OKLAHOMA HEALTH CARE AUTHORITY
REGULARLY SCHEDULED BOARD MEETING
February 8, 2018 at 1:00 P.M.
Oklahoma Health Care Authority
4345 N. Lincoln Blvd.
OKC, OK

A G E N D A

Items to be presented by Tony Armstrong, Vice-Chairman

1. Call to Order / Determination of Quorum

2. Action Item – Approval of the January 11, 2018 OHCA Board Meeting Minutes

Item to be presented by Becky Pasternik-Ikard, Chief Executive Officer

3. Discussion Item – Chief Executive Officer's Report

   a) All-Star Introduction
      - November All-Star – Lisa Cole, Payroll Supervisor (Carrie)
      - December All-Star – Gloria LaFitte, Research Analyst (Tywanda)

   b) Presentation of the 2017 T.J. Brickner Award – Becky Pasternik-Ikard, CEO and Vice-Chairman Armstrong

   c) Financial Update – Carrie Evans, Chief Financial Officer

      a. SFY 19 Budget Request – Tasha Black, Budget Fiscal Planning Director

   d) Medicaid Director's Update – Melody Anthony, Deputy State Medicaid Director

   e) Legislative Update – Cate Jeffries, Interim Legislative Liaison

   f) 2018-2022 Strategic Plan Presentation – Beth VanHorn, Director of Planning and Project Management

   g) 2017 Tribal Meeting and Annual Report – Dana Miller, Tribal Government Relations Director

   h) Medicaid Member Views – Rachel Buckles, Digital Communication Coordinator; Joni Bruce, Oklahoma Family Network Executive Director; Michael Tillman

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.

Action Item (a) Consideration and Vote upon a Declaration of a Compelling Public Interest for the promulgation of ***the Emergency Rules*** in action item five (b) 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:

A. AMENDING agency rules at ***OAC 317:35-5-42*** will update Aged, Blind and Disabled (ABD) countable income policy by removing specific amounts for the income disregard of a student's earned income and instead refer to the Oklahoma Department of Human Services (DHS) Appendix C-1. These amounts are used by DHS when determining countable income and eligibility for the ABD category. The Social Security Administration revises the student earned income exclusion yearly. Additionally, the proposed revisions will clarify the definition of student status to ensure that an unintended barrier is not created for the access of SoonerCare services.
Budget Impact: Budget neutral

(Reference APA WF # 17-15)

B. AMENDING agency rules at ***OAC 317:30-5-95 and 317:30-5-95.39*** will revise definitions and align them with federal regulations. Definitions will now be incorporated throughout policy in the Sections in which they are used. In addition, the term "American Osteopathic Accreditation" will be removed as an accrediting body for Psychiatric Residential Treatment Facilities (PRTFs), as it is no longer an accreditation option for this kind of facility. The term "Licensed independent practitioner" will be removed from the rules, and the rules will now specifically explain which types of practitioners can order restraint or seclusion, or perform face-to-face assessments of patients.

Revisions will also align policy with federal requirements for restraint or seclusion. PRTFs, a type of inpatient facility that exclusively serves minors and young adults, must comply with the condition of participation for restraint or seclusion, as is established by 42 C.F.R. §§ 483.350 through 483.376. Additionally, all general and psychiatric hospitals must comply with federally-established standards for restraint or seclusion, in accordance with 42 C.F.R. § 482.13(e) – (g).
Budget Impact: Budget neutral

(Reference APA WF # 17-19)

C. AMENDING agency rules at ***OAC 317:2-1-16*** will revise the grievance procedures and appeals processes for the supplemental payment program for nursing facilities owned and/or operated by non-state government-owned (NSGO) entities. The proposed revisions will remove the program eligibility determination as an appealable issue and add the requirement that the NSGO must have an attorney file their LD-2 form. Finally, revisions will update acronyms, definitions, and references to other legal authorities; and correct grammatical errors.
Budget Impact: There is no cost to the OHCA as the state share will be financed by the NSGO and will be transferred to the state by way of an intergovernmental transfer for claiming of federal financial participation.

(Reference APA WF # 17-33A)

D. AMENDING agency rules at ***OAC 317:30-5-136*** will update and revise the rules for the nursing home supplemental payment program for nursing facilities. Additionally, the proposed revisions will update the care criteria section and eligibility requirements that a nursing facility will be required to meet to receive the upper payment limit (UPL) reimbursement and participate in the UPL program. Finally, revisions will update acronyms, definitions and references to other legal authorities.

Budget Impact: There is no cost to the OHCA as the state share will be financed by the NSGO and will be transferred to the state by way of an intergovernmental transfer for claiming of federal financial participation.

(Reference APA WF # 17-33B)

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

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.

OHCA Initiated

E. Promulgating previously approved emergency rules through the permanent rulemaking process at ***OAC 317:35-5-41.6*** to comply with federal regulation. Federal regulation now allows mentally competent disabled individuals the same right to create an exempt trust as a parent, grandparent, guardian, or court for trusts established on or after December 13, 2016. Other requirements of these types of trusts which are exempt from Medicaid resource limits remain unchanged.
Budget Impact: Budget neutral

(Reference APA WF # 17-01)

F. Promulgating previously approved emergency rules through the permanent rulemaking process at ***OAC 317:30-5-1096*** to allow Indian Health Services, Tribal Program and Urban Indian Clinics who are designated as Federally Qualified Health Centers to be reimbursed at the Office of Management and Budget rate for services provided outside of the four walls of their facilities. Policy changes were needed in order to comply with federal regulations.
Budget Impact: Services provided to the Native American population are 100 percent federally funded; therefore, no impact on state revenue is expected.

(Reference APA WF # 17-03)

G. Promulgating previously approved emergency rules through the permanent rulemaking process at ***OAC 317:30-3-4.1 and 317:30-3-30*** to clarify that the authentication of medical records is expected on the day the record is completed. Additionally, revisions clarify that the signature of the rendering provider and date entry is expected, rather than required, within three business days from the day the record is completed if the record is being transcribed. These changes superseded a rule that required the record be authenticated within three days of the provision of service.
Budget Impact: Budget neutral

(Reference APA WF # 17-13)

ODMHSAS Initiated

H. Promulgating previously approved emergency rules through the permanent rulemaking process at ***OAC 317:30-5-1207*** to allow a fourth population to be served in the Money Follows the Person (MFP) demonstration. The change allowed transitioning efforts for eligible individuals being discharged from Psychiatric Residential Treatment Facilities (PRTF) back into the community. Oklahoma's MFP Demonstration for PRTF transitioning focuses on transitioning youth 16 to 18 years of age who have been in an inpatient psychiatric residential facility for 90 or more days during an episode of care. The individuals must meet criteria for Level 3 on the Individual Client Assessment Record or meet the criteria of Serious Emotional Disturbance. They may also show critical impairment on a caregiver rated Ohio Scales (score of 25 and above on the Problems

Subscale, or a score of 44 and below on the Functioning Subscales). In addition, the individuals are eligible for transitional Health Home services under Oklahoma's Living Choice program. Services are provided in accordance with an individualized plan of care under the direction of appropriate service providers.
ODMHSAS Budget Impact: Costs were realized during promulgation of the emergency rule.

(Reference APA WF # 17-04A)

I. Promulgating previously approved emergency rules through the permanent rulemaking process at ***OAC 317:35-23-2 and 317:35-23-3*** that are tied to APA WF # 17-04A, which allows a fourth population to be served in the Money Follows the Person (MFP) demonstration. Services are provided in accordance with an individualized plan of care under the direction of appropriate service providers. Revisions also replaced the term Intermediate Care Facility for Mentally Retarded with Intermediate Care Facility for Individuals with Intellectual Disabilities.
ODMHSAS Budget Impact: The budget impact is listed in APA WF #17-04A, there are no new costs.

(Reference APA WF # 17-04B)

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

OHCA Initiated

J. AMENDING agency rules at ***OAC 317:30-5-1094*** will update Indian Health Services, Tribal Program and Urban Indian Clinics (I/T/U) policy by removing the restriction to billing with only a Current Procedural Terminology procedure code for outpatient behavioral health encounters. Revisions will clarify and allow more flexibility when billing for an outpatient behavioral health encounter. Additionally, rules will require that services are billed on an appropriate claim form using the appropriate procedure code and guidelines.
Budget Impact: Services provided to the Native American population are 100% federally funded; therefore, no impact on state revenue is expected.

(Reference APA WF # 17-17)

K. AMENDING agency rules at ***OAC 317:35-5-2, 317:35-5-7, 317:35-5-63, and 317:35-6-1*** will update the Qualifying Categorical Relationship policy by removing the subsection "Grandfathered CHIP children." The current rule identifies that this eligibility group terminated December 31, 2015, necessitating the removal of this subsection from policy to eliminate any confusion.
Budget Impact: Budget neutral

(Reference APA WF # 17-20)

DHS Initiated

L. AMENDING agency rules at ***OAC 317:30-5-482*** will remove treatment extensions for habilitation services authorized by Developmental Disabilities Services area managers. New qualifications for psychological technicians will be added, which will allow for services to be provided under the supervision of a licensed psychologist. Additionally, revisions will require psychologists to implement the Protective Intervention Protocol (PIP) for the member's individual plan. New billing requirements will not allow psychologists to bill for more than twelve hours (48 units) for PIP preparation. The proposed revisions will also request that the authorization period for psychological services be changed from six to twelve months. Lastly, revisions will provide a detailed description and new documentation requirements for prevocational services.
DHS Budget Impact: Budget neutral

(Reference APA WF # 17-25A)

M. AMENDING agency rules at ***OAC 317:40-1-3, 317:40-7-3, and 317:40-7-4*** will affirm a member's rights to have visitors of his/her choosing, under the Home and Community-Based waiver. In addition, revisions will allow eligible members 16 years of age and older, to access waiver employment services through the Home and Community-Based Services waiver. Finally, revisions will also add new language to clarify state-funded employment services are available to members of the Homeward Bound class who are not eligible for Developmental Disabilities Services waiver services.
DHS Budget Impact: Budget neutral

(Reference APA WF # 17-25B)

Item to be presented by Tony Armstrong, Vice-Chairman

6. Action Item – Election of the Oklahoma Health Care Authority 2018 Board Officers

7. New Business

8. ADJOURNMENT

NEXT BOARD MEETING
March 22, 2017
Oklahoma Health Care Authority
Oklahoma City, OK

MINUTES OF A REGULAR BOARD MEETING
OF THE HEALTH CARE AUTHORITY BOARD
January 11, 2018
Oklahoma Health Care Authority Boardroom
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 10, 2018 at 12:45 p.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 5, 2018 at 1:05 p.m.

Pursuant to a roll call of the members, a quorum was declared to be present, and Vice-Chairman Armstrong called the meeting to order at 1:07 p.m.

BOARD MEMBERS PRESENT: Vice-Chairman Armstrong, Member Bryant, Member Case, Member McVay, Member Yaffe

BOARD MEMBERS ABSENT: Member Nuttle, Member Robison

OTHERS PRESENT:	OTHERS PRESENT:
Brent Wilborn, OKPCA	Rick Snyder, OHA
Tyler Telley, eCap	Kyle Janzen, OHCA
Daryn Kirkpatrick, OHCA	Bill Garrison, OHCA
Mary Brinkley, Leading Age OK	Dwyna Vick, OHCA
Harvey Reynolds, OHCA	Mike Fogarty
Lewis Robinson, OHCA	Mike Herndon, OHCA
Dan Arthrell, Retired citizen	Brenda Teel, Chickasaw Nation
Kelli Brodersen, OHCA	Fred Oraene, OHCA
Kevin Rupe, OHCA	Kimrey McGinnis, OHCA
Kasie Wren, OHCA	Gloria LaFitte, OHCA
David Dude, American Cancer Society	Laura Dempsey, Morton
Carter Kimble, OSU	Tasha Black, OHCA
Sandra Puebla, OHCA	Courtney Barrett, OHCA
David Ward, OHCA	

DISCUSSION AND POSSIBLE VOTE ON APPROVAL OF BOARD MINUTES OF THE SPECIAL SCHEDULED BOARD MEETINGS HELD DECEMBER 1 & 29, 2017.

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 Case moved for approval of the December 1 & 29, 2017 board meeting minutes as published. The motion was seconded by Member Bryant.

FOR THE MOTION: Vice-Chairman Armstrong, Member McVay, Member Yaffe

BOARD MEMBERS ABSENT: Member Nuttle, Member Robison

ITEM 3A / ALL-STAR INTRODUCTION

The following OHCA All-Star was recognized

- September – Della Gregg, HMP Manager (Melody)
- October – Dale Lippert, System Analyst II (Kyle)

ITEM 3B / MARCH OF DIMES NURSE OF THE YEAR

The following OHCA nurse was recognized

DRAFT

- Anataya Rucker, MFP Nurse Supervisor (Tywanda)

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

Ms. Evans gave a brief update on OHCA's November Financials. OHCA's state dollar budget variance is positive $2.1 million dollars. Program administrative services ran under budget in Medicaid program spending by $6 million state dollars. In administrative services, OHCA is currently under budget by $1.1 million state dollars. On the revenue side, OHCA is over budget in taxes and fees by $2.7 million state dollars. All cycles have been completed for the month of December which will bring OHCA under budget. Ms. Evans also gave an update on the $31 million dollar deferral OHCA received on December 11, 2017. OHCA was required to refund the $31.7 million to the feds as of December 31st. OHCA will have enough funds to operate through the end of February. OHCA is working with the providers that received those payments to refund those payments back to us. The providers have requested a supplemental appropriation from the legislature to fill the hole for them. The Governor's office has been made aware of the impact to our budget. Ms. Pasternik-Ikard added that the state is given 60-days to submit further documentation to support the expenditures and to have the deferral withdrawn by the federal government. OHCA has engaged a Medicaid specialty law firm, Covington, and submitted extensive documentation surrounding this issue. OHCA's response is due on February 9th. For more detailed information, see Item 3c in the board packet.

ITEM 3D / MEDICAID DIRECTOR'S UPDATE
Melody Anthony, Deputy State Medicaid Director

Ms. Anthony provided an update for November 2017 data that included a report on the number of SoonerCare enrollees in different areas of the Medicaid program including total in-state providers. Ms. Anthony also presented charts showing monthly enrollment and monthly change in enrollment for Choice, Traditional and Insure Oklahoma. For more detailed information, see Item 3d in the board packet.

ITEM 3E / LEGISLATIVE
Cate Jeffries, Interim Legislative Liaison

Ms. Jeffries gave a brief update regarding two legislative sessions. The legislature is scheduled to come back into special session to address revenue raising measures. The regular legislative session is set to convene on February 5th. OHCA has a budget hearing scheduled on January 16th at 2:30pm. Bill filing deadline is next week and included in agenda packet is the current bill tracking list. Also, included in the agenda packet is a summary for the report on SB773 which directed OHCA to issue a request for information (RFI) for care coordination models for children in state custody. OHCA partnered with OSDH and ODMHSAS to create a report which was submitted to the legislature two weeks prior to this meeting. OHCA continues to follow CHIP and will continue to operate through March. For more detailed information, see item 3e in the board packet.

ITEM 3F / 2017 OHCA ANNUAL REPORT
Kelli Brodersen, Public Information Representative

Ms. Brodersen presented to the board the SFY 2017 Annual report and played a member video.

ITEM 4 / ANNOUNCEMENTS OF CONFLICTS OF INTEREST PANEL RECOMMENDATIONS FOR ALL ACTION ITEMS
Nicole Nantois, Chief of Legal Services

There were no recommendations regarding conflicts.

ITEM 5A-C / CONSIDERATION AND VOTE OF THE AUTHORITY FOR EXPENDITURE OF FUND
Tiffany Lyon, Procurement & Contracts Development Director

a) Mandatory Statewide Non-Emergency Transportation

MOTION: Member Yaffe moved for approval of Item 5a as published. The motion was seconded by Member McVay

FOR THE MOTION: Vice-Chairman Armstrong, Member Bryant, Member Case

DRAFT

BOARD MEMBERS ABSENT: Member Nuttle, Member Robison

b) Health Management Program

MOTION: Member Bryant moved for approval of Item 5b as published. The motion was seconded by Member Yaffe

FOR THE MOTION: Vice-Chairman Armstrong, Member Case, Member McVay

BOARD MEMBERS ABSENT: Member Nuttle, Member Robison

c) Focus on Excellence – Nursing Facility Surveys

MOTION: Member Case moved for approval of Item 5c as published. The motion was seconded by Member Bryant

FOR THE MOTION: Vice-Chairman Armstrong, Member McVay, Member Yaffe

BOARD MEMBERS ABSENT: Member Nuttle, Member Robison

ITEM 6A-C / CONSIDERATION AND VOTE REGARDING RECOMMENDATIONS MADE BY THE DRUG UTILIZATION BOARD UNDER 63 OKLAHOMA STATUTES 5030.3
Nancy Nesser, Pharmacy Director

a) Consideration and vote to add **Mavyret™ (Glecaprevir/ Pibrentasvir) and Vosevi® (Sofosbuvir/Velpatasvir/Voxilaprevir)** to the utilization and scope prior authorization program under OAC 317:30-5-77.2(e).

b) Consideration and vote to add **Baxdela™ (Delafloxacin Injection and Tablets), Ofloxacin 300mg Tablets, Minolira™ (Minocycline Extended-Release Tablets), Solosec™ (Secnidazole Oral Granules), and Vabomere™ (Meropenem/Vaborbactam Injection)** to the utilization and scope prior authorization program under OAC 317:30-5-77.2(e).

c) Consideration and vote to add **Duzallo® (Lesinurad/Allopurinol)** to the utilization and scope prior authorization program under OAC 317:30-5-77.2(e).

MOTION: Member Case moved for approval of Item 8a-f as published. The motion was seconded by Member McVay

FOR THE MOTION: Vice-Chairman Armstrong, Member Bryant, Member Yaffe

BOARD MEMBERS ABSENT: Member Nuttle, Member Robison

ITEM 10 / NEW BUSINESS

There was no new business.

ITEM 11 / ADJOURNMENT

MOTION: Member Yaffe moved for approval for adjournment. The motion was seconded by Member Bryant

FOR THE MOTION: Vice-Chairman Armstrong, Member Case, Member McVay

BOARD MEMBERS ABSENT: Member Nuttle, Member Robison

Meeting adjourned at 1:48 p.m., 1/11/2018

DRAFT

NEXT BOARD MEETING
February 8, 2018
Oklahoma Health Care Authority
Oklahoma City, OK

Martina Ordonez
Board Secretary

Minutes Approved: _______________

*Initials:*______________

DRAFT

FINANCIAL REPORT

For the Six Months Ended December 31, 2017
Submitted to the CEO & Board

- Revenues for OHCA through December, accounting for receivables, were **$2,071,293,898** or **1.4% under** budget.

- Expenditures for OHCA, accounting for encumbrances, were **$2,042,784,431** or **.4% over** budget.

- The state dollar budget variance through December is a **negative ($22,634,750).** This includes the $31,770,310 Federal Deferral for Graduate Medical Education (GME) payments.

