OKLAHOMA HEALTH CARE AUTHORITY
SPECIAL BOARD MEETING
April 1, 2019 at 9:00 A.M.
Oklahoma Health Care Authority
4345 N. Lincoln Blvd.
OKC, OK

A G E N D A

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

1. Call to Order / Determination of Quorum

2. Discussion and Possible Action Item – Election of the Oklahoma Health Care Authority 2019 Board Officers

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

3. Discussion Item – Chief Executive Officer's Report

    a) Financial Update – Aaron Morris, Chief Financial Officer

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

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 Josh Richards, Director of Program Integrity

5. Action Item – Consideration and Vote Upon the Recommendations of the State Plan Amendment Rate Committee

A. Consideration and Vote for a rate and rate method change to the Residential Behavior Management Services (RBMS) providers. There are seven levels of RBMS rates (C, D, D+, E, E+, Enhanced E, and ITS). The per diem rate consists of staff, facility, operational, and administrative cost. The allocation of cost is split between Medicaid and Title IV-E funding using a direct care cost adjustment factor. The estimated budget impact for the remainder of SFY2020 will be an increase of $5,309,136 total; of which $1,804,045 is state share paid by the Oklahoma Department of Human Services. The estimated budget impact for the remainder of SFY2020 will be an increase of $1,323,638 total; of which $449,772 is state share paid the Oklahoma Office of Juvenile Affairs.

B. Consideration and Vote for a rate method change for Partial Hospitalization Programs (PHP). The current reimbursement rate is $42.80 per hour. The new reimbursement rate of $160.50 per day is based on the 2010 Medicare cost assumptions for PHP services. This is based on a blend of a 3.5 hour treatment day and a 4 hour treatment day. This change is estimated to be budget neutral.

C. Consideration and Vote for a rate and rate method change for Certified Community Behavioral Health Clinics (CCBHC) to change from a demonstration grant to a State Plan covered service. CCBHC currently receive a fixed PMPM reimbursement rate for every individual who has at least one qualifying visit in the month. There is a standard CCBHC (or base) rate and five Separate Reimbursement Rates for Special Populations (SPPOP). The proposed methodology will be two

separate reimbursement rates for special populations, instead of the current five. The net increase to ODMHSAS for the three months remaining in SFY2019 is $1,683,210 total, $618,222 state share which will be paid by ODMHSAS. Due to the rebasing and change in methodology for special populations, the estimated SFY2020 budget impact is a savings to ODMHSAS of $259,849 total, $90,661 state share.

D. Consideration and Vote for a rate and rate method change for intensive Therapeutic Foster Care (ITFC). This is a new program so there is no current methodology. ITFC is treatment focused program that serves children in the custody in a family setting that utilizes a team approach of professionals including therapist, care coordinators, and the foster parent to provide the services. The rate is a per diem rate that encompasses the cost of providing a foster home environment (IV-E compensable activities) along with the evidenced based and trauma informed therapies and treatments (Title XIX compensable activities). The Title XIX portion of the rate is $141.93. The state share will be paid by DHS and is cost neutral by reducing the number of beds in TFC to fund ITFC.

E. Consideration and Vote for a rate method change for Medicare Part A and Part B crossover claims. The methodology of paying Medicare crossover claims is not changing, but the State Plan is being updated to align with current practice. Due to a provider type and specialty change for psychiatric hospitals and Psychiatric Residential Treatment Facilities (PRTF), Medicare crossover claims were paying incorrectly. The original intent was to pay psychiatric hospitals and PRTFs the same way as hospitals, as that was their previous provider type. Psychiatric hospitals and PRTFS are paid 75% of deductible and 25% of coinsurance for Medicare Part A crossover claims. Medicare medical services and dialysis are receiving payment of 100% of deductible and 46.25% of coinsurance for Medicare Part B crossover claims. Payment for Indian Health Services (IHS) clinics and transportation services are made at 100% of deductible and 100% of coinsurance for Medicare Part B crossover claims. The proposed State Plan amendment is budget neutral as this proposed amendment is being submitted to align with current practice.

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

6. Action Item – Consideration and Vote of Agency Recommended Rulemaking Pursuant to Article I of the Administrative Procedures Act

The following permanent rule HAS previously been approved by the Board and the Governor under EMERGENCY rulemaking. This rule HAS been revised for PERMANENT rulemaking.

OHCA Initiated

A**.** AMENDING agency rules at ***OAC 317:30-5-20, 317:30-5-40.1 and 317:30-5-42.10*** will strengthen the language delineating medical necessity, and compensable and non-compensable lab services. Additional revisions will clarify that the OHCA does not pay for all lab services listed in the Centers for Medicare and Medicaid Services (CMS) fee schedule but only those that are medically necessary in addition to the four other conditions required for payment.
Budget Impact: Agency staff has determined that the proposed rule changes will result in a budget savings by further delineating medical necessity.

(Reference APA WF # 18-01)

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

OHCA Initiated

B. AMENDING agency rules at ***OAC 317:30-5-123*** will incorporate new language to clarify that the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) will be used for diagnostic purposes of a mental illness and/or intellectual disability in Medicaid certified nursing facility admissions. Further, revisions will reflect WF 18-15 policy changes made to the appeals rules to extend the length of time in which an appeal can be submitted from twenty (20) days to thirty (30) days of the date of an adverse agency action. Lastly, revisions will also involve limited rewriting aimed at clarifying text, eliminating redundancies, and updating outdated terminology.
Budget Impact: Budget neutral

(Reference APA WF # 18-07A)

C. AMENDING agency rules at ***OAC 317:35-19-8*** will incorporate new language to clarify that the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) will be used for diagnostic purposes of a mental illness and/or intellectual disability for admission to a Medicaid certified nursing facility. Additional revisions will involve limited rewriting aimed at clarifying text, eliminating redundancies, and updating outdated terminology.
Budget Impact: Budget neutral

(Reference APA WF # 18-07B)

D. ADDING agency rules at ***OAC 317:30-3-33*** will establish a new section addressing suspended claims review and/or prepayment review. This policy will align the agency with state and federal laws that require the OHCA to safeguard against unnecessary utilization of medical supplies and services. Additionally, the revisions will help to ensure that payments are consistent, efficient, economical, and provide good quality of care. Please refer to 42 United States Code § 1396a(a)(30)(A); 42 Code of Federal Regulations § 447.45(f); and, 56 Oklahoma Statutes § 1010.4(B)(5). These revisions will help ensure that reimbursements are for medically necessary, correctly and/or appropriately billed, medical supplies and services. The changes define and explain the various reviews that may be performed by the OHCA or its contractor before OHCA pays a claim.
Budget Impact: It is expected that these types of reviews will achieve significant savings, the exact amount of which cannot be quantified at this time.

(Reference APA WF # 18-09)

E. AMENDING agency rules at ***OAC 317:30-3-19.4*** will establish application fees required by federal law for providers enrolling or re-enrolling in Medicaid. The revisions will define providers who are exempted from the application fee as individual physician or non-physician practitioners; providers who enrolled with and paid the fee to Medicare; and providers who enrolled with and paid the fee to another state Medicaid agency. Additional revisions will outline provider screening and enrollment requirements designed to help defend against Medicaid provider fraud, waste, and/or abuse. Provider screening requirements are outlined according to three categorical screening levels: limited-risk, moderate-risk, and high-risk. Examples of screening requirements are licensure verification, on-site visits, and fingerprint-based background checks.
Budget Impact: Agency staff estimates that the proposed rule change will generate revenue due to the application/screening fees. Per federal law, the collected fees shall be used for the cost of conducting screenings

(Reference APA WF # 18-13)

F. AMENDING agency rules at ***OAC 317:35-5-41, 317:35-5-41.1, 317:35-5-41.2, 317:35-5-41.3, 317:35-5-41.8, 317:35-5-41.9*** and ADDING agency rules at ***OAC 317:35-5-41.12*** will update policy on resources that are disregarded by federal law due to Oklahoma transitioning from a 209(b) state to a Supplemental Security Income (SSI) criteria state for determination of eligibility for SSI related eligibility groups such as the Aged, Blind, and Disabled (ABD).
Budget Impact: Budget neutral

(Reference APA WF # 18-14)

G. AMENDING agency rules at ***OAC 317:2-1-2, 317:2-1-6, 317:2-1-7, 317:2-1-10, 317:2-1-11, 317:2-1-12, 317:2-1-13, 317:2-1-14 and 317:2-1-16*** will change all of the agency's appeals rules to extend the length of time that appeals can be submitted from twenty (20) days to thirty (30) days of the date of an adverse agency action. Additionally, the revisions will add Supplemental Hospital Offset Payment Program (SHOPP) appeals to the list of other grievance procedures and processes.
Budget Impact: Budget neutral

(Reference APA WF # 18-15A)

H. AMENDING agency rules at ***OAC 317:30-3-2.1, 317:30-5-95.31, 317:30-5-136, 317:30-5-136.1 and 317:30-5-746*** will change all of the agency's appeals rules to extend the length of time that appeals can be submitted from twenty (20) days to thirty (30) days of the date of an adverse agency action.
Budget Impact: Budget neutral

(Reference APA WF # 18-15B)

I. AMENDING agency rules at ***OAC 317:35-19-16*** will change all of the agency's appeals rules to extend the length of time that appeals can be submitted from twenty (20) days to thirty (30) days of the date of an adverse agency action.
Budget Impact: Budget neutral

(Reference APA WF # 18-15C)

J. AMENDING agency rules at ***OAC 317:35-22-2.1*** will provide non-emergency transportation (NET) to pregnant women covered under the Title XXI State Plan (Soon-to-be-Sooners and Soon-to-be-Sooners Maintenance of Effort populations). Under federal parity law requirements, children covered by the Children's Health Insurance Program (CHIP), including those in the unborn child category, must have the same access to secretary-approved coverage of all Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefits including health care, diagnostic services, treatment, and other measures to correct or ameliorate defects and physical and mental illness and conditions as per the approved State Plan.
Budget Impact: The agency anticipates that the proposed changes would potentially result in a budget impact of approximately $15,094 total, with $5,266 in state share for SFY 2020.

