Board Meeting
February 11, 2016
(December 2015 Data)

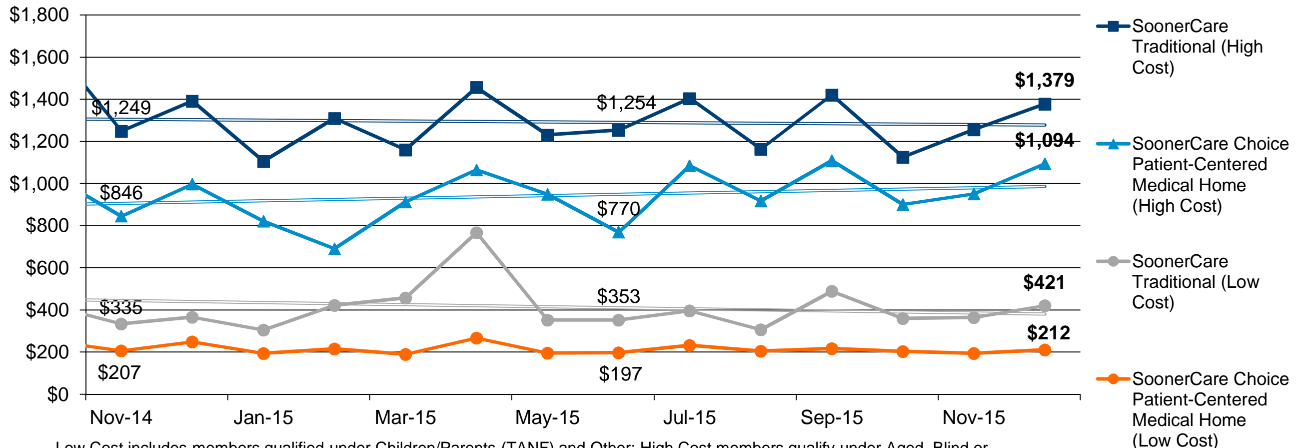
SOONERCARE ENROLLMENT/EXPENDITURES

Delivery System			Enrollment December 2015	Children December 2015	Adults December 2015	Enrollment Change	Total Expenditures December	PMPM December 2015	December 2015 Trend PMPM
SoonerCare Choice Patient-Centered Medical Home			**528,202**	**435,237**	**92,965**	**-3,470**	**$150,844,265**		
	Lower Cost	*(Children/Parents; Other)*	484,242	421,339	62,903	-3,567	$102,770,193	$212	$205
	Higher Cost	*(Aged, Blind or Disabled; TEFRA; BCC)*	43,960	13,898	30,062	97	$48,074,073	$1,094	$1,026
SoonerCare Traditional			**235,442**	**89,294**	**146,148**	**-2,467**	**$205,715,282**		
	Lower Cost	*(Children/Parents; Other)*	124,245	84,256	39,989	-2,265	$52,341,336	$421	$399
	Higher Cost	*(Aged, Blind or Disabled; TEFRA; BCC & HCBS Waiver)*	111,197	5,038	106,159	-202	$153,373,946	$1,379	$1,292
SoonerPlan			**37,232**	**2,862**	**34,370**	**-1,095**	**$310,278**	$8	$8
Insure Oklahoma			**18,444**	**530**	**17,914**	**292**	**$6,214,078**		
	Employer-Sponsored Insurance		14,598	349	14,249	324	$3,992,371	$273	$281
	Individual Plan		3,846	181	3,665	-32	$2,221,707	$578	$501
TOTAL			**819,320**	**527,923**	**291,397**	**-6,740**	**$363,083,904**		

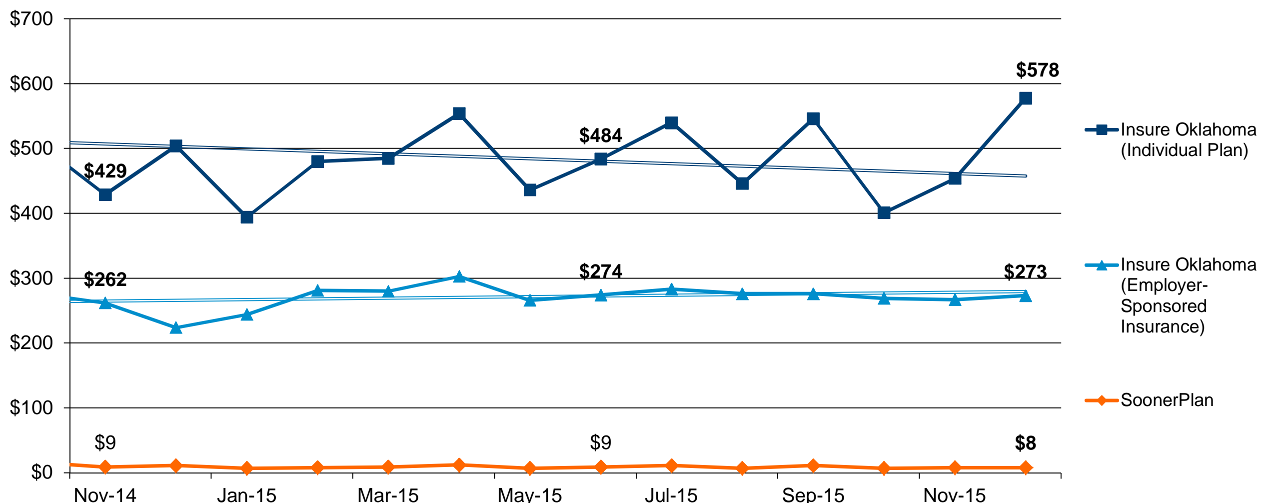
Enrollment totals include all members enrolled during the report month. Members may not have expenditure data. Children are members aged 0 - 20 or for Insure Oklahoma enrolled as Students or Dependents.

Total In-State Providers: 34,146 (+138)			**(In-State Providers counted multiple times due to multiple locations, programs, types, and specialties)**					
Physician	Pharmacy	Dentist	Hospital	Mental Health	Optometrist	Extended Care	Total PCPs	PCMH
9,758	942	1,220	197	5,437	642	236	6,710	2,552

PER MEMBER PER MONTH COST BY GROUP



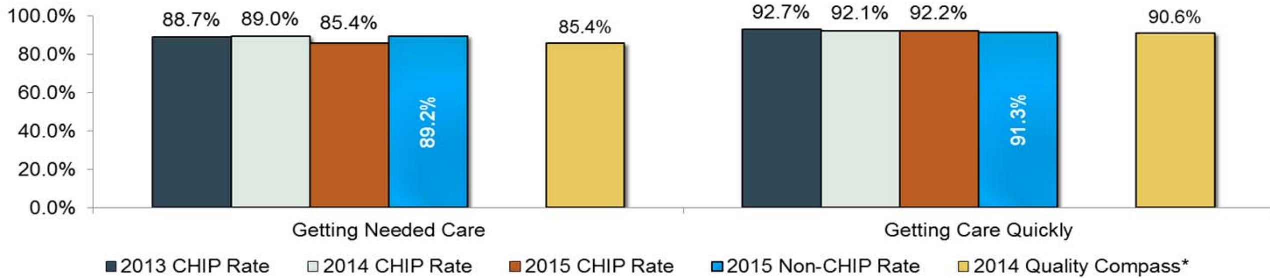
Low Cost includes members qualified under Children/Parents (TANF) and Other; High Cost members qualify under Aged, Blind or Disabled, Oklahoma Cares, TEFRA or a Home and Community-Based Services waiver.



SOONERCARE MEMBER SATISFACTION (CAHPS) SURVEYS

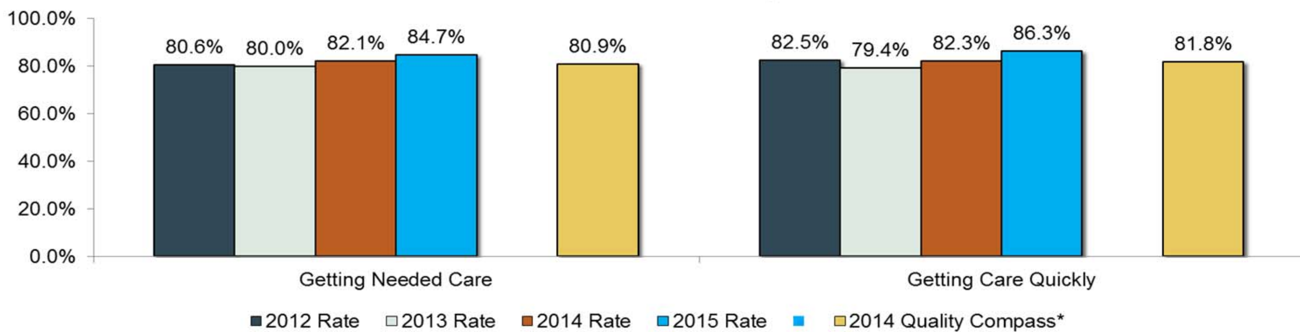
The Consumer Assessment of Healthcare Providers and Systems (CAHPS®) member satisfaction surveys are used nationally by both Medicaid and commercial programs as a tool to gauge how well their respective populations feel about the health care they are receiving. For the CHIP program version of the survey there were 1,966 surveys sent, with 500 responses (25% response rate). For the non-CHIP Child version of the survey there were 1,958 surveys sent out, with 473 responses (24% response rate). For the Adult version of the survey there were 1,823 surveys sent out, with 426 responses (23% response rate). For more comprehensive survey results to go www.okhca.org/CAHPS.

SoonerCare Child CAHPS Key Measures



*The 50th percentile of the 2014 Child Medicaid Quality Compass composite summary rate, which consists of 94 health plans who publicly and non-publicly reported their scores (All Lines of Business excluding PPOs). Measures scoring below the 50th percentile are an area for improvement while scoring above 50th percentile is an area of strength.

SoonerCare Adult CAHPS Key Measures



*The 50th percentile of the 2014 Adult Medicaid Quality Compass composite summary rate, which consists of 147 health plans who publicly reported their scores (All Lines of Business excluding PPOs). Measures scoring below the 50th percentile are an area for improvement while scoring above 50th percentile is an area of strength.

SOONERCARE CALL CENTER STATISTICS

SoonerCare Helpline Call Summary

July-December 2015

Tier I (MAXIMUS Call Center)	
Eligibility Inquiry	33%
Claim Inquiry	11%
Password Reset/Request	8%
PCP Change	8%
Med ID Card	4%
Program Question	3%
PA Inquiry	3%
PIN Number	3%
Application	3%
PCP Inquiry	3%

Tier II (Member Services)	
Eligibility Inquiry	69%
Program Question	7%
SoonerRide	4%
Pregnancy Letter Response	3%
Newborn Letter Response	3%
PA Inquiry	2%
PCP Change	2%
PCP Inquiry	1%
Med ID Card	1%
ER Letter Response	1%

FEBRUARY 11TH, 2016 OHCA BOARD MEETING

The Governor's State of the State address and the 2nd legislative session for the 55th Legislature began Monday, February 1st at noon.

With 1,735 new bills filed in January 2016, and the 1,732 bills carried over from the 2015 legislative session, our legislators have 3,467 measures to consider before sine die on May 27, 2016. OHCA is currently tracking 254 bills, of which two are OHCA request bills.

Over the summer and fall months, a few special elections were held to fill vacant House and Senate seats. The House has 71 Republicans and 30 Democrats, and the Senate has 39 Republicans and 9 Democrats.

A main focus for legislators this session will be the anticipated $1 billion shortfall for state fiscal year 2017. The Board of Equalization will meet on February 16, 2016, to certify the funds available for legislators to appropriate in their SFY2017 budget. House Appropriations and Budget Subcommittees met last week with their respective agencies to review SFY2017 budget requests during the annual budget performance review hearings.

OHCA REQUEST BILLS:

- SB1340 – Sen. A.J. Griffin - OHCA to develop and implement a Insure Oklahoma plan to assist eligible Oklahomans in purchasing health savings accounts;
- SB1548 – Sen. A.J. Griffin – Allows students up to age 26 to received coverage through Insure Oklahoma if they are an enrolled student in a technology center school, university or college.

The following are the remaining Senate and House deadlines for 2016:

SENATE AND HOUSE DEADLINES

February 25, 2016	Deadline for reporting Senate bills and joint resolutions from Senate committee
February 26, 2016	Deadline for Reporting House bills and joint resolutions from House committee
March 10, 2016	Deadline for Third Reading of Bills and Joint Resolutions in the Chamber of Origin
April 07, 2016	Senate deadline for reporting House bills and joint resolutions from committee
April 08, 2016	House deadline for reporting Senate bills and Joint Resolutions from committee
April 21, 2016	Deadline for Third Reading of Bills and Joint Resolutions from Opposite Chamber
May 27, 2015	Sine Die Adjournment, No later than 5:00 p.m.

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

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 21. OUTPATIENT BEHAVIORAL HEALTH AGENCY SERVICES

317:30-5-240.3 Staff Credentials

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

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

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

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

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

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

(b) **Licensure Candidates.** Licensure candidates are practitioners actively and regularly receiving board approved supervision, and extended supervision by a fully licensed clinician if board's supervision requirement is met but the individual is not yet licensed, to become licensed by one of the licensing boards listed in (2)(A) through (F) above. The supervising LBHP responsible for the member's care must:

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

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

(3) agree with the current plan for the member, and
(4) confirm that the service provided by the candidate was appropriate; and
(5) The member's medical record must show that the requirements for reimbursement were met and the LBHP responsible for the member's care has reviewed, countersigned, and dated the service plan and any updates thereto so that it is documented that the licensed professional is responsible for the member's care.

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

(d) **Multi-Systemic Therapy (MST) Provider**. Masters level therapist who works on a team established by OJA which may include Bachelor level staff.

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

(f) **Family Support and Training Provider (FSP).** FSPs are defined as follows:
(1) Have a high school diploma or equivalent;
(2) be 21 years of age and have successful experience as a family member of a child or youth with serious emotional disturbance, or a minimum of 2 years' experience working with children with serious emotional disturbance or be equivalently qualified by education in the human services field or a combination of work experience and education with one year of education substituting for one year of experience (preference is given to parents or care givers of child with SED);
(3) successful completion of ODMHSAS Family Support Training;
(4) pass background checks; and
(5) service plans must be overseen and approved by an LBHP or Licensure Candidate; and
(6) must function under the general direction of an LBHP, or Licensure Candidate or systems of care team, with an LBHP or Licensure Candidate available at all times to provide back up, support, and/or consultation.

(g) **Behavioral Health Aide (BHA).** BHAs are defined as follows:
(1) Behavioral Health Aides must have completed 60 hours or equivalent of college credit; or
(2) may substitute one year of relevant employment and/or responsibility in the care of children with complex emotional needs for up to two years of college experience; and
(3) must have successfully completed the specialized training and education curriculum provided by the ODMHSAS; and
(4) must be supervised by a bachelor's level individual with

a minimum of two years case management or care coordination experience; and
(5) service plans must be overseen and approved by an LBHP or Licensure Candidate; and
(6) must function under the general direction of an LBHP, or Licensure Candidate and/or systems of care team, with an LBHP or Licensure Candidate available at all times to provide back up, support, and/or consultation.

(h) **Behavioral Health Case Manager.** For behavioral health case management services to be compensable by SoonerCare, the provider performing the services must be an LBHP, Licensure Candidate, CADC or have and maintain a current certification as a Case Manager II (CM II) or Case Manager I (CM I) from ODMHSAS. The requirements for obtaining these certifications are as follows:
(1) Certified Behavioral Health Case Manager II (CM II) must meet the requirements in (A), (B), (C) or (D) below:
(A) Possess a Bachelor's or Master's degree in a behavioral health related field earned from a regionally accredited college or university recognized by the United States Department of Education (USDE) or a Bachelor's or Master's degree in education; and complete web-based training for behavioral health case management and behavioral health rehabilitation as specified by ODMHSAS; and complete one day of face-to-face behavioral health case management training and two days of face-to-face behavioral health rehabilitation training as specified by ODMHSAS; and pass web-based competency exams in behavioral health case management and behavioral health rehabilitation.
(B) Possess a current license as a registered nurse in the State of Oklahoma with experience in behavioral health care; complete web-based training for behavioral health case management and behavioral health rehabilitation as specified by ODMHSAS; complete one day of face-to-face behavioral health case management training and two days of face-to-face behavioral health rehabilitation training as specified by ODMHSAS; and pass web-based competency exams for behavioral health case management and behavioral health rehabilitation.
(C) Possess a Bachelor's or Master's degree in any field earned from a regionally accredited college or university recognized by the USDE and a current certification or Children's Certificate in Psychiatric Rehabilitation from the US Psychiatric Rehabilitation Association (USPRA); complete the behavioral health case management web-based training as specified by ODMHSAS; complete one day of face-to-face behavioral health case management training;

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

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

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

(A) completed 60 college credit hours; or

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

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

(3) **Wraparound Facilitator Case Manager.** LBHP, Licensure Candidate, CADC, or meets the qualifications for CM II and has the following:

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

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

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

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

(4) **Intensive Case Manager.** LBHP, Licensure Candidate, CADC or meets the provider qualifications of a Case Manager II and has the following:

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

(B) must have attended the ODMHSAS six hours Intensive case management training.

317:30-5-241.6 Behavioral Health Case Management [NEW]

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

(1) Payment is made for services rendered to SoonerCare 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 provider 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 members 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, psychotherapy 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's (and 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 or Licensure Candidate as defined in OAC 317:30-5-240.3(a) and (b).

(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. Behavioral Health Case Management is available to individuals transitioning from institutions to the community (except individuals ages 22 to 64 who reside in an institution for mental diseases (IMD) or individuals who are inmates of public institutions). Individuals are considered to be transitioning to the community during the last

30 consecutive days of a covered institutional stay. This time is 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. Transition services provided while the individual is in the institution are to be claimed as delivered on the day of discharge from the institution.

(B) **Levels of Case Management.**

(i) Basic Case Management/Resource Coordination. Resource coordination services are targeted to adults with serious 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 individual's strengths and meet needs in order to achieve stability in the community. Standard managers have caseloads of 30 - 35 members. Basic case management/resource coordination is limited to 25 units per member per month.

(ii) Intensive Case Management (ICM)/Wraparound Facilitation Case Management (WFCM). Intensive Case Management is targeted to adults with serious and persistent mental illness (including members in PACT programs) and Wraparound Facilitation Case Management is targeted to children with serious mental illness and emotional disorders (including 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 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. ICM/WFCM is limited to 54 units per member per month.

(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;
(x) non-face-to-face time spent preparing the assessment document and the service plan paperwork;
(xi) monitoring financial goals;
(xii) services to nursing home residents;
(xiii) psychotherapeutic or rehabilitative services, psychiatric assessment, or discharge; or
(xix) services to members residing in ICF/IID 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/IID 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 member and it must be

reviewed and signed by the member, the behavioral health case manager, and a licensed behavioral health professional or licensure candidate as defined at OAC 317:30-5-240.3(a) and (b). All behavioral health case management services rendered must be reflected by documentation in the records. In addition to a complete behavioral health case management service, plan documentation of each session must include but is not limited to:

(i) date;

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

(iii) start and stop times for each service;

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

(v) credentials of the service provider;

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

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

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

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

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

(xi) member satisfaction with staff intervention.