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

Expenditures:	
Medicaid Program Variance	2.1
Federal Deferral-GME	(31.8)
Administration	1.1
Revenues:	
Drug Rebate	2.6
Taxes and Fees	3.2
Overpayments/Settlements	.2
Total FY 18 Variance	**$ (22.6)**

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 2018, For the Six Month Period Ending December 31, 2017

REVENUES	FY18 Budget YTD	FY18 Actual YTD	Variance	% Over/ (Under)
State Appropriations	$ 536,876,677	$ 536,876,677	$ -	0.0%
Federal Funds	1,148,166,211	1,107,596,425	(40,569,787)	(3.5)%
Tobacco Tax Collections	24,710,710	27,647,801	2,937,091	11.9%
Quality of Care Collections	39,162,301	39,438,512	276,211	0.7%
Prior Year Carryover	41,749,967	41,749,967	-	0.0%
Federal Deferral - Interest	132,055	132,055	-	0.0%
Drug Rebates	162,548,355	168,895,493	6,347,138	3.9%
Medical Refunds	16,286,366	16,874,639	588,273	3.6%
Supplemental Hospital Offset Payment Program	120,830,665	120,830,665	-	0.0%
Other Revenues	11,229,720	11,251,664	21,945	0.2%
TOTAL REVENUES	**$ 2,101,693,027**	**$ 2,071,293,898**	**$ (30,399,129)**	**(1.4)%**

EXPENDITURES	FY18 Budget YTD	FY18 Actual YTD	Variance	% (Over)/ Under
ADMINISTRATION - OPERATING	**$ 27,946,694**	**$ 25,092,165**	**$ 2,854,529**	**10.2%**
ADMINISTRATION - CONTRACTS	**$ 52,172,758**	**$ 51,770,550**	**$ 402,208**	**0.8%**
MEDICAID PROGRAMS				
Managed Care:				
SoonerCare Choice	22,855,433	21,696,776	1,158,657	5.1%
Acute Fee for Service Payments:				
Hospital Services	451,597,898	451,624,487	(26,589)	(0.0)%
Behavioral Health	10,320,075	10,227,108	92,967	0.9%
Physicians	197,902,372	193,856,728	4,045,644	2.0%
Dentists	63,344,036	63,615,787	(271,751)	(0.4)%
Other Practitioners	27,474,347	26,632,063	842,284	3.1%
Home Health Care	8,598,202	9,197,300	(599,098)	(7.0)%
Lab & Radiology	15,581,857	13,610,690	1,971,167	12.7%
Medical Supplies	24,829,729	24,947,825	(118,096)	(0.5)%
Ambulatory/Clinics	100,424,152	101,967,898	(1,543,746)	(1.5)%
Prescription Drugs	294,435,594	294,706,079	(270,485)	(0.1)%
OHCA Therapeutic Foster Care	6,000	751	5,249	0.0%
Other Payments:				
Nursing Facilities	274,252,665	273,798,146	454,519	0.2%
Intermediate Care Facilities for Individuals with Intellectual Disabilities Private	30,866,524	30,588,176	278,349	0.9%
Medicare Buy-In	86,613,399	87,021,071	(407,673)	(0.5)%
Transportation	32,546,263	32,402,336	143,928	0.4%
Money Follows the Person-OHCA	118,404	147,712	(29,308)	0.0%
Electonic Health Records-Incentive Payments	4,444,924	4,444,924	-	0.0%
Part D Phase-In Contribution	54,432,619	54,950,229	(517,610)	(1.0)%
Supplemental Hospital Offset Payment Program	264,405,703	264,405,703	-	0.0%
Telligen	5,289,780	6,079,928	(790,148)	(14.9)%
Total OHCA Medical Programs	**1,970,339,975**	**1,965,921,716**	**4,418,260**	**0.2%**
OHCA Non-Title XIX Medical Payments	89,382	-	89,382	0.0%
TOTAL OHCA	**$ 2,050,548,809**	**$ 2,042,784,431**	**$ 7,764,379**	**0.4%**
REVENUES OVER/(UNDER) EXPENDITURES	**$ 51,144,217**	**$ 28,509,467**	**$ (22,634,750)**	

OKLAHOMA HEALTH CARE AUTHORITY
Total Medicaid Program Expenditures
by Source of State Funds
SFY 2018, For the Six Month Period Ending December 31, 2017

Category of Service	Total	Health Care Authority	Quality of Care Fund	HEEIA	SHOPP Fund	BCC Revolving Fund	Other State Agencies
SoonerCare Choice	$ 21,761,591	$ 21,690,526	$ -	$ 64,815	$ -	$ 6,250	$ -
Inpatient Acute Care	570,496,440	300,227,701	243,343	1,673,682	199,681,510	400,071	68,270,133
Outpatient Acute Care	204,527,249	149,147,663	20,802	2,194,025	51,579,852	1,584,906	-
Behavioral Health - Inpatient	24,765,152	6,344,513	-	171,517	12,480,047	-	5,769,074
Behavioral Health - Psychiatrist	4,546,889	3,882,595	-	-	664,294	-	-
Behavioral Health - Outpatient	7,558,434	-	-	-	-	-	7,558,434
Behaviorial Health-Health Home	25,531,530	-	-	-	-	-	25,531,530
Behavioral Health Facility- Rehab	118,829,105	-	-	-	-	38,140	118,829,105
Behavioral Health - Case Management	4,562,759	-	-	-	-	-	4,562,759
Behavioral Health - PRTF	27,454,611	-	-	-	-	-	27,454,611
Behavioral Health - CCBHC	25,455,243	-					25,455,243
Residential Behavioral Management	7,435,799	-	-	-	-	-	7,435,799
Targeted Case Management	33,413,341	-	-	-	-	-	33,413,341
Therapeutic Foster Care	751	751	-	-	-	-	-
Physicians	227,631,622	191,736,377	29,050	2,456,475	-	2,091,301	31,318,419
Dentists	63,634,565	63,610,518	-	18,778	-	5,268	-
Mid Level Practitioners	1,204,343	1,195,970	-	7,912	-	461	-
Other Practitioners	25,674,850	25,152,387	223,182	239,218	-	60,063	-
Home Health Care	9,199,922	9,194,377	-	2,622	-	2,923	-
Lab & Radiology	14,002,772	13,510,073	-	392,083	-	100,617	-
Medical Supplies	25,132,243	23,580,464	1,355,766	184,418	-	11,595	-
Clinic Services	103,426,721	98,431,738	-	658,852	-	93,808	4,242,323
Ambulatory Surgery Centers	3,525,746	3,438,580	-	83,394	-	3,773	
Personal Care Services	5,699,247	-	-	-	-	-	5,699,247
Nursing Facilities	273,798,146	166,236,809	107,553,721	-	-	7,616	-
Transportation	32,410,549	31,117,532	1,173,784	60,025	-	59,208	-
GME/IME/DME	93,679,196	-	-	-	-	-	93,679,196
ICF/IID Private	30,588,176	24,933,022	5,655,153	-	-	-	-
ICF/IID Public	7,995,735	-	-	-	-	-	7,995,735
CMS Payments	141,971,300	141,641,063	330,238	-	-	-	-
Prescription Drugs	300,721,176	293,412,089	-	6,015,097	-	1,293,990	-
Miscellaneous Medical Payments	51,811	49,862	-	-	-	1,950	-
Home and Community Based Waiver	98,781,400	-	-	-	-	-	98,781,400
Homeward Bound Waiver	38,339,746	-	-	-	-	-	38,339,746
Money Follows the Person	147,712	147,712	-	-	-	-	-
In-Home Support Waiver	12,223,365	-	-	-	-	-	12,223,365
ADvantage Waiver	84,163,380	-	-	-	-	-	84,163,380
Family Planning/Family Planning Waiver	2,321,153	-	-	-	-	-	2,321,153
Premium Assistance*	28,981,572	-	-	28,981,572	-	-	-
Telligen	6,079,928	6,079,928	-	-	-	-	-
Electronic Health Records Incentive Payments	4,444,924	4,444,924	-	-	-	-	-
Total Medicaid Expenditures	**$ 2,712,170,191**	**$ 1,579,207,171**	**$ 116,585,041**	**$ 43,204,484**	**$ 264,405,703**	**$ 5,761,941**	**$ 703,043,992**

* Includes $28,784,737.79 paid out of Fund 245

OKLAHOMA HEALTH CARE AUTHORITY

Summary of Revenues & Expenditures:
Other State Agencies
SFY 2018, For the Six Month Period Ending December 31, 2017

REVENUE	FY18 Actual YTD
Revenues from Other State Agencies	$ 313,376,881
Federal Funds	429,779,450
TOTAL REVENUES	**$ 743,156,331**

EXPENDITURES	Actual YTD
Department of Human Services	
Home and Community Based Waiver	$ 98,781,400
Money Follows the Person	-
Homeward Bound Waiver	38,339,746
In-Home Support Waivers	12,223,365
ADvantage Waiver	84,163,380
Intermediate Care Facilities for Individuals with Intellectual Disabilities Public	7,995,735
Personal Care	5,699,247
Residential Behavioral Management	4,337,629
Targeted Case Management	29,166,108
Total Department of Human Services	**280,706,609**
State Employees Physician Payment	
Physician Payments	31,318,419
Total State Employees Physician Payment	**31,318,419**
Education Payments	
Graduate Medical Education	50,325,348
Graduate Medical Education - Physicians Manpower Training Commission	4,665,226
Indirect Medical Education	34,013,202
Direct Medical Education	4,675,420
Total Education Payments	**93,679,196**
Office of Juvenile Affairs	
Targeted Case Management	1,139,968
Residential Behavioral Management	3,098,170
Total Office of Juvenile Affairs	**4,238,138**
Department of Mental Health	
Case Management	4,562,759
Inpatient Psychiatric Free-standing	5,769,074
Outpatient	7,558,434
Health Homes	25,531,530
Psychiatric Residential Treatment Facility	27,454,611
Certified Community Behavioral Health Clinics	25,455,243
Rehabilitation Centers	118,829,105
Total Department of Mental Health	**215,160,756**
State Department of Health	
Children's First	575,265
Sooner Start	2,001,836
Early Intervention	2,464,664
Early and Periodic Screening, Diagnosis, and Treatment Clinic	648,623
Family Planning	110,972
Family Planning Waiver	2,192,870
Maternity Clinic	2,226
Total Department of Health	**7,996,456**
County Health Departments	
EPSDT Clinic	364,728
Family Planning Waiver	17,312
Total County Health Departments	**382,040**
State Department of Education	**28**
Public Schools	**67,307**
Medicare DRG Limit	**65,000,000**
Native American Tribal Agreements	**1,224,909**
Department of Corrections	**707,943**
JD McCarty	**2,562,190**
Total OSA Medicaid Programs	**$ 703,043,992**
OSA Non-Medicaid Programs	**$ 43,254,875**
Accounts Receivable from OSA	**$ 3,142,536**

OKLAHOMA HEALTH CARE AUTHORITY

SUMMARY OF REVENUES & EXPENDITURES:

Fund 205: Supplemental Hospital Offset Payment Program Fund

SFY 2018, For the Six Month Period Ending December 31, 2017

REVENUES		FY 18 Revenue
SHOPP Assessment Fee	$	120,717,805
Federal Draws		156,675,087
Interest		77,092
Penalties		35,768
State Appropriations		(15,100,000)
TOTAL REVENUES	$	**262,405,752**

EXPENDITURES	Quarter	Quarter		FY 18 Expenditures
Program Costs:	7/1/17 - 9/30/17	10/1/17 - 12/31/17		
Hospital - Inpatient Care	98,870,820	100,810,689	$	199,681,510
Hospital -Outpatient Care	25,537,046	26,042,806		51,579,852
Psychiatric Facilities-Inpatient	7,574,695	4,905,352		12,480,047
Rehabilitation Facilities-Inpatient	328,886	335,409		664,294
Total OHCA Program Costs	132,311,447	132,094,256	$	264,405,703
Total Expenditures			$	**264,405,703**
CASH BALANCE			$	**(1,999,951)**

OKLAHOMA HEALTH CARE AUTHORITY

SUMMARY OF REVENUES & EXPENDITURES:

Fund 230: Nursing Facility Quality of Care Fund

SFY 2018, For the Six Month Period Ending December 31, 2017

REVENUES	Total Revenue	State Share
Quality of Care Assessment	$ 39,419,955	$ 39,419,955
Interest Earned	18,557	18,557
TOTAL REVENUES	**$ 39,438,512**	**$ 39,438,512**

EXPENDITURES	FY 18 Total $ YTD	FY 18 State $ YTD	Total State $ Cost
Program Costs			
Nursing Facility Rate Adjustment	$ 105,706,789	$ 43,075,516	
Eyeglasses and Dentures	135,232	55,107	
Personal Allowance Increase	1,711,700	697,518	
Coverage for Durable Medical Equipment and Supplies	1,355,766	552,475	
Coverage of Qualified Medicare Beneficiary	516,378	210,424	
Part D Phase-In	330,238	134,572	
ICF/IID Rate Adjustment	2,663,229	1,085,266	
Acute Services ICF/IID	2,991,924	1,219,209	
Non-emergency Transportation - Soonerride	1,173,784	478,317	
Total Program Costs	**$ 116,585,041**	**$ 47,508,404**	**$ 47,508,404**
Administration			
OHCA Administration Costs	$ 267,926	$ 133,963	
DHS-Ombudsmen	76,585	76,585	
OSDH-Nursing Facility Inspectors	211,508	211,508	
Mike Fine, CPA	-	-	
Total Administration Costs	**$ 556,019**	**$ 422,056**	**$ 422,056**
Total Quality of Care Fee Costs	**$ 117,141,060**	**$ 47,930,460**	
TOTAL STATE SHARE OF COSTS			**$ 47,930,460**

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 2018, For the Six Month Period Ending December 31, 2017

REVENUES	FY 17 Carryover	FY 18 Revenue	Total Revenue
Prior Year Balance	$ 7,673,082	$ -	$ 4,811,312
State Appropriations	(3,000,000)	-	-
Tobacco Tax Collections	-	22,739,665	22,739,665
Interest Income	-	82,990	82,990
Federal Draws	307,956	17,807,052	17,807,052
TOTAL REVENUES	**$ 4,981,038**	**$ 40,629,707**	**$ 45,441,019**

EXPENDITURES		FY 17 Expenditures	FY 18 Expenditures	Total $ YTD
Program Costs:				
	Employer Sponsored Insurance		$ 28,784,738	$ 28,784,738
	College Students/ESI Dental		196,834	80,210
Individual Plan				
	SoonerCare Choice		$ 62,649	$ 25,529
	Inpatient Hospital		1,645,195	670,417
	Outpatient Hospital		2,163,599	881,666
	BH - Inpatient Services-DRG		168,226	68,552
	BH -Psychiatrist		-	-
	Physicians		2,443,477	995,717
	Dentists		17,643	7,190
	Mid Level Practitioner		7,743	3,155
	Other Practitioners		236,012	96,175
	Home Health		2,622	1,069
	Lab and Radiology		384,345	156,621
	Medical Supplies		181,341	73,897
	Clinic Services		645,225	262,929
	Ambulatory Surgery Center		83,394	33,983
	Prescription Drugs		5,922,446	2,413,397
	Transportation		59,289	24,160
	Premiums Collected		-	(305,842)
Total Individual Plan			**$ 14,023,207**	**$ 5,408,614**
	College Students-Service Costs		**$ 199,705**	**$ 81,380**
Total OHCA Program Costs			**$ 43,204,484**	**$ 34,354,942**
Administrative Costs				
	Salaries	$ 40,359	$ 1,087,906	$ 1,128,265
	Operating Costs	25,578	92,202	117,780
	Health Dept-Postponing	-	-	-
	Contract - HP	103,788	407,626	511,414
Total Administrative Costs		**$ 169,725**	**$ 1,587,734**	**$ 1,757,459**
Total Expenditures				**$ 36,112,401**
NET CASH BALANCE		**$ 4,811,312**		**$ 9,328,618**

OKLAHOMA HEALTH CARE AUTHORITY

SUMMARY OF REVENUES & EXPENDITURES:

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

SFY 2018, For the Six Month Period Ending December 31, 2017

REVENUES	FY 18 Revenue	State Share
Tobacco Tax Collections	$ 453,775	$ 453,775
TOTAL REVENUES	**$ 453,775**	**$ 453,775**

EXPENDITURES	FY 18 Total $ YTD	FY 18 State $ YTD	Total State $ Cost
Program Costs			
SoonerCare Choice	$ 6,250	$ 1,783	
Inpatient Hospital	400,071	114,100	
Outpatient Hospital	1,584,906	452,015	
Inpatient Services-DRG	-	-	
Psychiatrist	-	-	
TFC-OHCA	-	-	
Nursing Facility	7,616	2,172	
Physicians	2,091,301	596,439	
Dentists	5,268	1,503	
Mid-level Practitioner	461	131	
Other Practitioners	60,063	17,130	
Home Health	2,923	834	
Lab & Radiology	100,617	28,696	
Medical Supplies	11,595	3,307	
Clinic Services	93,808	26,754	
Ambulatory Surgery Center	3,773	1,076	
Prescription Drugs	1,293,990	369,046	
Transportation	59,208	16,886	
Miscellaneous Medical	1,950	556	
Total OHCA Program Costs	**$ 5,723,800**	**$ 1,632,428**	
OSA DMHSAS Rehab	$ 38,140	$ 10,878	
Total Medicaid Program Costs	**$ 5,761,941**	**$ 1,643,306**	
TOTAL STATE SHARE OF COSTS			**$ 1,643,306**

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
SFY 2019
Budget Request Detail

Description of Priority	# FTE	State	Total
1 **Annualizations**			
FFP Match Rate from 58.57% to 62.38% (9 Months Impact from 10/01/18)		(82,888,002)	-
Savings from SFY-2018 Program efficiencies & changes (6 months impact)		(3,213,691)	(8,331,560)
		($86,101,693)	**($8,331,560)**
2 **Maintenance**			
FY'19 Growth/Utilization increases (1.9%)		18,971,036	59,807,039
Medicare A & B premiums - 01/01/2019		1,474,744	3,920,107
Rebase physician fee schedule to align with current RVUs		771,450	2,000,000
MMIS Fiscal Agent Contract Increase		650,000	3,250,000
	-	**$21,867,230**	**$68,977,147**
3 **One-Time Funding**			
FY-2017 one-time Carryover & Replace		35,249,968	-
FY-2017 General Revenue Return		4,650,843	-
FY-2018 Unfunded Liability*		31,557,345	81,813,067
Restore SFY-2018 Appropriation base		31,557,345	81,813,067
		$103,015,502	**$163,626,135**
FY-2019 Budget Request Totals	**-**	**$38,781,039**	**$224,271,722**

* 1.5 Delayed Provider Payment Cycles from June 2018 to July 2019 due to SFY-2018 Appropriation shortfall

OHCA Board Meeting
February 8, 2018
(December 2017 Data)

SOONERCARE ENROLLMENT/EXPENDITURES

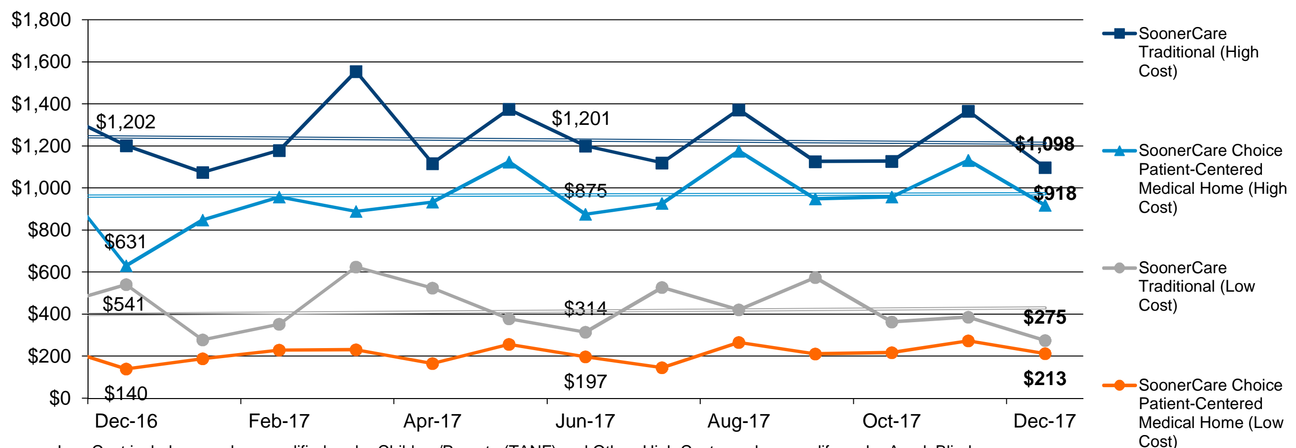
Delivery System			Enrollment December 2017	Children December 2017	Adults December 2017	Enrollment Change	Total Expenditures December	PMPM December 2017	December 2017 Trend PMPM
SoonerCare Choice Patient-Centered Medical Home			**528,165**	**435,424**	**92,741**	**-10,200**	**$143,762,098**		
	Lower Cost	*(Children/Parents; Other)*	483,501	421,170	62,331	-10,348	$102,773,105	$213	$239
	Higher Cost	*(Aged, Blind or Disabled; TEFRA; BCC)*	44,664	14,254	30,410	148	$40,988,993	$918	$1,067
SoonerCare Traditional			**238,754**	**91,241**	**147,513**	**1,634**	**$160,749,755**		
	Lower Cost	*(Children/Parents; Other; Q1; SLMB)*	123,230	86,302	36,928	1,708	$33,910,430	$275	$387
	Higher Cost	*(Aged, Blind or Disabled; LTC; TEFRA; BCC & HCBS Waiver)*	115,524	4,939	110,585	-74	$126,839,325	$1,098	$1,211
SoonerPlan			**30,840**	**2,557**	**28,283**	**-1,485**	**$244,651**	$8	$9
Insure Oklahoma			**19,474**	**490**	**18,984**	**-113**	**$7,159,964**		
	Employer-Sponsored Insurance		14,282	301	13,981	-69	$5,007,012	$351	$352
	Individual Plan		5,192	189	5,003	-44	$2,152,952	$415	$470
TOTAL			**817,233**	**529,712**	**287,521**	**-10,164**	**$311,916,469**		

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.
Dual Eligibles (Medicare & Medicaid) are in the Traditional delivery system in both the Low Cost (Q1 & SLMB) and High Cost (ABD) groups. OTHER includes DDSD, PKU, Q1, Refugee, SLMB, STBS and TB.

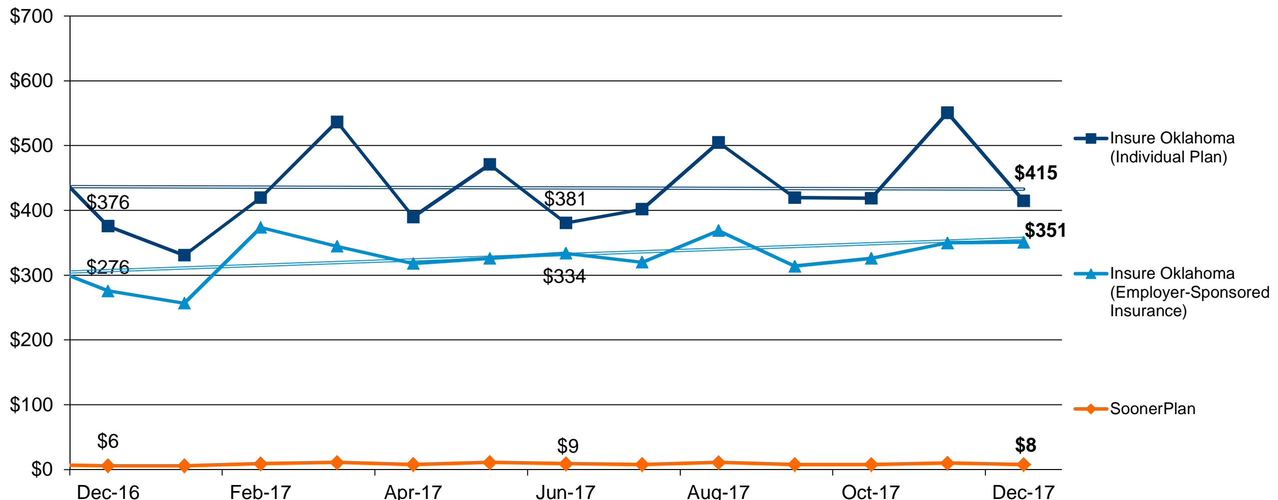
Total In-State Providers: 31,399 (-863)			**(In-State Providers counted multiple times due to multiple locations, programs, types, and specialties)**					
Physician	Pharmacy	Dentist	Hospital	Mental Health	Optometrist	Extended Care	Total PCPs*	PCMH
9,159	982	966	160	3,833	606	391	6,349	2,210

*PCPs consist of all providers contracted as a Certified Registered Nurse Practitioner, Family Practitioner, General Pediatrician, General Practitioner, Internist, General Internist, and Physician Assistant.