(Reference APA WF # 18-16)

K. AMENDING agency rules at ***OAC 317:30-3-65.4*** will add coverage and reimbursement language for maternal depression screenings at Early and Periodic Screening, Diagnostic and Treatment (EPSDT) at well-child visits. Providers will be reimbursed for conducting a maternal depression screening at the child's well-child visit. The policy will also reiterate how the Oklahoma Health Care Authority adopts and utilizes the American Academy of Pediatrics' Bright Futures periodicity schedule including for the maternal depression screenings. Additionally, the proposed revisions will update the child abuse section to provide a more thorough explanation of how to report abuse and neglect including clarifying text, and updating outdated citations.

Budget Impact: The agency anticipates that the proposed changes would potentially result in a budget impact of approximately $128,748 total with $43,749 in state share for SFY2020.

(Reference APA WF # 18-17)

L. AMENDING agency rules at ***OAC 317:30-5-2 and 317:30-5-11*** will clarify that when rendering a direct physician service visit in a nursing facility, a psychiatrist or a physician with appropriate behavioral health training is required to perform such service. Additionally, revisions will clarify that other than the two (2) allowable direct physician services visit in a nursing facility, reimbursement for psychiatric services to members residing in a nursing facility is not allowed. Revisions will also reflect WF 18-17 policy changes to update the child abuse section to provide a more thorough explanation of how to report abuse and neglect, including clarifying text, and updating outdated citations. Further, revisions will also reference WF 18-24 out-of-state policy.
Budget Impact: The proposed rule will result in small savings to the agency as it will place limits on any overutilization of services.

(Reference APA WF # 18-23)

M. AMENDING agency rules at ***OAC 317:30-3-31 and 317:30-5-95.24;*** ADDING agency rules at ***OAC 317:30-3-89, 317:30-3-90, and 317:30-3-91;*** AMENDING and RENUMBERING agency rules at ***OAC 317:30-3-64 to OAC 317:30-3-92*** will add a Part 6 to Chapter 30 in policy titled "Out-of-State Services." The new part will define and clarify coverage and reimbursement for services rendered by providers that are physically located outside of Oklahoma. Additions will delineate out-of-state services, provider participation requirements, prior authorizations, documentation/medical records requirements and will outline reimbursement criteria for out-of-state providers who do not accept the payment rate established through the State Plan. Additionally, the "payment for lodging and meals" section will be moved under the new Part 6. Finally, revisions will strike out old out-of-state policy then replace with references directing to the new part.
Budget Impact: It is expected that the new policy's reimbursement methodology will achieve significant savings, the exact amount of which cannot be quantified at this time.

(Reference APA WF # 18-24)

N. AMENDING agency rules at ***OAC 317:30-3-19.5 and 317:30-5-664.8*** will eliminate references to sections that have been revoked. The sections were revoked in past rulemaking sessions. However, language in other parts of the Chapter referring to these sections were inadvertently missed. Further revisions will correct misspelled words and grammatical mistakes for better flow and understanding.
Budget Impact: Budget neutral

(Reference APA WF # 18-25)

O. AMENDING agency rules at ***OAC 317:30-5-96.6*** will streamline crossover payments of Medicare/Medicaid dual eligible individuals for Part A and B services. Further revisions will also involve limited rewriting aimed at clarifying text, eliminating redundancies, and updating outdated terminology.
Budget Impact: Budget neutral

(Reference APA WF # 18-27)

P. AMENDING agency rules at ***OAC 317:30-5-95.33*** will comply with federal regulations by assuring that members under twenty-one (21) years of age who are residing in qualified inpatient psychiatric settings have access to a full range of medically necessary Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services. Revisions will also emphasize that EPSDT services are accessible, regardless of whether such services are listed on the member's individual plan of care.

Budget Impact: Budget neutral

(Reference APA WF # 18-28)

Q. AMENDING agency rules at ***OAC 317:30-5-664.3*** and ADDING agency rules at ***OAC 317:30-5-664.4*** will reinstate administrative rules to allow and better define multiple encounters at Federally Qualified Health Centers (FQHCs). Additional revisions will establish guidelines for these multiple encounters. Finally, revisions will update/remove outdated language in order to reflect current business practices and to provide consistency throughout policy.
Budget Impact: The agency predicts that the budget impact is nominal. Thus, the agency estimates this change to be budget neutral.

(Reference APA WF # 18-30)

DHS Initiated

R. AMENDING agency rules at ***OAC 317:40-7-5, 317:40-7-6, 317:40-7-15 and 317:40-7-21*** will add new language to provide general clarification that when a home-based business is established through the Oklahoma Department of Rehabilitation (OKDRS) services, Developmental Disabilities Services (DDS) stabilization services are utilized when the OKDRS end. In addition, new language will provide guidelines for the Personal Support Team to follow when the required thirty (30) hours of employment services through Home and Community-Based Service (HCBS) waivers is not met. Examples of these services include community-based services, center-based services, employment training specialist intensive training services, and job coaching services. Finally, revisions will include removal of outdated language relating to the exception process for employment services through the HCBS waiver and will update obsolete acronyms.
Budget Impact: Budget neutral

(Reference APA WF # 18-22B)

S. AMENDING agency rules at ***OAC 317:30-5-1041 through 317:30-5-1044 and 317:30-5-1046*** will streamline group home coverage and reimbursement policy language and develop consistency with current practice. The proposed revisions will outline and clarify provider requirements and remove references to any services provided in wilderness camps and Diagnostic and Evaluation (D&E) centers. Finally, revisions will involve limited rewriting aimed at updating outdated terminology.
Budget Impact: The proposed changes would potentially result in a combined federal and state spending of $7,048,848 total with $2,663,063 in state share for SFY2020. The state share will be paid by the Oklahoma Department of Human Services (DHS) and Oklahoma Juvenile Affairs (OJA) for their respective homes.

(Reference APA WF # 18-26)

Item to be presented by Burl Beasley, Pharmacy Director

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

   A. Arikayce® (Amikacin Liposome Inhalation Suspension) to the utilization and scope prior authorization program under OAC 317:30-5-77.2(e).

   B. Revcovi™ (Elapegdemase-Ivlr) to the utilization and scope prior authorization program under OAC 317:30-5-77.2(e).

C. Lokelma™ (Sodium Zirconium Cyclosilicate to the utilization and scope prior authorization program under OAC 317:30-5-77.2(e).

D. Tavalisse™ (Fostamatinib), Doptelet® (Avatrombopag), and Mulpleta® (Lusutrombopag) to the utilization and scope prior authorization program under OAC 317:30-5-77.2(e).

E. Carbaglu® (Carglumic Acid) to the utilization and scope prior authorization program under OAC 317:30-5-77.2(e).

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

8. New Business

9. ADJOURNMENT

NEXT BOARD MEETING
May 9, 2019
Oklahoma Health Care Authority
Oklahoma City, OK

FINANCIAL REPORT

For the Seven Months Ended January 31, 2019
Submitted to the CEO & Board

- Revenues for OHCA through January, accounting for receivables, were **$2,561,724,206** or **1.1% under** budget.
- Expenditures for OHCA, accounting for encumbrances, were **$2,591,010,686** or **1.5% under** budget.
- The state dollar budget variance through January is a positive **$10,668,863.**
- The budget variance is primarily attributable to the following (in millions):

Expenditures:		
Medicaid Program Variance		7.5
Administration		3.3
Revenues:		
Drug Rebate		2.5
Medical Refunds		.4
Taxes and Fees		(3.1)
Total FY 19 Variance	**$**	**10.6**

ATTACHMENTS

OKLAHOMA HEALTH CARE AUTHORITY
Summary of Revenues & Expenditures: OHCA
SFY 2019, For the Seven Month Period Ending January 31, 2019

REVENUES	FY19 Budget YTD	FY19 Actual YTD	Variance	% Over/ (Under)
State Appropriations	$ 598,074,416	$ 598,074,416	$ -	0.0%
State Appropriations - GME Appropriated Funds	$ 64,192,520	$ 64,192,520	$ -	0.0%
Federal Funds	1,466,551,950	1,432,435,123	(34,116,827)	(2.3)%
Tobacco Tax Collections	29,293,219	26,687,088	(2,606,131)	(8.9)%
Quality of Care Collections	46,405,112	45,572,236	(832,876)	(1.8)%
Prior Year Carryover	11,000,000	11,000,000	-	0.0%
Federal Deferral - Interest	165,785	165,785	-	0.0%
Drug Rebates	185,871,739	192,545,010	6,673,271	3.6%
Medical Refunds	22,180,996	23,145,265	964,269	4.3%
Supplemental Hospital Offset Payment Program	159,797,063	159,797,063	-	0.0%
Other Revenues	7,829,626	8,109,699	280,073	3.6%
TOTAL REVENUES	**$ 2,591,362,426**	**$ 2,561,724,206**	**$ (29,638,221)**	**(1.1)%**