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

317:30-5-249. Non-covered services

In addition to the general program exclusions [OAC 317:30-5-2(a)(2)] the following are excluded from coverage. Work and education services:

(1) Talking about the past and current and future employment goals, going to various work sites to explore the world of work, and assisting client in identifying the pros and cons of working.

(2) Development of an ongoing educational and employment

rehabilitation plan to help each individual establish job specific skills and credentials necessary to achieve ongoing employment. Psycho-social skills training however would be covered.

(3) Work/school specific supportive services, such as assistance with securing of appropriate clothing, wake-up calls, addressing transportation issues, etc. These would be billed as Case Management following ~~317:30-5-595 through 317:30-5-599~~317:30-5-241.6.

(4) Job specific supports such as teaching/coaching a job task.

PART 67. BEHAVIORAL HEALTH CASE MANAGEMENT SERVICES

317:30-5-595. Eligible providers [REVOKED]

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

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

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

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

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

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

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

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

~~(2) **Provider Qualifications.** For behavioral health case management services to be compensable by SoonerCare, the provider performing the service must be an LBHP, Licensure Candidate, CADC, or have and maintain a current certification as a Case Manager II (CM II) or Case Manager I (CM I) from~~

~~the ODMHSAS. The requirements for obtaining these certifications are as follows:~~

~~(A) Certified Behavioral Health Case Manager II (CM II) must meet the requirements in (i), (ii), (iii) or (iv) below:~~

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

~~(ii) Possess a current license as a registered nurse in the State of Oklahoma with experience in behavioral health care; complete web-based training for behavioral health case management and behavioral health rehabilitation as specified by ODMHSAS; complete one day of face-to-face behavioral health case management training and two days of face-to-face behavioral health rehabilitation training as specified by ODMHSAS; and pass web-based competency exams for behavioral health case management and behavioral health rehabilitation.~~

~~(iii) Possess a Bachelor's or Master's degree in any field earned from a regionally accredited college or university recognized by the USDE and a current certification or Children's Certificate in Psychiatric Rehabilitation from the US Psychiatric Rehabilitation Association (USPRA); complete the behavioral health case management web-based training as specified by ODMHSAS; complete one day of face-to-face behavioral health case management training; and pass web-based competency exams for behavioral health case management. Applicants who have not received a certificate in children's psychiatric rehabilitation from the US Psychiatric Association (USPRA) must also complete the behavioral health rehabilitation web-based training as specified by ODMHSAS.~~

~~(iv) Possess a Bachelor's or Master's degree in any field and proof of active progression toward obtaining a clinical licensure Master's or Doctoral degree at a regionally accredited college or university recognized~~

~~by the USDE and complete web-based training for behavioral health case management and behavioral health rehabilitation as specified by ODMHSAS; complete one day of face-to-face behavioral health case management training and two days of face-to-face behavioral health rehabilitation training as specified by ODMHSAS; and pass web-based competency exams in behavioral health case management and behavioral health rehabilitation.~~

~~(B) Certified Behavioral Health Case Manager I meets the requirements in either (i) or (ii), and (iii):~~

~~(i) completed 60 college credit hours; or~~

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

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

~~(C) **Wraparound Facilitator Case Manager.** LBHP, Licensure Candidate, CADC, or meets the qualifications for CM II and has the following:~~

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

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

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

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

~~(D) **Intensive Case Manager**. LBHP, Licensure Candidate, CADC or meets the provider qualifications of a Case Manager II and has the following:~~

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

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

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

317:30-5-596. Coverage by category [REVOKED]

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

~~(1) Payment is made for services rendered to SoonerCare 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's (and 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 or Licensure Candidate as defined in OAC 317:30-5-240.3(a) and (b).~~

~~(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. Behavioral Health Case Management is available to individuals transitioning from institutions to the community (except individuals ages 22 to 64 who reside in an institution for mental diseases (IMD) or individuals who are inmates of public institutions). Individuals are considered to be transitioning to the community during the last 30 consecutive days of a covered institutional stay.~~

This time is 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. Transition services provided while the individual is in the institution are to be claimed as delivered on the day of discharge from the institution.

(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 individual's strengths and meet needs in order to achieve stability in the community. Standard managers have caseloads of 30 - 35 members. Basic case management/resource coordination is limited to 25 units per member per month.

(ii) Intensive Case Management (ICM)/Wraparound Facilitation Case Management (WFCM). Intensive Case Management is targeted to adults with serious and persistent mental illness (including members in PACT programs) and Wraparound Facilitation Case Management is targeted to children with serious mental illness and emotional disorders (including 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 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. ICM/WFCM is limited to 54 units per member per month.

(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;~~
~~(x) Non face-to-face time spent preparing the assessment document and the service plan paperwork;~~
~~(xi) monitoring financial goals;~~
~~(xii) services to nursing home residents;~~
~~(xiii) psychotherapeutic or rehabilitative services, psychiatric assessment, or discharge; or~~
~~(xix) services to members residing in ICF/IID 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/IID 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 or licensure candidate as defined at OAC 317:30-5-240.3(a) and (b). All behavioral health case management services rendered must be reflected by documentation in the records. In addition to a complete behavioral health case management service, plan documentation of each session must include but is not limited to:

(i) date;

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

(iii) start and stop times for each service;

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

(v) credentials of the service provider;

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

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

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

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

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

(xi) member satisfaction with staff intervention.

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

317:30-5-599. Documentation of records [REVOKED]

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

(1) date;

(2) person(s) to whom services were rendered;

~~(3) start and stop time for each service;~~
~~(4) original signature of the service provider (in circumstances where it is necessary to fax a service plan to someone for review and then have them fax back their signature, this is acceptable; however, the provider needs to obtain the original signature for the clinical file within 30 days. No stamped or Xeroxed signatures are allowed);~~
~~(5) credentials of service provider;~~
~~(6) specific service plan need(s), goals and/or objectives addressed;~~
~~(7) specific activities performed by the behavioral health case manager on behalf of the child related to advocacy, linkage, referral, or monitoring used to address problem(s), goals and/or objectives;~~
~~(8) progress or barriers made towards goals and/or objectives;~~
~~(9) client (and family, when applicable) response to the services;~~
~~(10) any new individual plan of service need(s), goals and/or objectives identified during the service; and~~
~~(11) member satisfaction with staff intervention(s).~~

PART 75. FEDERALLY QUALIFIED HEALTH CENTERS

317:30-5-660.3. Health Center enrollment requirements for specialty behavioral health services

~~(a) For the provision of behavioral health related case management services, Health Centers must meet the requirements found at OAC 317:30-5-595 through 317:30-5-599.~~
~~(b)~~(a) For the provision of behavioral health related case management services and psychosocial rehabilitation services, Health Centers must contract as an outpatient behavioral health agency and meet the requirements found at OAC 317:30-5-240 through ~~30-5-249~~317:30-5-249.
~~(c)~~(b) Health Centers which provide substance abuse treatment services must also be certified by the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS).

317:30-5-661.4. Behavioral health professional services provided at Health Centers and other settings

(a) Medically necessary behavioral health services that are primary, preventive, and therapeutic and that would be covered if provided in another setting may be provided by Health Centers. Services provided by a Health Center (refer to OAC 317:30-5-240.3 for a description of services) must meet the same requirements as services provided by other behavioral health providers. Rendering providers must be eligible to individually

enroll or meet the requirements as an agency/organization provider specified in OAC 317:30-5-240.2~~,~~and 317:30-5-280~~ and 317:30-5-595~~.

(1) Behavioral Health services include:

(A) Assessment/Evaluation;

(B) Crisis Intervention Services;

(C) Individual/Interactive Psychotherapy;

(D) Group Psychotherapy;

(E) Family Psychotherapy;

(F) Psychological Testing; and

(G) Case Management (as an integral component of services 1-6 above).

(b) Medically necessary behavioral health professional therapy services are covered when provided in accordance with a documented individualized treatment plan, developed to treat the identified behavioral health disorder(s). A minimum of a 45 to 50 minute one-on-one standard clinical session must be completed by an health care professional authorized in the approved FQHC State Plan pages in order to bill the PPS encounter rate for the session. Services rendered by providers not authorized under the approved FQHC state plan pages to bill the PPS encounter rate will be reimbursed pursuant to the SoonerCare fee-for-service fee schedule and must comply with rules found at OAC 317:30-5-280 through 317:30-5-283.

(c) Centers are reimbursed the PPS rate for services when rendered by approved health care professionals, as authorized under FQHC state plan pages, if the Health Center receives funding pursuant to Section 330 or is otherwise funded under Public Law to provide primary health care services at locations off-site (not including satellite or mobile locations) to Health Center patients on a temporary or intermittent basis, unless otherwise limited by Federal law.

(d) Health Centers that operate day treatment programs in school settings must meet the requirements found at OAC ~~317:30-5-240.2(7)~~317:30-5-240.2(b)(7).

(e) In order to support the member's access to behavioral health services, these services may take place in settings away from the Health Center. Off-site behavioral health services must take place in a confidential setting.

317:30-5-664.1. Provision of other health services outside of the Health Center core services

(a) If the Center chooses to provide other SoonerCare State Plan covered health services which are not included in the Health Center core service definition in OAC 317:30-5-661.1, the practitioners of those services are subject to the same program coverage limitations, enrollment and billing procedures

described by the OHCA, and these services (e.g., home health services) are not included in the PPS settlement methodology in OAC 317:30-5-664.12.

(b) Other health services include, but are not limited to:

(1) dental services (refer to OAC 317:30-5-696) except for primary preventive dental services;

(2) eyeglasses (refer to OAC 317:30-5-450);

(3) clinical lab tests performed in the Center lab (other than the specific laboratory tests set out for Health Centers' certification and covered as Health Center services);

(4) technical component of diagnostic tests such as x-rays and EKGs (interpretation of the test provided by the Center physician is included as physician professional services);

(5) durable medical equipment (refer to OAC 317:30-5-210);

(6) emergency ambulance transportation (refer to OAC 317:30-5-335);

(7) prescribed drugs (refer to OAC 317:30-5-70);

(8) prosthetic devices (other than dental) which replace all or part of an internal body organ (including colostomy bags) and supplies directly related to colostomy care and the replacement of such devices;

(9) specialized laboratory services furnished away from the clinic;

(10) Psychosocial Rehabilitation Services [refer to OAC 317:30-5-241(a)(7)]; and

(11) Behavioral health related case management services (refer to OAC ~~317:30-5-585 through 317:30-5-589 and OAC 317:30-5-595 through 317:30-5-599~~317:30-5-240 through 317:30-5-249).

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) SoonerPlan family planning services;
(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 105. RESIDENTIAL BEHAVIORAL MANAGEMENT SERVICES IN GROUP SETTINGS AND NON-SECURE DIAGNOSTIC AND EVALUATION CENTERS

317:30-5-1043. Coverage by category

(a) **Adults.** Residential Behavioral Management Services in Group Settings and Non-Secure Diagnostic and Evaluation Center Services are not covered for adults.

(b) **Children.** Residential Behavioral Management Services (RBMS) in Group Settings and Non-Secure Diagnostic and Evaluation Centers are covered for children as set forth in this subsection.
(1) **Description**. Residential Behavior Management Services are provided by Organized Health Care Delivery Systems

(OHCDS) for children in the care and custody of the State who have special psychological, behavioral, emotional and social needs that require more intensive care than can be provided in a family or foster home setting. The behavior management services are provided in the least restrictive environment and within a therapeutic milieu. The group setting is restorative in nature, allowing children with emotional and psychological problems to develop the necessary control to function in a less restrictive setting. Residential Behavior Management Services are reimbursed in accordance with the intensity of supervision and treatment required for the group setting in which the child is placed. Members residing in a Level E and Intensive Treatment Services (ITS) Group Homes receive maximum supervision and treatment. In addition, ITS group homes provide crisis and stabilization intervention and treatment. Members residing in a Level D+ Group Home receive highly intensive supervision and treatment. Members residing in a Level D Group home or in a wilderness camp receive close supervision and moderate treatment. Members residing in a Level C Group Home receive minimum supervision and treatment. Members residing in Residential Diagnostic and Evaluation Centers receive intensive supervision and a 20 day comprehensive assessment. Members residing in a Sanctions Home receive highly intensive supervision and treatment. Members residing in an Independent Living Group Home receive intensive supervision and treatment. It is expected that RBMS in group settings are an all-inclusive array of treatment services provided in one day. In the case of a child who needs additional specialized services, under the Rehabilitation Option or by a psychologist, prior authorization by the OHCA or designated agent is required. Only specialized rehabilitation or psychological treatment services to address unique, unusual or severe symptoms or disorders will be authorized. If additional services are approved, the OHCDS collaborates with the provider of such services as directed by the OHCA or its agent. Any additional specialized behavioral health services provided to children in state custody are funded in the normal manner. The OHCDS must provide concurrent documentation that these services are not duplicative. The OHCDS determines the need for RBMS.

(2) **Medical necessity criteria.** The following medical necessity criteria must be met for residential behavior Management Services.

(A) Any DSM~~ IV AXIS I~~ primary diagnosis, with the exception of V codes, with a detailed description of the symptoms supporting the diagnosis. A detailed description of the child's emotional, behavioral and psychological

condition must be on file. A diagnosis is not required for behavior management services provided in Diagnostic and Evaluation centers.

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

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

(D) Documentation that the child's presenting emotional and/or behavioral problems prevent the child from living in a traditional family home. The child requires the availability of 24 hour crisis response/behavior management and intensive clinical interventions from professional staff.

(E) The Agency which has permanent or temporary custody of the child agrees to active participation in the child's treatment needs and planning.

(F) All of the medical necessity criteria must also be met for continued stay in residential group settings.

(3) **Treatment components.**

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

care must also address the provider agency's plans with regard to the provision of services in each of the following areas:

(i) group therapy;
(ii) individual therapy;
(iii) family therapy;
(iv) alcohol and other drug counseling;
(v) basic living skills redevelopment;
(vi) social skills redevelopment;
(vii) behavior redirection; and
(viii) the provider agency's plan to access appropriate educational placement services. (Any educational costs are excluded from calculation of the daily rate for behavior management services.)

(B) **Individual therapy.** The provider agency must provide individual therapy on a weekly basis with a minimum of one or more sessions totaling one hour or more of treatment per week to children and youth receiving RBMS in Wilderness Camps, Level D, Level D+ homes, Level E Homes, Independent Living Homes, and Sanctions Homes. ITS Level residents will receive a minimum of five or more sessions totaling a minimum of five or more hours of individual therapy per week. Members residing in Diagnostic and Evaluation Centers and Level C Group Homes receive Individual Therapy on an as needed basis. Individual therapy must be age appropriate and the techniques and modalities employed relevant to the goals and objectives of the individual's plan of care. Individual counseling is a face to face, one to one service, and must be provided in a confidential setting.

(C) **Group therapy.** The provider agency must provide group therapy to children and youth receiving residential behavioral management services. Group therapy must be a face to face interaction, age appropriate and the techniques and modalities employed relevant to the goals and objectives of the individual's plan of care. The minimum expected occurrence would be one hour per week in Level D, Level C, Wilderness Camps and Independent Living. Two hours per week are required in Levels D+ and E. Ten hours per week are required in Sanctions Homes, Intensive Treatment Service Level. Group therapy is not required for Diagnostic and Evaluation Centers. Group size should not exceed six members and group therapy sessions must be provided in a confidential setting. One half hour of individual therapy may be substituted for one hour of group therapy.

(D) **Family therapy.** Family therapy is a face to face

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

(E) **Alcohol and other drug abuse treatment education, prevention, therapy.** The provider agency must provide alcohol and other drug abuse treatment for residents who have emotional or behavioral problems related to substance abuse/chemical dependency, to begin, maintain and enhance recovery from alcoholism, problem drinking, drug abuse, drug dependency addiction or nicotine use and addiction. This service is considered ancillary to any other formal treatment program in which the child participates for treatment and rehabilitation. For residents who have no identifiable alcohol or other drug use, abuse, or dependency, age appropriate education and prevention activities are appropriate. These may include ~~self esteem~~self-esteem enhancement, violence alternatives, communication skills or other skill development curriculums.

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

(G) **Social skills redevelopment.** The provider agency must provide goal directed activities designed for each resident to restore, retain and improve the self help, communication, socialization, and adaptive skills

necessary to reside successfully in home and community based settings. These are age appropriate, culturally sensitive and relevant to the goals of the individual plan of care. For ITS level of care, the minimum skill redevelopment per day is three hours. Any combination of basic living skills and social skills redevelopment that is appropriate to the need and developmental abilities of the child is acceptable.

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

(4) **Providers.** For eligible RBMS agencies to bill the Oklahoma Health Care Authority for services of their providers, the providers of individual, group and family therapies must:

(A) be a licensed psychologist, social worker (clinical specialty only), professional counselor, marriage and family therapist, or behavioral practitioner, or under Board Supervision to be licensed in one of the above stated areas; or

(B) have one year of experience in a behavioral health treatment program and a master's degree in a mental health treatment field licensable in Oklahoma by one of the following licensing boards:

(i) Psychology,

(ii) Social work (clinical specialty only),

(iii) Licensed professional counselor,

(iv) Licensed marriage and family therapist, or

(v) Licensed behavioral practitioner; or

(C) have a baccalaureate degree in a mental health field in one of the stated areas listed in (B) of this paragraph AND three or more years post-baccalaureate experience in providing direct patient care in a behavioral health treatment setting and be provided a minimum of weekly supervision by a staff member licensed as listed in (A) of this paragraph; or

(D) be a registered psychiatric nurse; AND

(E) demonstrate a general professional or educational background in the following areas:

(i) case management, assessment and treatment planning;

(ii) treatment of victims of physical, emotional, and

sexual abuse;
(iii) treatment of children with attachment disorders;
(iv) treatment of children with hyperactivity or attention deficit disorders;
(v) treatment methodologies for emotional disturbed children and youth;
(vi) normal childhood development and the effect of abuse and/or neglect on childhood development;
(vii) treatment of children and families with substance abuse and chemical dependency disorders;
(viii) anger management; and
(ix) crisis intervention.

(5) For eligible RBMS agencies to bill the Oklahoma Health Care Authority for services provided by their staff for behavior management therapies (Individual, Group, Family) as of July 1, 2007, providers must have the following qualifications:

(A) be licensed in the state in which the services are delivered as a licensed psychologist, social worker (clinical specialty only), professional counselor, marriage and family therapist, or behavioral practitioner, alcohol and drug counselor or under Board approved Supervision to be licensed in one of the above stated areas; or

(B) be licensed as an Advanced Practice Nurse certified in a psychiatric mental health specialty, licensed as a registered nurse with a current certification of recognition from the Board of Nursing in the state in which services are provided, AND

(C) demonstrate a general professional or educational background in the following areas:
(i) case management, assessment and treatment planning;
(ii) treatment of victims of physical, emotional, and sexual abuse;
(iii) treatment of children with attachment disorders;
(iv) treatment of children with hyperactivity or attention deficit disorders;
(v) treatment methodologies for emotionally disturbed children and youth;
(vi) normal childhood development and the effect of abuse and/or neglect on childhood development;
(vii) treatment of children and families with substance abuse and chemical dependency disorders;
(viii) anger management; and
(ix) crisis intervention.