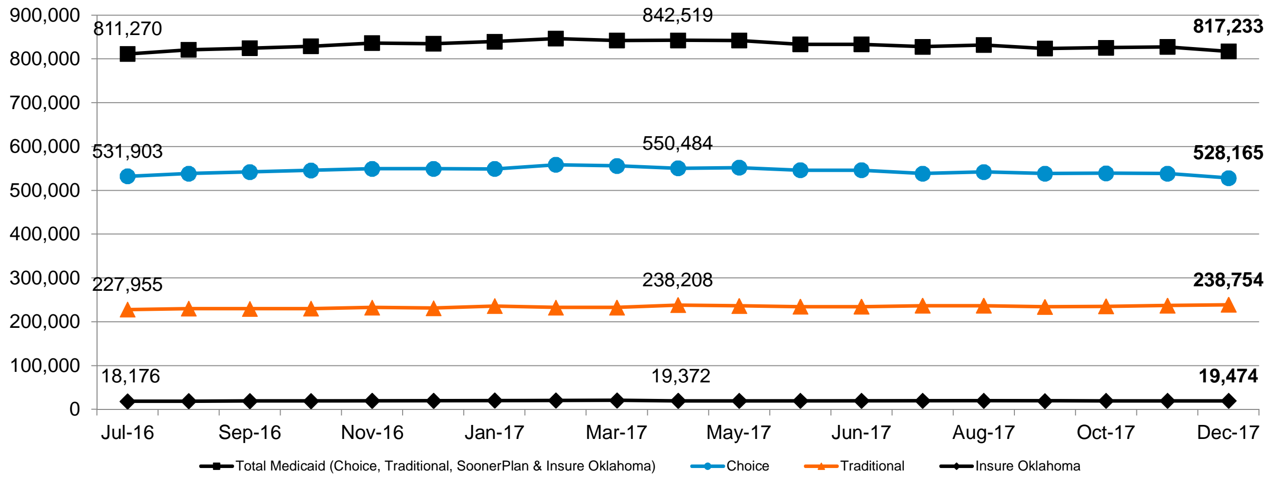
PER MEMBER PER MONTH COST BY GROUP



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.



ENROLLMENT BY MONTH



Legislative Update

Report for Feb. 8, 2018

The Governor will kick off the second regular session of the 56th legislature with her annual State of the State address when session convenes at noon Monday, Feb. 5, 2018.

In addition to conducting regular business, the Legislature will also continue the second special session concurrently. The House and Senate have filed a combined 1,953 bills. The Oklahoma Health Care Authority is tracking about 200 of those bills. Among them include two OHCA request bills:

- **Senate Bill 729** – Sen. Simpson – Medicaid super lien
- **Senate Bill 1094** – Sen. Bergstrom – Removes the requirement that the Attorney General's office appoints the administrative law judge for OHCA provider audit appeals

A list of tracked bills has been included in the board packet.

Upcoming House Legislative Deadlines

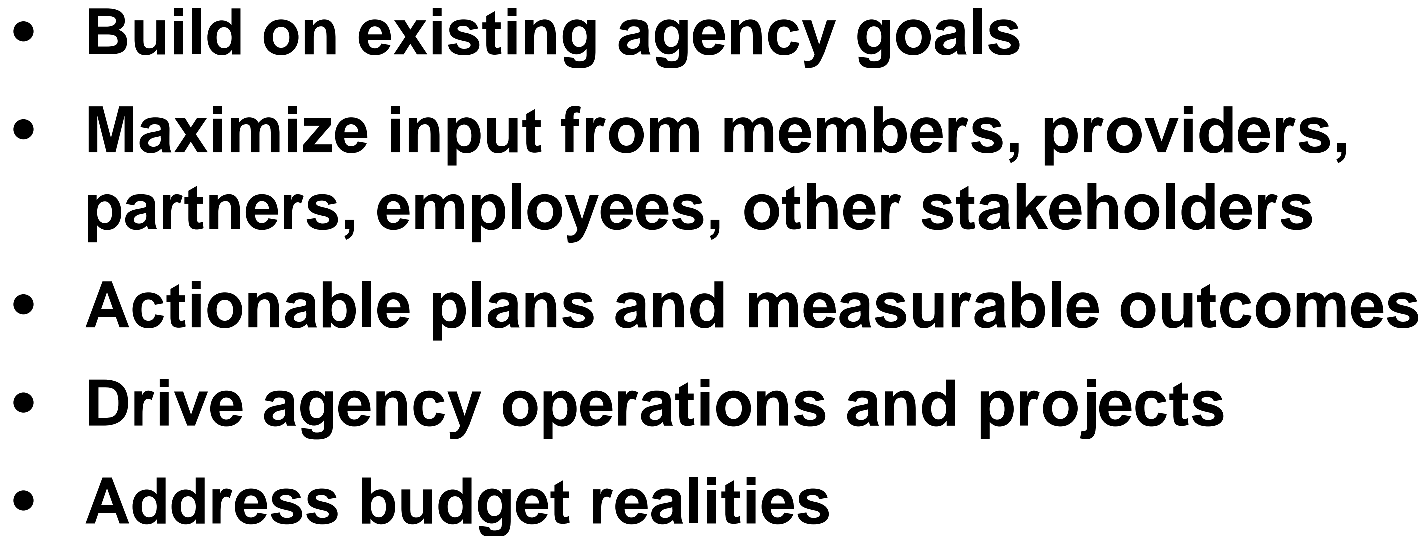
HBs/HJRs out of Subcommittee	Monday, February 19
HBs/HJRs out of Standing Committee	Thursday, March 1
Third Reading of Bills and Joint Resolutions in Chamber of Origin	Thursday, March 22
SBs/SJRs out of Subcommittee	Thursday, April 5
SBs/SJRs out of Standing Committee (Exception for SBs/SHRs in full A&B Committee)	Thursday, April 19
Third Reading of Bills and Joint Resolutions from Opposite Chamber	Thursday, April 26

Upcoming Senate Legislative Deadlines

SB/SJRs from Senate Committees	Thursday, March 1
Third Reading in House of Origin	Thursday, March 15
HB/HJRs from Senate Committees	Thursday, April 12
Third Reading in Opposite House	Thursday, April 26

Sine Die Adjournment (No Later Than 5:00 p.m.) Friday, May 25, 2018

OHCA STRATEGIC PLAN (2018-2022)



- Build on existing agency goals
- Maximize input from members, providers, partners, employees, other stakeholders
- Actionable plans and measurable outcomes
- Drive agency operations and projects
- Address budget realities

PARTICIPATION AND INPUT

June 2017:	Executive Staff, Board SPC
Sept:	Member Survey
Oct:	Stakeholder Strategy Forum
Oct:	Tribal Consultation
Nov:	Employee sessions
Jan 2018:	Executive Staff, Board SPC
Feb:	Board Presentation

Oklahoma HealthCare Authority

OCT. FORUM EVALUATION RESULTS

Ratings on a scale of 0 to 5

Content was relevant and valuable	4.68
Provided a good understanding of OHCA	4.74
Actionable plans, measurable outcomes	4.21
My opinions and ideas were heard	4.68
Better way for stakeholders to participate	4.81

OHCA Goals

Plan Focus Areas

	Responsible Financing	Responsive Programs	Member Engagement	Satisfaction & Quality	Effective Enrollment	Administrative Excellence	Collaboration
Changing Health Behaviors							
Ensuring Rural Access							
Improving Quality							
Legislative and Budget Innovation							
Minimizing Disparities							

Strategies and Objectives
Performance Measures
Action Plans

Oklahoma HealthCare Authority

VISION AND CURRENT STATE

Vision

- **Healthy culture and behaviors**
- **Outstanding provider network**
- **Integrated responsive care focused on prevention**
- **Improved coverage and benefits**
- **Comprehensive member self-service model**

Situational Analysis

- **SWOT – Agency and Environment**
- **Key Points from Subject Matter Experts**
- **Economic and Demographic Data**

TEN STRATEGIES

1. Focus on preventive care
2. Expand care management programs
3. Develop new services and providers for rural areas
4. Develop a continuum of insurance options with comprehensive benefits
5. Improve youth health literacy

TEN STRATEGIES (CONT.)

6. Improve advocacy and understanding
7. Promote cultural sensitivity
8. Develop streamlined online enrollment
9. Expand quality improvement efforts
10. Move to value-based payments

Oklahoma HealthCare Authority

STRATEGY ACTION PLANS

Strategy Description and Objectives

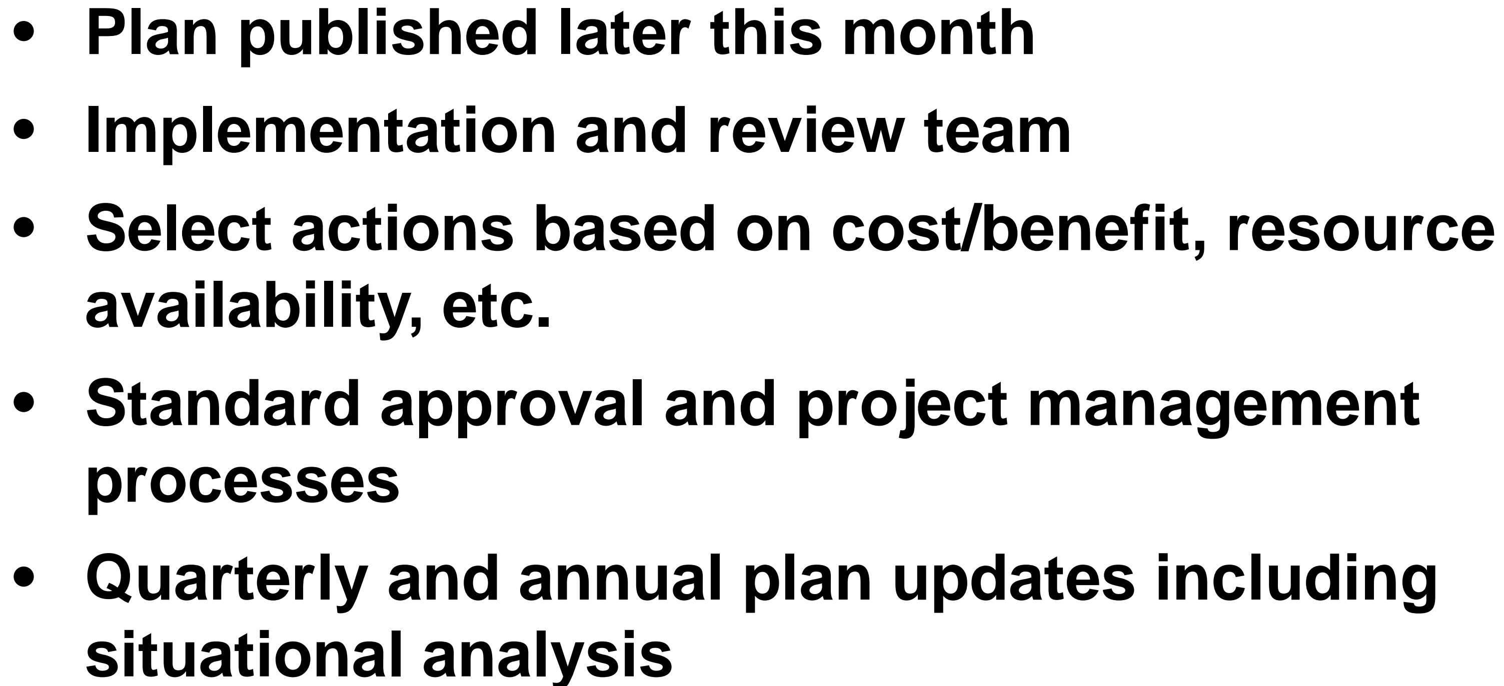
Implementation Activities

- Low to moderate cost/difficulty
- Moderate to high cost/difficulty

Performance Measures

Risks and Constraints

NEXT STEPS



FEBRUARY 8, 2018 OHCA BOARD MEETING

SoonerCare Tribal Consultation 11th Annual Meeting – October 17, 2017

The OHCA Tribal Government Relations team (along with staff from Provider Services and Office of Health Promotion) planned and facilitated the agency's tribal consultation 10th annual meeting on October 17, 2017 in Catoosa. Elected tribal leaders of all 39 tribes in the state, Indian Health Service OKC Area Office leadership, and key tribal health care partners were invited to attend this year's meeting. The purpose of the meeting is for OHCA leadership to listen and learn about how to better partner with tribes in an effort to better serve tribal SoonerCare members and communities. The roundtable format of the meeting encourages open discussion and sharing of best practices among OHCA and tribal leaders from throughout the state.

The meeting began with a breakfast that was sponsored by the Southern Plains Tribal Health Board (SPTHB); and was followed by welcoming remarks from former OHCA Board Chairman Ed McFall, OHCA CEO Rebecca Pasternik-Ikard, and SPTHB Chairperson Marty Wafford. After individual introductions by the attendees, OHCA Tribal Government Relations Director, Dana Miller presented the SFY 2017 Tribal Government Relations Annual Report and Consultation Summary.

Total attendance for the meeting was 48; including tribal leaders and their designees representing 15 tribal governments. Former OHCA Board Chairman Ed McFall and Member Carol Robison, along with 15 OHCA staff were also in attendance.

The roundtable discussion highlighted several topics including success of virtual visits, concern about additional state budget reductions, need for residency programs and increased recruitment of providers in rural areas, importance of dental services for adults, and access to prenatal care. Information that was learned at the meeting will be used to develop an OHCA Tribal Partnership Action Plan. The action plan is a joint effort between OHCA and tribal partners to address common goals, shared resources, and produce positive results for the upcoming year.

Tribes and key stakeholders represented

Absentee Shawnee Tribe of Oklahoma
Caddo Nation
Cherokee Nation of Oklahoma
Cheyenne and Arapaho Tribes of Oklahoma
Chickasaw Nation of Oklahoma
Choctaw Nation of Oklahoma
Citizen Potawatomi Nation
Delaware Nation
Indian Health Care Resource Center of Tulsa
Indian Health Service
Iowa Tribe of Oklahoma
Kickapoo Tribe of Oklahoma
Muscogee (Creek) Nation of Oklahoma
Northeastern Tribal Health System Oklahoma
City Indian Clinic
Oklahoma State Department of Health
Oklahoma State University
Osage Nation
Secretary of Native American Affairs
Sac & Fox Nation of Oklahoma
Shawnee Tribe of Oklahoma
Southern Plains Tribal Health Board
Wichita and Affiliated Tribes

February Board
Proposed Rule Changes

Face-to-face tribal consultations regarding the following proposed changes were held on Tuesday, March 7, 2017; Tuesday, September 5, 2017; Tuesday, November 7, 2017; and Tuesday, January 2, 2018 in the Board Room of the Oklahoma Health Care Authority (OHCA). The proposed rules were presented to the Medical Advisory Committee on Thursday, May 18, 2017; Thursday, September 21, 2017; and/or on Thursday, January 18, 2018. Additionally, the proposed **PERMANENT** rules were presented at a public hearing on Tuesday, January 16, 2018 at 1:00 p.m. in the OHCA Board Room.

APA work folder 17-15 was posted on the OHCA public website for a comment period from December 18, 2017 through January 17, 2018. APA work folders 17-01, 17-03, 17-04 A&B, 17-13, 17-17, 17-19, 17-20, and 17-25 A&B, were posted on the OHCA public website for a comment period from December 15, 2017 through January 16, 2018. APA work folder 17-33B was posted on the OHCA public website for a comment period from January 3, 2018 through January 25, 2018. APA work folder 17-33A was posted on the OHCA public website for a comment period from January 10, 2018 through January 25, 2018.

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

A. AMENDING agency rules at ***OAC 317:35-5-42*** will update Aged, Blind and Disabled (ABD) countable income policy by removing specific amounts for the income disregard of a student's earned income and instead refer to the Oklahoma Department of Human Services (DHS) Appendix C-1. These amounts are used by DHS when determining countable income and eligibility for the ABD category. The Social Security Administration revises the student earned income exclusion yearly. Additionally, the proposed revisions will clarify the definition of student status to ensure that an unintended barrier is not created for the access of SoonerCare services.
Budget Impact: Budget neutral

(Reference APA WF # 17-15)

B. AMENDING agency rules at ***OAC 317:30-5-95 and 317:30-5-95.39*** will revise definitions and align them with federal regulations. Definitions will now be incorporated throughout policy in the Sections in which they are used. In addition, the term "American Osteopathic Accreditation" will be removed as an accrediting body for Psychiatric Residential Treatment Facilities (PRTFs), as it is no longer an accreditation option for this kind of facility. The term "Licensed independent practitioner" will be removed from the rules, and the rules will now specifically explain which types of practitioners can order restraint or seclusion, or perform face-to-face assessments of patients.

Revisions will also align policy with federal requirements for restraint or seclusion. PRTFs, a type of inpatient facility that exclusively serves minors and young adults, must comply with the condition of participation for restraint or seclusion, as is established by 42 C.F.R. §§ 483.350 through 483.376. Additionally, all general and psychiatric hospitals must comply with federally-established standards for restraint or seclusion, in accordance with 42 C.F.R. § 482.13(e) – (g).
Budget Impact: Budget neutral

(Reference APA WF # 17-19)

C. AMENDING agency rules at ***OAC 317:2-1-16*** will revise the grievance procedures and appeals processes for the supplemental payment program for nursing facilities owned and/or operated by non-state government-owned (NSGO) entities. The proposed revisions will remove the program eligibility determination as an appealable issue and requirement that the non-state government-owned entity must have an attorney file their LD-2 form. Finally, revisions will update acronyms, definitions, and references to other legal authorities; and correct grammatical errors.
Budget Impact: There is no cost to the OHCA as the state share will be financed by the NSGO and will be transferred to the state by way of an intergovernmental transfer for claiming of federal financial participation.

(Reference APA WF # 17-33A)

D. AMENDING agency rules at ***OAC 317:30-5-136*** will update and revise the rules for the nursing home supplemental payment program for nursing facilities. Additionally, the proposed revisions will update the care criteria section and eligibility requirements that a nursing facility will be required to meet to receive the upper payment limit (UPL) reimbursement and participate in the UPL program. Finally, revisions will update acronyms, definitions and references to other legal authorities.
Budget Impact: There is no cost to the OHCA as the state share will be financed by the NSGO and will be transferred to the state by way of an intergovernmental transfer for claiming of federal financial participation.

(Reference APA WF # 17-33B)

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.

<u>OHCA Initiated</u>

E. Promulgating previously approved emergency rules through the permanent rulemaking process at ***OAC 317:35-5-41.6*** to comply with federal regulation. Federal regulation now allows mentally competent disabled individuals the same right to create an exempt trust as a parent, grandparent, guardian, or court for trusts established on or after December 13, 2016. Other requirements of these types of trusts which are exempt from Medicaid resource limits remain unchanged.
Budget Impact: Budget neutral

(Reference APA WF # 17-01)

F. Promulgating previously approved emergency rules through the permanent rulemaking process at ***OAC 317:30-5-1096*** to allow Indian Health Services, Tribal Program and Urban Indian Clinics who are designated as Federally Qualified Health Centers to be reimbursed at the Office of Management and Budget rate for services provided outside of the four walls of their facilities. Policy changes were needed in order to comply with federal regulations.
Budget Impact: Services provided to the Native American population are 100 percent federally funded; therefore, no impact on state revenue is expected.

(Reference APA WF # 17-03)

G. Promulgating previously approved emergency rules through the permanent rulemaking process at ***OAC 317:30-3-4.1 and 317:30-3-30*** to clarify that the authentication of medical records is expected on the day the record is completed. Additionally, revisions clarify that the signature of the rendering provider and date entry is expected, rather than required, within three business days from the day the record is completed if the record is being transcribed. These changes superseded a rule that required the record be authenticated within three days of the provision of service.
Budget Impact: Budget neutral

(Reference APA WF # 17-13)

ODMHSAS Initiated

H. Promulgating previously approved emergency rules through the permanent rulemaking process at ***OAC 317:30-5-1207*** to allow a fourth population to be served in the Money Follows the Person (MFP) demonstration. The change allowed transitioning efforts for eligible individuals being discharged from Psychiatric Residential Treatment Facilities (PRTF) back into the community. Oklahoma's MFP Demonstration for PRTF transitioning focuses on transitioning youth 16 to 18 years of age who have been in an inpatient psychiatric residential facility for 90 or more days during an episode of care. The individuals must meet criteria for Level 3 on the Individual Client Assessment Record or meet the criteria of Serious Emotional Disturbance. They may also show critical impairment on a caregiver rated Ohio Scales (score of 25 and above on the Problems Subscale, or a score of 44 and below on the Functioning Subscales). In addition, the individuals are eligible for transitional Health Home services under Oklahoma's Living Choice program. Services are provided in accordance with an individualized plan of care under the direction of appropriate service providers.
ODMHSAS Budget Impact: Costs were realized during promulgation of the emergency rule.

(Reference APA WF # 17-04A)

I. Promulgating previously approved emergency rules through the permanent rulemaking process at ***OAC 317:35-23-2 and 317:35-23-3*** that are tied to APA WF # 17-04A, which allows a fourth population to be served in the Money Follows the Person (MFP) demonstration. Services are provided in accordance with an individualized plan of care under the direction of appropriate service providers. Revisions also replaced the term Intermediate Care Facility for Mentally Retarded with Intermediate Care Facility for Individuals with Intellectual Disabilities.
ODMHSAS Budget Impact: The budget impact is listed in APA WF #17-04A, there are no new costs.

(Reference APA WF # 17-04B)

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

OHCA Initiated

J. AMENDING agency rules at ***OAC 317:30-5-1094*** will update Indian Health Services,

Tribal Program and Urban Indian Clinics (I/T/U) policy by removing the restriction to billing with only a Current Procedural Terminology procedure code for outpatient behavioral health encounters. Revisions will clarify and allow more flexibility when billing for an outpatient behavioral health encounter. Additionally, rules will require that services are billed on an appropriate claim form using the appropriate procedure code and guidelines.
Budget Impact: Services provided to the Native American population are 100% federally funded; therefore, no impact on state revenue is expected.