EXPENDITURES	FY19 Budget YTD	FY19 Actual YTD	Variance	% (Over)/ Under
ADMINISTRATION - OPERATING	**$ 34,282,525**	**$ 27,645,618**	**$ 6,636,907**	**19.4%**
ADMINISTRATION - CONTRACTS	**$ 63,244,220**	**$ 59,114,446**	**$ 4,129,774**	**6.5%**
MEDICAID PROGRAMS				
Managed Care:				
SoonerCare Choice	23,275,230	23,216,605	58,625	0.3%
Acute Fee for Service Payments:				
Hospital Services	559,583,404	555,724,783	3,858,621	0.7%
Behavioral Health	11,637,783	10,471,348	1,166,435	10.0%
Physicians	244,531,974	227,120,121	17,411,853	7.1%
Dentists	76,801,840	76,590,257	211,582	0.3%
Other Practitioners	32,339,719	31,554,019	785,699	2.4%
Home Health Care	12,771,711	14,108,350	(1,336,639)	(10.5)%
Lab & Radiology	16,173,881	15,228,774	945,107	5.8%
Medical Supplies	31,368,904	31,575,952	(207,047)	(0.7)%
Ambulatory/Clinics	138,045,540	140,739,627	(2,694,087)	(2.0)%
Prescription Drugs	381,268,037	366,789,503	14,478,534	3.8%
OHCA Therapeutic Foster Care	99,217	527	98,690	0.0%
Other Payments:				
Nursing Facilities	329,947,820	337,266,975	(7,319,155)	(2.2)%
Intermediate Care Facilities for Individuals with Intellectual Disabilities Private	37,079,146	37,759,421	(680,275)	(1.8)%
Medicare Buy-In	102,549,096	101,705,691	843,405	0.8%
Transportation	41,953,880	40,579,258	1,374,623	3.3%
Money Follows the Person-OHCA	206,863	227,051	(20,188)	0.0%
Electonic Health Records-Incentive Payments	1,706,942	1,706,942	-	0.0%
Part D Phase-In Contribution	64,314,952	63,794,721	520,231	0.8%
Supplemental Hospital Offset Payment Program	357,504,710	357,504,710	-	0.0%
Telligen	6,385,715	6,358,493	27,222	0.4%
Total OHCA Medical Programs	**2,469,546,365**	**2,440,023,129**	**29,523,236**	**1.2%**
OHCA Non-Title XIX Medical Payments	52,140	34,974	17,166	0.0%
OHCA Non-Title XIX - GME	64,192,520	64,192,519	1	0.0%
TOTAL OHCA	**$ 2,631,317,769**	**$ 2,591,010,686**	**$ 40,307,083**	**1.5%**
REVENUES OVER/(UNDER) EXPENDITURES	**$ (39,955,343)**	**$ (29,286,480)**	**$ 10,668,863**	

OKLAHOMA HEALTH CARE AUTHORITY

Total Medicaid Program Expenditures
by Source of State Funds
SFY 2019, For the Seven Month Period Ending January 31, 2019

Category of Service	Total	Health Care Authority	Quality of Care Fund	HEEIA	SHOPP Fund	BCC Revolving Fund	Other State Agencies
SoonerCare Choice	$ 23,269,063	$ 23,210,659	$ -	$ 52,458	$ -	$ 5,946	$ -
Inpatient Acute Care	779,738,885	357,773,237	283,901	1,759,335	266,940,917	463,287	152,518,209
Outpatient Acute Care	277,501,242	193,950,492	24,269	2,687,813	77,609,072	3,229,597	-
Behavioral Health - Inpatient	27,610,590	5,684,844	-	247,092	11,684,610	-	9,994,044
Behavioral Health - Psychiatrist	6,056,615	4,786,504	-	-	1,270,111	-	-
Behavioral Health - Outpatient	9,095,053	-	-	-	-	-	9,095,053
Behaviorial Health-Health Home	25,943,412	-	-	-	-	-	25,943,412
Behavioral Health Facility- Rehab	136,107,711	-	-	-	-	62,720	136,107,711
Behavioral Health - Case Management	1,573,786	-	-	-	-	-	1,573,786
Behavioral Health - PRTF	35,295,265	-	-	-	-	-	35,295,265
Behavioral Health - CCBHC	32,248,443	-					32,248,443
Residential Behavioral Management	6,564,594	-	-	-	-	-	6,564,594
Targeted Case Management	40,801,104	-	-	-	-	-	40,801,104
Therapeutic Foster Care	527	527	-	-	-	-	-
Physicians	266,902,944	224,532,640	33,892	3,008,914	-	2,553,589	36,773,908
Dentists	76,614,437	76,584,722	-	24,180	-	5,535	-
Mid Level Practitioners	1,236,646	1,231,598	-	4,764	-	284	-
Other Practitioners	30,616,444	29,999,810	260,379	294,306	-	61,949	-
Home Health Care	14,116,999	14,104,569	-	8,649	-	3,781	-
Lab & Radiology	15,674,446	15,118,813	-	445,672	-	109,961	-
Medical Supplies	31,711,296	29,972,954	1,581,727	135,345	-	21,270	-
Clinic Services	142,308,095	137,071,062	-	981,703	-	147,668	4,107,662
Ambulatory Surgery Centers	3,616,323	3,514,053	-	95,425	-	6,844	-
Personal Care Services	6,185,704	-	-	-	-	-	6,185,704
Nursing Facilities	337,266,975	206,114,715	131,152,260	-	-	-	-
Transportation	40,556,503	38,937,527	1,472,670	64,503	-	81,803	-
IME/DME	36,678,762	-	-	-	-	-	36,678,762
ICF/IID Private	37,759,421	30,875,220	6,884,200	-	-	-	-
ICF/IID Public	9,714,381	-	-	-	-	-	9,714,381
CMS Payments	165,500,412	165,234,940	265,472	-	-	-	-
Prescription Drugs	375,262,429	365,263,985	-	8,472,925	-	1,525,518	-
Miscellaneous Medical Payments	87,258	82,316	-	-	-	4,943	-
Home and Community Based Waiver	123,280,535	-	-	-	-	-	123,280,535
Homeward Bound Waiver	47,207,905	-	-	-	-	-	47,207,905
Money Follows the Person	227,051	227,051	-	-	-	-	-
In-Home Support Waiver	14,424,625	-	-	-	-	-	14,424,625
ADvantage Waiver	83,182,568	-	-	-	-	-	83,182,568
Family Planning/Family Planning Waiver	2,499,116	-	-	-	-	-	2,499,116
Premium Assistance*	33,481,053	-	-	33,481,053.18	-	-	-
Telligen	6,358,493	6,358,493	-	-	-	-	-
Electronic Health Records Incentive Payments	1,706,942	1,706,942	-	-	-	-	-
Total Medicaid Expenditures	**$ 3,305,984,055**	**$ -**	**$ 1,932,337,674**	**$ 141,958,770**	**$ 51,764,138**	**$ 357,504,710**	**$ 8,284,695**	**$ 814,196,788**

* Includes $33,229,791.18 paid out of Fund 245

OKLAHOMA HEALTH CARE AUTHORITY

Summary of Revenues & Expenditures:
Other State Agencies
SFY 2019, For the Seven Month Period Ending January 31, 2019

REVENUE		FY19 Actual YTD
Revenues from Other State Agencies	$	355,324,584
Federal Funds		509,897,475
TOTAL REVENUES	**$**	**865,222,059**

EXPENDITURES		Actual YTD
Department of Human Services		
Home and Community Based Waiver	$	123,280,535
Money Follows the Person		-
Homeward Bound Waiver		47,207,905
In-Home Support Waivers		14,424,625
ADvantage Waiver		83,182,568
Intermediate Care Facilities for Individuals with Intellectual Disabilities Public		9,714,381
Personal Care		6,185,704
Residential Behavioral Management		4,013,732
Targeted Case Management		35,826,885
Total Department of Human Services		**323,836,335**
State Employees Physician Payment		
Physician Payments		36,773,908
Total State Employees Physician Payment		**36,773,908**
Education Payments		
Indirect Medical Education		34,965,572
Direct Medical Education		1,713,190
Total Education Payments		**36,678,762**
Office of Juvenile Affairs		
Targeted Case Management		1,301,366
Residential Behavioral Management		2,550,862
Total Office of Juvenile Affairs		**3,852,228**
Department of Mental Health		
Case Management		1,573,786
Inpatient Psychiatric Free-standing		9,994,044
Outpatient		9,095,053
Health Homes		25,943,412
Psychiatric Residential Treatment Facility		35,295,265
Certified Community Behavioral Health Clinics		32,248,443
Rehabilitation Centers		136,107,711
Total Department of Mental Health		**250,257,715**
State Department of Health		
Children's First		405,947
Sooner Start		1,236,350
Early Intervention		2,372,920
Early and Periodic Screening, Diagnosis, and Treatment Clinic		1,052,936
Family Planning		197,879
Family Planning Waiver		2,294,748
Maternity Clinic		964
Total Department of Health		**7,561,744**
County Health Departments		
EPSDT Clinic		368,063
Family Planning Waiver		6,489
Total County Health Departments		**374,552**
State Department of Education		**92,836**
Public Schools		**801,150**
Medicare DRG Limit		**144,535,167**
Native American Tribal Agreements		**1,449,349**
Department of Corrections		**1,154,687**
JD McCarty		**6,828,355**
Total OSA Medicaid Programs	**$**	**814,196,788**
OSA Non-Medicaid Programs	**$**	**46,963,771**
Accounts Receivable from OSA	**$**	**(4,061,500)**