(D) Staff providing basic living skills redevelopment, social skills redevelopment, and alcohol and other

substance abuse treatment, must meet one of the following areas:

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

(ii) a current license as a registered nurse in Oklahoma; or

(iii) certification as an Alcohol and Drug Counselor to provide substance abuse rehabilitative treatment to those with alcohol and/or other drug dependencies or addictions as a primary or secondary DSM~~IV Axis I~~ diagnosis; or

(iv) current certification as a Behavioral Health Case Manager from DMHSAS and meets OHCA requirements to perform case management services, as described in OAC ~~317:30-5-595~~317:30-5-240 through 317:30-5-249.

(E) Staff providing behavior redirection services must have current certification and required updates in nationally recognized behavior management techniques, such as Controlling Aggressive Patient Environment (CAPE) or MANDT. Additionally, staff providing these services must receive initial and ongoing training in at least one of the following areas:

(i) trauma informed methodology,

(ii) anger management,

(iii) crisis intervention,

(iv) normal child and adolescent development and the effect of abuse,

(v) neglect and/or violence on such development,

(vi) grief and loss issues for children in out of home placement,

(vii) interventions with victims of physical, emotional and sexual abuse,

(viii) care and treatment of children with attachment disorders,

(ix) care and treatment of children with hyperactive, or attention deficit, or conduct disorders,

(x) care and treatment of children, youth and families with substance abuse and chemical dependency disorders,

(xi) passive physical restraint procedures,

(xii) procedures for working with delinquents or the Inpatient Mental Health and Substance Abuse Treatment of Minors Act.

(F) In addition, Behavioral Management staff must have access to consultation with an appropriately licensed

mental health professional.

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 21. OUTPATIENT BEHAVIORAL HEALTH AGENCY SERVICES

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

All providers must comply with the requirements as set forth in 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 and limitations.** Screening 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. To qualify for reimbursement, the screening tools used must be evidence based or otherwise approved by OHCA and ODMHSAS and appropriate for the age and/or developmental stage of the member.

(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 practitioners**. This service is performed by an LBHP or Licensure Candidate.

~~(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)~~(C) **Target population and limitations**. The Behavioral Health Assessment by a Non-Physician, moderate complexity, 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)~~(D) **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 at least one DSM diagnosis from the most recent DSM edition. The information in 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 or 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, (e.g., 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 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) Practitioner's interpretation of findings and diagnosis;~~

~~(xviii) Signature and credentials of the practitioner who performed the face-to-face behavioral assessment;~~

~~(xix) Client Data Core Elements reported into designated OHCA representative.~~

(i) Behavioral, including substance use, abuse, and dependence;

(ii) Emotional, including issues related to past or current trauma;

(iii) Physical;

(iv)Social and recreational;

(v) Vocational;

(vi)Date of the assessment sessions as well as start and stop times;

(vii) Signature of parent or guardian participating in face-to-face assessment. Signature required for members over the age of 14; and

(viii) Signature and credentials of the practitioner who

performed the face-to-face behavioral assessment

(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 plan is developed that addresses the 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. Behavioral Health 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. 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.

(B) **Qualified practitioners.** This service is performed by an LBHP or Licensure Candidate.

(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 qualified practitioner 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 service 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 or Licensure Candidate; 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). Any changes to the existing service plan must be signed and dated by the member (if 14 or over), the parent/guardian (if younger than 18 or otherwise applicable), and the lead LBHP or Licensure Candidate.
(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 service 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 or Licensure Candidate.
(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 service 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 practitioners.** Assessment/Evaluation testing will be provided by a psychologist, certified psychometrist, psychological technician of a psychologist, an LBHP or Licensure Candidate. 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 three, 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 a 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.

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 22. HEALTH HOMES

317:30-5-251. Eligible providers

(a) **Agency requirements.** Providers of Health Home (HH) services are responsible for providing HH services to qualifying individuals within the provider's specified service area. Qualifying providers must be:

(1) Certified by the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) as a Community Mental Health Center under OAC 450:17; or
(2) Accredited as a provider of outpatient behavioral health services from one of the national accrediting bodies; or
(3) Certified by ODMHSAS as a Mental Illness Service Program pursuant to OAC 450:27; or
(4) Certified by ODMHSAS as a Program of Assertive Community Treatment (PACT) pursuant to OAC 450:55.
(5) In addition to the accreditation/certification requirements in (1) - (4), providers must also have provider specific credentials from ODMHSAS for Health Home Services (OAC 450:17; OAC 450:27; OAC 450:55).

(b) **Health Home team.** Health Homes will utilize an interdisciplinary team of professionals and paraprofessionals to identify an individual's strengths and needs, create a unified plan to empower persons toward self-management and coordinate the individual's varied healthcare needs. HH teams will vary in size depending on the size of the member panel and acuity of members. HH team composition will vary slightly between providers working with adults and children.

(1) Health Homes working with adults with Serious Mental Illness (SMI) will utilize a multidisciplinary team consisting of the following:
(A) Health Home Director;
(B) Nurse Care Manager (RN or LPN);
(C) Consulting Primary Care Practitioner (PCP);
(D) Psychiatric Consultant (317:30-5-11);
(E) Certified Behavioral Health Case Manager(CM)(OAC 450:50; 317:30-5-595);
(F) Wellness Coach~~/Peer Support Specialist (OAC 450:53; 317:30-5-240.3)~~ credentialed through ODMHSAS; and
(G) Administrative support.
(2) In addition to the individuals listed in (1) (A) through (G) above, teams working with adults with SMI (PACT teams

only) will also have at least one of the following team members:

(A) Licensed Behavioral Health Professional or Licensure Candidate (317:30-5-240.3);

(B) Substance abuse treatment specialist (Licensed Alcohol and Drug Counselor (LADC) or Certified Alcohol and Drug Counselor (CADC); or

(C) Employment specialist.

(3) Health Homes working with children with Serious Emotional Disturbance (SED) will utilize a multidisciplinary team consisting of the following:

(A) ~~Project~~ Health Home Director;

(B) Nurse Care Manager (RN or LPN);

(C) Consulting Primary Care Practitioner (PCP);

(D) Psychiatric Consultant (317:30-5-11);

(E) Care Coordinator (CM II Wraparound Facilitator as defined in 317:30-5-595(2) (C);

(F)Family Support Provider (317:30-5-240.3);

(G) Youth/Peer Support Specialist (OAC 450:53; 317:30-5-240.3);

(H) Children's Health Home Specialist (Behavioral Health Aide or higher, with additional training in WellPower or credentialed as a Wellness Coach through ODMHSAS); and

(I) Administrative Support.

317:30-5-252. Covered Services

Health Home services are covered for adults with Serious Mental Illness (SMI) and children with Serious Emotional Disturbance (SED) as set forth in this Section unless specified otherwise, and when provided in accordance with a documented care plan. The care plan must be client directed, integrated, and reflect the input of the team (including the involvement of the consulting primary care physician or APRN in managing the medical component of the plan), as well as others the client chooses to involve. Coverage includes the following services:

(1) **Comprehensive Care Management.**

(A) **Definition.** Comprehensive care management services consist of developing a Comprehensive Care Plan to address needs of the whole person and involves the active participation of the Nurse Care Manager, certified Behavioral Health Case Manager, Primary Care Practitioner, the Health Home clinical support staff with participation of other team members, family and caregivers.

(B) **Service requirements.** Comprehensive care management services include the following, but are not limited to:

(i) Identifying high-risk members and utilizing member information to determine level of participation in care management services;

(ii) Assessing preliminary service needs; participating in comprehensive person-centered service plan development; responsible for member physical health goals, preferences and optimal clinical outcomes;
(iii) Developing treatment guidelines that establish clinical pathways for health teams to follow across risk levels or health conditions;
(iv) Monitoring individual and population health status and service use to determine adherence to or variance from best practice guidelines; and
(v) Developing and disseminating reports that indicate progress toward meeting outcomes for member satisfaction, health status, service delivery and cost.

(C) **Qualified professionals.** Comprehensive care management services are provided by a health care team with participation from the client, family and caregivers~~, consisting of the following required professionals and paraprofessionals~~. The following team members are eligible to provide comprehensive care management:
(i) Nurse Care Manager (RN or LPN within scope of practice);
(ii) Certified Behavioral Health Case Manager;~~ and~~
(iii) Primary Care Practitioner~~.~~;
(iv) Psychiatric consultant; and
(v) Licensed Behavioral Health Professional (LBHP).

(2) **Care coordination.**

(A) **Definition.** Care coordination is the implementation of the Comprehensive Care Plan with active member involvement through appropriate linkages, referrals, coordination, and follow-up to needed services and supports.

(B) **Service requirements.** Care coordination services include the following, but are not limited to:
(i) Care coordination for primary health care, specialty health care, and transitional care from emergency departments, hospitals and Psychiatric Residential Treatment Facilities (PRTFs);
(ii) Ensuring integration and compatibility of mental health and physical health activities;
(iii) Providing on-going service coordination and link members to resources;
(iv) Tracking completion of mental and physical health goals in member's Comprehensive Care Plan;
(v) Coordinating with all team members to ensure all objectives of the Comprehensive Care Plan are progressing;
(vi) Appointment scheduling;
(vii) Conducting referrals and follow-up monitoring;

(viii) Participating in hospital discharge processes; and

(ix) Communicating with other providers and members/family.

(C) **Qualified professionals.** Team members are responsible to ensure implementation of the Comprehensive Care Plan, which includes mental health goals, physical health goals, and other life domain goals for achievement of clinical outcomes. Care coordination services are provided by a primary care practitioner-led team which includes the following professionals and paraprofessionals:

(i) Nurse Care Manager (RN or LPN);~~ and~~

(ii) Certified Behavioral Health Case Managers~~.~~;

(iv) Health Home Director;

(v) Family Support Provider;

(vi) Youth/Peer Support Specialist; and

(vi) Health Home Specialist/Hospital Liaison.

(3) **Health promotion.**

(A) **Definition.** Health promotion consists of providing health education specific to the member's chronic condition.

(B) **Service requirements.** Health promotion will minimally consist of the following, but is not limited to:

(i) Providing health education specific to member's condition;

(ii) Developing self-management plans with the member;

(iii) Providing support for improving social networks and providing health promoting lifestyle interventions including:

(I) Substance use prevention;

(II) Smoking prevention and cessation;

(III) Obesity reduction and prevention;

(IV) Nutritional counseling; and

(V) Increasing physical activity.

(C) **Qualified professionals.** Health promotion services must be provided by the Primary Care Practitioner, Registered Nurse Care Manager (or LPN within full scope of practice) and the Wellness Coach or Health Home Specialist at the direction of the Health Home Director.

(4) **Comprehensive transitional care.**

(A) **Definition.** Care coordination services for comprehensive transitional care are designed to streamline plans of care, reduce hospital admissions and interrupt patterns of frequent hospital emergency department use.

(B) **Service requirements.** ~~In conducting comprehensive transitional care, the Nurse Care Manager and the case manager will work as co-leads.~~ The duties of the ~~Nurse Care Manager or the case manager~~ qualified team members

providing transitional care services include, but are not limited to the following:

(i) Developing contracts or Memorandums of Understanding (MOUs) with regional hospitals or system(s) to ensure a formalized structure for transitional care planning, to include communication of inpatient admissions and discharges of Health Home members;

(ii) Maintaining a mutual awareness and collaboration to identify individuals seeking emergency department services that may benefit from connection with a Health Home site; and

(iii) Motivate hospital staff to notify the Health Home staff of such opportunities.

(C) **Qualified individuals.** Comprehensive transitional care services can be provided by the following team members:

(i) Nurse Care Manager;

(ii) Certified behavioral health case manager; and

(iii) Family Support provider.

(5) **Individual and family support services.**

(A) **Definition.** Individual and family support services assist individuals in accessing services that will reduce barriers and improve health outcomes, with a primary focus on increasing health literacy, the ability of the member to self- manage their care, and facilitate participation in the ongoing revision of their Comprehensive Care Plan.

(B) **Service requirements.** Individual and family support services include, but are not limited to:

(i) Teaching individuals and families self-advocacy skills;

(ii) Providing peer support groups;

(iii) Modeling and teaching how to access community resources;

(iv) Assisting with obtaining and adhering to medications and other prescribed treatments; and

(v) Identifying resources to support the member in attaining their highest level of health and functioning in their families and in the community, including transportation to medically necessary services.

(C) **Qualified individuals.** Individual and family support service activities must be provided by one of the following:

(i) Wellness Coaches, Recovery support specialist, Children's Health Home specialist; or

(ii) Care coordinators; or

(iii) Family Support Providers~~.~~; or

(iv) Nurse Care Manager.

(6) **Referral to community and social support services.**

(A) **Definition.** Provide members with referrals to community and social support services in the community.

(B) **Service requirements**. Providing assistance for members to obtain and maintain eligibility for the following services as applicable, including but not limited to:

(i) Healthcare;
(ii) Disability benefits;
(iii) Housing;
(iv) Transportation;
(v) Personal needs; and
(vi) Legal services.

(C) **Limitations.** For members with Developmental Disabilities, the Health Home will refer to and coordinate with the approved Developmental Disabilities case management entity for these services.

(D) **Qualified individuals.** Referral to community and social support services may be provided by a certified behavioral health case manager, Family Support Provider or a nurse care manager.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY

CHAPTER 35. MEDICAL ASSISTANCE FOR ADULTS AND CHILDREN-ELIGIBILITY

SUBCHAPTER 1. ADVANTAGE WAIVER SERVICES

317:35-17-5. ADvantage program medical eligibility determination

The ~~OKDHS~~Oklahoma Department of Human Services(DHS) area nurse, or nurse designee, makes the medical eligibility determination utilizing professional judgment, the Uniform Comprehensive Assessment Tool (UCAT)Parts I~~, Part~~ and III, and other ~~available~~ medical information.

(1) When ADvantage care services are requested or the UCAT I is received in the county office, the:

(A) ~~the OKDHS~~DHS nurse is responsible for completing the UCAT III~~.~~;and

(B) ~~the~~ social ~~worker~~service specialist is responsible for contacting the ~~individual~~applicant within three ~~working~~business days to initiate the financial eligibility application process.

(2) Categorical relationship must be established for determination of eligibility for ADvantage services. If a categorical relationship to disability ~~has~~was not ~~already been~~ established, the local social ~~worker~~service specialist submits the same information ~~described in OAC~~per Oklahoma Administrative Code (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 the categorical relationship to the ~~disabled~~person with the disability using the ~~same definition used by SSA~~Social Security Administration (SSA) definition. A follow-up is required by the ~~OKDHS~~DHS social ~~worker~~service specialist with ~~the Social Security Administration~~SSA to ~~be sure their~~ensure the disability decision agrees with the LOCEU decision ~~of LOCEU~~.

(3) Community agencies complete the UCAT~~, Part~~ I, and ~~forwards~~forward the form to the county office. ~~If~~When 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. Members may also call the care line at 800-435-4711.

(4) The ~~OKDHS~~DHS nurse ~~completes the UCAT, Part III assessment visit~~visits with the member within 10 ~~working~~business days of receipt of the referral for ADvantage services for ~~a client~~an applicant who is Medicaid eligible at the time of the request. The ~~OKDHS~~DHS nurse completes the UCAT~~, Part~~ III assessment within 20 ~~working~~business days of the date the Medicaid application is completed for new applicants.

(5) During the assessment visit, the ~~OKDHS~~DHS nurse informs the applicant of medical eligibility and provides information about

the different long-term care service options. ~~If~~When there are multiple household members applying for the ADvantage program, the UCAT assessment is done for ~~the applicant household members~~them during the same visit. The ~~OKDHS~~DHS nurse documents whether the member chooses ~~NF~~nursing facility program services or ADvantage program services~~. In addition, the OKDHS nurse~~and makes a level of care and service program recommendation.

(6) The ~~OKDHS~~DHS nurse informs the 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~~applicant's primary and secondary informed choices~~.~~,ensuring adherence to conflict free case management requirements

(A) ~~If the member and/or family declines to make a provider choice, the OKDHS nurse documents that decision on the member choice form.~~Providers of ADvantage services for the member, or for those who have an interest in, or are employed by an ADvantage provider for the member must not provide case management or develop the person-centered service plan, except when the ADvantage Administration (AA) demonstrates the only willing and qualified entity to provide case management and/or develop person-centered service plans in a geographic area, also provides other ADvantage services.

(B) ~~The AA uses a rotating system to select an agency for the member from a list of all local certified case management and in-home care agencies.~~If the member and/or family declines to make a provider choice, the DHS nurse documents the decision on Form 02CB001, Member Consents and Rights.

(C) The AA uses a rotating system to select an agency for the member from a list of all local, certified case management and in-home care agencies, ensuring adherence to conflict free case management requirements.

(7) The ~~OKDHS~~DHS nurse documents the names of the chosen agencies and the agreement ~~(by dated signature)~~ of the member, by dated signature, to receive services provided by the agencies.

(8) ~~If~~When the ~~needs of the member~~member's needs require an immediate interdisciplinary team (IDT) meeting with home health agency nurse participation to develop a care plan and service plan, the ~~OKDHS~~DHS nurse documents the need for priority processing.

(9) The ~~OKDHS~~DHS nurse scores the UCAT, Part III. The ~~OKDHS~~DHS nurse forwards the UCAT, Parts I and III, documentation of financial eligibility, ~~and~~ documentation of the 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 ~~OKDHS~~DHS nurse determines ~~that~~ the member may be at risk for health and safety, ~~OKDHS~~DHS Adult Protective Services ~~(APS)~~ staff ~~are~~is notified immediately and the referral is documented on the UCAT.

(11) Within ~~ten working~~10 business days of receipt of a complete ADvantage application, the area nurse~~,~~ or nurse designee, determines medical eligibility using ~~NF~~nursing facility level of care criteria and service eligibility criteria ~~[refer to~~per OAC 317:35-17-2 and ~~OAC~~ 317:35-17-3~~]~~ and enters the medical decision on the system.

(12) Upon notification of financial eligibility from the social ~~worker~~service specialist, medical eligibility ~~(MS-52~~), and approval for ADvantage entry from the area nurse~~,~~ or nurse designee, the AA communicates with the case management provider to begin care ~~plan~~ and service plan development. The AA communicates to the ~~client's~~ case management provider, the member's name, address, case number, ~~and social security~~Social Security number, the number of units of case management and, ~~if~~when applicable, the number of units of home health agency nurse evaluation authorized for ~~care plan and~~ service plan development. ~~If~~When 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~~email.

(13) ~~If~~When the services must be in place to ensure the health and safety of the member upon discharge to the home from the ~~NF~~nursing facility or ~~Hospital~~hospital, a ~~nurse~~ case manager from an ADvantage case management provider selected by the ~~client~~member and referred by the AA follows the ADvantage ~~Institution Transition~~institution transition, case management procedures for care ~~plan~~ and service plan development and implementation.