(Reference APA WF # 17-17)

K. AMENDING agency rules at ***OAC 317:35-5-2, 317:35-5-7, 317:35-5-63, and 317:35-6-1*** will update the Qualifying Categorical Relationship policy by removing the subsection "Grandfathered CHIP children." The current rule identifies that this eligibility group terminated December 31, 2015, necessitating the removal of this subsection from policy to eliminate any confusion.
Budget Impact: Budget neutral

(Reference APA WF # 17-20)

<u>DHS Initiated</u>

L. AMENDING agency rules at ***OAC 317:30-5-482*** will remove treatment extensions for habilitation services authorized by Developmental Disabilities Services area managers. New qualifications for psychological technicians will be added, which will allow for services to be provided under the supervision of a licensed psychologist. Additionally, revisions will require psychologists to implement the Protective Intervention Protocol (PIP) for the member's individual plan. New billing requirements will not allow psychologists to bill for more than twelve hours (48 units) for PIP preparation. The proposed revisions will also request that the authorization period for psychological services be changed from six to twelve months. Lastly, revisions will provide a detailed description and new documentation requirements for prevocational services.
DHS Budget Impact: Budget neutral

(Reference APA WF # 17-25A)

M. AMENDING agency rules at ***OAC 317:40-1-3, 317:40-7-3, and 317:40-7-4*** will affirm a member's rights to have visitors of his/her choosing, under the Home and Community-Based waiver. In addition, revisions will allow eligible members 16 years of age and older, to access waiver employment services through the Home and Community-Based Services waiver. Finally, revisions will also add new language to clarify state-funded employment services are available to members of the Homeward Bound class who are not eligible for Developmental Disabilities Services waiver services.
DHS Budget Impact: Budget neutral

(Reference APA WF # 17-25B)

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

SUBCHAPTER 5. ELIGIBILITY AND COUNTABLE INCOME
PART 5. COUNTABLE INCOME AND RESOURCES

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

(a) **General.** The term income is defined as that gross gain or gross recurrent benefit which is derived from labor, business, property, retirement and other benefits, and many other forms which can be counted on as currently available for use on a regular basis. When an individual's income is reduced due to recoupment of an overpayment or garnishment, the gross amount before the recoupment or garnishment is counted as income. Verification of the member's countable income or resources held in bank accounts or at other financial institutions can be established through an ~~AVS~~Asset Verification System (AVS).

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

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

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

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

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

(1) The value of Supplemental Nutrition Assistance Program (food stamps) received;

(2) Any payment received under Title II of the Uniform Relocation

Assistance and Real Property Acquisition Policies Act of 1970;
(3) Educational grants (excluding work study), scholarships, etc., that are contingent upon the student regularly attending school. The student's classification (graduate or undergraduate) is not a factor;
(4) Loans (regardless of use) if a bona fide debt or obligation to pay can be established. Criteria to establish a loan as bona fide includes:

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

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

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

(5) One-third of child support payments received on behalf of the disabled minor child;
(6) Indian payments (including judgment funds or funds held in trust) distributed by the Secretary of the Interior (BIA) or distributed by the tribe subject to approval by the Secretary of the Interior. Also, any interest or investment income accrued on such funds while held in trust or any purchases made with judgment funds, trust funds, interest or investment income accrued on such funds. Any income from mineral leases, from tribal business investments, etc. However, any interest or income derived from the principal or produced by purchases made with funds after distribution is considered as any other income;
(7) Special allowance for school expenses made available upon petition (in writing) for funds held in trust for the student;
(8) Title III benefits from State and Community Programs on Aging;
(9) Payment for supportive services or reimbursement of out-of-pocket expenses made to individual volunteers serving as foster grandparents, senior health aides, or senior companions, and to persons serving in the Service Corps of Retired Executives (SCORE) and Active Corps of Executives (ACE);
(10) Payments to volunteers under the Domestic Volunteer Services Act of 1973 (VISTA), unless the gross amount of VISTA payments equals or exceeds the state or federal minimum wage, whichever is greater;
(11) The value of supplemental food assistance received under the Child Nutrition Act or the special food service program for children under the ~~national~~National School Lunch Act;

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

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

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

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

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

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

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

(32) Income tax refunds;

(33) Home energy assistance;

(34) Food or shelter based on need provided by nonprofit agencies;

(35) Money someone else spends to pay your expenses for items other than food or shelter (e.g., someone pays for your telephone or medical bills);

(36) ~~Earnings up to $1,750 per month to a maximum of $7,060 per year (effective January 2014) for a student under age 22~~Earned income for working students younger than 22 years of age when they regularly attend a school, college, university or a course of vocational or technical training. Refer to Appendix C-1, Schedule VIII.E; Maximum Income, Resource and Payment Standards for the maximum monthly and yearly exclusion amounts;

(37) The cost of impairment-related work expenses for items or services that a disabled person needs in order to work; and

(38) The first $2,000 of compensation received per calendar year for participating in certain clinical trials~~;~~.

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

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

(2) If a member is determined to be categorically needy and is also an SSI recipient, any change in countable income (see OAC 317:35-5-42(d)(3) to determine countable income) will not affect receipt of SoonerCare and amount of State Supplemental Payment (SSP) as long as the amount does not cause SSI ineligibility. Income which will be considered by SSI in the retrospective cycle is documented in the case with computer update at the time that SSI

makes the change (in order not to penalize the member twice). If the SSI change is not timely, the worker updates the computer using the appropriate date as if it had been timely. If the receipt of the income causes SSI ineligibility, the income is considered immediately with proper action taken to reduce or close the SoonerCare benefit and SSP case. Any SSI overpayment caused by SSA not making timely changes will result in recovery by SSI in the future. When the worker becomes aware of income changes which will affect SSI eligibility or payment amount, the information is to be shared with the SSA office.

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

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

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

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

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

(III) by using BENDEX and SDX.

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

(iii) The Veterans Administration allows their recipients the opportunity to request a reimbursement for medical expenses not covered by SoonerCare. If a recipient is eligible for the readjustment payment, it is paid in a lump sum for the entire past year. This reimbursement is disregarded as income and a resource in the month it is received; however, any amount retained in the month following receipt is considered a resource.

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

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

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

(v) Veterans or their surviving spouse who receive a VA pension may have their pension reduced to $90 by the VA if the veteran does not have dependents, is SoonerCare eligible, and is residing in a nursing facility that is approved under

SoonerCare. Section 8003 of Public Law 101-508 allows these veterans' pensions to be reduced to $90 per month. None of the $90 may be used in computing any vendor payment or spenddown. In these instances, the nursing home resident is entitled to the $90 reduced VA pension as well as the regular nursing facility maintenance standard. Any vendor payment or spenddown will be computed by using other income minus the monthly nursing facility maintenance standard minus any applicable medical deduction(s). Veterans or their surviving spouse who meet these conditions will have their VA benefits reduced the month following the month of admission to a SoonerCare approved nursing facility.

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

(C) **Lump sum payments.**

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

(ii) Lump sum payments used to establish dedicated bank accounts by representative payees in order to receive and maintain retroactive SSI benefits for disabled/blind children under age 18 are excluded as income. The interest income generated from dedicated bank accounts is also excluded. The dedicated bank account consisting of the retroactive SSI lump sum payment and accumulated interest is excluded as a resource in both the month received and any subsequent months.

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

(iv) Changing a resource from one form to another, such as

converting personal property to cash, is not considered a lump sum payment.

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

(i) If royalty income is received monthly but in irregular amounts, an average based on the previous six months' royalty income is computed and used to determine income eligibility. When the difference between the gross and net income represents a production or severance tax (e.g., most oil royalties are reduced by this tax), the OHCA only uses the net figure when determining income eligibility. The production or severance tax is the cost of producing the income, and, therefore, is deducted from the gross income. Exception: At any time that the county becomes aware of and can establish a trend showing a dramatic increase or decrease in royalty income, the previous two months' royalty income is averaged to compute countable monthly income.

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

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

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

coordination with SoonerCare benefits.

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

(ii) Money from the sale of whole blood or blood plasma is considered as self-employment income subject to necessary business expenses and appropriate earned income disregards.

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

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

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

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

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

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

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

(F) **Infrequent or irregular income.**

(i) Income is considered to be infrequent if the individual

receives it only once during a calendar quarter from a single source and the individual did not receive that type of income in the month preceding or following the month the income was received.
(ii) Income is considered to be irregular if the individual cannot reasonably expect to receive it.
(iii) OHCA excludes the following amount of infrequent or irregular income:
(I) the first $30 per calendar quarter of earned income; and
(II) the first $60 per calendar quarter of unearned income.
(iv) Infrequent or irregular income, whether earned or unearned, that exceeds these amounts is considered countable income in the month it is received.
(G) **Monthly income received in fluctuating amounts.** Income which is received monthly but in irregular amounts is averaged using two months' income, if possible, to determine income eligibility. Less than two months' income may be used when circumstances (e.g., new employment, unpaid sick leave, etc.) would indicate that previous income amounts would not be appropriate to use in determining future income amounts. Income received more often than monthly is converted to monthly amounts as follows:
(i) **Daily.** Income received on a daily basis is converted to a weekly amount then multiplied by 4.3.
(ii) **Weekly.** Income received weekly is multiplied by 4.3.
(iii) **Twice a month.** Income received twice a month is multiplied by 2.
(iv) **Biweekly.** Income received every two weeks is multiplied by 2.15.
(H) **Non-negotiable notes and mortgages.** Installment payments received on a note, mortgage, etc., are considered as monthly income.
(I) **Income from the Job Training and Partnership Act (JTPA).** Unearned income received by an adult, such as a needs based payment, cash assistance, compensation in lieu of wages, allowances, etc., from a program funded by JTPA is considered as any other unearned income. JTPA earned income received as wages is considered as any other earned income.
(J) **Other income.** Any other monies or payments which are available for current living expenses must be considered.
(d) **Computation of income.**
(1) **Earned income or unearned income.** The general income exclusion of $20 per month is allowed for earned or unearned income, unless the unearned income is SSP, on the combined income of the eligible individual and eligible or ineligible spouse. See paragraph (5) of this subsection if there are ineligible minor

children. After the $20 exclusion, deduct $65 and one-half of the remaining combined earned income. The total gross amount of unearned income of the eligible individual and eligible or ineligible spouse is considered.
(2) **Countable income.** The countable income is the sum of the earned income and the total gross unearned income after exclusions.
(3) **Deeming computation for disabled or blind minor child(ren).** An automated calculation is available for computing the income amount to be deemed from parent(s) and the spouse of the parent to eligible disabled or blind minor child(ren) by use of transaction CID. The ineligible minor child in the computation regarding allocation for ineligible child(ren) is defined as: a dependent child under age 18.
(A) An intellectually disabled child living in the home who is ineligible for SSP due to the deeming process may be approved for SoonerCare under the Home and Community Based Services Waiver (HCBS) Program as outlined in OAC 317:35-9- 5.
(B) For TEFRA, the income of child's parent(s) is not deemed to him/her.
(4) **Premature infants.** Premature infants (i.e., 37 weeks or less) whose birth weight is less than 1200 grams (approximately 2 pounds 10 ounces) will be considered disabled by SSA even if no other medical impairment(s) exist. In this event, the parents' income is not deemed to the child until the month following the month in which the child leaves the hospital and begins living with his/her parents.
(5) **Procedures for deducting ineligible minor child allocation.** When an eligible individual has an ineligible spouse and ineligible minor children (not receiving TANF), the computation is as follows:
(A) Each ineligible child's allocation (OKDHS Form 08AX001E, Schedule VII. C.) minus each child's gross countable income is deducted from the ineligible spouse's income. Deeming of income is not done from child to parent.
(B) The deduction in subparagraph (A) of this paragraph is prior to deduction of the general income exclusion and work expense.
(C) After computations in subparagraphs (A) and (B) of this paragraph, the remaining amount is the ineligible spouse's countable income considered available to the eligible spouse.
(6) **Special exclusions for blind individuals.** Any blind individual who is employed may deduct the general income exclusion and the work exclusion from the gross amount of earned income. After the application of these exclusions, one-half of the remaining income is excluded. The actual work expense is then deducted from the remaining half to arrive at the amount of countable income. If this blind individual has a spouse who is also eligible due to blindness and both are working, the amount of ordinary and necessary expenses attributable to the earning of income for each of the blind individuals may be deducted. Expenses are deductible as paid but may not exceed the amount

of earned income. To be deductible, an expense need not relate directly to the blindness of the individual, it need only be an ordinary and necessary work expense of the blind individual. Such expenses fall into three broad categories:

(A) transportation to and from work;
(B) job performance; and
(C) job improvement.

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 6. INPATIENT PSYCHIATRIC HOSPITALS

317:30-5-95. General provisions and eligible providers
~~(a) Inpatient psychiatric hospitals or psychiatric units provide treatment in a hospital setting 24 hours a day. Psychiatric Residential Treatment Facilities (PRTF) provide non-acute inpatient facility care for members who have a behavioral health disorder and need 24-hour supervision and specialized interventions. Payment for psychiatric and/or chemical dependency/detoxification services for adults between the ages of 21 and 64 are limited to acute inpatient hospital settings.~~
~~(b) **Definitions.** The following words and terms, when used in this Part, shall have the following meaning, unless the context clearly indicates otherwise:~~

~~(1) **"AOA"** means American Osteopathic Accreditation.~~

~~(2) **"CARF"** means the Commission on Accreditation of Rehabilitation Facilities.~~

~~(3) **"Licensed independent practitioner (LIP)"** means any individual permitted by law and by the licensed hospital to provide care and services, without supervision, within the scope of the individual's license and consistent with clinical privileges individually granted by the licensed hospital. Licensed independent practitioners may include Advanced Practice Nurses (APN) with prescriptive authority and Physician Assistants.~~

~~(4) **"Psychiatric Residential Treatment Facility (PRTF)"** means a facility other than a hospital.~~

~~(5) **"Restraint"** means any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a member to move his or her arms, legs, body, or head freely, or drug or medication when it is used as a restriction to manage the member's behavior or restrict the member's freedom of movement and is not the standard treatment or dosage for the member's condition. Restraint does not include devices such as orthopedically prescribed devices, surgical dressings or bandages, protective helmets, or other methods that involve the physical holding of a member for the purpose of conducting routine physical examinations or tests, or to protect the member from falling out of bed, or to permit the member to participate in activities without the risk of physical harm (this does not include physical escort).~~

~~(6) **"Seclusion"** means the involuntary confinement of a member alone in a room or area from which the member is physically prevented from leaving and may only be used for the management of violent or self-destructive behavior that jeopardizes the~~

~~immediate physical safety of the member, a staff member, or others.~~

~~(7) **"TJC"** means The Joint Commission.~~

~~(c) **Hospitals and freestanding psychiatric facilities.** To be eligible for payment under this Section, inpatient psychiatric programs must be provided to eligible SoonerCare members in a hospital that is:~~

~~(1) appropriately licensed and surveyed by the state survey agency;~~

~~(2) accredited by TJC; and~~

~~(3) contracted with the Oklahoma Health Care Authority (OHCA).~~

~~(d) **Psychiatric Residential Treatment Facility (PRTF).** A PRTF is any non-hospital facility contracted with the OHCA to provide inpatient services to SoonerCare eligible members under the age of 21. To enroll as a hospital-based or freestanding PRTF, the provider must be appropriately state licensed pursuant to Title 10 O.S. Section 402 accredited by TJC, CARF, COA or AOA and approved by the OHCA to provide services to individuals under age 21. Distinct PRTF units of state operated psychiatric hospitals serving individuals ages 18-22 are exempt from licensure pursuant to Title 63 O.S. Section 1-702. Out-of-state PRTFs should be appropriately licensed in the state in which they do business. In addition, the following requirements must be met:~~

~~(1) **Restraint and seclusion reporting requirements.** In accordance with Federal Regulations at 42 CFR 483.350, the OHCA requires a PRTF that provides SoonerCare inpatient psychiatric services to members under age 21 to attest, in writing, that the facility is in compliance with all of the standards governing the use of restraint and seclusion. The attestation letter must be signed by an individual who has the legal authority to obligate the facility. OAC 317:30-5-95.39 describes the documentation required by the OHCA.~~

~~(2) **Attestation letter.** The attestation letter at a minimum must include:~~

~~(A) the name and address, telephone number of the facility, and a provider identification number;~~

~~(B) the signature and title of the individual who has the legal authority to obligate the facility;~~

~~(C) the date the attestation is signed;~~

~~(D) a statement certifying that the facility currently meets all of the requirements governing the use of restraint and seclusion;~~

~~(E) a statement acknowledging the right of the State Survey Agency (or its agents) and, if necessary, Center for Medicare and Medicaid Services (CMS) to conduct an on-site survey at any time to validate the facility's compliance with the requirements of the rule, to investigate complaints lodged against the facility, or to investigate serious occurrences;~~

~~(F) a statement that the facility will notify the OHCA and the State Health Department if it no longer complies with the requirements; and~~

~~(G) a statement that the facility will submit a new attestation of compliance in the event the individual who has the legal authority to obligate the facility is no longer in such position.~~

~~(3) **Reporting of serious injuries or deaths.** Each PRTF is required to report a resident's death, serious injury, and a resident's suicide attempt to the OHCA, and unless prohibited by state law, to the state-designated Protection and Advocacy System (P and As). In addition to reporting requirements contained in this section, facilities must report the death of any resident to the CMS regional office no later than close of business the next business day after the resident's death. Staff must document in the resident's record that the death was reported to the CMS Regional Office.~~

~~(c) **Required documents.** The required documents for enrollment for each participating provider can be downloaded from the OHCA's website.~~

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

(1) **"C.F.R."** means Code of Federal Regulations.

(2) **"CMS"** means Centers for Medicare and Medicaid Services.

(3) **"General Hospital"** means a general medical surgical hospital, as defined by 63 Oklahoma Statutes, Sec. 1-701(2).

(4) **"Institution for Mental Diseases (IMD)"** means a hospital, nursing facility, or other institution of more than sixteen (16) beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services, as defined by 42 C.F.R. § 435.1010.

(5) **"OHCA"** means Oklahoma Health Care Authority.

(6) **"O.S."** means Oklahoma Statutes.

(7) **"Psychiatric Hospital"** means an institution which is primarily engaged in providing, by or under the supervision of a physician, psychiatric services for the diagnosis and treatment of mentally ill persons, as defined by 42 of the United States Code, Sec. 1395x(f).

(8) **"Psychiatric Residential Treatment Facility (PRTF)"** means a non-hospital facility contracted with the OHCA to provide inpatient psychiatric services to SoonerCare-eligible members under the age of twenty-one (21), as defined by 42 C.F.R. § 483.352.

(9) **"U.S.C."** means United States Code.

(b) **Eligible settings for inpatient psychiatric services.** The following individuals may receive SoonerCare-reimbursable inpatient psychiatric services in the following eligible settings:

(1) Individuals twenty-one (21) to sixty-four (64) years of age

may receive SoonerCare-reimbursable inpatient psychiatric and/or chemical dependency/substance use/detoxification services in a psychiatric unit of a general hospital.

(2) Individuals sixty-five (65) years of age or older may receive SoonerCare-reimbursable inpatient psychiatric services in a psychiatric unit of a general hospital, or in a psychiatric hospital.

(3) Individuals under twenty-one (21) years of age, in accordance with OAC 317:30-5-95.23, may receive SoonerCare-reimbursable inpatient psychiatric services in a psychiatric unit of a general hospital, a psychiatric hospital, or a PRTF.

(c) **Psychiatric hospitals and psychiatric units of general hospitals.** To be eligible for payment under this Part, inpatient psychiatric programs must be provided to eligible SoonerCare members in a hospital that:

(1) is a psychiatric hospital that:

(A) successfully underwent a State survey to determine whether the hospital meets the requirements for participation in Medicare as a psychiatric hospital per 42 C.F.R. § 482.60; or

(B) is accredited by a national organization whose psychiatric accrediting program has been approved by CMS; or

(2) is a general hospital with a psychiatric unit that:

(A) successfully underwent a State survey to determine whether the hospital meets the requirements for participation in Medicare as a hospital as specified in 42 C.F.R. Part 482; or

(B) is accredited by a national accrediting organization whose accrediting program has been approved by CMS; and

(3) meets all applicable federal regulations, including, but not limited to:

(A) Medicare Conditions of Participation for Hospitals (42 C.F.R. Part 482), including special provisions applying to psychiatric hospitals (42 C.F.R. §§ 482.60-.62);

(B) Medicaid for Individuals Age 65 or over in Institutions for Mental Diseases (42 C.F.R. Part 441, Subpart C);

(C) Inpatient Psychiatric Services for Individuals under Age 21 in Psychiatric Facilities or Programs (42 C.F.R. Part 441, Subpart D); and/or

(D) Utilization Control [42 C.F.R. Part 456, Subpart C (Utilization Control: Hospitals) or Subpart D (Utilization Control: Mental Hospitals)]; and

(4) is contracted with the OHCA; and

(5) if located within Oklahoma and serving members under eighteen (18) years of age, is appropriately licensed by the Oklahoma Department of Human Services (DHS) as a residential child care facility (10 O.S. §§ 401 to 402) that is providing services as a residential treatment facility in accordance with OAC 340:110-3-168.

(d) **PRTF.** Every PRTF must:

(1) be individually contracted with OHCA as a PRTF;
(2) meet all of the state and federal participation requirements for SoonerCare reimbursement, including, but not limited to, 42 C.F.R. § 483.354, as well as all requirements in 42 C.F.R. Part 483, Subpart G governing the use of restraint and seclusion;
(3) be appropriately licensed by DHS as a residential child care facility (10 O.S. §§ 401 to 402) that is providing services as a residential treatment facility in accordance with OAC 340:110-3-168; and
(4) be accredited by TJC, the Council on Accreditation of Rehabilitation Facilities (CARF), or the Council on Accreditation (COA).

(e) **Out-of-state PRTF.** Any out-of-state PRTF must be appropriately licensed and/or certified in the state in which it does business, and must provide an attestation to OHCA that the PRTF is in compliance with the condition of participation for restraint and seclusion, as is required by federal law. Any out-of-state PRTF must also be accredited in conformance with OAC 317:30-5-95(d)(4).

(f) **Required documents.** The required documents for enrollment for each participating provider can be downloaded from the OHCA's website.