OKLAHOMA HEALTH CARE AUTHORITY

SUMMARY OF REVENUES & EXPENDITURES:

Fund 205: Supplemental Hospital Offset Payment Program Fund

SFY 2019, For the Seven Month Period Ending January 31, 2019

REVENUES		FY 19 Revenue
SHOPP Assessment Fee		159,701,738
Federal Draws	$	218,652,500
Interest		93,042
Penalties		2,283
State Appropriations		(22,650,000)
TOTAL REVENUES	**$**	**355,799,563**

EXPENDITURES	Quarter 7/1/18 - 9/30/18	Quarter 10/1/18 - 12/31/18	Quarter 1/1/19 - 3/31/19	Quarter 4/1/19 - 6/30/19		FY 19 Expenditures
Program Costs:						
Hospital - Inpatient Care	**84,988,728**	**181,952,189**			**$**	**266,940,917**
Hospital -Outpatient Care	**25,649,937**	**51,959,135**				**77,609,072**
Psychiatric Facilities-Inpatient	**3,352,856**	**8,331,754**				**11,684,610**
Rehabilitation Facilities-Inpatient	**416,290**	**853,821**				**1,270,111**
Total OHCA Program Costs	**114,407,810**	**243,096,899**	**-**	**-**	**$**	**357,504,710**
Total Expenditures					**$**	**357,504,710**
CASH BALANCE					**$**	**(1,705,146)**

*** Expenditures and Federal Revenue processed through Fund 340

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OKLAHOMA HEALTH CARE AUTHORITY

SUMMARY OF REVENUES & EXPENDITURES:

Fund 230: Nursing Facility Quality of Care Fund

SFY 2019, For the Seven Month Period Ending January 31, 2019

REVENUES	Total Revenue	State Share
Quality of Care Assessment	$ 45,547,990	$ 45,547,990
Interest Earned	24,246	24,246
TOTAL REVENUES	**$ 45,572,236**	**$ 45,572,236**

EXPENDITURES	FY 19 Total $ YTD	FY 19 State $ YTD	Total State $ Cost
Program Costs			
Nursing Facility Rate Adjustment	$ 129,006,469	$ 50,574,748	
Eyeglasses and Dentures	162,051	63,545	
Personal Allowance Increase	1,983,740	778,429	
Coverage for Durable Medical Equipment and Supplies	1,581,727	620,873	
Coverage of Qualified Medicare Beneficiary	602,441	236,475	
Part D Phase-In	265,472	265,472	
ICF/IID Rate Adjustment	3,175,457	1,245,254	
Acute Services ICF/IID	3,708,744	1,453,400	
Non-emergency Transportation - Soonerride	1,472,670	577,959	
Total Program Costs	**$ 141,958,770**	**$ 55,816,155**	**$ 55,816,155**
Administration			
OHCA Administration Costs	$ 314,217	$ 157,109	
DHS-Ombudsmen	109,330	109,330	
OSDH-Nursing Facility Inspectors	35,001	35,001	
Mike Fine, CPA	-	-	
Total Administration Costs	**$ 458,548**	**$ 301,440**	**$ 301,440**
Total Quality of Care Fee Costs	**$ 142,417,318**	**$ 56,117,595**	
TOTAL STATE SHARE OF COSTS			**$ 56,117,595**

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 2019, For the Seven Month Period Ending January 31, 2019

REVENUES	FY 18 Carryover	FY 19 Revenue	Total Revenue
Prior Year Balance	$ 12,902,064	$ -	$ 6,997,587
State Appropriations	(6,000,000)	-	-
Tobacco Tax Collections	-	21,949,084	21,949,084
Interest Income	-	138,103	138,103
Federal Draws	208,931	21,055,321	21,055,321
TOTAL REVENUES	$ 7,110,995	$ 43,142,507	$ 50,140,094

EXPENDITURES		FY 18 Expenditures	FY 19 Expenditures	Total State $ YTD
Program Costs:				
	Employer Sponsored Insurance		$ 33,229,791	$ 33,229,791
	College Students/ESI Dental		251,262	98,925
Individual Plan				
	SoonerCare Choice		$ 50,997	$ 20,026
	Inpatient Hospital		1,756,113	693,042
	Outpatient Hospital		2,613,304	1,033,230
	BH - Inpatient Services-DRG		235,062	91,890
	BH -Psychiatrist		-	-
	Physicians		2,968,559	1,168,846
	Dentists		23,720	9,224
	Mid Level Practitioner		4,569	1,798
	Other Practitioners		291,588	114,630
	Home Health		8,649	3,446
	Lab and Radiology		438,081	171,769
	Medical Supplies		134,789	53,063
	Clinic Services		947,707	371,699
	Ambulatory Surgery Center		95,126	37,679
	Prescription Drugs		8,291,289	3,235,362
	Transportation		63,798	24,905
	Premiums Collected		-	(319,126)
Total Individual Plan			$ 17,923,352	$ 6,711,482
	College Students-Service Costs		$ 359,733	$ 140,648
Total OHCA Program Costs			$ 51,764,138	$ 40,180,845
Administrative Costs				
	Salaries	$ 24,543	$ 1,341,302	$ 1,365,845
	Operating Costs	9,662	73,588	83,250
	Health Dept-Postponing	-	-	-
	Contract - HP	79,204	491,423	570,627
Total Administrative Costs		$ 113,409	$ 1,906,313	$ 2,019,722
Total Expenditures				$ 42,200,567
NET CASH BALANCE		$ 6,997,587		$ 7,939,527

OKLAHOMA HEALTH CARE AUTHORITY
SUMMARY OF REVENUES & EXPENDITURES:
Fund 250: Belle Maxine Hilliard Breast and Cervical Cancer Treatment Revolving Fund
SFY 2019, For the Seven Month Period Ending January 31, 2019

REVENUES	FY 19 Revenue	State Share
Tobacco Tax Collections	$ 438,074	$ 438,074
TOTAL REVENUES	**$ 438,074**	**$ 438,074**

EXPENDITURES	FY 19 Total $ YTD	FY 19 State $ YTD	Total State $ Cost
Program Costs			
SoonerCare Choice	$ 5,946	$ 1,630	
Inpatient Hospital	463,287	125,493	
Outpatient Hospital	3,229,597	884,556	
Inpatient Services-DRG	-	-	
Psychiatrist	-	-	
TFC-OHCA	-	-	
Nursing Facility	-	-	
Physicians	2,553,589	707,488	
Dentists	5,535	1,515	
Mid-level Practitioner	284	78	
Other Practitioners	61,949	16,926	
Home Health	3,781	1,032	
Lab & Radiology	109,961	30,185	
Medical Supplies	21,270	5,760	
Clinic Services	147,668	40,663	
Ambulatory Surgery Center	6,844	1,836	
Prescription Drugs	1,525,518	418,483	
Transportation	81,803	22,505	
Miscellaneous Medical	4,943	1,313	
Total OHCA Program Costs	**$ 8,221,975**	**$ 2,259,463**	
OSA DMHSAS Rehab	$ 62,720	17,153	
Total Medicaid Program Costs	**$ 8,284,695**	**$ 2,276,616**	
TOTAL STATE SHARE OF COSTS			**$ 2,276,616**

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

OHCA Board Meeting
March 2019
(January 2018 Data)

SOONERCARE ENROLLMENT/EXPENDITURES

Delivery System			Enrollment January 2019	Children January 2019	Adults January 2019	Enrollment Change	Total Expenditures January 2019	PMPM January 2019
SoonerCare Choice Patient-Centered Medical Home			**525,486**	**436,396**	**89,090**	**-4,303**	**$179,687,745**	
	Lower Cost	*(Children/Parents; Other)*	482,692	423,198	59,494	-4,490	$128,820,837	$267
	Higher Cost	*(Aged, Blind or Disabled; TEFRA; BCC)*	42,794	13,198	29,596	187	$50,866,907	$1,189
SoonerCare Traditional			**231,784**	**84,305**	**147,479**	**-44**	**$204,887,103**	
	Lower Cost	*(Children/Parents; Other; Q1; SLMB)*	116,459	79,597	36,862	101	$48,485,640	$416
	Higher Cost	*(Aged, Blind or Disabled; LTC; TEFRA; BCC & HCBS Waiver)*	115,325	4,708	110,617	-145	$156,401,463	$1,356
Insure Oklahoma			**18,754**	**532**	**18,222**	**100**	**$7,732,014**	
	Employer-Sponsored Insurance		13,647	332	13,315	15	$4,754,271	$348
	Individual Plan		5,107	200	4,907	85	$2,977,744	$583
SoonerPlan			**28,322**	**2,265**	**26,057**	**-793**	**$274,975**	$10
TOTAL			**804,346**	**523,498**	**280,848**	**-5,040**	**$392,581,837**	