(14) A new medical level of care determination is required when a member requests any ~~of the following~~ changes in service program, from:

(A) ~~from~~ State Plan Personal Care to ADvantage services~~.~~;

(B) ~~from~~ ADvantage to State Plan Personal Care services~~.~~;

(C) ~~from Nursing Facility~~nursing facility to ADvantage services~~.~~; or

(D) ~~from~~ ADvantage to ~~Nursing Facility~~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 ~~(~~of 90 calendar-days or less~~)~~ in a ~~Nursing Facility~~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~~was completed more than 90 calendar-days prior to submission to the area nurse or nurse designee for a medical decision, a new assessment is required.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY

CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE

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~~management.**

(A) Case ~~Management~~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~~Waiver program eligibility. Case managers develop the member's comprehensive service plan ~~of care~~, listing only services ~~which are~~ necessary to prevent institutionalization of the member, as determined through the 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 service plan ~~of care~~ reviews. Case managers submit an individualized Form 02CB014, Services Backup Plan, on all initial service plans, annually at reassessment, and on updates as appropriate throughout the year, reflecting risk factors and measures in place to minimize risks. ~~If~~When 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~~prepares services to start on the date the member is discharged from the institution. Case ~~Managers~~managers must meet ADvantage Program minimum requirements for qualification and training prior to providing services to ADvantage members. Providers of ADvantage services for the member, or for those who have an interest in, or are employed by an ADvantage provider for the member must not provide case management or develop the person-centered service plan, except when the AA demonstrates the only willing and qualified entity to

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

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

(i) ~~A billable case management activity is~~ any task or function ~~defined under~~per Oklahoma Administrative Code ~~OAC~~(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; and

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

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

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

prior authorized and billed using the ~~Standard~~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~~Services are provided on a short-term basis ~~because of~~due to the primary caregiver's 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~~is only ~~be~~ utilized when other sources of care and support ~~have been~~are exhausted. Respite care ~~will~~is only ~~be~~ listed on the service 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 service plan ~~of care~~.

(B) ~~In-Home Respite~~In-home respite services are billed per 15-minute ~~unit~~units of 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~~Facility-based extended respite is filed for a per diem rate ~~if~~when provided in ~~Nursing Facility~~a nursing facility. Extended ~~Respite~~respite must be at least eight hours in duration.

(D) ~~In-Home Extended Respite~~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~~ day health care.**

(A) Adult ~~Day Health Care~~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 member's optimal functioning ~~of the member~~. Physical, occupational, and~~/or~~ speech therapies ~~may~~are only ~~be~~ provided as an enhancement to the basic ~~Adult Day Health Care~~adult day health care service when authorized by the service plan ~~of care~~ and are billed as a separate procedure. Meals provided as part of this service do not constitute a full nutritional regimen. Personal ~~Care~~care service enhancement in ~~Adult Day Health Care~~adult day

health care is assistance in bathing, ~~and/or~~ hair ~~washing~~care, or laundry service, authorized by the service plan ~~of care~~ and billed as ~~a~~ separate ~~procedure~~procedures. Most assistance with activities of daily living (ADL), such as eating, mobility, toileting, and nail care~~,~~ are ~~services that are~~ integral services to ~~the Adult Day Health Care~~adult day health care service and are covered by the ~~Adult Day Health Care~~adult day health care basic reimbursement rate. Assistance with bathing, hair care, or laundry service is not a usual and customary adult day health care service. Enhanced personal care in adult day health care for assistance with bathing, hair care, or laundry ~~will be~~service is authorized when an ADvantage ~~waiver~~Waiver member who uses adult day health care requires assistance with bathing, hair care, or laundry service to maintain his or her health and safety.

(B) Adult ~~Day Health Care~~day health care is a 15-minute unit of service. No more than ~~8~~eight hours, ~~(32 units)~~32 units, are authorized per day. The number of units of service a member may receive is limited to the number of units approved on the member's approved service plan ~~of care~~.

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

(D) Adult ~~Day Health Personal Care Enhancement~~day health personal care enhancement is a maximum of one unit per day ~~unit~~ of bathing, hair care, or laundry service.

(4) **Environmental ~~Modifications~~modifications.**

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

(B) All services require prior authorization.

(5) **Specialized ~~Medical Equipment~~medical equipment and ~~Supplies~~supplies.**

(A) Specialized ~~Medical Equipment~~medical equipment and ~~Supplies~~supplies are devices, controls, or appliances specified in the service plan ~~of care, which~~that enable members to increase their abilities to perform ~~activities of daily living~~ADLs, or to perceive, control, or communicate with the environment in which they live. ~~Also~~

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

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

(6) **Advanced~~Supportive/RestorativeAssistance~~supportive/restorative assistance**.

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

(B) Advanced~~Supportive/Restorative Assistance~~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 service plan ~~of care~~.

(7) **Nursing.**

(A) Nursing services are services listed in the service plan ~~of care which~~that are within the scope of the Oklahoma Nursing Practice Act. ~~and~~These services are provided by a registered ~~professional~~ nurse(RN), ~~or~~a licensed practical nurse (LPN), or a licensed vocational nurse (LVN) under the supervision of ~~a registered nurse,~~an RN licensed to practice in the ~~State~~state. Nursing services may be provided on an intermittent or part-time basis or may be comprised of continuous care. The

provision of the nursing service ~~will work~~works to prevent or postpone the institutionalization of the member.

(B) Nursing services are services of a maintenance or ~~preventive~~preventative 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~~the Medicare Home Health Program. This service primarily provides nurse supervision to the ~~Personal Care Assistant~~personal care assistant or to the ~~Advanced Supportive/Restorative Assistance Aide~~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 service plan ~~of care~~. A nursing assessment/evaluation, on-site visit is made to each member for whom ~~Advanced Supportive/Restorative Assistance~~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~~is made to the ADvantage Program case manager in accordance with review schedule determined ~~in consultation~~ between the ~~Case Manager~~case manager and ~~the Nurse~~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 ~~Nursing~~nursing services as part of the interdisciplinary team planning for the member's service plan and/or assessment/evaluation of the:

(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~~ per rules and regulations for the 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 ~~Nursing~~nursing services ~~for the following~~ to:

(I) ~~preparing~~prepare a one-week supply of insulin syringes for a ~~blind diabetic~~person who is blind and has diabetes, who can safely self-inject the medication but cannot fill ~~his/her~~his or her own

syringe. This service ~~would include~~includes monitoring the member's continued ability to self-administer the insulin;

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

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

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

(V) ~~providing~~provide 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~~Skills training, ~~(including return skills demonstration to establish competency)~~ 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 are also provided.

(C) Nursing service ~~can be billed for~~includes interdisciplinary team planning and recommendations for the member's 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 interdisciplinary team planning and recommendations for the member's service plan and for performing assessment/evaluations, ~~assessment/evaluation/service plan development nursing services and other~~another procedure ~~codesare~~code is used to bill for all other authorized nursing services. A maximum of eight units per day of nursing for ~~assessment /evaluation and/or~~ service plan development and assessment evaluation are allowed. An agreement by a provider to perform a nurse evaluation is also an agreement~~,~~ to provide ~~the 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~~when the provider that produced the nurse

evaluation fails to provide the nurse assessment identified in the Medicaid in-home care services for which the provider is certified and contracted.

(8) **Skilled ~~Nursing Services~~nursing services.**

(A) Skilled ~~Nursing Services~~nursing services listed in the service plan ~~of carewhich~~that are within the scope of the ~~State's~~state's Nurse Practice Act and are ordered by a licensed ~~medical~~ physician, osteopathic physician, physician assistant, or an advanced practice nurse and are provided by ~~a registered professional nurse, or licensed practical or vocational nurse~~an RN, or an LPN or LVN under the supervision of a registered nurse, licensed to practice in the ~~State~~state. Skilled ~~Nursing~~nursing services provided in the member's home or other community setting are services requiring the specialized skills of a licensed nurse. The scope and nature of these services are intended for treatment of a disease or a medical condition and are beyond the scope of ADvantage ~~Nursing Services~~nursing services. These intermittent nursing services are targeted toward a prescribed treatment or procedure that must be performed at a specific time or other predictable rate of occurrence. ~~It is the responsibility of the RN to contact~~The RN contacts the member's physician to obtain ~~any~~ necessary information or orders pertaining to the member's care ~~of the member~~. ~~If~~When the member has an ongoing need for service activities~~, which require~~requiring more or less units than authorized, the RN ~~shall~~must recommend, in writing, that the ~~Plan of Care~~service plan be revised.

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

(9) **Home ~~Delivered Meals~~ delivered meals.**

(A) Home ~~Delivered Meals~~ 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~~ dietary reference intakes 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~~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~~in accordance with the member's service plan ~~of care~~. The provider must obtain a signature from the member or the member's representative at the time the ~~meals are~~meal is delivered. In the event ~~that~~ the member is temporarily unavailable~~ (i.e., doctor's appointment, etc.)~~, such as at a doctor's appointment and the meal is left at the member's home, the provider must document the reason a signature ~~is~~was not obtained. The signature logs must be available for review.

(10) **Occupational ~~Therapy Services~~therapy services.**

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

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

(11) **Physical ~~Therapy Services~~therapy services.**

(A) Physical ~~Therapy~~therapy services are those services that ~~prevent~~maintain or improve physical disability through the evaluation and rehabilitation of members

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

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

(12) **Speech and ~~Language Therapy Services~~language therapy services.**

(A) Speech~~/Language Therapy~~and language therapy services are those that ~~prevent~~maintain or improve 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 the 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~~speech and 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~~limitations of ~~their~~his or her practice, working under the supervision of the licensed ~~Speech/Language Pathologist~~speech and language pathologist. The regimen includes education and training for informal caregivers to assist with and/or maintain services~~, where~~when appropriate. The ~~Pathologist will~~

~~ensure~~speech and language pathologist ensures monitoring and documentation of the member's rehabilitative progress and ~~will report~~reports to the member's case manager and physician to coordinate the necessary addition and/or deletion of services, based on the member's condition and ongoing rehabilitation potential.

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

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

(A) Hospice ~~is~~services are palliative and~~/or~~ comfort care provided to the member and ~~his/her~~his or her family when a physician certifies ~~that~~ the member has a terminal illness ~~and has six months or less to live~~, with a life expectancy of six months or less, and orders hospice care. ADvantage ~~Hospice Care~~hospice care is authorized for a ~~six month~~six-month period, and requires ~~a~~ physician certification of a terminal illness and orders of hospice care. ~~If~~When 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~~30-calendar 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~~hospice may be authorized for a maximum of ~~60~~60-calendar 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~~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~~, through the end of life, and bereavement. The member signs a statement choosing hospice care instead of routine medical care ~~that has~~with the objective to treat and cure the member's illness. Once the member has elected hospice care, the hospice medical team assumes responsibility for the member's medical care for the ~~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~~therapies, medical social services, dietary counseling, and grief and

bereavement counseling to the member and/or the member's 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. A member that is eligible for Medicare Hospice provided as a Medicare Part A benefit, is not eligible to receive ADvantage Hospice services.~~

(C) 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 member to maintain ADL and basic functional skills. A member who is eligible for Medicare hospice provided as a Medicare Part A benefit, is not eligible to receive ADvantage hospice services.

~~(C)~~(D) Hospice services are billed per diem of service for days covered by a ~~Hospice~~hospice plan of care and ~~during which~~while the hospice provider is responsible for providing hospice services as needed by the member or member's family. The maximum total annual reimbursement for a member's ~~Hospice~~hospice care within a ~~twelve~~12-month period is limited to an amount equivalent to 85~~%~~percent of the Medicare ~~Hospice Cap~~hospice cap payment, and must be authorized on the member's service plan.

(14) **ADvantage ~~Personal Care~~personal care.**

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

(B) ADvantage ~~Home Care Agency Skilled Nursing~~home care agency skilled nursing staff working in coordination with an ADvantage ~~Case Manager~~case manager are responsible for the development and monitoring of the member's ~~Personal Care plan~~personal care services.

(C) ADvantage ~~Personal Care~~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 service plan ~~of care~~.

(15) **Personal ~~Emergency Response System~~emergency response system.**

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

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

(ii) member lives alone and ~~has no~~without a regular caregiver, paid or unpaid, and therefore is left alone for long periods of time;

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

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

(v) member 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 PERS purchase ~~of PERS~~. All services are ~~prior authorized~~prior authorized in accordance with the ADvantage approved service plan ~~of care~~.

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

(A) ~~Consumer-Directed Personal Assistance Services and Supports~~CD-PASS are ~~Personal Services Assistance~~personal services assistance (PSA) and ~~Advanced Personal Services Assistance~~advanced personal services assistance (APSA)

that enable ~~an individual~~a member 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~~self-care, and mobility. CD-PASS services are delivered as authorized on the service plan. The member becomes the employer of record and employs the ~~Personal Services Assistant (PSA)~~PSA and~~/or~~ the ~~Advanced Personal Services Assistant (APSA)~~APSA. ~~and~~The member is responsible, with assistance from ADvantage Program Administrative Financial Management Services (FMS), for ensuring ~~that~~ the employment complies with ~~State~~ state and ~~Federal Labor Law~~federal labor law requirements. The member/employer 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~~the employer functions. The member/employer:

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

(ii) ~~provides~~is solely responsible to provide instruction and training to the PSA or APSA on tasks ~~to be done~~ and works with the ~~Consumer Directed Agent/Case Manager~~consumer directed agent/case manager (CDA) to obtain ADvantage skilled nursing services assistance with training, when necessary. Prior to performing an ~~Advanced Personal Services Assistance~~APSA task for the first time, the APSA must demonstrate competency in the tasks in an on-the-job training session conducted by the member and the member must document the attendant's competency in performing each task in the ~~ASPA's~~APSA's personnel file;

(iii) determines where and how the PSA or APSA works, hours of work, what is to be accomplished and, within ~~Individual Budget Allocation~~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~~services the PSA may provide include:

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

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

(I) bathing and personal hygiene;

(II) dressing and grooming; and

(III) eating, including meal preparation and cleanup;

(iii) assistance with ~~homemaker type~~home services that may include shopping, laundry service, 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~~, and 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~~An APSA provides assistance with ADLs to 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~~member were physically capable, and the procedure may be safely performed in the home. ~~Advanced Personal Services Assistance is a~~Services provided by the APSA are maintenance ~~service~~services and ~~should~~are never ~~be~~ used as ~~a~~ therapeutic treatment. Members who develop medical complications requiring skilled nursing services while receiving ~~Advanced Personal Services Assistance should be~~APSA services are referred to ~~their~~his or her attending physician, who ~~may, if~~when appropriate, order home health services. ~~The service of Advanced Personal Services Assistance~~APSA 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~~including tracheotomies, gastrostomies, and colostomies with well-healed stoma, external, indwelling, and suprapubic catheters ~~which includes~~that include changing bags and soap and water hygiene around the ostomy or catheter site;

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

(iii) ~~administer~~administering prescribed bowel program, including use of suppositories and sphincter stimulation, and enemas ~~(Pre-packaged only) with~~

members(pre-packaged only without contraindicating rectal or intestinal conditions;
(iv) applyapplying medicated (prescription) lotions or ointments, and dry, non-sterile dressings to unbroken skin;
(v) useusing a lift for transfers;
(vi) manually assistassisting with oral medications;
(vii) provideproviding passive range of motion (non-resistive flexion of joint) therapy, delivered in accordance with the service plan of care, unless contraindicated by underlying joint pathology;
(viii) applyapplying non-sterile dressings to superficial skin breaks or abrasions; and
(ix) use Universalusing universal precautions as defined by the CenterCenters for Disease Control and Prevention.

(D) The service FinancialManagement ServicesFMS are program administrative services provided to participating CD-PASS employer/membersmembers/employers by the OKDHS/ASDDHS AS. Financial Management ServicesFMS are employer relatedemployer-related assistance that provides Internal Revenue Service (IRS) fiscal reporting agent and other financial management tasks and functions including, but not limited to:
(i) processing employer payroll, after the member/employer has verified and approved the employee timesheet, at a minimum of semi monthlysemi-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/employer and in accordance with the member/employer'sIndividual Budget Allocationindividual budget allocation;
(iii) responsibility for obtaining criminal and abuse registry background checks, on behalf of the member, on prospective hires for PSAs or APSAs on the member/employer's behalf;
(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 providing orientation and training regarding employer

responsibilities, as well employer information and management guidelines, materials, tools and staff consultant expertise to support and assist the member in successfully performing employer-related functions; and

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

(E) The ~~service of Personal Services Assistance~~PSA service 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~~service plan.

(F) The ~~service of Advanced Personal Services Assistance~~APSA service 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~~service plan.

(17) **~~Institution Transition Services~~ Institutional transition services.**

(A) ~~Institution Transition Services~~Institutional transition services are those services ~~that are~~ necessary to enable ~~an individual~~a member to leave the institution and receive necessary support through ADvantage ~~waiver~~Waiver services in ~~their~~his or her home and~~/or in the~~ community.

(B) ~~Institution Transition Case Management Services~~Transitional case management services are services ~~as described in~~per OAC 317:30-5-763(1) required by the ~~individual's plan of care, which~~ member and included on the member's service plan that are necessary to ensure the health, welfare, and safety of the ~~individual~~member, or to enable the ~~individual~~member to function with greater independence in the home, and without which, the ~~individual~~member would continue to require institutionalization. ADvantage ~~Transition Case Management Services~~transitional case management services assist institutionalized ~~individuals that~~members who are eligible to receive ADvantage services in gaining access to needed ~~waiver~~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. ~~TransitionCase Management Services~~Transitional case management services may be authorized for periodic monitoring of an ADvantage member's progress during an institutional stay~~,~~ and for assisting the member transition from institution to home by updating the

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

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

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

(C) Institutional ~~Transition Services~~transition services may be authorized and reimbursed ~~under the following~~per the conditions~~:~~in (i) through (iv).

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

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

(iii) Institutional ~~Transition Services~~transition services are provided to the ~~individual~~member within 180 calendar-days of discharge from the institution~~;~~.

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

(D) ~~If~~When the member ~~has received Institution Transition Services~~receives institutional transition services but fails to enter the ~~waiver~~Waiver, any ~~Institution Transition Services~~institutional transition services provided are not reimbursable.

(18) **Assisted ~~Living Services~~living services.**

(A) Assisted ~~Living Services~~living services (ALS) are personal care and supportive services ~~that are~~ furnished to ~~waiver~~Waiver members who reside in a homelike, non-institutional setting that includes 24-hour, on-site response capability to meet scheduled or unpredictable

~~resident~~member needs and to provide supervision, safety, and security. Services also include social and recreational programming and medication assistance, ~~(to the extent permitted under State law)~~to the extent permitted under State law. The ~~assisted living services~~ALS 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~~ALS. ADvantage reimbursement for ~~Assisted Living Services~~ALS includes services of personal care, housekeeping, laundry service, meal preparation, periodic nursing evaluations, nursing supervision during nursing intervention, intermittent or unscheduled nursing care, medication administration, assistance with cognitive orientation, assistance with transfer and ambulation, planned programs for socialization, activities, and exercise, and for arranging or coordinating transportation to and from medical appointments. Services, except for planned programs for socialization, activities, and exercise~~,~~ are to meet the member's specific needs ~~of the participant~~ as determined through the individualized assessment and documented on the ~~participant's~~member's service plan.

(B) The ADvantage ~~Assisted Living Services~~ALS philosophy of service delivery promotes ~~service~~ member choice, and to the greatest extent possible, ~~service~~ member control. ~~Members have~~A member has control over ~~their~~his or her living space and his or her choice of personal amenities, ~~furnishing~~furnishings, and activities in ~~their~~the residence. The ADvantage member must have the freedom to control his or her schedule and activities. The ~~Assisted Living Service~~ALS 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~~emphasizing member dignity, privacy, individuality, and independence.