317:30-5-95.39. ~~Seclusion, restraint~~ Restraint, seclusion, and serious ~~incident~~ occurrence reporting requirements for ~~children~~members under the age of twenty-one (21)

~~(a) Restraint or seclusion may only be used when less restrictive interventions have been determined to be ineffective to protect the member, a staff member or others from harm and may only be imposed to ensure the immediate physical safety of the member, a staff member or others. The use of restraint or seclusion must be in accordance with a written modification to the member's individual plan of care. The type or technique of restraint or seclusion used must be the least restrictive intervention that will be effective to protect the member or others from harm. Restraint or seclusion must be discontinued at the earliest possible time, regardless of the length of time identified in the order. Mechanical restraints will not be used on children under age 18.~~

~~(1) Each facility must have policies and procedure to describe the conditions, in which seclusion and restraint would be utilized, the behavioral/management intervention program followed by the facility and the documentation required. Each order by a physician or Licensed Independent Practitioner (LIP) may authorize the RN to continue or terminate the restraint or seclusion based on the member's face to face evaluation. Each order for restraint or seclusion may only be renewed in accordance with the following limits for up to a total of 24 hours:~~

~~(A) four hours for children 18 to 20 years of age;~~
~~(B) two hours for children and adolescents nine to 17 years of age; or~~

~~(C) one hour for children under nine years of age.~~

~~(2) The documentation required to ensure that seclusion and restraint was appropriately implemented and monitored will include at a minimum:~~

~~(A) documentation of events leading to intervention used to manage the violent or self-destructive behaviors that jeopardize the immediate physical safety of the member or others;~~

~~(B) documentation of alternatives or less restrictive interventions attempted;~~

~~(C) an order for seclusion/restraint including the name of the LIP, date and time of order;~~

~~(D) orders for the use of seclusion/restraint must never be written as a standing order or on an as needed basis;~~

~~(E) documentation that the member continually was monitored face to face by an assigned, trained staff member, or continually monitored by trained staff using both video and audio equipment during the seclusion/restraint;~~

~~(F) the results of a face to face assessment completed within one hour by a LIP or RN who has been trained in accordance with the requirements specified at OAC 317:30-5-95.35 to include the:~~

~~(i) member's immediate situation;~~

~~(ii) member's reaction to intervention;~~

~~(iii) member's medical and behavioral conditions; and~~

~~(iv) need to continue or terminate the restraint or seclusion.~~

~~(G) in events the face to face was completed by a trained RN, documentation that the trained RN consulted the attending physician or other LIP responsible for the care of the member as soon as possible after the completion of the one-hour face to face evaluation;~~

~~(H) debriefing of the child within 24 hours by an LBHP or licensure candidate;~~

~~(I) debriefing of staff within 48 hours; and~~

~~(J) notification of the parent/guardian.~~

~~(b) Staff must be trained and able to demonstrate competency in the application of restraints, implementation of seclusion, monitoring, assessment, and providing care for a member in restraint or seclusion before performing any of these actions and subsequently on an annual basis. The PRTF must require appropriate staff to have education, training, and demonstrated knowledge based on the specific needs of the member population in at least the following:~~

~~(1) techniques to identify staff and member behaviors, events, and environmental factors that may trigger circumstances that require the use of restraint or seclusion;~~

~~(2) the use of nonphysical intervention skills;~~

~~(3) choosing the least restrictive intervention based on an individualized assessment of the member's medical behavior status or condition;~~

~~(4) the safe application and use of all types of restraint or~~

~~seclusion used in the PRTF, including training in how to recognize and respond to signs of physical and psychological distress;~~

~~(5) clinical identification of specific behavioral changes that indicate that restraint or seclusion is no longer necessary;~~

~~(6) monitoring the physical and psychological well-being of the member who is restrained or secluded, including but not limited to, respiratory and circulatory status, skin integrity, vital signs, and any special requirements specified by the policy of the PRTF associated with the one hour face to face evaluation; and~~

~~(7) the use of first aid techniques and certification in the use of cardiopulmonary resuscitation, including annual re-certification.~~

~~(c) Individuals providing staff training must be qualified as evidence by education, training and experience in techniques used to address members' behaviors. The PRTF must document in staff personnel records that the training and demonstration of competency were successfully completed.~~

~~(d) The process by which a facility is required to inform the OHCA of a death, serious injury, or suicide attempt is as follows:~~

~~(1) The hospital administrator, executive director, or designee is required to contact the OHCA Behavioral Health Unit by phone no later than 5:00 p.m. on the business day following the incident.~~

~~(2) Information regarding the SoonerCare member involved, the basic facts of the incident, and follow-up to date must be reported. The agency will be asked to supply, at a minimum, follow-up information with regard to member outcome, staff debriefing and programmatic changes implemented (if applicable).~~

~~(3) Within three days, the OHCA Behavioral Health Unit must receive the above information in writing (example: Facility Critical Incident Report).~~

~~(4) Member death must be reported to the OHCA Behavioral Health Services Unit as well as to the Centers for Medicare and Medicaid Regional office in Dallas, Texas.~~

~~(5) Compliance with seclusion and restraint reporting requirements will be verified during the onsite inspection of care see OAC 317:30-5-95.42, or using other methodologies.~~

(a) All PRTFs must comply with the condition of participation for restraint or seclusion, as is established by 42 C.F.R. §§ 483.350 through 483.376, which is hereby incorporated by reference in its entirety. All general and psychiatric hospitals must comply with the standard for restraint or seclusion, as is established by 42 C.F.R. § 482.13(e) - (g), which is hereby incorporated by reference in its entirety. In the case of any inconsistency or duplication between these federal regulations and OAC 317:30-5-95.39, the federal regulations shall prevail, except where OAC 317:30-5-95.39 and/or other Oklahoma law is more protective of a member's health, safety, or well-being.

(b) Restraint or seclusion may only be used when less restrictive interventions have been determined to be ineffective to protect the member, a staff member, or others from harm and may only be imposed to ensure the immediate physical safety of the member, a staff member, or others. The use of restraint or seclusion must be in accordance with a written modification to the member's individual plan of care. The type or technique of restraint or seclusion used must be the least restrictive intervention that will be effective to protect the member or others from harm. Restraint or seclusion must be discontinued at the earliest possible time, regardless of the length of time identified in the order. Mechanical restraints will not be used on children under age eighteen (18).

(1) Each facility must have policies and procedure to describe the conditions in which restraint or seclusion would be utilized, the behavioral/management intervention program followed by the facility, and the documentation required. Restraint or seclusion may only be ordered by the following individuals trained in the use of emergency safety interventions: a Physician; a Physician Assistant (PA); or an Advanced Practice Registered Nurse (APRN) with prescriptive authority. If, however, the member's treatment team physician is available, then only he or she can order restraint or seclusion. Each order for restraint or seclusion may only be renewed in accordance with the following limits for up to a total of twenty-four (24) hours:

(A) four (4) hours for adults eighteen (18) to twenty-one (21) years of age;

(B) two (2) hours for children and adolescents nine (9) to seventeen (17) years of age; or

(C) one (1) hour for children under nine (9) years of age.

(2) An order for the use of restraint/seclusion must never be written as a standing order or on an as-needed basis.

(3) The documentation required to ensure that restraint or seclusion was appropriately implemented and monitored will include, at a minimum:

(A) documentation of events leading to intervention used to manage the violent or self-destructive behaviors that jeopardize the immediate physical safety of the member or others;

(B) documentation of alternatives or less restrictive interventions attempted;

(C) a signed order for restraint/seclusion that includes the name of the individual ordering the restraint/seclusion, the date and time the order was obtained, and the length of time for which the order was authorized;

(D) the time the restraint/seclusion actually began and ended;

(E) the name of staff involved in the restraint/seclusion;

(F) documentation sufficient to show the member was monitored in accordance with 42 C.F.R. § 482.13(e) (for general and psychiatric hospitals) or 42 C.F.R. §§ 483.362 and 483.364

(for PRTFs), as applicable;
(G) the time and results of a face-to-face assessment completed within one (1) hour after initiation of the restraint/seclusion by a Physician, PA, APRN with prescriptive authority, or Registered Nurse, who has been trained in the use of emergency safety interventions. The assessment must evaluate the member's well-being, including those criteria set forth in 42 C.F.R. § 482.13(e) (for general and psychiatric hospitals) or 42 C.F.R. § 483.358(f) (for PRTFs), as applicable;
(H) in the event the face-to-face assessment was completed by anyone other than the member's treatment team physician, documentation that he or she consulted the member's treatment team physician as soon as possible after completion of the face-to-face assessment;
(I) debriefing of the child and staff involved in the emergency safety intervention within twenty-four (24) hours, in accordance with 42 C.F.R. § 483.370, as applicable;
(J) debriefing of all staff involved in the emergency safety intervention and appropriate supervisory and administrative staff within twenty-four (24) hours, in accordance with 42 C.F.R. § 483.370, as applicable; and
(K) for minors, notification of the parent(s)/guardian(s).

(c) Serious occurrences, including death, serious injury, or suicide attempt, must be reported as follows:

(1) In accordance with 42 C.F.R. § 483.374, PRTFs must notify the OHCA Behavioral Health Unit and Oklahoma Department of Human Services (DHS) by phone no later than 5:00 p.m. on the business day following a serious occurrence and disclose, at a minimum: the name of the member involved in the serious occurrence; a description of the occurrence; and the name, street address, and telephone number of the facility.

(A) Within three (3) days of the serious occurrence, a PRTF must also submit a written Facility Critical Incident Report to the OHCA Behavioral Health Unit containing: the information in OAC 317:30-5-95.39(c)(1), above; and any available follow-up information regarding the member's condition, debriefings, and programmatic changes implemented (if applicable). A copy of this report must be maintained in the member's record, along with the names of the persons at OHCA and DHS to whom the occurrence was reported. A copy of the report must also be maintained in the incident and accident report logs kept by the facility.
(B) In the case of a minor, the PRTF must also notify the member's parent(s) or legal guardian(s) as soon as possible, and in no case later than twenty-four (24) hours after the serious occurrence.

(2) In addition to the requirements in paragraph (1), above, the death of any member must be reported in accordance with 42 C.F.R. § 482.13(g) (hospital reporting requirements for deaths associated with the use of seclusion or restraint) or 42 C.F.R.

§ 483.374(c) (PRTF reporting requirements for deaths), as applicable.

(d) In accordance with 42 C.F.R. § 483.374(a), OHCA requires all PRTFs that provide SoonerCare inpatient psychiatric services to members under age twenty-one (21) to attest in writing at the time of contracting, that the facility is in compliance with all federal standards governing the use of restraint and seclusion. The attestation letter must be signed by the facility director, and must include, at a minimum:

(1) the name, address, and telephone number of the facility, and its provider identification number;

(2) the name and signature of the facility director;

(3) the date the attestation is signed;

(4) a statement certifying that the facility currently meets all of the federal requirements governing the use of restraint and seclusion;

(5) a statement acknowledging the right of OHCA, the Center for Medicare and Medicaid Services (CMS), and/or any other entity authorized by law, to conduct an on-site survey at any time to validate the facility's compliance with 42 C.F.R. §§ 483.350 through 483.376, to investigate complaints lodged against the facility, and to investigate serious occurrences;

(6) a statement that the facility will notify the OHCA if it is out of compliance with 42 C.F.R. §§ 483.350 through 483.376; and

(7) a statement that the facility will submit a new attestation of compliance in the event the facility director changes, for any reason.

TITLE 317: OKLAHOMA HEALTH CARE AUTHORITY

CHAPTER 2. GRIEVANCE PROCEDURES AND PROCESS

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

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

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

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

(3) To file an appeal, the ~~provider (Appellant~~NSGO (appellant is the ~~provider~~NSGO who files an appeal) shall file an LD-2 form within twenty (20) days from the date of the OHCA letter which advises the ~~provider~~NSGO of ~~the program eligibility determination,~~ component of ~~intergovernmental transfer (IGT)~~IGT, UPL payment, UPL ~~GAP~~Gap payment and/or a penalty. An IGT that is not received by the date specified by OHCA, or that is not in the total amount indicated on the ~~NPR shall~~notice of program reimbursement (NPR) shall be subject to penalty and suspension from the program. Any applicable penalties ~~must~~shall also be deducted from the UPL payment regardless of any appeal action requested by the facility. Any change in the payment amount resulting from an appeals decision in which a recoupment or additional allocation is necessary will be adjusted in the future from any ~~Medicaid~~SoonerCare payments.

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

~~(4)~~(5) Consistent with Oklahoma rules of practice, the non-state ~~government owned~~government-owned (NSGO) entity ~~must~~shall be represented by an attorney licensed to practice within the State of Oklahoma. Attorneys not licensed to practice in Oklahoma ~~must~~shall comply with ~~5 O.S. Art II,~~

~~Sec. 5~~ Article II, Section (§) 5 of Title 5 of the Oklahoma Statutes (O.S.), and rules of the Oklahoma Bar Association.

~~(5)~~(6) The hearing will be conducted in an informal manner, without formal rules of evidence or procedure. However, parties who fail to appear at a hearing, after notification of said hearing date, will have their cases dismissed for failure to prosecute.

~~(6)~~(7) The ~~provider~~appellant has the burden of proof by the preponderance of the evidence standard as defined by the Oklahoma Supreme Court.

~~(7)~~(8) The docket clerk will send the ~~Appellant~~appellant and any other necessary party a notice which states the hearing location, date, and time.

~~(8)~~(9) The ALJ may:

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

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

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

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

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

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

(G) Rule on whether discovery requests are relevant;

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

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

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

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

(L) Dismiss an issue or appeal if:

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

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

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

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

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

~~(9)~~(10) After the hearing:

(A) The ALJ should attempt to make the final hearing decision within ninety (90) days from the date of the hearing and send a copy of the ALJ's decision to both parties outlining their rights to appeal the decision. Any appeal of the final order pursuant to 12 O.S. § 951 ~~must~~shall be filed with the District Court of Oklahoma County within 30 days.

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

~~(10)~~(11) All orders and settlements are non-precedential decisions.

~~(11)~~(12) The hearing shall be digitally recorded and closed to the public.

~~(12)~~(13) The case file and any audio recordings shall remain confidential.

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 9. ~~LONG TERM~~LONG-TERM CARE FACILITIES

317:30-5-136. Nursing Facility Supplemental Payment Program
(a) **Purpose.** The Nursing Facility Supplemental Payment Program (NFSPP) is a supplemental payment, up to the Medicare upper payment limit (UPL), made to a non-state ~~government owned~~government-owned entity that owns and as applicable has operating responsibility for a nursing facility(ies).
(b) **Definitions.** The following words and terms, when used in this Section have the following meaning, unless the context clearly indicates otherwise:

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

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

(3) **"Non-state government-owned (NSGO)"** means an entity owned ~~and~~and/or ~~as applicable~~ operated by a unit of government other than the state and ~~approved~~the application packet is accepted and determined complete by OHCA as a qualified NSGO. ~~Pursuant to federal and OHCA approval an NSGO may include public trusts pursuant to the Trust Authorities established under Oklahoma Statute Title 60.~~

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

(5) **"Supplemental payment calculation period"** ~~means the calendar quarter for which supplemental payment amounts are calculated based on adjudicated claims for days of service provided in the qualifying quarter. Note, in the event there are no paid days in the quarter as a result of the time in~~

~~which the claims are adjudicated, the supplemental payment will be calculated on days billed in a subsequent quarter.~~ means the State Fiscal Year for which supplemental payment amounts are calculated based on Medicaid paid claims (less leave days) compiled from the state's Medicaid Management Information System (MMIS) at a minimum yearly to a maximum quarterly.

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

(c) **Eligible nursing facilities.** A nursing facility that is owned and as applicable under the operational responsibility of an NSGO, is eligible for participation when the following conditions are met:

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

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

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

~~(4) the NSGO has signed an attestation that a plan towards the reduction and mitigation of unnecessary Return to Acute Admissions (RTA) will be implemented within six (6) months of program participation start date;~~

~~(5)~~(4) the facility is an active participant in the Focus on Excellence program and has earned at minimum 100 points; does not receive an immediate jeopardy (IJ) scope and severity tag for abuse or neglect on three (3) separate surveys within a twelve (12) month period; and

~~(6)~~(5) the facility and NSGO comply with care criteria requirements. All facilities ~~must~~shall provide supporting documentation (e.g., baselines, written plan, improvement summary, data sources) for the care criteria metrics.

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

~~(1) must execute a nursing facility provider contract as well as an agreement of participation with the OHCA;~~

~~(2) must provide and identify the state share dollars' source of the IGT;~~

~~(3) must pay the calculated IGT to OHCA by the required deadline;~~

~~(4) must provide proof of ownership, if applicable (i.e. Change of Ownership) as Licensed Operator of the nursing facility;~~

~~(5) must provide OHCA with an executed Management Agreement between the NSGO and the facility Manager;~~

~~(6) must provide proof of district authority for nursing facility participants which include proximity requirements of no greater than one hundred fifty (150) miles of NSGO. Exceptions may be made at the sole discretion of OHCA; and~~

~~(7) must provide per facility, the per patient per Medicaid day (PPMD) IGT within specified timeframe of receipt of the Notice of Program Reimbursement (NPR) as indicated below:~~

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

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

~~(C) For the third year-$8.50 PPMD, or the equivalent of ten percent (10%) of nursing facility budget of the current fiscal year, whichever is less. This amount excludes any IGT for actual administration cost associated with the nursing home UPL supplemental program. Any remaining IGT after administration cost will be distributed through the rate setting methodology process. Distribution will occur once escrowed funds reach an amount sufficient to distribute as determined by OHCA.~~

~~(e) **Care Criteria.**~~

~~(1)Each facility will be required to meet or exceed at minimum two (2) of the five (5) established care criteria metrics contained in paragraphs (A) through (E) of this section. The facility will be required to develop and implement a plan and identify the current baseline for each criterion. Each facility must demonstrate ongoing progress through baseline outcomes, performance summary and goals. Care criteria data and forms must be completed and submitted within five (5) business day after quarter end.~~

~~(A) Facilities must develop and implement a written plan for the mitigation of unnecessary Return to Acute Admissions (RTA) within six (6) months of participation. The plan will include the RTA for the trailing twelve (12) month period. The resulting outcome is to improve the efficiency and care avoidance cost to the overall SoonerCare program. A written plan must be developed and must include the following:~~

~~(i) the RTA management tool which identifies those residents at high risk for the potential return to acute;~~

~~(ii) the RTA management tools to support effective communications;~~

~~(iii) advance directive planning and implementation;~~

~~and~~

~~(iv) application of Quality Assurance/Program Integrity (QA/PI) methodology in review of RTAs for the root cause analysis and teaching needs.~~

~~(B) Facilities are required to implement a pro-active Pneumonia/Flu Vaccination program which will result in improved vaccination scores above the facility specific baseline at or above the national average, as measured using the CMS Quality Metrics. The resulting outcome is to improve efficiency and care avoidance costs to the overall SoonerCare program. A written plan must be developed and must include the following:~~

~~(i) the latest available three quarter average of CMS measure code 411 (% of long-stay residents assessed and appropriately given the seasonal influenza vaccine) and 415 (% of long-stay residents assessed and appropriately given the pneumococcal vaccine) to establish baseline;~~

~~(ii) the current measure code 411 and 415 score; and~~

~~(iii) the written plan for flu and pneumonia vaccination program to address new admissions and current residents.~~

~~(C) Facilities are required to participate in the Oklahoma Healthy Aging Initiative. The resulting outcome is to improve the quality of care and health of members. Facilities must attest to elevate healthy aging in Oklahoma by implementing a plan that accomplishes at least one of the following strategies:~~

~~(i) preventing and reducing of falls;~~

~~(ii) improving of nutrition;~~

~~(iii) increasing physical activity; or~~

~~(iv) reducing depression.~~

~~(D) Facilities are required to actively take part in an OHCA approved satisfaction survey. The resulting outcome is to improve the quality of care being delivered to members. A written plan must be developed and implemented and must include the following:~~

~~(i) the satisfaction survey results;~~

~~(ii) analysis of satisfaction survey with identification of, at minimum, one area for improvement; and~~

~~(iii) plan of action towards identified areas of improvement.~~

~~(E) Facilities are required to demonstrate improvement above the facility specific baseline in the five (5) Star Quality Measures Composite scoring. Metrics will be determined based upon CMS Nursing Home Compare composite~~

~~score over the trailing twelve (12) month period. Facilities with Quality Measures star rating of three (3) or better for the most recent quarter or showing improvement in composite scoring with no two (2) quarters consistently below three (3), will be recognized as meeting the care criteria. The resulting outcome is to improve the quality of care being provided.~~

~~(i) Facilities must provide the most recent three (3) quarter average of the CMS quality measure star rating to establish baseline.~~

~~(ii) Facilities are required to have a star rating of (3) or better or must demonstrate improvement over previous quarter with no two (2) quarters below three (3) stars.~~

~~(2) The care criteria measures may be evaluated at the discretion of OHCA on an annual basis after each fiscal year, following implementation of the program. However, OHCA reserves the right to conduct intermittent evaluations within any given year based on the quality, care and safety of SoonerCare members. The evaluation may be conducted by an independent evaluator. In addition, care criteria metrics may be internally evaluated after each fiscal year at the discretion of OHCA, in collaboration with an advisory committee composed of OHCA agency staff and provider representatives. The OHCA may make adjustments to the care criteria measures based on findings and recommendations as a result of the independent or internal evaluation.~~

~~(f) **Supplemental Payments.**~~

~~(1) The nursing facility supplemental payments to a NSGO under this program shall not exceed Medicare payment principles pursuant to 42 CFR 447.272. Payments are made in accordance with the following criteria:~~

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

~~(B) The eligible supplemental amount is the difference/gap between the SoonerCare payment and the Medicare upper payment limit as determined based on compliance with the Care Criteria metrics.~~

~~(2) The amount of the eligible supplemental payment is associated with improvement of care of SoonerCare nursing facility residents as demonstrated through the care criteria. NSGO participants receive payment under the program based on earned percentages related to the care criteria. The NSGO must meet or exceed at least two (2) of the five (5) established care criteria metrics to be eligible for UPL payment for each quarter. After at least two (2) of the five (5) metrics have been met, the NSGO is eligible for eighty-~~

~~five percent (85%) of the total eligible UPL amount for participating nursing facilities. The NSGO may qualify for the remaining fifteen percent (15%) of the total UPL by attribution in five percent (5%) increments for each additional care criterion that is met resulting in the full one hundred percent (100%) of the eligible UPL amount.~~

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

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

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

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

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

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

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

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

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

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

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

(C) For the third year-$8.50 PPMD, or the equivalent of ten percent (10%) of nursing facility budget of the current fiscal year, whichever is less. This amount excludes any IGT for actual administration cost associated with the nursing home UPL supplemental program. Any remaining IGT after administration cost shall be distributed through the rate setting methodology process. Distribution shall occur once escrowed funds reach an amount sufficient to distribute as determined by OHCA.

(e) **Change in ownership.**

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

(2) For a nursing facility that changes ownership on or after the first day of the SoonerCare supplemental payment limit calculation period, the data used for the calculations will include data from the facility for the entire upper payment

limit calculation period relating to payments for days of service provided under the prior owner, pro-rated to reflect only the number of calendar days during the calculation period that the facility is owned by the new owner.