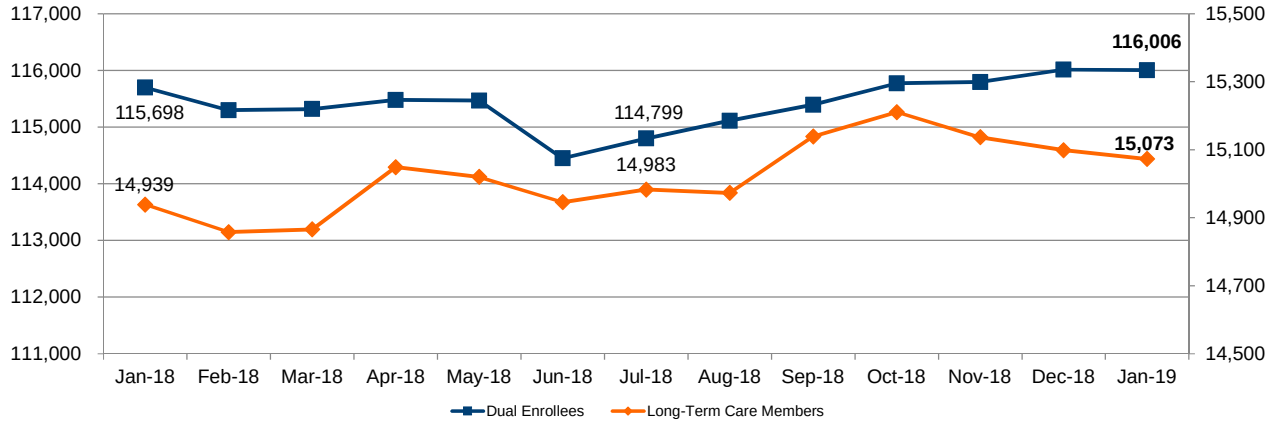
Enrollment totals include all members enrolled during the report month. Members may not have expenditure data. Children are members aged 0 - 20 or for Insure Oklahoma enrolled as Students or Dependents.
Dual Eligibles (Medicare & Medicaid) are in the Traditional delivery system in both the Low Cost (Q1 & SLMB) and High Cost (ABD) groups. OTHER includes DDSD, PKU, Q1, Refugee, SLMB, STBS and TB.

Total In-State Providers: 33,892 (+288) **(In-State Providers counted multiple times due to multiple locations, programs, types, and specialties)**

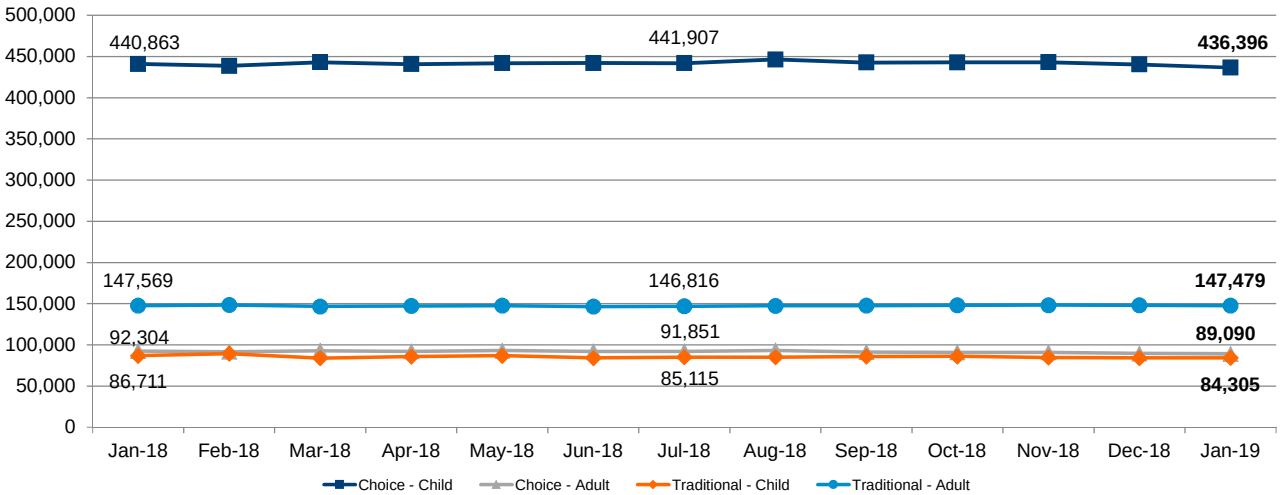
Physician	Pharmacy	Dentist	Hospital	Mental Health	Optometrist	Extended Care	Total PCPs*	PCMH
9,901	892	1,132	161	4,787	641	413	7,162	2,602