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

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

(I) rental unit availability;

(II) the compatibility of the ~~participant~~member 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; or

(IV) restrictions initiated by statutory limitations.

(ii) The ALC may specify the number of units the provider is making available to service ADvantage ~~participants~~members. The number of rental units available to service the ADvantage participants may be altered based upon written request from the provider and acceptance by the ADvantage Administration (AA).

(iii) Mild or moderate, cognitive impairment of the applicant is not a justifiable reason to deny ALC admission. Centers are required to specify whether they are able to accommodate ~~individuals~~members who have behavior problems or wander. Denial of admission due to a determination of incompatibility must be approved by the case manager and the ADvantage Administration (AA). Appropriateness of placement is not a unilateral determination by the ALC. The ADvantage ~~Case Manager~~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~~.~~, respect, and freedom from coercion and restraint. The ALC must optimize the member's initiative, autonomy and independence in making life choices. The ALC must facilitate member choices regarding services and supports, and who provides them. Inability to meet those needs ~~will~~ is not ~~be~~ recognized as a reason for determining ~~that~~ an ADvantage ~~participant's~~member'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~~:~~listed in (I) through (III).

(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'~~the member's needs and choices; and provide members with 24-hour access to food by giving members control in the selection of the foods they eat, by allowing the member to store personal food in his or her room, by allowing the member to prepare and eat food in his or her room, and allowing him or her to decide when to eat.

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

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

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

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

(ix) The specific ~~Assisted Living Services~~ALS 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~~that is

incorporated as supplemental detail into the ADvantage comprehensive service plan. The ADvantage ~~Case Manager~~case manager in cooperation with ~~the Assisted Living Center~~ALC 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 in (I) through (IV) 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~~interfere 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~~the ALC attempted interventions to resolve behavior problems~~;~~.

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

(IV) The member fails to pay room and board charges and/or ~~the OKDHS~~DHS 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~~ALC must inform the member and~~/or~~ the member's representative, if any, the AA and the member's ADvantage ~~Case Manager~~case manager. The ALC must develop a discharge plan in consultation with the member, the member's ~~support network~~representative, the ADvantage ~~Case Manager~~case manager, and the AA. The ALC and ~~Case Manager~~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~~transitioning out of the ALC, ~~if~~when the 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~~case manager and the AA, giving the member 30 calendar-days, written notice of the ALC's intent to terminate the residency agreement and move the member to ~~a more~~an appropriate care provider. The 30 calendar-day requirement ~~shall~~must not apply when emergency termination of the residency agreement is mandated by the member's immediate health needs or when the termination of the residency agreement is necessary for the physical safety of the member or other ALC residents ~~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 notice date ~~of the notice~~;

(III) the date notice was given to the member and the member's representative, the ADvantage Case Manager, and the AA;

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

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

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

(i) Physical environment.

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

(II) The member has a legally enforceable agreement (lease) with the ALC. The member must have the same responsibilities and protections from eviction as

all tenants under the landlord tenant law of the state, county, city, or other designated entity.

~~(II)~~(III) The ALC must provide each rental unit with a means for each member ~~resident~~ to control the temperature in the ~~individual living~~residential unit through the use of a damper, register, thermostat, or other reasonable means that is under the control of the ~~resident~~member 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)~~(IV) For ~~ALCS~~ALCs built prior to January 1, 2008, each ALC individual residential unit must have a minimum total living space, ~~(including closets and storage area)~~including closets and storage areas, 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)~~ including closets and storage areas, of 360 square feet.

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

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

~~(VI)~~(VII) The member is responsible for furnishing ~~their~~the 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~~ADvantage case manager in coordination with the ALC must assist the member in obtaining basic furnishings for the rental unit. The member must have the freedom to furnish and decorate the rental unit within the scope of the lease or residency agreement.

~~(VII)~~(VIII) 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)~~(IX) The ALC must ensure the design of common areas accommodates the special needs of ~~their~~the resident population and that the rental unit accommodates the special needs of the ~~individual~~member in compliance with ~~ADA Accessibility Guidelines~~the Americans with Disabilities Act accessibility guidelines per~~(28 CFR Part 36 Appendix A)~~28 Code of Federal Regulations, Part 36, Appendix A, at no additional cost to the member.

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

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

(XII) The ALC must provide the member with the right to have visitors of his or her choosing at any time. Overnight visitation is allowed, but may be limited by the ALC to the extent to which a visitor may stay overnight.

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

(ii) Sanitation.

(I) The ALC must maintain the facility, including its individual rental units~~,~~ that ~~is~~are 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 rental units ~~that maintains~~to maintain 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~~members from intruders with security measures appropriate to building design,

~~environment~~environmental risk factors, and the resident population.

(II) The ALC must respond immediately and appropriately to missing ~~residents~~members, 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 (OSDH).

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

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

(VI) The ALC must ensure ~~that~~ staff is 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~~members.

(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~~social or recreational outings.

(iv) Staff to resident ratios.

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

(II) The ALC must ensure ~~that~~ staffing is sufficient to meet the needs of the ADvantage Program ~~residents~~members in accordance with each ~~individual's~~member's ADvantage ~~Service Plan~~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~~has qualifications consistent with their job responsibilities.

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

(III) The ALC must provide staff orientation and ongoing training to develop and maintain ~~the~~staff 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 ~~or memory care~~ unit must receive four additional hours of dementia specific training. Annual first aid and cardiopulmonary resuscitation ~~CPR~~(CPR) certification do not count ~~towards~~toward 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~~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~~member health and nutritional status.

(vii) Resident rights.

(I) The ALC must provide to each member and each member's representative, at the time of admission, a copy of the resident statutory rights listed in ~~O.S. 63-1-1918~~Section 1-1918 of Title 63 of the Oklahoma Statutes (O.S. 63-1-1918) amended to include additional rights and the clarification of rights as listed in the ADvantage ~~assisted living~~ Member 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~~member, the ~~resident's~~member's representative, or ~~where appropriate,~~ the ~~court appointed~~legal 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~~grievance and appeal rights, including a description of the process for submitting a ~~grievance/appeal~~grievance or appeal of any decision that decreases Medicaid services to the member.

(viii) Incident reporting.

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

(II) Incidents requiring report by licensed ~~Assisted Living Centers~~ALC are those defined by ~~the Oklahoma State Department of Health (OSDH) in~~OSDH per OAC 310:663-19-1 and listed on the AA Critical Incident Reporting Form.

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

(IV) Each ALC having reasonable cause to believe that a member is suffering from abuse, neglect, exploitation, or misappropriation of member property must make a report to ~~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~~DHS Adult Protective Services (APS) as soon as the person is aware of the situation~~, in accordance with Section 10-104.A of Title 43A of Oklahoma Statutes~~per O.S. 43A § 10-104.A. Reports ~~should~~are also ~~be~~ made to ~~the~~ OSDH, as appropriate, ~~in accordance with the ALC's~~per ALC licensure rules.

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

(ix) Provision of or arrangement for necessary health services.

(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~~case manager for delivery of necessary health services. The ADvantage ~~Case Manager~~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. The member has the freedom to choose any available provider qualified by licensure or certification to provide necessary health services in the ALC.

(E) ~~Assisted Living Services~~ALS are billed per diem of service for days covered by the ADvantage member's service plan and during which the ~~Assisted Living Services~~ALS provider is responsible for providing ~~Assisted Living servicedas needed by~~ ALS for the member. The per diem rate for ~~the~~ ADvantage assisted living services for a member ~~will be~~is one of three per diem rate levels based ~~upon individual~~on a member's need for ~~service~~ type of, intensity of, and frequency of service to address member ~~ADL/IADL~~ADLs, IADLs, and health care needs. The rate level is based ~~upon (UCAT)~~on the Universal Comprehensive Assessment Tool (UCAT) assessment by the member's ADvantage ~~Case Manager~~case manager employed by a ~~Case Management~~case management agency ~~that is~~ independent of the ~~Assisted Living Services~~ALS provider. The determination of the appropriate per diem rate is made by the AA clinical review staff.

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

SUBCHAPTER 3. GENERAL PROVIDER POLICIES

PART 1. GENERAL SCOPE AND ADMINISTRATION

317:30-3-11. Timely filing limitation

(a) ~~According to federal regulations, claims must be received by the Fiscal Agent within one year from the date of service.~~ According to federal regulations, the Authority must require providers to submit all claims no later than 12 months from the date of service. Federal regulations provide no exceptions to this requirement. For dates of service provided on or after July 1, 2015, the timely filing limit, for SoonerCare reimbursement, is 6 months from the date of service. Payment will not be made on claims when more than ~~12~~6 months have elapsed between the date the service was provided and the date of receipt of the claim by the Fiscal Agent. ~~Federal regulations provide no exceptions to this requirement. Because of this requirement, caution should be exercised to assure claims are filed timely in all cases where an application for assistance has been filed. The following procedure is recommended. If the service is approaching the one year time limit and a case number has not been assigned and an approval for medical assistance has not been received, or there is a case number but the medical assistance case has not been approved, or a provider contract has not been approved, file a claim. The claim will be denied, however, the denial is proof of timely filing.~~ A denied claim can be considered proof of timely filing.

(b) Claims may be submitted anytime during the month.

(c) To be eligible for payment under ~~Medicaid~~SoonerCare, claims for coinsurance and/or deductible must meet the Medicare timely filing requirements. If a claim for payment under Medicare has been filed in a timely manner, the Fiscal Agent must receive a ~~Medicaid~~SoonerCare claim relating to the same services within 90 days after the agency or the provider receives notice of the disposition of the Medicare claim.

317:30-3-11.1. Resolution of claim payment

(a) After the submission of a claim from a provider which had been adjudicated by the Authority, a provider may resubmit the claim under the following rules.

(b) The provider must have submitted the claim initially under the timely filing requirements found at OAC 317:30-3-11.

(c) ~~The provider's resubmission of the claim must be received by the Oklahoma Health Care Authority no later than 24 months from the date of service.~~ For dates of service provided on or after July 1, 2015, the provider's resubmission of the claim must be received by the Oklahoma Health Care Authority no later than 12 months from the date of service. The only exceptions to the ~~24~~12 month resubmission claim deadline are the following:

(1) administrative agency corrective action or agency actions taken to resolve a dispute, or
(2) reversal of the eligibility determination, or
(3) investigation for fraud or abuse of the provider, or
(4) court order or hearing decision.

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 3. HOSPITALS

317:30-5-44. Medicare eligible individuals

Payment is made to hospitals for services to Medicare eligible individuals as set forth in this section.

(1) Claims filed with Medicare automatically cross over to OHCA. The explanation of Medicare Benefits (EOMB) reflects a message that the claim was referred to SoonerCare. If such a message is not present, a claim for coinsurance and deductible must be filed with the OHCA within 90 days of the date of Medicare payment ~~or~~and within one year of the date of service in order to be considered timely filed.

(2) If payment is denied by Medicare and the service is a SoonerCare covered service, mark the claim "denied by Medicare" and attach the Medicare EOMB showing the reason for denial.

(3) In certain circumstances, some claims do not automatically "cross over". Providers must file a claim for coinsurance and/or deductible to SoonerCare within 90 days of the Medicare payment ~~or~~and within one year from the date of service.

(4) For individuals who have exhausted Medicare Part A benefits, claims must be accompanied by a statement from the Medicare Part A intermediary showing the date benefits were exhausted.

PART 83. RESIDENTIAL BEHAVIOR MANAGEMENT SERVICES IN FOSTER CARE SETTINGS

317:30-5-744. Billing

~~(a) Claims must not be submitted prior to OHCA's determination of the member's eligibility, and must not be submitted later than 1 year after the date of service. If the eligibility of the individual has not been determined after ten months from the date of service, a claim should be submitted in order to assure that the claim is timely filed and reimbursement from SoonerCare funds can be made should the individual be determined eligible at a later date.~~

(a) Claims must be submitted in accordance with guidelines found at OAC 317:30-3-11 and 317:30-3-11.1.

(b) Claims for dually eligible individuals (Medicare/Medicaid) should be filed directly with the OHCA.

PART 87. BIRTHING CENTERS

317:30-5-893. Billing

Billing for birthing center services will be on HCFA-1500. ~~Under Medicaid, the claim must be received by OHCA within 12 months of the date of service in order to be eligible for payment. If the eligibility of the individual has not been determined after ten months from the date of services, a claim should be submitted in order to assure that the claim is timely filed and reimbursement from Title XIX funds can be made should the individual be determined eligible at a later date.~~ Claims must be submitted in accordance with guidelines found at OAC 317:30-3-11 and 317:30-3-11.1.

PART 97. CASE MANAGEMENT SERVICES FOR UNDER AGE 18 AT RISK OF OR IN THE TEMPORARY CUSTODY OR SUPERVISION OF OFFICE OF JUVENILE AFFAIRS

317:30-5-973. Billing

Billing for case management services is on Form HCFA-1500. ~~Claims should not be submitted until Medicaid eligibility of the individual has been determined. However, a claim must be received by OHCA within 12 months of the date of service. If the eligibility of the individual has not been determined after ten months from the date of service, a claim should be submitted in order to assure that the claim is timely filed and reimbursement from Title XIX funds can be made should the individual be determined eligible at a later date.~~ Claims must be submitted in accordance with guidelines found at OAC 317:30-3-11 and 317:30-3-11.1.

PART 99. CASE MANAGEMENT SERVICES FOR UNDER AGE 18 IN EMERGENCY, TEMPORARY OR PERMANENT CUSTODY OR SUPERVISION OF THE DEPARTMENT OF HUMAN SERVICES

317:30-5-993. Billing

Billing for case management services is on Form HCFA-1500. ~~Claims should not be submitted until Medicaid eligibility of the individual has been determined. However, a claim must be received by OHCA within 12 months of the date of service. If the eligibility of the individual has not been determined after ten months from the date of service, a claim must be submitted in order to assure that the claim is timely filed and reimbursement from Title XIX funds can be made should the individual be determined eligible at a later date.~~ Claims must be submitted in accordance with guidelines found at OAC 317:30-3-11 and 317:30-3-11.1.

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

317:30-5-1045. Billing

(a) Billing is on the HCFA-1500.

~~(b) Claims should not be submitted until the Medicaid eligibility of the individual has been determined. However, a claim must be received by the fiscal agent within 12 months of the date of~~

~~service. If the eligibility of the individual has not been determined after ten months from the date of service, a claim is submitted in order to assure that the claim is timely filed and reimbursement from Title XIX funds can be made should the individual be determined eligible at a later date.~~
(b) Claims must be submitted in accordance with guidelines found at OAC 317:30-3-11 and 317:30-3-11.1.

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. 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 (increased by the annual percentage increase in the urban component of the consumer price index beginning in 2011, rounded to the nearest $1,000).

(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 (increased by the annual percentage increase in the urban component of the consumer price index beginning in 2011, rounded to the nearest $1,000) 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.

(E) An individual may reduce their total equity interest in the home through the use of a reverse mortgage or home equity loan.

(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 an 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~~minor child under 21, or child who is blind or permanently disabled 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~~, minor child, or child who is blind or permanently disabled 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)~~(G) 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~~, and the value of such note, loan, or mortgage shall be 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.; or~~

~~(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.~~

(1) The purchase of an annuity shall be treated as the disposal of an asset for less than fair market value unless the Oklahoma Health Care Authority is named as the remainder beneficiary -

(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 is named in the first position if the spouse or a representative of the child disposes of any such remainder for less than fair market value.

(2) For purposes of determining financial eligibility for long-term care services under this chapter, the term "assets" shall include an annuity purchased by or on behalf of an annuitant who has applied for SoonerCare nursing facility services or other long-term care services unless the annuity meets one of the following conditions.

(A) The annuity is an annuity described in subsection (b) or (q) of Section 408 of the United States Internal Revenue Code of 1986; or

(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 Service Code of 1986;

(iii) A Roth IRA described in Section 408A of the United States Internal Revenue Service Code of 1986; or

(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.

(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~~Long-Term Care Partnership Program policy.

(1) Benefits from the LTCP policy must be exhausted before the individual can be eligible for ~~long term~~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.

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 3. HOSPITALS

317:30-5-41. Inpatient hospital coverage/limitations

(a) Covered hospital inpatient services are those medically necessary services which require an inpatient stay ordinarily furnished by a hospital for the care and treatment of inpatients and which are provided under the direction of a physician or dentist in an institution approved under OAC:317:30:5-40.1(a) or (b). ~~Effective October 1, 2005, claims for inpatient admissions provided on or after October 1st in acute care or critical access hospitals are reimbursed utilizing a Diagnosis Related Groups (DRG) methodology.~~Claims for inpatient admissions in acute care or critical access hospitals are reimbursed the lesser of the billed charges or the Diagnosis Related Groups (DRG) amount.

(b) **Inpatient status.** OHCA considers a member an inpatient when the member is admitted to the hospital and is counted in the midnight census. In situations when a member inpatient admission occurs and the member dies, is discharged following an obstetrical stay, or is transferred to another facility on the day of admission, the member is also considered an inpatient of the hospital.

(1) **Same day admission.** If a member is admitted and dies before the midnight census on the same day of admission, the member is considered an inpatient.

(2) **Same day admission/discharge ~~C~~- obstetrical and newborn stays.** A hospital stay is considered inpatient stay when a member is admitted and delivers a baby, even when the mother and baby are discharged on the date of admission (i.e., they are not included in the midnight census). This rule applies when the mother and/or newborn are transferred to another hospital.

(3) **Same day admission/discharges other than obstetrical and newborn stays.** In the event a member is admitted as an inpatient, but is determined to not qualify for an inpatient payment based on OHCA criteria, the hospital may bill on an outpatient claim for the ancillary services provided during that time.

(4) **Discharges and Transfers**. A hospital inpatient is considered discharged from a hospital paid under the DRG-based payment system when:

~~(A) **Discharges.** A hospital inpatient is considered discharged from a hospital paid under the DRG-based payment system when:~~

~~(i)~~(A) The patient is formally released from the hospital; or

~~(ii)~~(B) The patient dies in the hospital; or

~~(iii)~~(C) The patient is transferred to a hospital that is excluded from the DRG-based payment system, or transferred to a distinct part psychiatric or rehabilitation unit of the same hospital. Such instances will result in two or more claims. Effective January 1, 2007, distinct part psychiatric and rehabilitation units excluded from the Medicare Prospective Payment System (PPS) of general medical surgical hospitals will require a separate provider identification number.

317:30-5-47. Reimbursement for inpatient hospital services

Reimbursement will be made for inpatient hospital services ~~rendered on or after October 1, 2005,~~ in the following manner:

(1) Covered inpatient services provided to eligible SoonerCare members admitted to in-state acute care and critical access hospitals will be reimbursed ~~at a prospectively set rate which compensates hospitals an amount per discharge for discharges classified according to the Diagnosis Related Group (DRG) methodology. For each SoonerCare member's stay, a peer group base rate is multiplied by the relative weighting factor for the DRG which applies to the hospital stay.~~ the lesser of the billed charges or the Diagnosis Related Group (DRG) amount. In addition to the billed charges or DRG payment, whichever is less, an outlier payment may be made to the hospital for very high cost stays. Additional outlier payment is applicable if ~~the DRG payment~~ either the amount billed by the hospital or DRG payment, whichever applies, is less than a threshold amount of the hospital cost. Each inpatient hospital claim is tested to determine whether the claim qualified for a cost outlier payment. Payment is equal to a percentage of the cost after the threshold is met.