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

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

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

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

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

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

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

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

(A) A facility shall hold quarterly Health Improvement Plan meetings. The meetings shall be tailored to identify an improvement plan for the quality indicators of urinary tract infection, unintended weight loss, developing or

worsening pressure ulcers, and received antipsychotic medication. Meetings include the following:

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

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

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

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

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

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

(g) **Supplemental Payments.**

(1) The nursing facility supplemental payments to a NSGO

under this program shall not exceed Medicare payment principles pursuant to Inpatient Services: Application of Upper Payment Limits, 42 Code of Federal Regulation, Sec. 447.272. Payments are made in accordance with the following criteria:

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

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

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

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

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

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

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

(1) The OHCA or its designee will notify the NSGO of the non-federal share amount to be transferred by an IGT, via ~~a designated portal~~electronic communications and NPR, for purposes of seeking federal financial participation (FFP) for the UPL supplemental payment, within twenty-five (25) business days after the end of the quarter. This amount will take into account the percentage of metrics achieved under the care criteria requirement. The NSGO will have five (5)

business days to sign the participant agreement and make payment of the state share in the form of an IGT either in person or via mail. ~~In addition, the NSGO will be responsible to also remit, upon receipt of the NPR, the applicable PPMD IGT in full, pursuant to (d)(7) above~~The date the NPR is sent by OHCA or its designee to the provider (NSGO) is the official date the clock starts to measure the five (5) business days. In addition, the NSGO shall also be required to remit, upon receipt of the NPR, the applicable PPMD IGT in full, pursuant to (d) (7) above.

(2)~~ If the total transfer and PPMD IGT are received within five (5) business days, the UPL payment will then be disbursed to the NSGO by OHCA within ten (10) business days in accordance with established payment cycles. An IGT that is not received by the date specified by OHCA, or that is not the total indicated on the NPR shall be subject to penalty and suspension from the program.~~If the full IGT and the PPMD IGT are received within five (5) business days, the UPL payment will then be disbursed to the NSGO by OHCA within ten (10) business days in accordance with established payment cycles.

~~(i) **Penalties/Adjustments.** Failure by an NSGO to remit the full IGT indicated on the NPR by OHCA or its designee within the defined timeframes below indicates the NSGO has voluntarily elected to withdraw participation for that current quarter and may reapply for participation in the program in subsequent quarter(s).~~

~~(1) The total IGT must be received within five (5) business days from receipt of the NPR uploaded by OHCA or its designee in the program portal.~~

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

~~(B) The date the NPR is uploaded to the portal the official date the clock starts to measure the five (5) business days.~~

~~(2) Any IGT received after the fifth business day but with an OHCA date stamp or mailing postal mark on or prior to five (5) business days from the official date of the uploaded NPR in the portal will not be subject to penalty; however, payment will be disbursed during the next available OHCA payment cycle.~~

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

~~(A) Any NSGO that remits payment of the total IGT under~~

~~the above circumstances will receive payment during the next available OHCA payment cycle including an assessed penalty as described below.~~

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

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

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

(i) **Penalties.**

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

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

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

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

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

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

(4) The first violation by an NSGO to remit the full IGT as indicated on the NPR by OHCA or its designee within the defined timeframes shall subject the NSGO to a penalty. The second violation by an NSGO to remit the full IGT indicated on the NPR by OHCA or its designee within the defined timeframes shall subject the NSGO to a penalty and a suspension for two (2) consecutive quarters. The NSGO will not be eligible to participate in the program during suspended quarters. A third violation by an NSGO to remit the full IGT indicated on the NPR by OHCA or its designee within the defined timeframes shall subject the NSGO to termination from the NFSPP. If the NSGO desires to participate again, it will be required to reapply. Reentry into the program is at the sole discretion of the OHCA. If the NSGO is readmitted to the program, terms of participation may include a probationary period with defined requirements.

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

(6) If a nursing facility fails to meet the benchmarks of component 1 and/or component 2 of the care criteria for two (2) consecutive quarters, the facility shall be suspended for two (2) subsequent quarters and will not be eligible to participate in the program during suspended quarters. A facility that has been suspended for a total of four (4)

quarters within a two (2) year period due to non-compliance with the Care Criteria shall be terminated from the program, and if the facility wishes to participate again, it will be required to reapply. Reentry into the program is at the sole discretion of the OHCA. If the facility is readmitted to the program, terms of participation may include a probationary period with defined requirements as it relates to care.

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

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

317:35-5-41.6. Trust accounts

Monies held in trust for an individual applying for or receiving SoonerCare must have the availability of the funds determined. Funds held in trust are considered available when they are under the direct control of the individual or his/her spouse, and disbursement is at their sole discretion. Funds may also be held in trust and under the control of someone other than the individual or his/her spouse, such as the courts, agencies, other individuals, ~~etc.,~~ or the Bureau of Indian Affairs (BIA).

(1) **Availability determinations.** The worker should be able to determine the availability of a trust using the definitions and explanations listed in (2) of this subsection. However, in some cases, the worker may wish to submit a trust to the ~~OKDHS~~Oklahoma Department of Human Services State Office for determination of availability. In these instances, all pertinent data is submitted to Family Support Services Division, Attention: Health Related and Medical Services Section, for a decision.

(2) **Definition of terms**. The following words and terms, when used in this paragraph, have the following meaning, unless the context clearly indicates otherwise:

(A) **Beneficiary**. Beneficiary means the person(s) who is to receive distributions of either income or principal, or on behalf of whom the trustee is to make payments.

(B) **Corpus/principal**. Corpus/principal means the body of the trust or the original asset used to establish the trust, such as a sum of money or real property.

(C) **Discretionary powers**. Discretionary powers means the grantor gives the trustee the power to make an independent determination whether to distribute income and/or principal to the beneficiary(ies) or to retain the income and add it to the principal of the trust.

(D) **Distributions**. Distributions means payments or allocations made from the trust from the principal or from the income produced by the principal (e.g., interest on a bank account).

(E) **Grantor (trustor/settlor)**. Grantor (trustor/settlor)

means the individual who establishes the trust by transferring certain assets.

(F) **Irrevocable trust**. Irrevocable trust means a trust in which the grantor has expressly not retained the right to terminate or revoke the trust and reclaim the trust principal and income.

(G) **Pour over or open trust**. Pour over or open trust means a trust which may be expanded from time to time by the addition to the trust principal (e.g., a trust established to receive the monthly payment of an annuity, a workers' compensation settlement, a disability benefit or other periodic receivable). The principal may accumulate or grow depending upon whether the trustee distributes the receivable or permits it to accumulate. Generally, the terms of the trust will determine the availability of the income in the month of receipt and the availability of the principal in subsequent months.

(H) **Primary beneficiary**. Primary beneficiary means the first person or class of persons to receive the benefits of the trust.

(I) **Revocable trust**. Revocable trust means a trust in which the grantor has retained the right to terminate or revoke the trust and reclaim the trust principal and income. Unless a trust is specifically made irrevocable, it is revocable. Even an irrevocable trust is revocable upon the written consent of all living persons with an interest in the trust.

(J) **Secondary beneficiary**. Secondary beneficiary means the person or class of persons who will receive the benefits of the trust after the primary beneficiary has died or is otherwise no longer entitled to benefits.

(K) **Testamentary trust**. Testamentary trust means a trust created by a will and effective upon the death of the individual making the will.

(L) **Trustee**. Trustee means an individual, individuals, a corporation, court, bank or combination thereof with responsibility for carrying out the terms of the trust.

(3) **Documents needed.** To determine the availability of a trust for an individual applying for or receiving SoonerCare, copies of the following documents are obtained:

(A) Trust document;

(B) When applicable, all relevant court documents including the Order establishing the trust, Settlement Agreement, Journal Entry, etc.; and

(C) Documentation reflecting prior disbursements (date, amount, purpose).

(4) **Trust accounts established on or before August 10, 1993.** The rules found in (A) - (C) of this paragraph apply to trust accounts established on or before August 10, 1993.

(A) **Support trust.** The purpose of a support trust is the provision of support or care of a beneficiary. A support trust will generally contain language such as "to provide for the care, support and maintenance of ...", "to provide as necessary for the support of ...", or "as my trustee may deem necessary for the support, maintenance, medical expenses, care, comfort and general welfare." Except as provided in (i)-(iii) of this subparagraph, the amount from a support trust deemed available to the beneficiary is the maximum amount of payments that may be permitted under the terms of the trust to be distributed to the beneficiary, assuming the full exercise of discretion by the trustee(s) for distribution of the maximum amount to the beneficiary. The beneficiary of a support trust, under which the distribution of payments to the beneficiary is determined by one or more trustees who are permitted to exercise discretion with respect to distributions, may show that the amounts deemed available are not actually available by:

(i) Commencing proceedings against the trustee(s) in a court of competent jurisdiction;

(ii) Diligently and in good faith asserting in the proceedings that the trustee(s) is required to provide support out of the trust; and

(iii) Showing that the court has made a determination, not reasonably subject to appeal, that the trustee must pay some amount less than the amount deemed available. If the beneficiary makes the showing, the amount deemed available from the trust is the amount determined by the court. Any action by a beneficiary or the beneficiary's representative, or by the trustee or the trustee's representative, in attempting a showing to make the Agency or the State of Oklahoma a party to the proceeding, or to show to the court that SoonerCare benefits may be available if the court limits the amounts deemed available under the trust, precludes the showing of good faith required.

(B) **Medicaid Qualifying Trust (MQT).** A Medicaid Qualifying Trust is a trust, or similar legal device, established (other than by will) by an individual or an individual's spouse, under which the individual may be the beneficiary of all or part of the distributions from the trust and such distributions are determined by one or more trustees

who are permitted to exercise any discretion with respect to distributions to the individual. A trust established by an individual or an individual's spouse includes trusts created or approved by a representative of the individual (parent, guardian or person holding power of attorney) or the court where the property placed in trust is intended to satisfy or settle a claim made by or on behalf of the individual or the individual's spouse. This includes trust accounts or similar devices established for a minor child pursuant to 12 ~~O.S.~~Oklahoma Statutes 83. In addition, a trust established jointly by at least one of the individuals who can establish an MQT and another party or parties (who do not qualify as one of these individuals) is an MQT as long as it meets the other MQT criteria. The amount from an irrevocable MQT deemed available to the individual is the maximum amount of payments that may be permitted under the terms of the trust to be distributed to the individual assuming the full exercise of discretion by the trustee(s). The provisions regarding MQT apply even though an MQT is irrevocable or is established for purposes other than enabling an individual to qualify for SoonerCare, and, whether or not discretion is actually exercised.

(i) **Similar legal device.** MQT rules listed in this subsection also apply to "similar legal devices" or arrangements having all the characteristics of an MQT except that there is no actual trust document. An example is the member petitioning the court to irrevocably assign all or part of his/her income to another party (usually the spouse). The determination whether a given document or arrangement constitutes a "similar legal device" should be made by the OKDHS Office of General Counsel, Legal Unit.

(ii) **MQT resource treatment.** For revocable MQTs, the entire principal is an available resource to the member. Resources comprising the principal are subject to the individual resource exclusions (e.g., the home property exclusion) since the member can access those resource items without the intervention of the trustee. For irrevocable MQTs, the countable amount of the principal is the maximum amount the trustee can disburse to (or for the benefit of) the member, using his/her full discretionary powers under the terms of the trust. If the trustee has unrestricted access to the principal and has discretionary power to disburse the entire principal to the member (or to use it for

the member's benefit), the entire principal is an available resource to the member. Resources transferred to such a trust lose individual resource consideration (e.g., home property transferred to such a trust is no longer home property and the home property exclusions do not apply). The value of the property is included in the value of the principal. If the MQT permits a specified amount of trust income to be distributed periodically to the member (or to be used for his/her benefit), but those distributions are not made, the member's countable resources increase cumulatively by the undistributed amount.

(iii) **Income treatment.** Amounts of MQT income distributed to the member are countable income when distributed. Amounts of income distributed to third parties for the member's benefit are countable income when distributed.

(iv) **Transfer of resources**. If the MQT is irrevocable, a transfer of resources has occurred to the extent that the trustee's access to the principal (for purposes of distributing it to the member or using it for the member's benefit) is restricted (e.g., if the trust stipulates that the trustee cannot access the principal but must distribute the income produced by that principal to the member, the principal is not an available resource and has, therefore, been transferred).

(C) **Special needs trusts**. Some trusts may provide that trust benefits are intended only for a beneficiary's "special needs" and require the trustee to take into consideration the availability of public benefits and resources, including SoonerCare benefits. Some trusts may provide that the trust is not to be used to supplant or replace public benefits, including SoonerCare benefits. If a trust contains such terms and is not an MQT, the trust is not an available resource.

(5) **Trust accounts established after August 10, 1993.** The rules found in (A) - (C) of this paragraph apply to trust accounts established after August 10, 1993.

(A) For purposes of this subparagraph, the term "trust" includes any legal document or device that is similar to a trust. An individual is considered to have established a trust if assets of the individual were used to form all or part of the principal of the trust and if the trust was established other than by will and by any of the following individuals:

(i) the individual;
(ii) the individual's spouse;
(iii) a person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual or the individual's spouse; or
(iv) a person, including a court or administrative body, acting at the direction or upon the request of the individual or the individual's spouse.

(B) Where trust principal includes assets of an individual described in this subparagraph and assets of any other person(s), the provisions of this subparagraph apply to the portion of the trust attributable to the assets of the individual. This subparagraph applies without regard to the purposes for which the trust is established, whether the trustees have or exercise any discretion under the trust, and restrictions on when or whether distributions may be made from the trust, or any restrictions on the use of the distribution from the trust.

(C) There are two types of trusts, revocable trusts and irrevocable trusts.

(i) In the case of a revocable trust, the principal is considered an available resource to the individual. Payments from the trust to or for the benefit of the individual are considered income of the individual. Other payments from the trust are considered assets disposed of by the individual for purposes of the transfer of assets rule and are subject to the 60 months look back period.

(ii) In the case of an irrevocable trust, if there are any circumstances under which payments from the trust could be made to or for the benefit of the individual, the portion of the principal of the trust, or the income on the principal, from which payment to the individual could be made is considered available resources. Payments from the principal or income of the trust is considered income of the individual. Payments for any other purpose are considered a transfer of assets by the individual and are subject to the 60 months look back period. Any portion of the trust from which, or any income on the principal from which no payment could under any circumstances be made to the individual is considered as of the date of establishment of the trust (or if later, the date on which payment to the individual was foreclosed) to be assets disposed by the individual for purposes of the

asset transfer rules and are subject to the 60 months look back period.

(6) **Exempt trusts.** Paragraph (5) of this subsection does not apply to the following trusts:

(A) A trust containing the assets of a disabled individual under the age of 65 which was established for the benefit of such individual by the individual, parent, grandparent, legal guardian of the individual or a court if the State receives all amounts remaining in the trust on the death of the individual up to an amount equal to the total medical assistance paid on behalf of the individual. This type of trust requires:

(i) The trust may only contain the assets of the disabled individual.

(ii) The trust must be irrevocable and cannot be amended or dissolved without the written agreement of the Oklahoma Department of Human Services or the Oklahoma Health Care Authority.

(iii) Trust records must be open at all reasonable times to inspection by an authorized representative of the OHCA or OKDHS.

(iv) The exception for the trust continues after the disabled individual reaches age 65. However, any addition or augmentation after age 65 involves assets that were not the assets of an individual under age 65; therefore, those assets are not subject to the exemption.

(v) Establishment of this type of trust does not constitute a transfer of assets for less than fair market value if the transfer is made into a trust established solely for the benefit of a disabled individual under the age of 65.

(vi) Payments from the trust are counted according to SSI rules. According to these rules, countable income is anything the individual receives in cash or in kind that can be used to meet the individual's needs for food, clothing and shelter. Accordingly, any payments made directly to the individual are counted as income to the individual because the payments could be used for food, clothing, or shelter for the individual. This rule applies whether or not the payments are actually used for these purposes, as long as there is no legal impediment which would prevent the individual from using the payments in this way. In addition, any payments made by the trustee to a third party to purchase food, clothing, or shelter for the individual

can also count as income to the individual. For example, if the trustee makes a mortgage payment for the individual, that payment is a shelter expense and counts as income.
(vii) A corporate trustee may charge a reasonable fee for services in accordance with its published fee schedule.
(viii) The OKDHS Form 08MA018E, Supplemental Needs Trust, is an example of the trust. Workers may give the sample form to the member or his/her representative to use or for their attorney's use.
(ix) To terminate or dissolve a Supplemental Needs Trust, the worker sends a copy of the trust instrument and a memorandum to OKDHS Family Support Services Division, Attention: Health Related and Medical Services (HR&MS) explaining the reason for the requested termination or dissolution of the Supplemental Needs Trust, and giving the name and address of the trustee. The name and address of the financial institution and current balance are also required. Health Related and Medical Services notifies ~~OHCA/TPL~~<u>Oklahoma Health Care Authority/Third Party Liability(OHCA/TPL)</u> to initiate the recovery process.

(B) A trust (known as the Medicaid Income Pension Trust) established for the benefit of an individual if:
(i) The individual is in need of long-term care and has countable income above the categorically needy standard for long-term care (OKDHS Appendix C-1 Schedule VIII.B) but less than the average cost of nursing home care per month (OKDHS Appendix C-1 Schedule VIII.B).
(ii) The Trust is composed only of pension, social security, or other income of the individual along with accumulated income in the trust. Resources cannot be included in the trust.
(iii) All income is paid into the trust and the applicant is not eligible until the trust is established and the monthly income has been paid into the trust.
(iv) The trust must retain an amount equal to the member's gross monthly income less the current categorically needy standard of OKDHS Appendix C-1. The Trustee distributes the remainder.
(v) The income disbursed from the trust is considered as the monthly income to determine the cost of their care, and can be used in the computations for spousal diversion.

(vi) The trust must be irrevocable and cannot be amended or dissolved without the written agreement of the OHCA. Trust records must be open at all reasonable times to inspection by an authorized representative of the OHCA or OKDHS.

(vii) The State will receive all amounts remaining in the trust up to an amount equal to the total SoonerCare benefits paid on behalf of the individual subsequent to the date of establishment of the trust.

(viii) Accumulated funds in the trust may only be used for medically necessary items not covered by SoonerCare, or other health programs or health insurance and a reasonable cost of administrating the trust. Reimbursements cannot be made for any medical items to be furnished by the nursing facility. Use of the accumulated funds in the trust for any other reason will be considered as a transfer of assets and would be subject to a penalty period.

(ix) The trustee may claim a fee of up to 3% of the funds added to the trust that month as compensation.

(x) An example trust is included on OKDHS Form 08MA011E. Workers may give this to the member or his/her representative to use or for their attorney's use as a guide for the Medicaid Income Pension Trust.

(xi) To terminate or dissolve a Medicaid Income Pension Trust, the worker sends a memorandum with a copy of the trust to OKDHS Family Support Services Division, Attention: HR&MS, explaining the reason and effective date for the requested termination or dissolution of the Medicaid Income Pension Trust, and giving the name and address of the trustee. The name and address of the financial institution, account number, and current balance are also required. Health Related and Medical Services notifies OHCA/TPL to initiate the recovery process.

(C) A trust containing the assets of a disabled individual when all of the following are met:

(i) The trust is established and managed by a non-profit association;

(ii) The trust must be made irrevocable;

(iii) The trust must be approved by the Oklahoma Department of Human Services and may not be amended without the permission of the Oklahoma Department of Human Services;

(iv) The disabled person has no ability to control the spending in the trust;

(v) A separate account is maintained for each beneficiary of the trust but for the purposes of investment and management of funds, the trust pools these accounts;

(vi) The separate account on behalf of the disabled person may not be liquidated without payment to OHCA for the medical expenses incurred by the members;

(vii) Accounts in the trust are established by the parent, grandparent, legal guardian of the individual, the individual, or by a court;

(viii) To the extent that amounts remaining in the beneficiary's account on the death of the beneficiary are not retained by the trust, the trust pays to the State from such remaining amounts an amount equal to the total medical assistance paid on behalf of the individual. A maximum of 30% of the amount remaining in the beneficiary's account at the time of the beneficiary's death may be retained by the trust.

(7) **Funds held in trust by Bureau of Indian Affairs (BIA).** Interests of individual Indians in trust or restricted lands are not considered in determining eligibility for assistance under the Social Security Act or any other federal or federally assisted program.

(8) **Disbursement of trust.** At any point that disbursement occurs, the amount disbursed is counted as a non-recurring lump sum payment in the month received. Some trusts generate income on a regular basis and the income is sent to the beneficiary. In those instances, the income is treated as unearned income in the month received.

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CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

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

317:30-5-1096. ~~I/T/U off-site services~~Off-site services

~~I/T/U covered services provided off-site or outside of the I/T/U setting, including mobile clinics or places of residence, are compensable when billed by the I/T/U.~~I/T/U covered services provided off-site or outside of the I/T/U setting, including mobile clinics or places of residence, are compensable at the OMB rate when billed by an I/T/U that has been designated as a Federally Qualified Health Center. The I/T/U must meet provider participation requirements listed in OAC 317:30-5-1088. I/T/U off-site services may be covered if the services rendered were within the provider's scope of practice and are of the same integrity of services rendered at the I/T/U facility.

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

These rules regulate the format, use, and retention of electronic records and signatures generated, sent, communicated, received, or stored by the Oklahoma Health Care Authority (OHCA), in conformity with the Uniform Electronic Transaction Act, found at Section 15-101 et seq. of Title 12A of the Oklahoma Statutes.

(1) **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 OHCA, 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~~online 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 the author by a designated ~~personal identification number~~(PIN) 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) ~~must occur within three (3) days of the provision of the underlying service, including those instances in which~~ 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 (3) business days from the day the record is completed. Before any claim is submitted to the OHCA for payment of a provided service, the provider must authenticate the electronic medical records relating to that service.

(F) Records may be edited by designated administrators within the provider's facility. 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 forty-five (45) days after the date of service, whichever occurs first.

(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.

(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.

(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.

(2) **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.