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

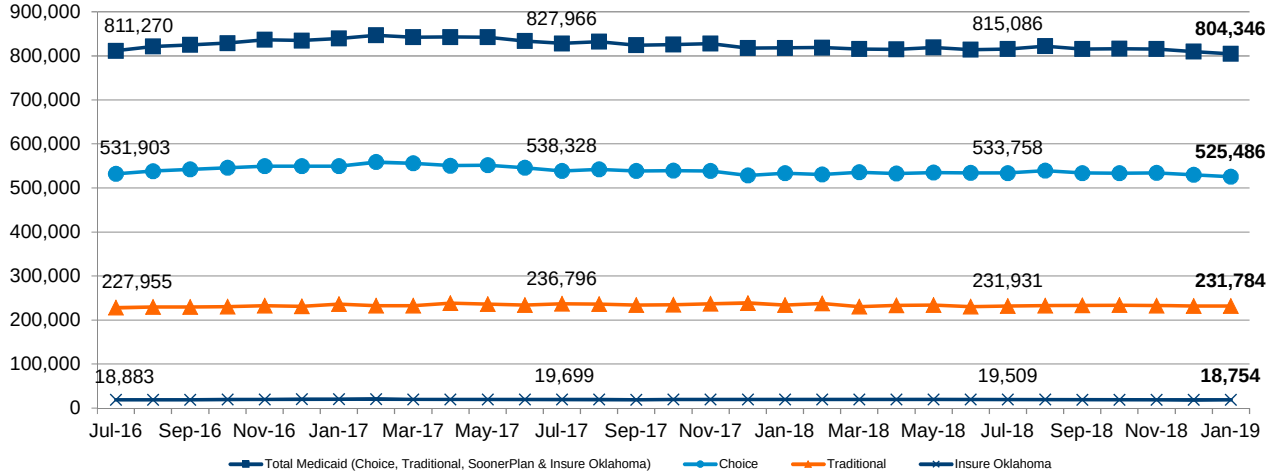
DUAL ENROLLEES & LONG-TERM CARE MEMBERS

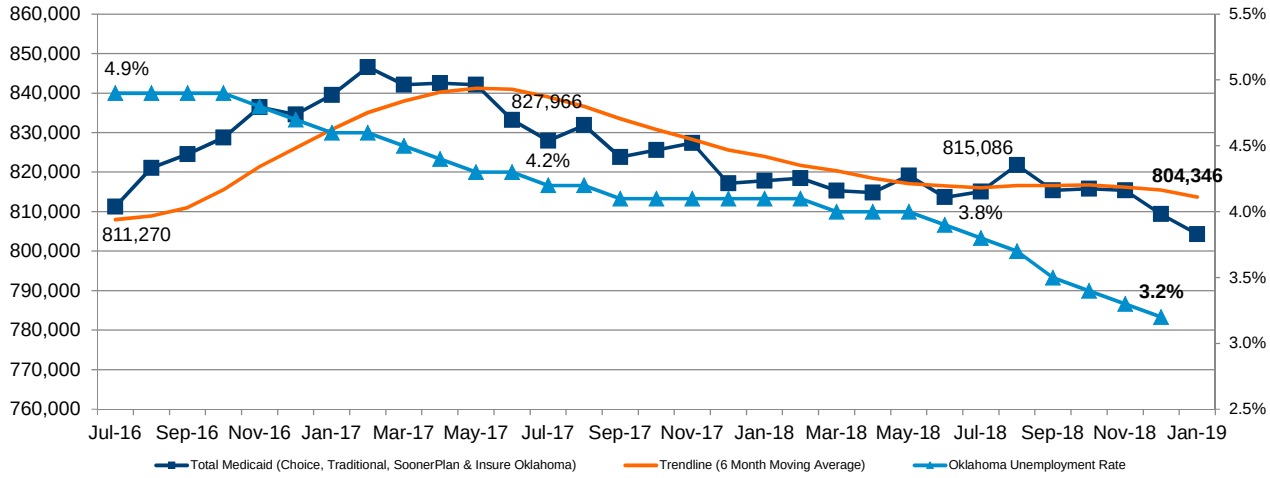


CHILDREN & ADULTS ENROLLMENT



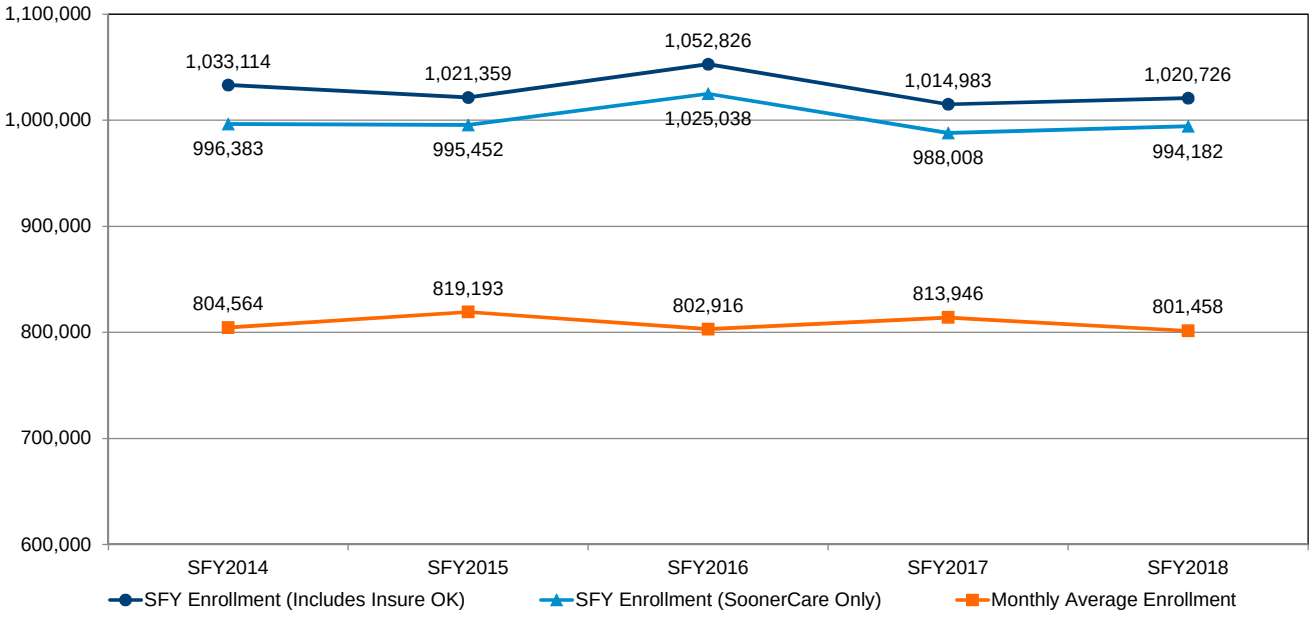
ENROLLMENT BY MONTH





Oklahoma Unemployment Rate is from the Bureau of Labor Statistics 'Local Area Unemployment Statistics' (https://www.bls.gov/lau/) and is seasonally adjusted. Data was extracted on 9/26/2018.
In June 2017 there were changes to the passive renewal system criteria that reduced the number of passively renewed members by 2/3rds.

ENROLLMENT BY STATE FISCAL YEAR



State Fiscal Year (SFY) is July - June. Enrollment is unduplicated. Monthly Average Enrollment excludes Insure OK.

RESIDENTIAL BEHAVIOR MANAGEMENT SERVICES (RBMS) RATES

1. **IS THIS A RATE CHANGE OR A METHOD CHANGE?**
   Rate and Method Change

2. **IS THIS CHANGE AN INCREASE, DECREASE, OR NO IMPACT?**
   Increase

3. **PRESENTATION OF ISSUE – WHY IS THIS CHANGE BEING MADE?**
   The Oklahoma Department of Human Services (DHS) and the Oklahoma Office of Juvenile Affairs (OJA) requests a rate and a rate method change for Residential Behavioral Management Services (RBMS) rates. The rates and rate method has not been changed or updated since 1996. Due to the rate/rate methodology being developed over 20 years ago, the exact calculations for the current rates are not available.

4. **CURRENT METHODOLOGY AND/OR RATE STRUCTURE.**
   The current methodology is similar to the proposed methodology. The current methodology was created in 1996 and the direct care cost adjustment factors could not be located.

Group Home Cost at Current Rates

Level	Total Beds Budgeted	2018 Per Diem Rate amount	Direct Care Cost Adj Factor	Proposed Medicaid Rate	Total Bed Days	Medicaid Days - Medicaid % x total days
C	12	$100.10	18.00%	$18.02	4,380	4,336
D	28	$101.72	N/A	$0.00	10,220	10,118
D+	104	$134.20	33.10%	$44.42	37,960	37,580
E	188	$169.40	52.65%	$89.20	68,620	67,934
E+	16	$256.00	52.65%	$134.78	5,840	5,782
Enhanced E	12	$307.20	52.65%	$161.74	4,380	4,336
ITS	9	$214.50	53.96%	$115.74	3,285	3,252

5. **NEW METHODOLOGY OR RATE STRUCTURE.**
   The proposed methodology is similar to the previous methodology using updated calculations. The proposed methodology is as follows:

   Staff cost is calculated by using state salary and benefit package guidelines for similar jobs. Jobs at the group homes consist of Direct Care staff and supervisors, Nurses, Therapist,

Program Director, and administrative staff. The total staff cost can then be divided into a, per day per child rate.
Facility cost is based on the Oklahoma Child Care licensing standard for the minimum square foot in the living quarters for each resident. That square footage is then grossed up to include common spaces, administrative office space, and activity areas. The total square footage is used to calculate the total facility cost by using the standard rent estimates for Oklahoma. The total cost is then divided into a, per day per child rate.

Operational cost include food, clothing, transportation, liability insurance (required), accreditation (if applicable), and miscellaneous. The amounts for food, clothing, and transportation come from the USDA cost of raising a child report. Liability Insurance and miscellaneous come from actual cost incurred by facilities and reported on audited financial statements. The total cost is then divided into a, per day per child rate.

The total per child per day rate is sum of all three and is referred to as the group home per diem rate for that level of care with an additional 15% admin cost. The per diem rate is compensable for both Medicaid and Title IV-E funding. The allocation of cost between the two programs is as follows.
Staff – Direct care staff perform Basic Living Skills Redevelopment, Social Skills Redevelopment, and Behavior redirection to children in the facility during all times the child is awake and not in school, whether on or off campus school, therefore the direct care staff time allocated to Medicaid is calculated as follows:

24 hr. per day
8 hr. average sleep time per day
2.96 hr. average time per day in school (Oklahoma requires 1,080 per year)
13.04 hr. allocated to Medicaid or 54.34%

Therapist and Nurses salary are 100% compensable to Medicaid. Using the formula below gives the percent of program staff allocated to Medicaid.

(54.34% x Direct Care Sal. + Therapist Sal. + Nurse Sal.)
(Direct Care Sal. + Therapist Sal. + Nurse Sal.)

This percentage will then be applied to the Program Director, Administrative personnel, facility cost, miscellaneous, and the 15% admin cost because these cost apply at that percent to both Medicaid and IV-E. Food, clothing, transportation, liability insurance, and accreditation cost are allocated entirely to Title IV-E.

Group Home Cost at Proposed Rates

Level	Total Beds Budgeted	2018 Per Diem Rate amount Proposed	Direct Care Cost Adj Factor	Proposed Medicaid Rate	Total Bed Days	Medicaid Days - Medicaid % x total days
C	12	$172.07	53.18%	$91.51	4,380	4,336
D	32	$140.81	0.00%	$0.00	11,680	11,563
D+	108	$201.80	61.43%	$123.97	39,420	39,026
E	188	$225.86	59.21%	$133.73	68,620	67,934
E+	16	$307.45	57.23%	$175.95	5,840	5,782
Enhanced E	12	$339.03	55.17%	$187.04	4,380	4,336
ITS	9	$312.75	58.50%	$182.96	3,285	3,252

6. **BUDGET ESTIMATE.**

The estimated budget impact for the remainder of SFY2020 will be an increase of $5,309,136 total; of which $1,804,045 is state share. The state share will be paid by the Oklahoma Department of Human Services (DHS).

The estimated budget impact for the remainder of SFY2020 will be an increase of $1,323,638 total; of which $449,772 is state share. The state share will be paid by the Oklahoma Office of Juvenile Affairs (OJA).

7. **AGENCY ESTIMATED IMPACT ON ACCESS TO CARE.**

The Oklahoma Department of Human Services (DHS) and the Oklahoma Office of Juvenile Affairs (OJA) does not anticipate any negative impact on access to care.

8. **RATE OR METHOD CHANGE IN THE FORM OF A MOTION.**

The Oklahoma Department of Human Services (DHS) and the Oklahoma Office of Juvenile Affairs (OJA) requests a rate and a rate method change for Residential Behavioral Management Services (RBMS) rates listed in the following table:

Group Home Cost at Proposed Rates

Level	Total Beds Budgeted	2018 Per Diem Rate amount Proposed	Direct Care Cost Adj Factor	Proposed Medicaid Rate	Total Bed Days	Medicaid Days - Medicaid % x total days
C	12	$172.07	53.18%	$91.51	4,380	4,336
D	32	$140.81	0.00%	$0.00	11,680	11,563
D+	108	$201.80	61.43%	$123.97	39,420	39,026
E	188	$225.86	59.21%	$133.73	68,620	67,934
E+	16	$307.45	57.23%	$175.95	5,840	5,782
Enhanced E	12	$339.03	55.17%	$187.04	4,380	4,336
ITS	9	$312.75	58.50%	$182.96	3,285	3,252

9. EFFECTIVE DATE OF CHANGE.

September 1, 2019

PARTIAL HOSPITALIZATION (PHP) SERVICES RATE

1. **IS THIS A RATE CHANGE OR A METHOD CHANGE?**
   Method Change

2. **IS THIS CHANGE AN INCREASE, DECREASE, OR NO IMPACT?**
   No Impact

3. **PRESENTATION OF ISSUE – WHY IS THIS CHANGE BEING MADE?**
   Current reimbursement for Partial Hospitalization Programs (PHP) is made using a one hour unit of service of at least 3 hours per day and no more than 4 hours per day. However, the national HCPCS code used for PHP (H0035) is an encounter code of less than 24 hours, not an hourly code. In order to avoid a potential perm error with CMS, ODMHSAS is recommending to convert the current hourly code to a daily reimbursement rate.