(2) ~~The DRG payment~~The lesser of the billed charges or DRG amount and outlier, if applicable, represent full reimbursement for all non-physician services provided during the inpatient stay. Payment includes but is not limited to:

(A) laboratory services;

(B) prosthetic devices, including pacemakers, lenses, artificial joints, cochlear implants, implantable pumps;

(C) technical component on radiology services;

(D) transportation, including ambulance, to and from another facility to receive specialized diagnostic and therapeutic services;

(E) pre-admission diagnostic testing performed within 72 hours of admission; and

(F) organ transplants.

(3) Hospitals may submit a claim for payment only upon the final discharge of the patient or upon completion of a transfer of the patient to another hospital.
(4) Covered inpatient services provided to eligible members of the Oklahoma SoonerCare program, when treated in out-of-state hospitals will be reimbursed in the same manner as in-state hospitals.
(5) Cases which indicate transfer from one acute care hospital to another will be monitored under a retrospective utilization review policy to help ensure that payment is not made for inappropriate transfers.
(6) The transferring hospital will be paid the lesser of the calculated transfer fee or the DRG base payment amount for a non-transfer.
~~(6)~~(7) If the transferring or discharge hospital or unit is exempt from the DRG, that hospital or unit will be reimbursed according to the method of payment applicable to the particular facility or units.
~~(7)~~(8) Covered inpatient services provided in out-of-state specialty hospitals may be reimbursed at a negotiated rate not to exceed 100% of the cost to provide the service. Negotiation of rates will only be allowed when the OHCA determines that the specialty hospital or specialty unit provides a unique (non-experimental) service required by SoonerCare members and the provider will not accept the DRG payment rate. Prior authorization is required.
~~(8)~~(9) New providers entering the SoonerCare program will be assigned a peer group and will be reimbursed at the peer group base rate for the DRG payment methodology or the statewide median rate for per diem methods.
~~(9)~~(10) When services are delivered via telemedicine to hospital inpatients, the originating site facility fee will be paid outside the DRG payment.
~~(10)~~(11) All inpatient services are reimbursed per the ~~DRG~~ methodology described in this section and/or as approved under the Oklahoma State Medicaid Plan.

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 5. DETERMINATION OF ELIGIBILITY FOR SOONERCARE HEALTH BENEFITS FOR PREGNANT WOMEN AND FAMILIES WITH CHILDREN

317:35-6-37. Financial eligibility of categorically needy individuals related to AFDC or pregnancy-related services

Individuals whose income is less than the ~~standards on DHS Appendix C-1~~SoonerCare Income Guidelines for the applicable eligibility group are financially eligible for SoonerCare.

(1) **~~Categorically needy standards/categorically~~Categorically related to pregnancy-related services.** For an individual related to pregnancy-related services to be financially eligible, the countable income must be less than the appropriate standard according to the family size on ~~DHS Appendix C-1~~the SoonerCare Income Guidelines. In determining the household size, the pregnant woman and her unborn child(ren) are included.

(2) **~~Categorically needy standards/categorically~~Categorically related to children's and parent/caretakers' groups.**

(A) **~~Categorical relationship.~~Parent/caretakers' group.** For the individual ~~related to AFDC~~in the parent/caretakers' group to be considered categorically needy, the ~~standards on DHS Appendix C-1 schedules~~SoonerCare Income Guidelines must be used.

(i) **~~DHS Appendix C-1, Schedule X.~~SoonerCare Income Guidelines.** Individuals age 19 years or older, other than pregnant women, are determined categorically needy if countable income is less than the Categorically Needy Standard, according to the family size.

(ii) **~~DHS Appendix C-1, Schedule I.A.~~SoonerCare Income Guidelines.** All individuals under 19 years of age are determined categorically needy if countable income is equal to or less than the Categorically Needy Standard, according to the size of the family.

(B) **Families with children.** Individuals who meet financial eligibility criteria for the children's and parent/caretakers' groups are:

(i) All persons included in an active TANF case.

(ii) Individuals related to the children's or parent/caretakers' groups whose countable income is within the current appropriate income standard, but who do not receive TANF assistance.

(iii) All persons in a TANF case in Work Supplementation status who meet TANF eligibility conditions other than earned income.
(iv) Those individuals who continue to be eligible for Medicaid in a TANF case after they become ineligible for a TANF payment. These individuals will continue to be considered categorically needy if the TANF case was closed due to child or spousal support, the loss or reduction of earned income exemption by any member of the assistance unit, or the new or increased earnings of the caretaker relative.

317:35-6-39. General calculation of countable income for MAGI eligibility groups

(a) The income that is counted in determining eligibility for an individual is that individual's household income.
(b) In order to calculate the countable household income for an individual:

(1) Determine who is in the individual's household (see OAC 317:35-6-40 to 317:35-6-43);
(2) Identify all sources of income for all household members;
(3) Determine whether each source of income is considered for SoonerCare eligibility or is excluded (see Part 6, Countable Income, of this Subchapter);
(4) Determine the gross monthly amount of each source of countable income (see Part 6, Countable Income, of this subchapter);
(5) Determine whether each household member's income counts toward the household (see 317:35-6-44);
(6) Sum the gross monthly amounts of all countable sources of income of all household members whose income is counted;
(7) Subtract allowable adjustments to income (see OAC 317:35-6-52); and
(8) Compare the result to the income limit for the individual's eligibility group ~~(see the appropriate Schedule of OKDHS Appendix C-1)~~(see SoonerCare Income Guidelines). If the result is equal to or less than the dollar amount of the income limit, the individual is financially eligible.
(9) When calculating the percentage of the Federal Poverty Level (FPL) that corresponds to the individual's monthly countable income, subtract 5% from the FPL percentage reached to determine the countable FPL level for the individual. This countable percentage of FPL is compared to the FPL limit for the individual's eligibility group in order to determine whether the individual is financially eligible. This 5% deduction from FPL has already been accounted for in the dollar amounts of the income limits given in ~~OKDHS Appendix C-1~~the SoonerCare Income Guidelines.

(c) If an individual's household income using this methodology

is over the income limit for SoonerCare eligibility and that individual's household income using the MAGI household and income-counting methodology used by the Federally Facilitated Exchange (FFE) is less than 100% of FPL, the FFE's MAGI rules, as promulgated by the Internal Revenue Service, are used to determine SoonerCare eligibility in place of the rules in this Chapter. The FFE rules including, but not limited to, those in the following areas may need to be followed in place of the SoonerCare rules in this Chapter:

(1) Rules on household composition;

(2) Rules on countable sources of income; and

(3) Rules on the budget period used to calculate income, i.e. annual income (FFE) versus current monthly income (SoonerCare).

PART 7. CERTIFICATION, REDETERMINATION AND NOTIFICATION

317:35-6-64.1. Transitional Medical Assistance (TMA)

(a) **Conditions for TMA.**

(1) **Transitional Medical Assistance.** Health benefits are continued when the benefit group loses eligibility due to new or increased earnings of the parent(s)/caretaker relative or the receipt of ~~child or~~ spousal support. The health benefit coverage is of the same amount, duration, and scope as if the benefit group continued receiving SoonerCare. Eligibility for TMA begins with the effective date of case closure or the effective date of closure had the income been reported timely. An individual is included for TMA only if that individual was eligible for SoonerCare and included in the benefit group at the time of the closure. To be eligible for TMA the benefit group must meet all of the requirements listed in (A) - (C) of this paragraph.

(A) At least one member of the benefit group was included in at least three of the six months immediately preceding the month of ineligibility.

(B) The health benefit cannot have been received fraudulently in any of the six months immediately preceding the month of ineligibility.

(C) The benefit group must have included a dependent child who met the age and relationship requirements for SoonerCare and whose needs were included in the benefit group at the time of closure, unless the only eligible child is a Supplemental Security Income (SSI) recipient.

(2) **Closure due to ~~child support or~~ spousal support**. Health benefits are continued if the case closure is due to the receipt of new or increased ~~child support or~~ payments for spousal support in the form of alimony. The needs of the parent(s)or caretaker relative must be included in the

benefit group at the time of closure. The health benefits are continued for four months.

(3) **Closure due to new or increased earnings of parent(s) or caretaker relative.** Health benefits are continued if the closure is due to the new or increased earnings of the parent(s) or caretaker relative. The needs of the parent(s)or caretaker relative must be included in the benefit group at the time of closure. The parent(s) or caretaker relative is required to cooperate with OKDHS Oklahoma Child Support Services during the period of time the family is receiving TMA.

(4) **Eligibility period.** Health benefits may be continued for a period up to 12 months if the reason for closure is new or increased earnings of the parent(s) or caretaker relative. This period is divided into two six-month periods with eligibility requirements and procedures for each period.

(A) **Initial six-month period.**

(i) The benefit group is eligible for an initial six-month period of TMA without regard to income or resources if:

(I) an eligible child remains in the home;

(II) the parent(s) or caretaker relative remains the same; and

(III) the benefit group remains in the state.

(ii) An individual benefit group family member remains eligible for the initial six-month period of TMA unless the individual:

(I) moves out of the state,

(II) dies,

(III) becomes an inmate of a public institution,

(IV) leaves the household,

(V) does not cooperate, without good cause, with the OKDHS Oklahoma Child Support Services or third party liability requirements.

(B) **Additional Six-month period.**

(i) Health benefits are continued for the additional six-month period if:

(I) an eligible child remains in the home;

(II) the parent(s) or caretaker relative remains the same;

(III) the benefit group remains in the state;

(IV) the benefit group was eligible for and received TMA for each month of the initial six-month period;

(V) the benefit group has complied with reporting requirements in subsection (g) of this Section;

(VI) the benefit group has average monthly earned income (less child care costs that are necessary for the employment of the parent or caretaker relative) that does not exceed the 185% of the Federal Poverty

Level ~~(see OKDHS Appendix C-1, Schedule I.A;)~~(see SoonerCare Income Guidelines); and

(VII) the parent(s) or caretaker relative had earnings in each month of the required three-month reporting period described in (g)(2) of this Section, unless the lack of earnings was due to an involuntary loss of employment, illness, or other good cause.

(ii) An individual benefit group family member remains eligible for the additional six-month period unless the individual meets any of the items listed in (4)(A)(ii) of this paragraph.

(b) **Income and resource eligibility.**

(1) The unearned income and resources of the benefit group are disregarded in determining eligibility for TMA. There is no earned income test for the initial six-month period.

(2) Health benefits are continued for the additional six-month period if the benefit group's countable earnings less child care costs that are necessary for the employment of the parent(s) or caretaker relative are below 185% of the Federal Poverty Level (see the standards on the OHCA website or the OKDHS Form 08AX001E, Schedule I.A) and the benefit group meets the requirements listed in (a)(4)(B).

(A) The earnings of all benefit group members are used in determining the earned income test. The only exception is that earnings of full time students included in the benefit group are disregarded.

(B) Income is determined by averaging the benefit group's gross monthly earnings (except full time student earnings) for the required three-month reporting period.

(C) A deduction from the benefit group's earned income is allowed for the cost of approved child care necessary for the employment of the parent(S) or caretaker relative. The child care deduction is averaged for the same three-month reporting period. There is no maximum amount for this deduction.

(D) All individuals whose earnings are considered are included in the benefit group. The family size remains the same during both reporting periods.

(c) **Eligible child.** When the SoonerCare benefit is closed and TMA begins, the benefit group must include an eligible child whose needs were included in the SoonerCare benefit at the time of closure, unless the only eligible child is a SSI recipient. After the TMA begins, the benefit group must continue to include an eligible child. Age is the only requirement an eligible child must meet.

(d) **Additional members.** After the TMA begins, family members who move into the home cannot be added to the TMA coverage. This includes siblings and a natural or adoptive parent(s) or

caretaker relative. If the additional member is in need of health benefits, an application for services under the SoonerCare program is completed. If a benefit group member included in TMA leaves the home and then returns, that member may be added back to TMA coverage if all conditions of eligibility are met.

(e) **Third party liability**. The benefit group's eligibility for TMA is not affected by a third party liability. However, the benefit group is responsible for reporting all insurance coverage and any changes in the coverage. The worker must explain the necessity for applying benefits from private insurance to the cost of medical care.

(f) **Notification**.

(1) **Notices.** Notices are sent to the benefit group, both at the onset of and throughout the TMA period. These notices, which are sent at specific times, inform the benefit group of its rights and responsibilities. When SoonerCare is closed and the benefit group is eligible for TMA, the computer generated closure notice includes notification of the continuation of health benefits. Another computer generated notice is sent at the same time to advise the benefit group of the reporting requirements and under what circumstances the health benefits may be discontinued. Each notice listed in (A)-(C) of this paragraph includes specific information about what the benefit group must report. The notices serve as the required advance notification in the event benefits are discontinued as a result of the information furnished in response to these notices.

(A) **Notice #1**. Notice #1 is issued in the third month of the initial TMA period. This notice advises the benefit group of the additional six-month period of TMA, the eligibility conditions, reporting requirements, and appeal rights.

(B) **Notice #2**. Notice #2 is issued in the sixth month of the TMA period, but only if the benefit group is eligible for the additional six-month period. This notice advises the benefit group of the eligibility conditions, reporting requirements, and appeal rights.

(C) **Notice #3**. Notice #3 is issued in the ninth month of the TMA period, or the third month of the additional six-month period. This notice advises the benefit group of the eligibility conditions, the reporting requirements, appeal rights, and the expiration of TMA coverage.

(2) **Notices not received.** In some instances the benefit group does not receive all of the notices listed in (1) of this subsection. The notices and report forms are not issued retroactively.

(g) **Reporting**. The benefit group is required to periodically report specific information. The information may be reported by

telephone or by letter.

(1) The benefit group must report:

(A) gross earned income of the entire benefit group for the appropriate three-month period;

(B) child care expenses, for the appropriate three-month period, necessary for the continued employment of the parent(s) or caretaker relative;

(C) changes in members of the benefit group;

(D) residency; and

(E) third party liability.

(2) The reporting requirement time frames are explained in this subparagraph.

(A) The information requested in the third month must be received by the 21st day of the fourth month and is used to determine the benefit group's eligibility for the additional six-month period. While this report is due in the fourth month, negative action cannot be taken during the initial period for failure to report. If the benefit group fails to submit the requested information, benefits are automatically suspended effective the seventh month. If action to reinstate is not taken by deadline of the suspension month, the computer automatically closes the case effective the next month.

(B) The information requested in the sixth month must be furnished by the 21st day of the seventh month. The decision to continue benefits into the eighth month is determined by the information reported.

(C) The information requested in the ninth month must be furnished by the 21st day of the tenth month. The decision to continue health benefits into the 11th month is determined by the information reported. When the information is not reported timely, the TMA is automatically suspended by the computer for the appropriate effective date. If the benefit group subsequently reports the necessary information, the worker determines eligibility. If all eligibility factors are met during and after the suspension period, the health benefits are reinstated. The effective date of the reinstatement is the same as the effective date of the suspension so the benefit group has continuous medical coverage.

(h) **Termination of TMA**. The TMA coverage is discontinued any time the benefit group fails to meet the eligibility requirements as shown in this Section. If it becomes necessary to discontinue the TMA coverage for the benefit group or any member of the benefit group, the individual(s) must be advised that he or she may be eligible for health benefits under the SoonerCare program and how to obtain these benefits.

(i) **Receipt of health benefits after TMA ends**. To ensure

continued medical coverage a computer generated recertification form is mailed to the benefit group during the third month of TMA for benefits closed due to the receipt of child or spousal support or the 11th month of TMA for benefits closed due to increased earnings. The benefit group must return the form prior to the termination of the TMA benefits. When determined eligible, health benefits continue as SoonerCare, not TMA. If the benefit group fails to return the recertification form, TMA benefits are terminated.

SUBCHAPTER 7. MEDICAL SERVICES

PART 5. DETERMINATION OF ELIGIBILITY FOR MEDICAL SERVICES

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

(a) 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 the applicable standard on the ~~OKDHS Appendix C-1~~SoonerCare Income Guidelines. Prior to October 1, 2013, 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). Effective October 1, 2013, MAGI financial eligibility rules are used to determine eligibility for SoonerPlan.

(2) Prior to October 1, 2013, 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. October 1, 2013, MAGI household composition rules are used to determine eligibility for SoonerPlan.

(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.

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

(5) Persons who have Medicare or creditable health insurance coverage are not precluded from applying for the SoonerPlan Family Planning program.

(b) All health insurance is listed on ~~the OKDHS computer system~~applicable systems 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 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 Program.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY

CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 1. PHYSICIANS

317:30-5-9. Medical services

(a) **Use of medical modifiers.** The Physicians' Current Procedural Terminology (CPT) and the second level HCPCS provide for 2-digit medical modifiers to further describe medical services. Modifiers are used when appropriate.

(b) **Covered office services.**

(1) Payment is made for four office visits (or home) per month per member, for adults (over age 21), regardless of the number of physicians involved. Additional visits per month are allowed for services related to emergency medical conditions.

(2) Visits for the purpose of family planning are excluded from the four per month limitation.

(3) Payment is allowed for the insertion and/or implantation of contraceptive devices in addition to the office visit.

(4) Separate payment will be made for the following supplies when furnished during a physician's office visit.

(A) Casting materials

(B) Dressing for burns

(C) Contraceptive devices

(D) IV Fluids

(5) Payment is made for routine physical exams only as prior authorized by the OKDHS and are not counted as an office visit.

(6) Medically necessary office lab and X-rays are covered.

(7) Hearing exams by physician for members between the ages of 21 and 65 are covered only as a diagnostic exam to determine type, nature and extent of hearing loss.

(8) Hearing aid evaluations are covered for members under 21 years of age.

(9) IPPB (Intermittent Positive Pressure Breathing) is covered when performed in physician's office.

~~(10) Payment is made for both an office visit and an injection of joints performed during the visit if the joint injection code does not have a global coverage designation.~~

~~(11)~~(10) Payment is made for an office visit in addition to allergy testing.

~~(12)~~(11) Separate payment is made for antigen.

~~(13)~~(12) Eye exams are covered for members between ages 21 and 65 for medical diagnosis only.

~~(14)~~(13) If a physician personally sees a member on the same day as a dialysis treatment, payment can be made for a separately identifiable service unrelated to the dialysis.

~~(15)~~(14) Separate payment is made for the following specimen collections:

(A) Catheterization for collection of specimen; and

(B) Routine Venipuncture.

~~(16)~~(15) The Professional Component for electrocardiograms, electroencephalograms, electromyograms, and similar procedures are covered on an inpatient basis as long as the interpretation is not performed by the attending physician.

~~(17)~~(16) Cast removal is covered only when the cast is removed by a physician other than the one who applied the cast.

(c) **Non-covered office services.**

(1) Payment is not made separately for an office visit and rectal exam, pelvic exam or breast exam. Office visits including one of these types of exams should be coded with the appropriate office visit code.

(2) Payment cannot be made for prescriptions or medication dispensed by a physician in his office.

(3) Payment will not be made for completion of forms, abstracts, narrative reports or other reports, separate charge for use of office or telephone calls.

(4) Additional payment will not be made for mileage.

(5) Payment is not made for an office visit where the member did not keep appointment.

(6) Refractive services are not covered for persons between the ages of 21 and 65.