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

(A) The OHCA's system provides that receivers of electronic information may both print and store the electronic information they receive. The OHCA 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 OHCA 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 OHCA will vary 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) **Member format requirements.** The OHCA 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 OHCA will permit providers to contract with the OHCA, check and amend claims filed with the OHCA, and file prior authorization requests with the OHCA. Providers with a

social security number or federal employer's identification number will be given a ~~personal identification number (PIN)~~ 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 OHCA 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 two (2) of this section.

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

(4) **Time and place of sending and receipt.** The provisions of the Electronic Transaction Act apply to the time and place of sending and receipt. Should a power failure, ~~Internet~~internet interruption or ~~Internet~~internet virus occur, confirmation by the receiving party will be required to establish receipt.

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

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 handwritten signature, electronic signature, or signature attestation statement. Stamped signatures are not acceptable. Pursuant to ~~Federal and/or State law~~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 handwritten 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 handwritten or electronic signature.

(b) A handwritten 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) ~~must occur within three (3) days of provision of the underlying service, including those instances in which the electronic medical record is transcribed by someone other than the provider. Before any claim is submitted to the OHCA for payment of a provided service, the provider must authenticate the electronic medical records relating to that service.~~ <u>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 (3) business days from the day the record is completed. Before any claim is submitted to the OHCA for payment of a provided service, the provider must authenticate the medical records relating to that service.</u>

(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.

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 113. LIVING CHOICE PROGRAM

317:30-5-1207. Benefits for members ages sixteen (16) through eighteen (18) in a psychiatric residential treatment facility

(a) Living Choice program participants, ages sixteen (16) through eighteen (18), may receive a range of necessary home and community based services for one year after transitioning to the community from a psychiatric residential treatment facility (PRTF) setting. In order to be eligible for the Living Choice program, the member must:

(1) Have been in a PRTF facility for 90 or more days during an episode of care; and

(2) Meet Level 3 criteria on the Individual Client Assessment Record; or

(3) Meet the criteria for Serious Emotional Disturbance as defined in OAC 317:30-5-240.1; or

(4) Show critical impairment on a caregiver rated Ohio Scales (score of 25 and above on the Problems Subscale or a score of 44 and below on the Functioning Subscales).

(b) Services must be billed using the appropriate Healthcare Common Procedure Code System and must be medically necessary.

(c) All services must be necessary for the individual to live successfully in the community, must be documented in the individual care plan and require prior authorization.

(d) Services that may be provided to members transitioning from a PRTF are found in OAC 317:30-5-252.

(e) Reimbursement will be for a monthly care coordination payment upon successful submission of a claim for one or more of the covered services listed in OAC 317:30-5-252.

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

SUBCHAPTER 23. LIVING CHOICE PROGRAM

317:35-23-2. Eligibility criteria

(a) Adults with disabilities or long-term illnesses, members with intellectual disabilities and members with physical disabilities are eligible to transition into the community through the Living Choice program if they meet all of the criteria in paragraphs (1) through (7) of this subsection.

(1) He/she must be at least 19 years of age.

(2) He/she must reside in ~~an institution (nursing facility or public ICF/MR)~~a nursing facility or public Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) for at least 90 consecutive days prior to the proposed transition date. If any portion of the 90 days includes time in a skilled nursing facility, those days cannot be counted toward the 90 day requirement, if the member received Medicare post-hospital extended care rehabilitative services.

(3) He/she must have at least one day of Medicaid paid long-term care services prior to transition.

(4) If transitioning from an out of state institution, he/she must be SoonerCare eligible.

(5) He/she requires at least the same level of care that necessitated admission to the institution.

(6) He/she must reside in a qualified residence after leaving the institution. A qualified residence is defined in (A) through (C) of this paragraph.

(A) a home owned or leased by the individual or the individual's family member;

(B) an apartment with an individual lease, with a locking entrance/exit, and which includes living, sleeping, bathing, and cooking areas over which the individual or the individual's family has domain and control; and

(C) a residence, in a community-based residential setting, in which no more than four unrelated individuals reside.

(7) His/her needs can be met by the Living Choice program while living in the community.

(8) He/she must not be a resident of a nursing facility or ~~ICF/MR~~ICF/IID in lieu of incarceration.

(b) Youth ages sixteen (16) through eighteen (18) are eligible to transition back into the community from a psychiatric residential treatment facility (PRTF) through the Living Choice program if they meet the following criteria:

(1) Have been in a PRTF facility for 90 or more days during

an episode of care; and

(2) Meet Level 3 criteria on the Individual Client Assessment Record; or

(3) Meet the criteria for Serious Emotional Disturbance as defined in OAC 317:30-5-240.1; or

(4) Show critical impairment on a caregiver rated Ohio Scales (score of 25 and above on the Problems Subscale or a score of 44 and below on the Functioning Subscales).

317:35-23-3. Participant disenrollment

(a) A member is disenrolled from the program if he/she:

(1) is admitted to a hospital, nursing facility, ~~ICF/MR,~~ICF/IID, residential care facility or behavioral health facility for more than 30 consecutive days;

(2) is incarcerated;

(3) is determined to no longer meet SoonerCare financial eligibility for home and community based services;

(4) determined by the Social Security Administration or OHCA Level of Care Evaluation Unit to no longer have a disability that qualifies for services under the Living Choice program; or

(5) moves out of state.

(b) Payment cannot be made for an individual who is in imminent danger of harm to self or others.

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CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

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

317:30-5-1094. Behavioral health services provided at I/T/Us

(a) Behavioral health services that are primary, preventive, and therapeutic and would be covered if provided in another setting may be provided by I/T/U providers. Services provided by an I/T/U (refer to OAC 317:30-5-241 for a description of services) must meet the same requirements as services provided by another provider. Services include:

(1) Mental Health and/or Substance Use Assessment/Evaluation And Testing;
(2) Service Plan Development;
(3) Crisis Intervention Services;
(4) Medication Training and Support;
(5) Individual/Interactive Psychotherapy;
(6) Group Psychotherapy; and
(7) Family Psychotherapy.

(b) Behavioral health professional therapy services are covered when provided in accordance with a documented individualized treatment plan, developed to treat the identified mental health and/or substance use disorder(s). Behavioral health services must be billed on an appropriate claim form using the appropriate ~~Current Procedural Terminology (CPT)~~ procedure code and guidelines. The time indicated on the claim form must be the time actually spent with the member.

(c) In order to support access to mental health services, these services may be provided in settings outside of the I/T/U. Offsite services must take place in a confidential setting.

(d) The outpatient behavioral health services' provider enrollment and reimbursement process in no way changes the OHCA's policy with regard to reimbursement of practitioners. Licensed clinical social workers (LCSW), licensed marital and family therapists (LMFT), licensed professional counselors (LPC), licensed behavioral practitioners (LBP), licensed alcohol and drug counselors (LADC), and licensure candidates are not eligible for direct reimbursement as practitioners. Their services are compensable only when billed by their employers and when provided in those clinical settings in which they are currently approved to render services. Licensure candidates must meet the requirements contained in OAC 317:30-5-240.3.

(e) For the provision of behavioral health related case management services, I/T/U providers must meet the requirements found at OAC 317:30-5-241.6, and be contracted as such. The provision of these services is considered to be outside of the I/T/U encounter.

Contracted behavioral health case management providers are responsible for obtaining all necessary prior authorizations, if needed, and will be paid at the current fee-for-service rate.
(f) For the provision of psychosocial rehabilitation services, I/T/U facilities must meet the requirements found at OAC 317:30-5-241.3, and must contract as an outpatient behavioral health agency. The provision of these services is considered to be outside of the I/T/U encounter. Contracted psychosocial rehabilitation service providers are responsible for obtaining all necessary prior authorizations, if needed, and will be paid at the current fee-for-service rate.

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

SUBCHAPTER 5. ELIGIBILITY AND COUNTABLE INCOME

PART 1. DETERMINATION OF QUALIFYING CATEGORICAL RELATIONSHIP

317:35-5-2. Categorically related programs

(a) In order to be eligible for SoonerCare, an individual must first meet the description of a member eligibility group. For individuals related to the aged, blind, or disabled groups, categorical relationship is established using the same definitions of age, disability and blindness as used by the Social Security Administration (SSA) in determining eligibility for Supplemental Security Income (SSI) or SSA benefits. If the individual is a SSA/SSI recipient in current payment status (including presumptive eligibility), a TANF recipient, an adoption assistance or kinship guardianship assistance recipient, or is under age 19, categorical relationship is automatically established. Categorical relationship to the pregnancy group is established when the determination is made by medical evidence that the individual is or has been pregnant. Effective January 1, 2014, verification of pregnancy is only required if the individual's declaration that she is pregnant is not reasonably compatible with other information available to the agency. Pregnancy-related services include all medical services provided within the scope of the program during the prenatal, delivery and postpartum periods for women in this pregnancy group; see Subchapter 22 of this Chapter for services for unborn children covered under Title XXI. For an individual age 19 or over to be related to the parent and caretaker relative group, the individual must have a minor dependent child. For an individual to be related to the former foster care children group, the individual must not be eligible for the Title XIX pregnancy or parent or caretaker relative groups, must be aged 19-26, and must have been receiving SoonerCare as a foster care child when he/she aged out of foster care in Oklahoma. There is no income or resource test for the former foster care children group. Categorical relationship to Refugee services is established in accordance with OAC 317:35-5-25. Categorical relationship for the Breast and Cervical Cancer Treatment program is established in accordance with OAC 317:35-21. Categorical relationship for the SoonerPlan Family Planning Program is established in accordance with OAC 317:35-5-8. Categorical relationship for pregnancy related benefits covered under Title XXI is established in accordance with OAC 317:35-22.

Benefits for pregnancies covered under Title XXI medical services are provided within the scope of the program during the prenatal, delivery and postpartum care when included in the global delivery payment. To be eligible for SoonerCare benefits, an individual must be related to one of the following eligibility groups:

(1) Aged
(2) Disabled
(3) Blind
(4) Pregnancy
(5) Children, also including newborns deemed eligible
~~(A) Newborns deemed eligible, and~~
~~(B) Grandfathered CHIP children~~
(6) Parents and Caretaker Relatives
(7) Refugee
(8) Breast and Cervical Cancer Treatment program
(9) SoonerPlan Family Planning Program
(10) Benefits for pregnancies covered under Title XXI
(11) Former foster care children.

(b) The Authority may provide SoonerCare to reasonable categories of individuals under age 21.

(1) Individuals eligible for SoonerCare benefits include individuals between the ages of 19 and 21:
(A) for whom a public agency is assuming full or partial financial responsibility who are in custody as reported by the Oklahoma Department of Human Services (OKDHS) and in foster homes, private institutions or public facilities; or
(B) in adoptions subsidized in full or in part by a public agency; or
(C) individuals under age 21 receiving active treatment as inpatients in public psychiatric facilities or programs if inpatient psychiatric services for individuals under age 21 are provided under the State Plan and the individuals are supported in full or in part by a public agency; or

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

317:35-5-7. Determining categorical relationship to the children and parent and caretaker relative groups

(a) **Categorical relationship.** All individuals under age 19 are automatically related to the children's group and further determination is not required. Adults age 19 or older are related to the parent and caretaker relative group when there is a minor dependent child(ren) in the home and the individual is

the parent, or is the caretaker relative other than the parent who meets the proper degree of relationship. A minor dependent child is any child who meets the AFDC eligibility requirements of age and relationship.

~~(b) **Grandfathered CHIP children.** As provided in OAC 317:35-6-1, the MAGI methodology is not applied to determine eligibility for children who are enrolled in SoonerCare on December 31, 2013 until March 31, 2014 or the child's next regularly scheduled renewal, whichever is later.~~

~~(1) The MAGI methodology eliminates the following income disregards, which are subtracted from gross income under the TANF methodology prior to October 1, 2013:~~

~~(A) The $240 work related expense deduction from earned income per employed household member;~~

~~(B) The disregard of the first $50 of child support received by a household; and~~

~~(C) The deduction for child support expenses paid by an employed parent or caretaker who needs child care in order to work, in the amount of the actual expense paid up to a maximum of $200 per month for children under 2 years of age and up to a maximum of $175 per month for children 2 years of age or older.~~

~~(2) If the elimination of the disregards listed in (1) when the MAGI methodology is applied to a child who was enrolled in SoonerCare on December 31, 2013 makes the child financially ineligible, the child is related to the Grandfathered CHIP children group.~~

~~(3) The following children are not eligible for the Grandfathered CHIP Children group:~~

~~(A) Children who are eligible for SoonerCare through another eligibility group;~~

~~(B) Children who have other creditable health insurance coverage;~~

~~(C) Children who are inmates of public institutions or are patients in institutions for mental disease; or~~

~~(D) Children who are eligible for coverage under a health plan offered to employees of the State of Oklahoma.~~

~~(4) If a child's eligibility in this group is redetermined during his/her certification period and the child is financially ineligible without regard to elimination of the disregards in (1), the child's benefits are closed using normal procedures.~~

~~(5) Eligibility for children in this group expires on the date of the child's next regularly scheduled recertification after the recertification for which the MAGI methodology was first used. This eligibility group terminates for all children December 31, 2015.~~

~~(c)~~(b) **Requirement for referral to the Oklahoma Child Support Services Division (OCSS).** As a condition of eligibility, when both the parent or caretaker and minor child(ren) are receiving SoonerCare and a parent is absent from the home, the parent or caretaker relative must agree to cooperate with OCSS. However, federal regulations provide for a waiver of this requirement when cooperation with OCSS is not in the best interest of the child. OCSS is responsible for making the good cause determination. If the parent or caretaker relative is claiming good cause, he/she cannot be certified for SoonerCare in the parent and caretaker relative group unless OCSS has determined good cause exists. There is no requirement of cooperation with OCSS for child(ren) or pregnant women to receive SoonerCare.

PART 7. APPLICATION AND ELIGIBILITY DETERMINATION PROCEDURES

317:35-5-63. Agency responsible for determination of eligibility

(a) **Determination of eligibility by OHCA.** OHCA is responsible for determining eligibility for the following eligibility groups:

(1) children
(2) newborns deemed eligible
~~(3) grandfathered CHIP children~~
~~(4)~~(3) pregnant women
~~(5)~~(4) pregnancy-related services under Title XXI
~~(6)~~(5) parents and caretaker relatives
~~(7)~~(6)former foster care children
~~(8)~~(7) Oklahoma Cares Breast and Cervical Cancer program
~~(9)~~(8) SoonerPlan Family Planning program.

(b) **Determination of eligibility by OKDHS.** OKDHS is responsible for determining eligibility for the following eligibility groups:

(1) TANF recipients
(2) recipients of adoption assistance or kinship guardianship assistance
(3) state custody
(4) Refugee Medical Assistance
(5) aged
(6) blind
(7) disabled
(8) Tuberculosis
(9) QMBP
(10) QDWI
(11) SLMB
(12) QI-1
(13) Long term care services

(14) alien emergency services.

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

SUBCHAPTER 6. SOONERCARE FOR PREGNANT WOMEN AND FAMILIES WITH CHILDREN

PART 1. GENERAL

317:35-6-1. Scope and applicability

(a) The rules in this Subchapter apply when determining financial eligibility for SoonerCare Health Benefits for groups whose eligibility is determined using Modified Adjusted Gross Income (MAGI). These rules apply to the following groups:

(1) Children,
~~(2) Grandfathered CHIP children,~~
~~(3)~~(2) Pregnant women,
~~(4)~~(3) Pregnancy-related services under Title XXI,
~~(5)~~(4) Parents and caretaker relatives,
~~(6)~~(5) SoonerPlan Family Planning program,
~~(7)~~(6) Independent foster care adolescents,
~~(8)~~(7) Inpatients in public psychiatric facilities under 21, and
~~(9)~~(8) Tuberculosis.

(b) See 42 ~~CFR~~Code of Federal Regulation, Sec. 435.603 to determine whether MAGI applies to a group not specifically listed in this Section.

(c) MAGI rules take effect on October 1, 2013.

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 51. HABILITATION SERVICES

317:30-5-482. Description of services

Habilitation services include the services identified in (1) through (15) of this ~~section. Providers of habilitation services~~ Section. Habilitation services providers must have an applicable agreement with the Oklahoma Health Care Authority (OHCA) to provide Developmental Disabilities Services (DDS) Home and ~~Community Based~~Community-Based Services (HCBS).

(1) **Dental services.** Dental services are provided per Oklahoma Administrative Code (OAC) 317:40-5-112.

(A) **Minimum qualifications.** ~~Providers of dental services~~Dental services providers must have non-restrictive licensure by the ~~Board of Governors of Registered Dentists of Oklahoma~~Oklahoma State Board of Dentistry to practice dentistry in Oklahoma.

(B) **Description of services.** Dental services include services for maintenance or improvement of dental health as well as relief of pain and infection. These services may include:

(i) an oral examination;
(ii) bite-wing ~~x-rays;~~X-rays;
(iii) ~~a prophylaxis;~~dental cleaning;
(iv) ~~topical fluoride~~topical-fluoride treatment;
(v) development of a sequenced treatment plan that prioritizes:

(I) elimination of pain;
(II) adequate oral hygiene; and
(III) restoration or an improved ability to chew;

(vi) routine training of member or primary caregiver regarding oral hygiene; and
(vii) preventive, restorative, replacement, and repair services to achieve or restore functionality~~, that are~~ provided after appropriate review when applicable, per OAC 317:40-5-112.

(C) **Coverage limitations.** Coverage of dental services is specified in the member's Individual Plan (IP)~~,~~ in accordance with applicable Waiver limits. Dental services are not authorized when recommended for cosmetic purposes.

(2) **Nutrition services.** Nutrition Services are provided per OAC 317:40-5-102.

(3) **Occupational therapy services.**

(A) **Minimum qualifications.** Occupational therapists and

occupational therapy assistants must have current, non-restrictive licensure by the Oklahoma~~ State~~ Board of Medical Licensure and Supervision. Occupational therapy assistants must be employed by~~ the~~ occupational ~~therapist.~~therapists.

(B) **Description of services.** Occupational therapy services include evaluation, treatment, and consultation in leisure management, daily living skills, sensory motor, perceptual motor, and mealtime assistance. Occupational therapy services may include the use of occupational therapy assistants, within the limits of the occupational therapist's practice.

(i) Services are:

(I) intended to help the member achieve greater independence to reside and participate in the community; and

(II) rendered in any community setting as specified in the member's ~~individual plan (IP).~~IP. The IP must include a practitioner's prescription.

(ii) For purposes of this Section, a practitioner is defined as medical and osteopathic physicians, physician assistants, and other licensed health care professionals with prescriptive authority to order occupational therapy services in accordance with the rules and regulations governing the SoonerCare program.

(iii) The provision of services includes a written report or record documentation in the member's record, as required.

(C) **Coverage limitations.** Payment is made for compensable services to the individual occupational therapist for direct services or for services provided by a qualified occupational therapist assistant, within the occupational therapist's employment. Payment is made in 15-minute units, with a limit of 480 units per Plan of Care year. Payment is not allowed solely for written reports or record documentation.

(4) **Physical therapy services.**

(A) **Minimum qualifications.** Physical therapists and physical therapist assistants must have current, non-restrictive licensure with the Oklahoma~~ State~~ Board of Medical Licensure and Supervision. The physical therapist must employ the physical therapist assistant.

(B) **Description of services.** Physical therapy services include evaluation, treatment, and consultation in locomotion or mobility and skeletal and muscular conditioning to maximize the member's mobility and skeletal/muscular well-being. Physical therapy services may include the use of physical therapist assistants,

within the limits of the physical therapist's practice.

(i) Services are intended to help the member achieve greater independence to reside and participate in the community. Services are provided in any community setting as specified in the member's IP. The IP must include a practitioner's prescription.

(ii) For purposes of this Section, a practitioner is defined as a licensed medical and osteopathic physicians, and physician assistants in accordance with the rules and regulations covering the OHCA SoonerCare program.

(iii) The provision of services includes a written report or record documentation in the member's record, as required.

(C) **Coverage limitations.** Payment is made for compensable services to individual physical therapists for direct services or for services provided by a qualified physical therapist assistant within the physical therapist's employment. Payment is made in 15-minute units with a limit of 480 units per Plan of Care year. Payment is not allowed solely for written reports or record documentation.

(5) **Psychological services.**

(A) **Minimum qualifications.** Qualification as a provider of psychological services requires current, non-restrictive licensure as a psychologist by the Oklahoma ~~Psychologist~~State Board of Examiners~~,~~ of Psychologists or licensing board in the state in which service is provided. Psychological technicians who have completed all board certification and training requirements may provide services under a licensed psychologist's supervision.

(B) **Description of services.** Psychological services include evaluation, psychotherapy, consultation, and behavioral treatment. Service is provided in any community setting as specified in the member's IP. The provider must develop, implement, evaluate and revise the Protective Intervention Protocol (PIP) corresponding to the relevant outcomes identified in the member's IP.

(i) Services are:

(I) intended to maximize a member's psychological and behavioral well-being; and

(II) provided in individual and group formats, with a ~~six person~~six-person maximum.

(ii) ~~A minimum of 15 minutes for each individual encounter, 15 minutes for each group encounter, and record documentation of each treatment session is included and required.~~Approval of services is based upon assessed needs per OAC 340:100-5-51.

(C) **Coverage limitations.**

(i) ~~Limitations for psychological services are:~~

~~(I) description: psycho therapy services and behavior treatment services, individual: unit: 15 minutes; and~~

~~(II) description: cognitive/behavioral treatment, group: unit: 15 minutes.~~Payment is made in 15 minute units. A minimum of 15 minutes for each individual and group encounter is required.

(ii) Psychological services are authorized for a period, not to exceed ~~six~~twelve (12) months.

(I) Initial authorization ~~is obtained through the Developmental Disabilities Services (DDS) case manager, with review and approval by the DDS case management supervisor.~~must not exceed 192 units, 48 hours of service.

(II) ~~Initial authorization must not exceed 192 units, 48 hours of service.~~Authorizations may not exceed 288 units per plan of care year unless an exception is made by the DDS director of Behavior Support Services or his or her designee.

(III) ~~Quarterly progress notes must include a statement of hours and types of services provided, and an empirical measure of member status as it relates to each objective in the member's IP.~~No more than 12 hours of services, 48 units, may be billed for PIP preparation. Any clinical document must be prepared within sixty (60) calendar days of the request. Further, if the document is not prepared, payments are suspended until the requested document is provided.