4. **CURRENT METHODOLOGY AND/OR RATE STRUCTURE.**
   The current reimbursement rate is $42.80 per hour, which is converted from a blend of the 2010 Medicare two tiered per diem payment approach for partial hospitalization services: one for days with three services (APC172) and one for days with four or more services (APC173). Physician services, physician assistant services, nurse practitioner and clinical nurse specialist services, qualified psychologist services and services furnished to SNF residents are separately covered and not paid as partial hospitalization services.

5. **NEW METHODOLOGY OR RATE STRUCTURE.**
   A survey of the PHP providers in the state and a review of claims data showed that average minimum PHP treatment days consist of 3.5 hours of treatment services with no more than 4 hours in a day. Accordingly, the new reimbursement rate of $160.50 per day is based on the 2010 Medicare cost assumptions for PHP services, but is a blend of a 3.5 hour treatment day and a 4 hour treatment day. Physician services, physician assistant services, nurse practitioner and clinical nurse specialist services, qualified psychologist services and services furnished to SNF residents are separately covered and not paid as partial hospitalization services.

6. **BUDGET ESTIMATE.**
   This change is estimated to be budget neutral.

7. **AGENCY ESTIMATED IMPACT ON ACCESS TO CARE.**
   The agency has determined that this change will not have an impact on access to care.

8. **RATE OR METHOD CHANGE IN THE FORM OF A MOTION.**
   The agency requests the SPARC to approve the proposed reimbursement methodology for partial hospitalization services of a daily rate of $160.50 per day which is a blend of the current hourly rate for a 3.5 hour treatment day and a 4 hour treatment day.

9. **EFFECTIVE DATE OF CHANGE.**
   April 1, 2019

CERTIFIED COMMUNITY BEHAVIORAL HEALTH CLINIC REIMBURSEMENT

1. **IS THIS A RATE CHANGE OR A METHOD CHANGE?**
   Rate and Method Change

2. **IS THIS CHANGE AN INCREASE, DECREASE, OR NO IMPACT?**
   Increase

3. **PRESENTATION OF ISSUE – WHY IS THIS CHANGE BEING MADE?**
   The Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) was awarded a demonstration grant from the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Centers for Medicare and Medicaid Services (CMS) to implement Certified Community Behavioral Health Clinic (CCBHC) pilots in Oklahoma. Oklahoma was one of 8 states chosen for this 2- year demonstration (demo) program. Three outpatient behavioral health clinics (2 urban and 1 rural) were certified and are responsible for directly providing nine required types of behavioral health treatment services, with an emphasis on the provision of 24-hour crisis care, utilization of evidence-based practices, care coordination, and integration with physical health. CCBHCS are reimbursed utilizing a Prospective Payment System (PPS). In establishing the PPS rate, CCBHC completed cost reports for the period of April 1, 2017 to March 31, 2018 that include the cost of providing all services to all patients to establish a Per-Member Per Month (PMPM) cost of serving patients in that clinic. The reports included actual plus anticipated costs related to new services or new costs which will be provided or incurred during the demonstration phase. This demonstration will end March 31, 2019. In order to sustain this delivery model, the state will submit a state plan amendment that will be open to any willing and qualified provider. If approved by the OHCA board, this change will be effective April 1, 2019, contingent upon CMS approval.

4. **CURRENT METHODOLOGY AND/OR RATE STRUCTURE.**
   CCBHC receive a fixed PMPM reimbursement rate for every individual who has at least one qualifying visit in the month. There is a standard CCBHC (or base) rate and five Separate Reimbursement Rates for Special Populations (SPPOP). The ODMHSAS developed SPPOP categories that recognize the higher costs and resource needs for individuals who have been assessed and designated as Severely Mentally Ill (SMI), Severe Emotional Disturbance

(SED), homeless and those requiring intensive substance abuse programming. Each provider assigns a client to a SPPOP category based on the established criteria.

5. **NEW METHODOLOGY OR RATE STRUCTURE.**
New CCBHCS will receive an interim rate of 90% of the rates established for urban CCBHCS that participated in the 2-year demonstration until a provider specific cost report is completed.

Effective April 1, 2019, there will be two separate reimbursement rates for special populations instead of five. The ODMHSAS has developed a list of individuals who are "most in need" and the provider may choose from this list to assign individuals to SPPOP rate categories and bill for the SPPOP rate. At the end of 90 days, ODMHSAS will review care needs and rates for clients assigned to special populations to determine a need for continued stay at this level of service intensity. If the client has been admitted for an inpatient psychiatric hospital stay during this time period, the state will recoup the difference in the applicable provider-specific SPPOP rate and the standard rate. The rate will then be updated annually based on the Medicare Economic Index (MEI)

6. **BUDGET ESTIMATE.**
Federal impact: Due to CCBHC moving from a demonstration to a State Plan Medicaid covered service, the Centers for Medicare & Medicaid Services (CMS) views the budget as new Medicaid program and requires the total net budget to be reported. Prior to the CCBHC demonstration, most of the amounts below were being paid on a fee-for-service basis and are now paid on a Prospective Payment System (PPS) methodology. The net increase for the six remaining months of FFY2019 will be $42,048,685 total, 26,444,418 federal share. The net increase for FFY2020 will be $84,097,370 total, $55,521,084 federal share.

State impact: The net increase to ODMHSAS for the three months remaining in SFY2019 is $1,683,210 total, $618,222 state share which will be paid by ODMHSAS. Due to the rebasing and change in methodology for special populations, the estimated SFY2020 budget impact is a savings to ODMHSAS of $259,849 total, $90,661 state share.

7. **AGENCY ESTIMATED IMPACT ON ACCESS TO CARE.**
The agency anticipates there will be increased access to care.

8. **RATE OR METHOD CHANGE IN THE FORM OF A MOTION.**
   The agency requests the SPARC to approve the proposed change in reimbursement method for CCBHCS.

9. **EFFECTIVE DATE OF CHANGE.**
   April 1, 2019 contingent upon CMS approval.

ITFC RATES

1. **IS THIS A RATE CHANGE OR A METHOD CHANGE?**
   Rate and Method Change

2. **IS THIS CHANGE AN INCREASE, DECREASE, OR NO IMPACT?**
   Increase

3. **PRESENTATION OF ISSUE – WHY IS THIS CHANGE BEING MADE?**
   THE OKLAHOMA DEPARTMENT HUMAN SERVICES (DHS) REQUEST A NEW RATE AND A RATE METHODOLOGY FOR INTENSIVE THERAPEUTIC FOSTER CARE (ITFC).

4. **CURRENT METHODOLOGY AND/OR RATE STRUCTURE.**
   This is a new program so there is no current methodology.

5. **NEW METHODOLOGY OR RATE STRUCTURE.**
   ITFC IS TREATMENT FOCUSED PROGRAM THAT SERVES CHILDREN IN THE CUSTODY IN A FAMILY SETTING THAT UTILIZES A TEAM APPROACH OF PROFESSIONALS INCLUDING THERAPIST, CARE COORDINATORS, AND THE FOSTER PARENT TO PROVIDE THE SERVICES. THE RATE IS A PER DIEM RATE THAT ENCOMPASSES THE COST OF PROVIDING A FOSTER HOME ENVIRONMENT (IV-E COMPENSABLE ACTIVITIES) ALONG WITH THE EVIDENCED BASED AND TRAUMA INFORMED THERAPIES AND TREATMENTS (TITLE XIX COMPENSABLE ACTIVITIES).
   THE RATE CONSIDERS COST TO COVER THE RECRUITMENT, LICENSING, AND SUPPORT OF THE FOSTER PARENT ALONG WITH COST ASSOCIATED PLACING A CHILD IN THIS TYPE OF FAMILY SETTING AND THE ROOM AND BOARD COST, THE FOSTER CARE REIMBURSEMENT RATE ESTABLISHED FOR ALL FOSTER PARENTS, ALL OF WHICH ARE TITLE IV-E COMPENSABLE ACTIVITIES. THE RATE ALSO INCLUDES THE COST OF THERAPIST THAT SERVE UP TO 12 CHILDREN EACH AND THE PAYMENT TO THE FOSTER PARENT FOR SERVICES AND TREATMENT THEY PROVIDE IN THE HOME, ALL OF WHICH ARE TITLE XIX COMPENSABLE ACTIVITIES. THE IV-E ACTIVITIES ACCOUNT FOR 37.01% AND THE TITLE XIX ACTIVITIES ACCOUNT FOR 62.99%. THERE ARE ALSO COST THAT BENEFIT BOTH PROGRAMS SUCH AS PROGRAM DIRECTOR SALARY, LIABILITY INSURANCE, AND GENERAL OVERHEAD OF WHICH ARE SPLIT BETWEEN THE PROGRAMS AT THE 37.01% TO TITLE IV-E AND 62.99% TO TITLE XIX.