(7) Removal of stitches is considered part of post-operative care.

(8) Payment is not made for a consultation in the office when the physician also bills for surgery.

(9) Separate payment is not made for oxygen administered during an office visit.

(d) **Covered inpatient medical services.**

(1) Payment is allowed for inpatient hospital visits for all SoonerCare covered admissions. Psychiatric admissions must be prior authorized.

(2) Payment is allowed for the services of two physicians when supplemental skills are required and different specialties are involved.

(3) Certain medical procedures are allowed in addition to office visits.

(4) Payment for critical care is all-inclusive and includes payment for all services that day. Payment for critical care, first hour is limited to one unit per day.

(e) **Non-covered inpatient medical services.**

(1) For inpatient services, all visits to a member on a single day are considered one service except where specified. Payment is made for only one visit per day.

(2) A hospital admittance or visit and surgery on the same day would not be covered if post-operative days are included in the

surgical procedure. If there are no post-operative days, a physician can be paid for visits.

(3) Drugs administered to inpatients are included in the hospital payment.

(4) Payment will not be made to a physician for an admission or new patient work-up when the member receives surgery in out-patient surgery or ambulatory surgery center.

(5) Payment is not made to the attending physician for interpretation of tests on his own patient.

(f) **Other medical services.**

(1) Payment will be made to physicians providing Emergency Department services.

(2) Payment is made for two nursing facility visits per month. The appropriate CPT code is used.

(3) When payment is made for "Evaluation of arrhythmias" or "Evaluation of sinus node", the stress study of the arrhythmia includes inducing the arrhythmia and evaluating the effects of drugs, exercise, etc. upon the arrhythmia.

(4) When the physician bills twice for the same procedure on the same day, it must be supported by a written report.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY

CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 5. PHARMACIES

317:30-5-72.1. Drug benefit

OHCA administers and maintains an Open Formulary subject to the provisions of Title 42, United States Code (U.S.C.), Section 1396r-8. The OHCA covers a drug that has been approved by the Food and Drug Administration (FDA) and whose manufacturers have entered into a drug rebate agreement with the Centers for Medicare and Medicaid Services (CMS), subject to the following exclusions and limitations.

(1) The following drugs, classes of drugs, or their medical uses are excluded from coverage:

(A) Agents used to promote fertility.

(B) Agents primarily used to promote hair growth.

(C) Agents used for cosmetic purposes.

(D) Agents used primarily for the treatment of anorexia or weight gain. Drugs used primarily for the treatment of obesity, such as appetite suppressants are not covered. Drugs used primarily to increase weight are not covered unless otherwise specified.

(E) Agents that are experimental or whose side effects make usage controversial.

(F) Covered outpatient drugs which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or designee.

<u>(G) Agents when used for the treatment of sexual or erectile dysfunction, unless such agents are used to treat a condition, other than sexual or erectile dysfunction, for which the agents have been approved by the Food and Drug Administration.</u>

(2) The drug categories listed in (A) through (E) of this paragraph are covered at the option of the state and are subject to restrictions and limitations. An updated list of products in each of these drug categories is included on the OHCA's public website.

(A) Agents used for the systematic relief of cough and colds. Antihistamines for allergies or antihistamine use associated with asthmatic conditions may be covered when medically necessary and prior authorized.

(B) Vitamins and Minerals. Vitamins and minerals are not covered except under the following conditions:

(i) prenatal vitamins are covered for pregnant women up to

age 50;

(ii) fluoride preparations are covered for persons under 16 years of age or pregnant;

(iii) vitamin D, metabolites, and analogs when used to treat end stage renal disease are covered;

(iv) iron supplements may be covered for pregnant women if determined to be medically necessary;

(v) vitamin preparations may be covered for children less than 21 years of age when medically necessary and furnished pursuant to EPSDT protocol; and

(vi) some vitamins are covered for a specific diagnosis when the FDA has approved the use of that vitamin for a specific indication.

(C) Agents used for smoking cessation. A limited smoking cessation benefit is available.

(D) Coverage of non-prescription or over the counter drugs is limited to:

~~(i) Insulin, PKU formula and amino acid bars, other certain nutritional formulas and bars for children diagnosed with certain rare metabolic conditions;~~

(i) Insulin, PKU formula and amino acid bars, other certain nutritional formulas and bars for children diagnosed with certain rare metabolic conditions;

(ii) certain smoking cessation products;

(iii) family planning products;

(iv) OTC products may be covered if the particular product is both cost-effective and clinically appropriate; and

(v) prescription and non-prescription products which do not meet the definition of outpatient covered drugs, but are determined to be medically necessary.

(E) Coverage of food supplements is limited to PKU formula and amino acid bars for members diagnosed with PKU, other certain nutritional formulas and bars for children diagnosed with certain rare metabolic conditions when medically necessary and prior authorized.

(3) All covered outpatient drugs are subject to prior authorization as provided in OAC 317-30-5-77.2 and 317:30-5-77.3.

(4) All covered drugs may be excluded or coverage limited if:

(A) the prescribed use is not for a medically accepted indication as provided under 42 U.S.C. § 1396r-8; or

(B) the drug is subject to such restriction pursuant to the rebate agreement between the manufacturer and CMS.

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

SUBCHAPTER 3. GENERAL PROVIDER POLICIES

PART 1. GENERAL SCOPE AND ADMINISTRATION

317:30-3-4.1. Uniform Electronic Transaction Act

The Oklahoma Health Care Authority enacts the provisions of the Uniform Electronic Transaction Act as provided in this Section with the exception to the act as provided in this Section.

(1) **Scope of Act.** The Electronic Transaction Act applies to an electronic record and an electronic signature created with a record that is generated, sent, communicated, received or stored by the Oklahoma Health Care Authority.

(2) **Use of electronic records and electronic signatures.** The rules regarding electronic records and electronic signatures apply when both parties agree to conduct business electronically. Nothing in these regulations requires parties to conduct business electronically. However, should a party have the capability and desire to conduct business electronically with the Oklahoma Health Care Authority, then the following guidelines must be adhered to:

(A) Only employees designated by the provider's agency may make entries in the member's medical record. All entries in the member's medical record must be dated and authenticated with a method established to identify the author. The identification method may include computer keys, Private/Public Key Infrastructure (PKIs), voice authentication systems that utilize a personal identification number (PIN) and voice authentication, or other codes. Providers must have a process in place to deactivate an employee's access to records upon termination of employment of the designated employee.

(B) When PKIs, computer key/code(s), voice authentication systems or other codes are used, a signed statement must be completed by the agency's employee documenting that the chosen method is under the sole control of the person using it and further demonstrate that:

(i) A list of PKIs, computer key/code(s), voice authentication systems or other codes can be verified;

(ii) All adequate safeguards are maintained to protect against improper or unauthorized use of PKIs, computer keys, or other codes for electronic signatures; and

(iii) Sanctions are in place for improper or unauthorized use of computer key/code(s), PKIs, voice authentication systems or other code types of

electronic signatures.

(C) There must be a specific action by the author to indicate that the entry is verified and accurate. Systems requiring an authentication process include but are not limited to:

(i) Computerized systems that require the provider's employee to review the document on-line and indicate that it has been approved by entering a unique computer key/code capable of verification;

(ii) A system in which the provider's employee signs off against a list of entries that must be verified in the member's records;

(iii) A mail system that sends transcripts to the provider's employee for review;

(iv) A postcard identifying and verifying the accuracy of the record(s) signed and returned by the provider's employee; or

(v) A voice authentication system that clearly identifies author by a designated personal identification number or security code.

(D) Auto-authentication systems that authenticate a report prior to the transcription process do not meet the stated requirements and will not be an acceptable method for the authentication process.

(E) The authentication of an electronic medical record (signature and date entry) is expected on the day the record is completed. If the electronic medical record is transcribed by someone other than the provider, the signature of the rendering provider and date entry is expected within three business days from the day the record is completed.

~~(E)~~(F) Records may be edited by designated administrators within the provider's facility ~~but must be authenticated by the original author~~. Edits must be in the form of a correcting entry which preserves entries from the original record. Edits must be completed prior to claims submission or no later than 45 days after the date of service, whichever is later.

~~(F)~~(G) Use of the electronic signature, for clinical documentation, shall be deemed to constitute a signature and will have the same effect as a written signature on the clinical documentation. The section of the electronic record documenting the service provided must be authenticated by the employee or individual who provided the described service.

~~(G)~~(H) Any authentication method for electronic signatures must:

(i) be unique to the person using it;

(ii) identify the individual signing the document by name and title;
(iii) be capable of verification, assuring that the documentation cannot be altered after the signature has been affixed;
(iv) be under the sole control of the person using it;
(v) be linked to the data in such a manner that if the data is changed, the signature is invalidated; and
(vi) provide strong and substantial evidence that will make it difficult for the signer to claim that the electronic representation is not valid.

~~(H)~~(I) Failure to properly maintain or authenticate medical records (i.e., signature and date entry) may result in the denial or recoupment of SoonerCare payments.

(3) **Record retention for provider medical records.** Providers must retain electronic medical records and have access to the records in accordance with guidelines found at OAC 317:30-3-15.

(4) **Record retention for documents submitted to OHCA electronically.**

(A) The Oklahoma Health Care Authority's system provides that receivers of electronic information may both print and store the electronic information they receive. The Oklahoma Health Care Authority is the custodian of the original electronic record and will retain that record in accordance with a disposition schedule as referenced by the Records Destruction Act. The Oklahoma Health Care Authority will retain an authoritative copy of the transferable record as described in the Electronic Transaction Act that is unique, identifiable and unalterable.

(i) **Manner and format of electronic signature.** The manner and format required by the Oklahoma Health Care Authority will vary ~~dependant~~dependent upon whether the sender of the document is a member or a provider. In the limited case where a provider is a client, the manner and format is dependent upon the function served by the receipt of the record. In the case the function served is a request for services, then the format required is that required by a recipient. In the case the function served is related to payment for services, then the format required is that required by a provider.

(ii) **Recipient format requirements.** The Oklahoma Health Care Authority will allow members to request SoonerCare services electronically. An electronic signature will be authenticated after a validation of the data on the form by another database or databases.

(iii) **Provider format requirements.** The Oklahoma Health Care Authority will permit providers to contract with the Oklahoma Health Care Authority, check and amend claims filed with the Oklahoma Health Care Authority, and file prior authorization requests with the Oklahoma Health Care Authority. Providers with a social security number or federal employer's identification number will be given a personal identification number (PIN). After using the PIN to access the database, a PIN will be required to transact business electronically.

(B) Providers with the assistance of the Oklahoma Health Care Authority will be required to produce and enforce a security policy that outlines who has access to their data and what transaction employees are permitted to complete as outlined in the policy rules for electronic records and electronic signatures contained in paragraph (2) of this section.

(C) Third Party billers for providers will be permitted to perform electronic transaction as stated in paragraph (2) only after the provider authorizes access to the provider's PIN and a power of attorney by the provider is executed.

(5) **Time and place of sending and receipt.** The provisions of the Electronic Transaction Act apply to the time and place of receipt with the exception of a power failure, Internet interruption or Internet virus. Should any of the exceptions in this paragraph occur, confirmation is required by the receiving party.

(6) **Illegal representations of electronic transaction.** Any person who fraudulently represents facts in an electronic transaction, acts without authority, or exceeds their authority to perform an electronic transaction may be prosecuted under all applicable criminal and civil laws.

317:30-3-15. Record retention

Federal regulations and rules promulgated by the Oklahoma Health Care Authority Board require that the provider retain, for a period of six years, any records necessary to disclose the extent of services the provider, wholly owned supplier, or subcontractor, furnishes to recipients and, upon request, furnish such records to the Secretary of the Department of Health and Human Services. Records in a provider's office must contain adequate documentation of services rendered. ~~Documentation must include the provider's signature and credentials.~~ Documentation must include the dated provider's signature and credentials. The provider's signature must be handwritten or electronically submitted if the provider and the Oklahoma Health Care Authority have agreed to conduct

transactions by electronic means pursuant to the Uniform Electronic Act. Electronic records and electronic signatures must be in accordance with guidelines found at OAC 317:30-3-4.1. Where reimbursement is based on units of time, it will be necessary that documentation be placed in the member's record as to the beginning and ending times for the service claimed. All records must be legible. Failure to maintain legible records may result in denial of payment or recoupment of payment for services provided when attempts to obtain transcription of illegible records is unsuccessful or the transcription of illegible records appears to misrepresent the services documented. The provider may, after one year from the date of service(s), microfilm or microfiche the records for the remaining five years, as long as the microfilm or microfiche is of a quality that assures that the records remain legible. Electronic records are acceptable as long as they have a secured signature. Provider (other than individual practitioner) agrees to disclose, upon request, information relating to ownership or control, business transactions and criminal offenses involving any program under Title V of the Child Health Act or Titles, XVIII, XIX, XX, or XXI of the Federal Social Security Act.

317:30-3-30. Signature requirements

(a) For medical review purposes, the Oklahoma Health Care Authority (OHCA) requires that all services provided and/or ordered be authenticated by the author. The method used shall be a hand written signature, electronic signature, or signature attestation statement. Stamped signatures are not acceptable. Pursuant to federal and/or state law, there are some circumstances for which an order does not need to be signed.

(1) Facsimile of original written or electronic signatures are acceptable for the certifications of terminal illness for hospice.

(2) Orders for clinical diagnostic tests are not required to be signed. If the order for the clinical diagnostic test is unsigned, there must be medical documentation by the treating physician that he/she intended the clinical diagnostic test be performed. This documentation showing the intent that the test be performed must be authenticated by the author via a hand written or electronic signature.

(3) Orders for outpatient prescription drugs are not required to be signed. If the order for a prescription drug is unsigned, there must be medical documentation by the treating physician that he/she intended that the prescription drug be ordered. This documentation showing the intent that the prescription drug be ordered must be authenticated by the author via a hand written or electronic signature.

(b) A hand written signature is a mark or sign by an individual

on a document to signify knowledge, approval, acceptance, or obligation. The authentication of a medical record (signature and date entry) is expected on the day the record is completed. If the medical record is transcribed by someone other than the provider, the signature of the rendering provider and date entry is expected within three business days from the day the record is completed.

(1) If a signature is illegible, the OHCA will consider evidence in a signature log or attestation statement to determine the identity of the author of a medical record entry.

(2) If the signature is missing from an order, the OHCA will disregard the order during the review of the claim.

(3) If the signature is missing from any other medical documentation, the OHCA will accept a signature attestation from the author of the medical record entry.

(c) Providers may include in the documentation they submit a signature log that lists the typed or printed name of the author associated with initials or an illegible signature.

(1) The signature log may be included on the actual page where the initials or illegible signature are used or may be a separate document.

(2) The OHCA will not deny a claim for a signature log that is missing credentials.

(3) The OHCA will consider all submitted signature logs regardless of the date they were created.

(d) Providers may include in the documentation they submit a signature attestation statement. In order to be considered valid for medical review purposes, an attestation statement must be signed and dated by the author of the medical record entry and must contain sufficient information to identify the member.

(1) The OHCA will not consider signature attestation statements where there is no associated medical record entry.

(2) The OHCA will not consider signature attestation statements from someone other than the author of the medical record entry in question.

(3) The OHCA will consider all signature attestation statements that meet the above requirements regardless of the date the attestation was created, except in those cases where the regulations or rules indicate that a signature must be in place prior to a given event or a given date.

(e) Providers may use electronic signatures as an alternate signature method.

(1) Providers must use a system and software products which are protected against modification and must apply administrative procedures which are adequate and correspond to recognized standards and laws.

(2) Providers utilizing electronic signatures bear the

responsibility for the authenticity of the information being attested to.

(3) Providers utilizing electronic signatures must comply with OAC 317:30-3-4.1.

(f) Nothing in this section is intended to absolve the provider of their obligations in accordance with the conditions set forth in their SoonerCare contract and the rules delineated in OAC 317:30.

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 1. PHYSICIANS

317:30-5-3. Documentation of services

(a) Records in a physician's office or a medical institution (hospital, nursing home or other medical facility), must contain adequate documentation of services rendered. Such documentation must include the physician's signature or identifiable initials in relation to every patient visit, every prescription, or treatment. In verifying the accuracy of claims for procedures which are reimbursed on a time frame basis, it will be necessary that documentation be placed in the patient's chart as to the beginning and ending times for the service claimed.

(b) Providers must adhere to signature requirements found at OAC 317:30-3-30.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 25. SOONERCARE CHOICE

SUBCHAPTER 7. SOONERCARE

PART 1. GENERAL PROVISIONS

317:25-7-5. Primary care providers

For provision of health care services, the OHCA contracts with qualified Primary Care Providers. All providers serving as PCPs must have a valid SoonerCare Fee-for-Service contract as well as an exercised SoonerCare Choice addendum. Additionally, all PCPs, excluding Provider or Physician Groups, must agree to accept a minimum capacity of patients, however this does not guarantee PCPs a minimum patient volume. Primary Care Providers are limited to:

(1) **Physicians.** Any physician licensed to practice medicine in the state in which he or she practices who is engaged in a general practice or in family medicine, general internal medicine or general pediatrics may serve as a PCP. The Chief Executive Officer (CEO) of the OHCA may designate physicians to serve as PCPs who are licensed to practice medicine in the state in which they practice who are specialized in areas other than those described above. In making this determination, the CEO may consider such factors as the percentage of primary care services delivered in the physician's practice, the availability of primary care providers in the geographic area of the state in which the physician's practice is located, the extent to which the physician has historically provided services to SoonerCare members, and the physician's medical education and training.

(A) For physicians serving as SoonerCare Choice PCPs, the State caps the number of members per physician at 2,500. However, the CEO in his/her discretion may increase this number in under served areas based on a determination that this higher cap is in conformance with usual and customary standards for the community. If a physician practices at multiple sites, the capacity at each site is determined based on the number of hours per week the physician holds office hours, not to exceed one FTE. Thus, the physician cannot exceed a maximum total capacity of 2500 members.

(B) In areas of the State where cross-state utilization patterns have developed because of limited provider capacity in the State, the CEO may authorize contracts with out-of-state providers for PCP services. Out-of-State PCPs are required to comply with all access standards imposed on Oklahoma physicians.

(2) **Advanced Practice Nurses.** Advanced Practice Nurses who have prescriptive authority may serve as PCPs for the Primary Care Case Management delivery system if licensed to practice in the state in which he or she practices. Advanced Practice Nurses

who have prescriptive authority may serve as PCPs for a maximum number of 1,250 members. However, the CEO in his/her discretion may increase this number.

(3) **Physician Assistants.** Physician Assistants may serve as PCPs if licensed to practice in the state in which he or she practices. Physician Assistants may serve as PCPs for a maximum number of 1,250 members. However, the CEO in his/her discretion may increase this number.

~~(4) **Medical Residents.**~~

~~(A) Medical residents may serve as PCPs when the following conditions are met:~~

~~(i) The resident is licensed to practice in the state in which he or she practices.~~

~~(ii) The resident is at least at the Post-Graduate 2 (PG-2) level.~~

~~(iii) The resident serves as a PCP only within his or her continuity clinic setting (for example, Family Practice residents may only serve as the PCP within the Family Practice Residency clinic setting).~~

~~(iv) The resident works under the supervision of a licensed attending physician.~~

~~(v) The resident specifies the residency program or clinic to which payment will be made.~~

~~(B) Medical residents practicing as a PCP may not exceed a capacity of more than 875 members. However, the CEO in his/her discretion may increase this number.~~

~~(5)~~(4) **Indian Health Service (IHS) Facilities and Federally Qualified Health Center (FQHC) provider groups.**

(A) Indian Health Service facilities whose professional staff meet the general requirements in paragraphs (1) through (3) of this Section and the provider participation requirements at OAC 317:30-5-1088 may serve as PCPs.