(IV) When ~~progress notes for each quarter of service provision are not submitted to the DDS case manager, authorization for payment must be withdrawn until such time as progress notes are submitted.~~revising a PIP to accommodate recommendations of a required committee review, the provider may bill for only one revision. The time for preparing the revision must be clearly documented and must not exceed four hours.

~~(iii) Treatment extensions may be authorized by the DDS area manager, based upon evidence of continued need and effectiveness of treatment.~~

~~(I) Evidence of continued need of treatment, treatment effectiveness, or both, is submitted by the provider to the DDS case manager and must include, at a minimum, completion of the Service~~

~~Utilization and Evaluation protocol.~~

~~(II) When revising a protective intervention plan (PIP) to accommodate recommendations of a required committee review or an Oklahoma Department of Human (DHS) audit, the provider may bill for only one revision. The time for preparing the revision must be clearly documented and must not exceed four hours.~~

~~(III) Treatment extensions must not exceed 24 hours, 96 units, of service, per request.~~

~~(iv) The provider must develop, implement, evaluate, and revise the PIP corresponding to the relevant goals and objectives identified in the member's IP.~~

~~(v) No more than 12 hours, 48 units, may be billed for the preparation of a PIP. Any clinical document must be prepared within 45 calendar days of the request. Further, if the document is not prepared, payments are suspended until the requested document is provided.~~

~~(vi) Psychological technicians may provide up to 140 billable hours, 560 units, of service per month to members.~~

~~(vii) The psychologist must maintain a record of all billable services provided by a psychological technician.~~

(6) **Psychiatric services.**

(A) **Minimum qualifications.** Qualification as a~~ provider of~~ psychiatric services provider requires a current, non-restrictive license to practice medicine in Oklahoma. Certification by the American Board of Psychiatry and Neurology or satisfactory completion of an approved residency program in psychiatry is required.

(B) **Description of services.** Psychiatric services include outpatient evaluation, psychotherapy, medication and prescription management and consultation, and are provided to eligible members. Services are provided in community setting specified in the member's IP.

(i) Services are intended to contribute to the member's psychological well-being.

(ii) A minimum of 30 minutes for encounter and record documentation is required.

(C) **Coverage limitations.** A unit is 30 minutes, with a limit of 200 units, per Plan of Care year.

(7) **Speech/language services.**

(A) **Minimum qualifications.** Qualification as a ~~provider of~~ speech and/or language services provider requires current, non-restrictive licensure as a speech and/or language pathologist by the ~~State~~Oklahoma Board of Examiners for Speech Pathology and Audiology.

(B) **Description of services.** Speech therapy includes evaluation, treatment, and consultation in communication and oral motor and/or feeding activities provided to eligible members. Services are intended to maximize the member's community living skills and may be provided in the community setting specified in the member's IP. The IP must include a practitioner's prescription.

(i) For purposes of this Section, practitioners are defined as licensed medical and osteopathic physicians, physician assistants, and other licensed professionals with prescriptive authority to order speech and/or language services in accordance with rules and regulations covering the OHCA SoonerCare program.

(ii) A minimum of 15 minutes for encounter and record documentation is required.

(C) **Coverage limitations.** A unit is 15 minutes, with a limit of 288 units, per Plan of Care year.

(8) **Habilitation training specialist (HTS) services.**

(A) **Minimum qualifications.** Providers must complete the ~~DHS DDS sanctioned~~Oklahoma Department of Human Services (DHS) DDS-sanctioned training curriculum. Residential habilitation providers:

(i) are at least 18 years of age;

(ii) are specifically trained to meet ~~the~~members' unique needs~~ of members~~;

(iii) ~~have~~were not~~ been~~ convicted of, pled guilty to, or pled nolo contendere to misdemeanor assault and battery, or a felony, per Section 1025.2 of Title 56 of the Oklahoma Statutes (56 O.S. § 1025.2)~~,~~; unless a waiver is granted, per 56 O.S. § 1025.2; and

(iv) receive supervision and oversight from ~~a contracted agency~~contracted-agency staff with a minimum of four years of any combination of ~~college level~~college-level education or full-time equivalent experience in serving persons with disabilities.

(B) **Description of services.** HTS services include services to support the member's self-care, daily living, and adaptive and leisure skills needed to reside successfully in the community. Services are provided in community-based settings in a manner that contributes to the member's independence, self-sufficiency, community inclusion, and well-being.

(i) Payment ~~will~~is not~~ be~~ made for:

(I) routine care and supervision normally provided by family; or

(II) services furnished to a member by a person who is legally responsible per OAC 340:100-3-33.2.

(ii) Family members who provide HTS services must meet

the same standards as providers who are unrelated to the member. HTS staff residing in the same household as the member may not provide services in excess of 40 hours per week. Members ~~who require~~requiring more than 40 hours per week of HTS services, must use staff members, who do not reside in the household and are employed by the member's chosen provider agency to deliver the balance of necessary support staff hours. Exceptions may be authorized, when needed, for members who receive services through the Homeward Bound Waiver.

(iii) Payment does not include room and board or maintenance, upkeep, ~~and~~or improvement of the member's or family's residence.

(iv) For members who also receive intensive personal supports (IPS), the member's IP must clearly specify the role of the HTS and person providing IPS to ensure there is no duplication of services.

(v) ~~DDS case management supervisor review~~Review and approval by the DDS plan of care reviewer is required.

(vi) Pre-authorized HTS services accomplish the same objectives as other HTS services, but are limited to situations where the HTS provider is unable to obtain required professional and administrative oversight from an ~~OHCA approved~~OHCA-approved oversight agency. For pre-authorized HTS services, the service:

(I) provider receives DDS area staff oversight; and

(II) must be pre-approved by the DDS director or his or her designee.

(C) **Coverage limitations.** HTS services are authorized per OAC 317:40-5-110, 317:40-5-111,~~ and~~ 317:40-7-13, and 340:100-3-33.1.

(i) A unit is 15 minutes.

(ii) Individual HTS services providers are limited to a maximum of 40 hours per week regardless of the number of members served.

(iii) More than one HTS may provide care to a member on the same day.

(iv) Payment cannot be made for services provided by two or more HTSs to the same member during the same hours of a day.

(v) A HTS may receive reimbursement for providing services to only one member at any given time. This does not preclude services from being provided in a group setting where services are shared among members of the group.

(vi) HTS providers may not perform any job duties associated with other employment~~,~~ including on-call

duties, at the same time they are providing HTS services.

(9) **Self Directed HTS (SD HTS).** SD HTS are provided per OAC 317:40-9-1.

(10) **Self Directed Goods and Services (SD GS).** SD GS are provided per OAC 317:40-9-1.

(11) **Audiology services.**

(A) **Minimum qualifications.** Audiologists must have licensure as an audiologist by the ~~State~~Oklahoma Board of Examiners for Speech Pathology and Audiology.

(B) **Description of services.** Audiology services include individual evaluation, treatment, and consultation in hearing to eligible members. Services are intended to maximize the member's auditory receptive abilities. The member's IP must include a practitioner's prescription.

(i) For purposes of this Section, practitioners are defined as licensed medical and osteopathic physicians, and physician assistants in accordance with rules and regulations covering the OHCA SoonerCare program.

(ii) A minimum of 15 minutes for encounter and record documentation is required.

(C) **Coverage limitations.** Audiology services are provided in accordance with the member's IP.

(12) **Prevocational services.**

(A) **Minimum qualifications.** Prevocational services providers:

(i) are at least 18 years of age;

(ii) complete the DHS ~~DDS sanctioned~~DDS-sanctioned training curriculum;

(iii) ~~have~~were not ~~been~~ convicted of, pled guilty to, or pled nolo contendere to misdemeanor assault and battery, or a felony per 56 O.S. §1025.2, unless a waiver is granted per 56 O.S. §1025.2; and

(iv) receive supervision and oversight by a person with a minimum of four years of any combination of ~~college level~~college-level education or full-time equivalent experience in serving persons with disabilities.

(B) **Description of services.** Prevocational services are not available to persons who can be served under a program funded per Section 110 of the Rehabilitation Act of 1973 or~~ Section 602(16) and (17) of~~ the Individuals with Disabilities Education Act (IDEA)~~. Services are aimed at preparing a member for employment, but are not job-task oriented. Services include teaching concepts, such as compliance, attendance, task completion, problem solving, and safety.~~ per Section 1401 et seq. of Title 20 of the United States Code.

(i) Prevocational services are ~~provided to members who~~

~~are not expected to:~~learning and work experiences where the individual can develop general, non-job, task-specific strengths that contribute to employability in paid employment in integrated community settings.

~~(I) join the general work force; or~~

~~(II) participate in a transitional sheltered workshop within one year, excluding supported employment programs.~~

(ii) ~~When compensated, members are paid at less than 50 percent of the minimum wage. Activities included in this service are not primarily directed at teaching specific job skills, but at underlying, habilitative goals, such as attention span and motor skills.~~Activities include teaching concepts, such as communicating effectively with supervisors, co-workers, and customers, attendance, task completion, problem solving, and safety. These activities are associated with building skills necessary to perform work.

(iii) Pre-vocational services are delivered for the purpose of furthering habilitation goals that lead to greater opportunities for competitive, integrated employment. All prevocational services are reflected in the member's IP~~ as habilitative, rather than explicit employment objectives~~. Documentation must be maintained in the record of each member receiving this service, noting the service is not otherwise available through a program funded under the Rehabilitation Act of 1973 or IDEA.

(iv) ~~Documentation must be maintained in the record of each member receiving this service, noting the service is not otherwise available through a program funded under the Rehabilitation Act of 1973 or IDEA.~~

~~(v)~~Services include:

(I) center-based prevocational services, per OAC 317:40-7-6;

(II) community-based prevocational services per, OAC 317:40-7-5;

(III) enhanced community-based prevocational services per, OAC 317:40-7-12; and

(IV) supplemental supports, as specified in OAC 317:40-7-13.

(C) **Coverage limitations.** A unit of center-based or community-based prevocational services is one hour and payment is based ~~upon~~on the number of hours the member participates in the service. All prevocational services and ~~supported employment~~supported-employment services combined may not exceed $27,000, per Plan of Care year. The~~ following~~ services that may not be provided to the

same member at the same time as prevocational services~~:~~ are:

(i) HTS;

(ii) Intensive Personal Supports;

(iii) Adult Day Services;

(iv) Daily Living Supports;

(v) Homemaker; or

(vi) therapy services, such as occupational therapy~~,~~; physical therapy~~,~~; nutrition, speech, or psychological services~~,~~; family counseling~~,~~; or family training, except to allow the therapist to assess the individual's needs at the workplace or to provide staff training, ~~and as allowed~~ per OAC 317:40-7-6.

(13) **Supported employment.**

(A) **Minimum qualifications.** Supported employment providers:

(i) are at least 18 years of age;

(ii) complete the DHS ~~DDS sanctioned~~DDS-sanctioned training curriculum;

(iii) ~~have~~were not~~ been~~ convicted of, pled guilty to, or pled nolo contendere to misdemeanor assault and battery, or a felony, per ~~56 O.S. §1025.2,~~Section 1025.2 of Title 56 of the Oklahoma Statutes (O.S. 56 § 1025.2) unless a waiver is granted, per 56 O.S. ~~§1025.2;~~§ 1025.5; and

(iv) receive supervision and oversight by a person with a minimum of four years of any combination of ~~college level~~college-level education or full-time equivalent experience in serving persons with disabilities.

(B) **Description of services.** Supported employment is conducted in a variety of settings, particularly ~~work sites~~worksites in which persons without disabilities are employed, and includes activities that are outcome based and needed to sustain paid work by members receiving services through HCBS Waivers, including supervision and training. The outcome of supported employment is sustained paid employment at or above minimum wage, but not less than the customary wage and benefit level paid by the employer for the same or similar work performed by individuals without disabilities. The paid employment occurs in an integrated setting in the general workforce in a job that meets personal and career goals.

(i) When ~~supported employment~~supported-employment services are provided at a ~~work site~~worksite in which persons without disabilities are employed, payment:

(I) is made for the adaptations, supervision, and training required by members as a result of their disabilities; and

(II) does not include payment for the supervisory activities rendered as a normal part of the business setting.

(ii) Services include:

(I) job coaching per OAC 317:40-7-7;

(II) enhanced job coaching per OAC 317:40-7-12;

(III) employment training specialist services per OAC 317:40-7-8; and

(IV) stabilization per OAC 317:40-7-11.

(iii) ~~Supported employment~~Supported-employment services furnished under HCBS Waivers are not available under a program funded by the Rehabilitation Act of 1973 or ~~IDEA.~~Individuals with Disabilities Education Act (IDEA).

(iv) Documentation that the service is not otherwise available under a program funded by the Rehabilitation Act of 1973 or IDEA must be maintained in the record of each member receiving ~~this~~the service.

(v) Federal financial participation (FFP) may not be claimed for incentive payment subsidies or unrelated vocational training expenses, such as:

(I) incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program;

(II) payments passed through to users of ~~supported employment~~supported-employment programs; or

(III) payments for vocational training not directly related to a member's ~~supported employment~~supported-employment program.

(C) **Coverage limitations.** A unit is 15 minutes and payment is made per OAC 317:40-7-1 through 317:40-7-21. All prevocational services and ~~supported employment~~supported-employment services combined cannot exceed $27,000, per Plan of Care year. The DDS case manager assists the member to identify other alternatives to meet identified needs above the limit. The~~ following~~ services that may not be provided to the same member, at the same time~~,~~ as ~~supported employment services:~~supported-employment services are:

(i) HTS;

(ii) Intensive Personal Supports;

(iii) Adult Day Services;

(iv) Daily Living Supports;

(v) Homemaker; or

(vi)~~Therapy~~therapy services, such as occupational therapy~~,~~; physical therapy~~,~~; nutrition, speech, or psychological services, family counseling, or family training, except to allow the therapist to assess the

individual's needs at the workplace or to provide staff training.

(14) **Intensive personal supports (IPS).**

(A) **Minimum qualifications.** IPS provider agencies must have a current provider agreement with OHCA and DHS DDS. Providers:

(i) are at least 18 years of age;

(ii) complete the DHS ~~DDS sanctioned~~DDS-sanctioned training curriculum;

(iii) ~~have~~were not ~~been~~ convicted of, pled guilty to, or pled nolo contendere to misdemeanor assault and battery, or a felony, per ~~56 O.S. §1025.2,~~Section 1025.2 of Title 56 of the Oklahoma Statutes (O.S. 56 § 1025.2) unless a waiver is granted, per 56 O.S. ~~§1025.2;~~§ 1025.2;

(iv) receive supervision and oversight by a person with a minimum of four years of any combination of ~~college level~~college-level education or full-time equivalent experience in serving persons with disabilities; and

(v) receive oversight regarding specific methods to be used with the member to meet the member's complex behavioral or health support needs.

(B) **Description of services.**

(i) IPS:

(I) are support services provided to members who need an enhanced level of direct support in order to successfully reside in a community-based setting; and

(II) build upon the level of support provided by a HTS or daily living supports (DLS) staff by utilizing a second staff person on duty to provide assistance and training in self-care, daily living, and recreational~~,~~ and habilitation activities.

(ii) The member's ~~IP~~Individual Plan (IP) must clearly specify the role of HTS and the person providing IPS to ensure there is no duplication of services.

(iii) ~~DDS case management supervisor review~~Review and approval by the DDS plan of care reviewer is required.

(C) **Coverage limitations.** IPS are limited to 24 hours per day and must be included in the member's IP, per OAC 317:40-5-151 and 317:40-5-153.

(15) **Adult day services.**

(A) **Minimum qualifications.** Adult day services provider agencies must:

(i) meet the licensing requirements, per 63 O.S. ~~§§1-873~~§ 1-873 *et seq*. and comply with OAC 310:605; and

(ii) be approved by the DHS DDS director and have a valid OHCA contract for adult day services.

(B) **Description of services.** Adult day services provide assistance with the retention or improvement of self-help, adaptive~~,~~ and socialization skills, including the opportunity to interact with peers in order to promote a maximum level of independence and function. Services are provided in a non-residential setting ~~separate~~<u>away</u> from the home or facility where the member resides.

(C) **Coverage limitations.** Adult day services are ~~typically~~ furnished four or more hours per day on a regularly scheduled basis, for one or more days per week. A unit is 15 minutes for up to a maximum of six hours daily, at which point a unit is one day. All services must be authorized in the member's IP.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 40. DEVELOPMENTAL DISABILITIES SERVICES

SUBCHAPTER 1. GENERAL PROVISIONS

317:40-1-3. Requirements for Home and Community-Based settings

(a) The Oklahoma Department of Human Services Developmental Disabilities Services Home and Community-Based Services (HCBS) Waiver settings have the following qualities defined in federal regulation per ~~42 CFR § 441.301(c)(4)~~Section 441.301(c)(4) of Title 42 of the Code of Federal Regulations [42 CFR § 441.301(c)(4)] based on the needs of the individual defined in his or her Individual Plan (Plan).

(1) The setting is integrated and supports full access of individuals receiving HCBS Waivers to the greater community, including opportunities to:

(A) seek employment and work in competitive, integrated settings;

(B) engage in community life;

(C) control personal resources; and

(D) receive services in the community, to the same degree as individuals not receiving Medicaid HBCS Waiver Services.

(2) The setting is selected by the member from options including non-disability settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and based on individual needs and preferences.

(3) For residential settings, the member must have income available for room and board.

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

(5) The setting optimizes individual initiative, autonomy, and independence in making life choices including, but not limited to:

(A) daily activities;

(B) the physical environment; and

(C) with whom to interact.

(6) The setting facilitates individual choice regarding services and supports, including who provides them.

(b) In a provider-owned or controlled residential setting, in addition to the attributes specified above, the additional conditions listed in (1) through (8) of this subsection must be met.

(1) The unit or dwelling is a specific, physical place, owned, rented, or occupied under a ~~legally enforceable~~legally-enforceable agreement by the member receiving services.

(2) The member has the same responsibilities and protections from eviction, that tenants have per the Residential Landlord and Tenant Act, ~~41 O.S. § 101, et seq.~~Section 101 et. seq. of Title 41 of the Oklahoma Statutes (41 O.S. § 101, et. seq.)

(3) In settings where landlord tenant laws do not apply, the provider agency completes a lease, residency agreement, or other form of written agreement for each member. The document provides protections that address eviction processes and appeals comparable to those provided in the Residential Landlord and Tenant Act, 41 O.S. § 101, et seq.

(4) Each member has privacy in his or her sleeping or living unit, where:

(A) units have entrance doors lockable by the member, with only appropriate staff having keys to doors;

(B) members sharing units have a choice of roommates; and

(C) members have freedom to furnish and decorate~~ his or her~~ sleeping or living units within the lease or other agreement.

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

(6) ~~Each member may have visitors whenever he or she chooses.~~Members are able to have visitors of his or her choosing, at any time.

(7) The setting is physically accessible to the member.

(8) Any modifications of the additional conditions specified in this subsection, must be supported by a specific, assessed need,~~ and~~ justified in the person-centered ~~Plan~~plan and includes:

(A) an identified individualized assessed need;

(B) documentation of the positive interventions and supports used prior to any modifications to the person-centered plan;

(C) documentation of less intrusive methods tried, including those that did not work;

(D) a clear description of the condition, proportionate to the specific assessed need;

(E) regular collection and review of data to measure the ongoing effectiveness of the modification;

(F) established time limits for periodic reviews to determine if the modification continues to be necessary or can be terminated;

(G) the informed consent of the member; and

(H) an assurance the interventions and supports will cause no harm to the member.

(c) Any setting that isolates members from the broader community of individuals not receiving HCBS is not considered an HCBS.

(1) Settings that are not HCBS per 42 CFR § 441.301(c)(5)(v) include:

(A) a nursing facility;

(B) an institution for mental diseases;

(C) an intermediate care facility for individuals with intellectual disabilities;

(D) a hospital; or

(E) any other locations with qualities of an institutional setting per 42 CFR § 441.301(c)(5)(v).

SUBCHAPTER 7. EMPLOYMENT SERVICES THROUGH HOME AND COMMUNITY-BASED SERVICES WAIVERS

317:40-7-3. Eligibility for Waiver Employment Services

(a) Individuals served through Waiver Employment Services must be:

(1) 16 years of age ~~or~~and older for persons receiving services through the Community Waiver, ~~or 18 years of age or older for persons receiving services through the~~ In Home Supports Waiver, or the Homeward Bound Waiver; and

(2) approved for waiver services~~ in accordance with OAC~~, per Oklahoma Administrative Code (OAC) 317:40-1-1.

(b) Services available to the ~~service recipient~~member through the Oklahoma Department of Rehabilitation Services (DRS) or through the state or local education agency are not funded under Waiver Employment Services.

(1) ~~Service recipients~~Members may utilize waiver employment services during times when school is not in session, ~~unless an IEP approved program through the school system is in place.~~and/or the member is not participating in an Individual Education Program that includes extended school year services through the school system.

(2) All ~~service recipients~~members seeking ~~supported~~ competitive, integrated employment make application to DRS. Prior to the authorization of Waiver Employment Services, the case manager ~~completes OKDHS Form DDS-55, Documentation of Application for DRS Supported Employment Services, to be maintained as a permanent entry in the local case record.~~documents the application for DRS services. The documentation is permanently maintained in the Client Contact Manager record.

(3) Since services provided by DRS are time-limited by federal law, ~~DDSD~~Developmental Disabilities Services provides ~~long term,~~long-term, on-going supports for individuals who need long-term supports, ~~as described in~~per OAC 317:40-7-11.

317:40-7-4. Services provided through Waiver Employment Services

(a) Waiver Employment Services are offered under the~~ Medicaid~~ Home and Community-Based Waiver for persons with intellectual disabilities at rates prescribed by the Oklahoma Health Care Authority.

(b) ~~Types of ~~Waiver Employment Services~~ offered~~ include:

(1) Vocational Habilitation Training Specialist~~ (VHTS)~~, Supplemental Support;

(2) Employment Training Specialist~~ (ETS)~~;

(3) Center-Based Services;

(4) Community-Based Services;

(5) Enhanced Community-Based Services;

(6) Job Coaching;

(7) Enhanced Job Coaching; and

(8) Stabilization Services.

(c) ~~State-funded services described in OAC 340:100-17-30 may supplement Employment Services funded through the Community Waiver.~~State-funded employment services are available to members of the Homeward Bound class who are not eligible for Developmental Disabilities Services Waiver services.