(B) Federally Qualified Health Centers whose professional staff meet the general requirements in paragraphs (1) through (3) of this Section and the provider participation requirements in OAC 317:30-5-660.2 may serve as PCPs.

~~(6)~~(5) **Provider or physician group capacity and enrollment**.

(A) Provider or physician groups must agree to accept a minimum enrollment capacity and may not exceed 2,500 members per physician participating in the provider group.

(B) If licensed physician assistants or advanced practice nurses are members of a group, the capacity may be increased by 1,250 members if the provider is available full-time.

(C) Provider or physician groups must designate a medical director to serve as the primary contact with OHCA.

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 75. FEDERALLY QUALIFIED HEALTH CENTERS

317:30-5-660.5. Health Center service definitions

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

"Core Services" means outpatient services that may be covered when furnished to a patient at the Center or other location, including the patient's place of residence.

"Encounter or Visit" means a face-to-face contact between an approved health care professional as authorized in the FQHC state plan pages and an eligible SoonerCare member for the provision of defined services through a Health Center within a 24-hour period ending at midnight, as documented in the patient's medical record.

"Licensed Behavioral Health Professional (LBHP)" means licensed psychologists, licensed clinical social workers (LCSWs), licensed marital and family therapists (LMFTs), licensed professional counselors (LPCs), licensed behavioral practitioners (LBPs), and licensed alcohol and drug counselors (LADCs).

"Other ambulatory services" means other health services covered under the State plan other than core services.

"Physician" means:

(A) a doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which the function is performed or who is a licensed physician employed by the Public Health Service;

(B) within limitations as to the specific services furnished, a doctor of dentistry or dental or oral surgery, a doctor of optometry, or a doctor of podiatry;

~~(C) a resident as defined in OAC 317:25-7-5(4) who meet the requirements for payment under SoonerCare;~~

"Physicians' services" means professional services that are performed by a physician at the Health Center (or are performed away from the Center, excluding inpatient hospital services) whose agreement with the Center provides that he or she will be paid by the Health Center for such services.

"PPS" means prospective payment system all-inclusive per visit rate method specified in the State plan.

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

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

PART 11. PAYMENT, BILLING, AND OTHER ADMINISTRATIVE PROCEDURES

317:35-9-95. Payment to ICF/~~MR~~IID (public and private)

The Oklahoma Health Care Authority may execute agreements to provide care only with facilities which are properly licensed by the state licensing agency. The agreement is initiated by application from the facility and expires on a specified date, or with termination of the facility license, or shall be automatically terminated on notice to OHCA that the facility is not in compliance with Medicaid (or other federal long-term care) requirements.

(1) In the event that a facility changes ownership, the agreement with the previous owner may be extended to the new owner, pending certification of the new owner to provide care to individuals during the change of ownership. In the event that the new owner is not showing good faith in pursuit of certification, the OHCA will begin planning for alternate placement of Medicaid patients. The county office is immediately notified of any relevant change in facility status.

(2) Payment for long-term care is made only for those individuals who have been approved by the DHS for such care. The amount of payment is based on the actual time the individual received care (including therapeutic/hospital leave) from a nursing facility during any given month. Payment for nursing care cannot be made for any period during which the care has been temporarily interrupted for reasons other than therapeutic leave. Therapeutic leave is any planned leave other than hospitalization that is for the benefit of the patient. Therapeutic leave must be clearly documented in the patient's plan of care before payment for a reserved bed can be made by the OHCA. Hospital leave is planned or unplanned leave when the patient is admitted to a licensed hospital.

(3) A nursing facility may receive payment for up to 7 days per calendar year for each eligible individual in order to reserve a bed when the patient is on therapeutic leave.

(4)The ICF/~~MR~~IID may receive payment for a maximum of 60 days of therapeutic leave per calendar year for each recipient to reserve a bed. No more than 14 consecutive days of therapeutic leave may be claimed per absence. Recipients approved for ICF/~~MR~~IID on or after July 1 of the year will

only be eligible for 30 days of therapeutic leave during the remainder of that year.

(5) The Statement of Compensable Therapeutic Leave Only form is used by the facility to record use of therapeutic leave. This form is to be made available by the local office to the nursing facility upon request.

(6) ~~Effective August 1, 1995, a nursing facility may receive payment for a maximum of three (3) days of hospital leave per calendar year for each recipient to reserve a bed when the patient is admitted to a licensed hospital, if the facility has an occupancy rate of at least 90 percent at the time of hospital admission. Claims for hospital leave are submitted on Form Adm-41 (Long Term Care Claim Form).~~No payment shall be made for hospital leave.

~~(7) Effective January 1, 1996, the nursing facility may receive payment for a maximum of five (5) days of hospital leave per calendar year for each recipient to reserve the bed when the patient is admitted to a licensed hospital.~~

SUBCHAPTER 19. NURSING FACILITY SERVICES

317:35-19-26. Payment to NF

The OHCA may execute agreements to provide care only with facilities which are properly licensed by the state licensing agency. The agreement is initiated by application from the facility and expires on a specified date, or with termination of the facility license, or shall be automatically terminated on notice to this Authority that the facility is not in compliance with Medicaid (or other federal long-term care) requirements.

(1) In the event that a facility changes ownership, the agreement with the previous owner may be extended to the new owner, pending certification of the new owner to provide care to individuals during the change of ownership. In the event that the new owner is not showing good faith in pursuit of certification, the OHCA will begin planning for alternate placement of Medicaid patients. The county office is immediately notified of any relevant change in facility status.

(2) Payment for long-term care is made only for those individuals who have been approved by the Department of Human Services for such care. The amount of payment is based on the actual time the individual received care (including therapeutic leave) from a nursing facility during any given month. Payment for nursing care cannot be made for any period during which the care has been temporarily interrupted for reasons other than therapeutic leave. Therapeutic leave is any planned leave other than hospitalization that is for the benefit of the patient. Therapeutic leave must be clearly

documented in the patient's plan of care before payment for a reserved bed can be made by the OHCA.

(3) Effective July 1, 1994, the nursing facility may receive payment for a maximum of seven days of therapeutic leave per calendar year for each eligible individual to reserve the bed.

(4) The Statement of Compensable Therapeutic Leave Only form is used by the facility to record use of therapeutic leave. This form is to be made available by the local office to the nursing facility upon request.

(5) ~~Effective August 1, 1995, a nursing facility may receive payment for a maximum of three (3) days of hospital leave per calendar year for each recipient to reserve a bed when the patient is admitted to a licensed hospital, if the facility has an occupancy rate of at least 90 percent at the time of hospital admission. Claims for hospital leave are submitted on Form Adm-41 (Long Term Care Claim Form).~~No payment shall be made for hospital leave.

~~(6) Effective January 1, 1996, the nursing facility may receive payment for a maximum of five (5) days of hospital leave per calendar year for each recipient to reserve the bed when the patient is admitted to a licensed hospital.~~

Recommendation 1: Prior Authorize Daklinza™ (Daclatasvir) and Technivie™ (Ombitasvir/Paritaprevir/Ritonavir)

The Drug Utilization Review Board recommends the prior authorization of Daklinza™ (daclatasvir) and Technivie™ (ombitasvir/paritaprevir/ritonavir) with criteria similar to the other prior authorized hepatitis C medications.

Daklinza™ (Daclatasvir) Approval Criteria:

1. Member must be 18 years of age or older; and
2. An FDA approved diagnosis of Chronic Hepatitis C (CHC) **genotype-3**; and
3. Member must have a METAVIR fibrosis score of **F2** or greater or equivalent scoring with an alternative test. Fibrosis testing type and scoring must be indicated on prior authorization request; and
4. Daklinza™ must be prescribed by a gastroenterologist, infectious disease specialist, or transplant specialist or the member must have been evaluated by a gastroenterologist, infectious disease specialist, or transplant specialist for hepatitis C therapy within the last three months; and
5. Hepatitis C Virus (HCV) genotype testing must be confirmed and indicated on prior authorization request; and
6. Pre-treatment viral load (HCV-RNA) must be confirmed and indicated on the petition. Viral load should have been taken within the last three months; and
7. The following regimens and requirements based on genotype and concomitant drug therapy will apply:
    a. **Genotype-3, treatment-naïve or treatment-experienced, without cirrhosis:**
        i. Daklinza™ 60mg with Sovaldi® for 12 weeks
    b. **Genotype-3, treatment-naïve or treatment-experienced, with cirrhosis:**
        i. Daklinza™ 60mg with Sovaldi® in combination with weight-based ribavirin for 12 weeks
    c. **Genotype-3, without cirrhosis, and concomitant use of moderate CYP3A inducer(s):**
        i. Daklinza™ 90mg with Sovaldi® 400mg for 12 weeks
        ii. Moderate Inducers: bosentan, dexamethasone, efavirenz, etravirine, modafinil, nafcillin, and rifapentine
    d. **Genotype-3, without cirrhosis, and concomitant use of strong CYP3A inhibitors:**
        i. Daklinza™ 30mg with Sovaldi® for 12 weeks
        ii. Strong CYP3A inhibitors include the following: atazanavir/ritonavir, clarithromycin, indinavir, itraconazole, ketoconazole, nefazodone, nelfinavir, posaconazole, saquinavir, telithromycin, and voriconazole
    e. New regimens will apply as approved by the FDA
8. Member must sign and submit the Hepatitis C Intent to Treat contract; and
9. Member's pharmacy must submit the Hepatitis C Therapy Pharmacy Agreement for each member on therapy; and
10. The prescriber must verify that they will provide SoonerCare with all necessary labs to evaluate hepatitis C therapy efficacy including Sustained Viral Response (SVR-12); and
11. Member must have no illicit IV drug use or alcohol abuse in the last six months and member must agree to no illicit IV drug use or alcohol use while on treatment and post-therapy; and
12. Must have documentation of initiation of immunization with the hepatitis A and B vaccines; and

13. Member must not have decompensated cirrhosis; and
14. Female members must not be pregnant and must have a pregnancy test immediately prior to therapy initiation. Male and female members must be willing to use two forms of non-hormonal birth control while on therapy and for six months after therapy completion; and
15. Member must not be taking the following medications: carbamazepine, phenytoin, phenobarbital, rifampin, amiodarone, and St. John's wort; and
16. All other clinically significant issues must be addressed prior to starting therapy including but not limited to the following: neutropenia, anemia, thrombocytopenia, surgery, depression, psychosis, epilepsy, obesity, weight management, severe concurrent medical diseases, such as but not limited to, retinal disease or autoimmune thyroid disease; and
17. Prescribing physician must verify that they will work with the member to ensure the member remains adherent to hepatitis C therapies; and
18. Members must be adherent for continued approval. Treatment gaps of therapy longer than 3 days/month will result in denial of subsequent requests for continued therapy.
19. Approvals for treatment regimen initiation for 12 weeks of therapy will not be granted prior to the 10th of a month in order to prevent prescription limit issues from affecting the member's compliance.

Technivie™ (Ombitasvir/Paritaprevir/Ritonavir) Approval Criteria:

1. Member must be 18 years of age or older; and
2. An FDA approved diagnosis of Chronic Hepatitis C (CHC) **genotype-4**; and
3. Member must have a METAVIR fibrosis score of **F2** or **F3** (Technivie™ is not indicated in cirrhotic patients) or equivalent scoring with an alternative test. Fibrosis testing type and scoring must be indicated on prior authorization request; and
4. Technivie™ must be prescribed by a gastroenterologist, infectious disease specialist, or transplant specialist or the member must have been evaluated by a gastroenterologist, infectious disease specialist, or transplant specialist for hepatitis C therapy within the last three months; and
5. Hepatitis C Virus (HCV) genotype testing must be confirmed and indicated on prior authorization request; and
6. Pre-treatment viral load (HCV-RNA) must be confirmed and indicated on the petition. Viral load should have been taken within the last three months; and
7. The following regimens and requirements based on genotype, cirrhosis status, and prior treatment status will apply:
    a. **Genotype-4, treatment-naïve and experienced, non-cirrhotic:**
        i. Technivie™ in combination with weight-based ribavirin for 12 weeks
    b. New regimens will apply as approved by the FDA
8. Member must not have previously failed treatment with a hepatitis C protease inhibitor (non-responder or relapsed); and
9. Member must sign and submit the Hepatitis C Intent to Treat contract; and
10. Member's pharmacy must submit the Hepatitis C Therapy Pharmacy Agreement for each member on therapy; and
11. The prescriber must verify that they will provide SoonerCare with all necessary labs to evaluate hepatitis C therapy efficacy including Sustained Viral Response (SVR-12); and
12. Member must have no illicit IV drug use or alcohol abuse in the last six months and member must agree to no illicit IV drug use or alcohol use while on treatment and post-therapy; and

13. Must have documentation of initiation of immunization with the hepatitis A and B vaccines; and
14. Member must not have cirrhosis, decompensated cirrhosis or moderate-to-severe hepatic impairment (Child-Pugh B and C); and
15. Female members must not be pregnant and must have a pregnancy test immediately prior to therapy initiation. Male and female members must be willing to use two forms of non-hormonal birth control while on therapy (and for six months after therapy completion for ribavirin); and
16. The prescriber must verify that the member's ALT levels will be monitored during the first four weeks of starting treatment and as clinically indicated thereafter; and
17. Member must not be taking the following medications: alfuzosin, carbamazepine, phenytoin, phenobarbital, rifampin, ergotamine, dihydroergotamine, ergonovine, methylergonovine, ethinyl estradiol containing medications (combined oral contraceptives), St. John's wort, lovastatin, simvastatin, pimozide, efavirenz, sildenafil, triazolam, orally administered midazolam, atazanavir/ritonavir, darunavir/ritonavir, lopinavir/ritonavir, rilpivirine, salmeterol and voriconazole; and
18. All other clinically significant issues must be addressed prior to starting therapy including but not limited to the following: neutropenia, anemia, thrombocytopenia, surgery, depression, psychosis, epilepsy, obesity, weight management, severe concurrent medical diseases, such as but not limited to, retinal disease or autoimmune thyroid disease; and
19. Prescribing physician must verify that they will work with the member to ensure the member remains adherent to hepatitis C therapies; and
20. Members must be adherent for continued approval. Treatment gaps of therapy longer than 3 days/month will result in denial of subsequent requests for continued therapy.
21. Approvals for treatment regimen initiation for 12 weeks of therapy will not be granted prior to the 10th of a month in order to prevent prescription limit issues from affecting the member's compliance.

Recommendation 2: Prior Authorize Noxafil® (Posaconazole) and Cresemba® (Isavuconazonium Sulfate)

The Drug Utilization Review Board recommends the prior authorization of Noxafil® (posaconazole) and Cresemba® (isavuconazonium sulfate) with the following criteria:

Noxafil® (Posaconazole) Approval Criteria:

1. An FDA approved diagnosis of one of the following:
    a. Prophylaxis of invasive *Aspergillus* and *Candida* infections in high-risk patients due to being severely immunocompromised, such as hematopoietic stem cell transplant (HSCT) recipients with graft-versus-host disease (GVHD) or those with hematologic malignancies with prolonged neutropenia from chemotherapy; or
    b. Treatment of oropharyngeal candidiasis (OPC), including OPC refractory (rOPC) to itraconazole and/or fluconazole; or
2. Treatment of invasive mucormycosis; or
3. Other appropriate diagnoses for which Noxafil® is not FDA approved may be considered with submission of a manual prior authorization; and
4. For the diagnosis of OPC, only the oral suspension may be used.

Cresemba® (Isavuconazonium Sulfate) Approval Criteria:

1. An FDA approved diagnosis of one of the following:
    a. Invasive aspergillosis

    b. Invasive mucormycosis
2. For the treatment of invasive aspergillosis, a patient-specific, clinically significant reason why voriconazole cannot be used must be provided.

Recommendation 3: Prior Authorize Neulasta® (Pegfilgrastim), Granix® (Tbo-filgrastim), and Zarxio™ (Filgrastim-sndz)

The Drug Utilization Review Board recommends the prior authorization of Neulasta® (pegfilgrastim), Granix® (tbo-filgrastim), and Zarxio™ (filgrastim-sndz) with the following criteria:

Neulasta® (Pegfilgrastim), Granix® (Tbo-filgrastim), and Zarxio™ (Filgrastim-sndz) Approval Criteria:

1. An FDA approved diagnosis; and
2. A patient-specific, clinically significant reason why the member cannot use Neupogen® (filgrastim).
3. Additional consideration for Neulasta® will be given for caregivers or members who cannot self-inject at home. The prescriber must provide specific documentation of the reason the caregiver or member cannot self-inject at home.

Recommendation 4: Prior Authorize Aggrenox® (Aspirin/Dipyridamole Extended-Release)

The Drug Utilization Review Board recommends the prior authorization of Aggrenox® (aspirin/dipyridamole ER) with the following criteria:

Aggrenox® (Aspirin/Dipyridamole ER) Approval Criteria:

1. An FDA approved indication for the prophylaxis of recurrent thromboembolic stroke in patients who have had transient ischemia of the brain or completed ischemic stroke due to thrombosis; and
2. Member must be 18 years of age or older; and
3. A patient-specific, clinically significant reason why member cannot use immediate-release dipyridamole and over-the-counter (OTC) aspirin in place of Aggrenox® must be provided.
4. A quantity limit of 60 capsules for a 30 day supply will apply.

Recommendation 5: Prior Authorize Nucala® (Mepolizumab)

The Drug Utilization Review Board recommends the prior authorization of Nucala® (Mepolizumab) with the following criteria:

Nucala® (Mepolizumab Injection) Approval Criteria:

1. An FDA approved indication for add-on maintenance treatment of patients with severe eosinophilic phenotype asthma; and
2. Member must be age 12 years or older; and
3. Member must have a baseline blood eosinophil count of 150 cell/mcL or greater within the last six weeks of initiation of dosing; and

4. Member must have had at least two asthma exacerbations requiring systemic corticosteroids within the last 12 months or require daily systemic corticosteroids despite compliant use of high-dose inhaled corticosteroid (ICS) plus at least one additional controller medication; and
5. Member must have failed a high-dose ICS (≥ 880 mcg/day fluticasone propionate or equivalent daily dose or ≥ 440 mcg/day in ages 12 to 17) used compliantly for at least the past 12 months (for ICS/LABA combination products, the highest approved dose meets this criteria); and
6. Member must have failed at least one other asthma controller medication used in addition to the high-dose ICS compliantly for at least the past three months; and
7. Nucala® must be prescribed by an allergist, pulmonologist, or pulmonary specialist or the member must have been evaluated by an allergist, pulmonologist, or pulmonary specialist within the last twelve months (or be an advanced care practitioner with a supervising physician who is an allergist, pulmonologist, or pulmonary specialist); and
8. Initial approvals will be for the duration of six months after which time compliance will be evaluated for continued approval; and
9. A quantity limit of 1 vial per 28 days will apply.