Component	Per Diem	IV-E Admin	IV-E Maint.	XIX
Recruitment	*$11.14*	$11.14		
Licensing	*$7.02*	$7.02		
Placement	*$8.70*	$8.70		
Support	*$22.41*	$22.41		
Therapy	*$24.74*			$24.74
Foster Parent	*$150.80*		$33.61	$117.19
Total	***$224.81***	***$49.27***	***$33.61***	***$141.93***

6. BUDGET ESTIMATE.

	Annual Budget	FY19 Est	FY20 Est
State	$9,595,439	$788,310	$5,032,209
IV-E	$2,125,376	$522,700	$3,088,192
XIX	$9,686,944	$889,621	$5,256,018
Total	$21,407,759	$2,264,062	$13,376,420

THE STATE SHARE WILL BE PAID BY DHS AND IS COST NEUTRAL BY REDUCING THE NUMBER OF BEDS IN TFC TO FUND ITFC. THE BEDS REDUCTION IS BUDGET ONLY AND WILL NOT IMPACT THE NUMBER OF CHILDREN CURRENTLY BEING SERVED.

7. AGENCY ESTIMATED IMPACT ON ACCESS TO CARE.

DHS DO NOT ANTICIPATE ANY NEGATIVE IMPACT ON ACCESS OF CARE.

8. RATE OR METHOD CHANGE IN THE FORM OF A MOTION.

DHS REQUEST A RATE AND A RATE METHOD FOR ITFC OF $224.81 WITH $141.61 MEDICAID RATE.

9. EFFECTIVE DATE OF CHANGE.

April 1, 2019 or approval by CMS

MEDICARE CROSSOVER CLAIMS

1. **IS THIS A RATE CHANGE OR A METHOD CHANGE?**
   Method Change

2. **IS THIS CHANGE AN INCREASE, DECREASE, OR NO IMPACT?**
   No Impact

3. **PRESENTATION OF ISSUE – WHY IS THIS CHANGE BEING MADE?**
   The Oklahoma Health Care Authority (OHCA) proposes a change in the Oklahoma State Plan to align the payment methodology for Medicare Part A and Part B crossover claims with current practice.

4. **CURRENT METHODOLOGY AND/OR RATE STRUCTURE.**
   The methodology of paying Medicare crossover claims is not changing, but the State Plan is being updated to align with current practice.

5. **NEW METHODOLOGY OR RATE STRUCTURE.**
   Due to a provider type and specialty change for psychiatric hospitals and Psychiatric Residential Treatment Facilities (PRTF), Medicare crossover claims were paying incorrectly. The original intent was to pay psychiatric hospitals and PRTFs the same way as hospitals, as that was their previous provider type. Psychiatric hospitals and PRTFS are paid 75% of deductible and 25% of coinsurance for Medicare Part A crossover claims.

   Medicare medical services and dialysis are receiving payment of 100% of deductible and 46.25% of coinsurance for Medicare Part B crossover claims.

   Payment for Indian Health Services (IHS) clinics and transportation services are made at 100% of deductible and 100% of coinsurance for Medicare Part B crossover claims.

6. **BUDGET ESTIMATE.**
   The proposed State Plan amendment is budget neutral as this proposed amendment is being submitted to align with current practice.

7. **AGENCY ESTIMATED IMPACT ON ACCESS TO CARE.**
   OHCA does not anticipate any impact on access of care.

8. RATE OR METHOD CHANGE IN THE FORM OF A MOTION.

OHCA requests the State Plan Amendment Rate Committee to approve the following State Plan amendment:

- Pay psychiatric hospitals and PRTFS 75% of deductible and 25% of coinsurance for Medicare Part A crossover claims.
- Pay Medicare medical services and dialysis 100% of deductible and 46.25% of coinsurance for Medicare Part B crossover claims.
- Pay Indian Health Services (IHS) clinics and transportation services 100% of deductible and 100% of coinsurance for Medicare Part B crossover claims.

9. EFFECTIVE DATE OF CHANGE.

April 1, 2019

March Board
Proposed Rule Changes

Face-to-face tribal consultations regarding the following proposed changes were held on Tuesday, May 16, 2018, Tuesday, November 6, 2018, and Tuesday, January 8, 2019 in the Charles Ed McFall Boardroom of the Oklahoma Health Care Authority (OHCA). The proposed rules were presented to the Medical Advisory Committee (MAC) on Thursday, September 20, 2018, Thursday, January 17, 2019, and Thursday, March 14, 2019. Additionally, the proposed rules were presented at public hearings on Wednesday, January 16, 2019 and Wednesday, February 20, 2019 at 1 p.m. in the OHCA Boardroom.

APA work folder 18-22B was posted on the OHCA public website for a comment period from December 17, 2018 through January 16, 2019. APA work folders 18-01, 18-07A, 18-07B, 18-09, 18-13, 18-14, 18-15A, 18-15B, 18-15C, 18-16, 18-17, 18-23, 18-24, 18-25, 18-26, 18-27, 18-28, and 18-30 were posted on the OHCA public website for a comment period from December 17, 2018 through January 16, 2019.

The following permanent rule HAS previously been approved by the Board and the Governor under EMERGENCY rulemaking. This rule HAS NOT been revised for PERMANENT rulemaking.

OHCA Initiated

A. AMENDING agency rules at ***OAC 317:30-5-20, 317:30-5-40.1 and 317:30-5-42.10*** will strengthen the language delineating medical necessity, and compensable and non-compensable lab services. Additional revisions will add language to define penalties that can be enforced if a provider does not abide by the rules regarding medical necessity of lab services. Revisions also clarify that the OHCA does not pay for all lab services listed in the Centers for Medicare and Medicaid Services (CMS) fee schedule, but only those that are medically necessary, in addition, to the four other conditions required for payment.
Budget Impact: Agency staff has determined that the proposed rule changes will result in a budget savings by decreasing reimbursement of medically unnecessary lab tests. Between 2014 and 2017, despite a decrease in member enrollment of 1.8 percent, there has been a 9.8 percent increase in members receiving lab tests and an increase of approximately $502,384 in reimbursement for laboratory tests.

(Reference APA WF # 18-01)

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

OHCA Initiated

B. AMENDING agency rules at ***OAC 317:30-5-123*** will incorporate new language to clarify that the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) will be used for diagnostic purposes of a mental illness and/or intellectual disability in Medicaid certified nursing facility admissions. Further revisions will reflect WF 18-15 policy changes made to the appeals rules to extend the length of time in which an appeal can be submitted from twenty (20) days to thirty (30) days of the date of an adverse agency action. Lastly, revisions will also involve limited rewriting aimed at clarifying text, eliminating redundancies, and updating outdated terminology.
Budget Impact: Budget neutral

(Reference APA WF # 18-07A)

C. AMENDING agency rules at ***OAC 317:35-19-8*** will incorporate new language to clarify that the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) will be used for diagnostic purposes of a mental illness and/or intellectual disability for admission to a Medicaid certified nursing facility. Additional revisions will involve limited rewriting aimed at clarifying text, eliminating redundancies, and updating outdated terminology.
Budget Impact: Budget neutral

(Reference APA WF # 18-07B)

D. ADDING agency rules at ***OAC 317:30-3-33*** will establish a new section addressing suspended claims review and/or prepayment review. This policy will align the agency with state and federal laws that require the OHCA to safeguard against unnecessary utilization of medical supplies and services. Additionally, the revisions will help to ensure that payments are consistent, efficient, economical, and provide good quality of care. Please refer to 42 United States Code § 1396a(a)(30)(A); 42 Code of Federal Regulations § 447.45(f); and 56 Oklahoma Statutes § 1010.4(B)(5). These revisions will help ensure that reimbursements are for medically necessary, correctly and/or appropriately billed, medical supplies and services. The changes define and explain the various reviews that may be performed by the OHCA or its contractor before OHCA pays a claim.
Budget Impact: It is expected that these types of reviews will achieve significant savings, the exact amount of which cannot be quantified.

(Reference APA WF # 18-09)

E. AMENDING agency rules at ***OAC 317:30-3-19.4*** will establish application fees required by federal law for providers enrolling or re-enrolling in Medicaid. The revisions will define providers who are exempted from the application fee as individual physician or non-physician practitioners; providers who enrolled with and paid the fee to Medicare; and providers who enrolled with and paid the fee to another state Medicaid agency. Additional revisions will outline provider screening and enrollment requirements designed to help defend against Medicaid provider fraud, waste, and/or abuse. Provider screening requirements are outlined according to three categorical screening levels: limited-risk, moderate-risk, and high-risk. Examples of screening requirements are licensure verification, on-site visits, and fingerprint-based background checks.
Budget Impact: Agency staff estimates that the proposed rule change will generate revenue due to the application/screening fees. Per federal law the collected fees shall be used for the cost of conducting screenings

(Reference APA WF # 18-13)

F. AMENDING agency rules at ***OAC 317:35-5-41, 317:35-5-41.1, 317:35-5-41.2, 317:35-5-41.3, 317:35-5-41.8, 317:35-5-41.9*** and ADDING agency rules at ***OAC 317:35-5-41.12*** will update policy on resources that are disregarded by federal law due to Oklahoma transitioning from a 209(b) state to a Supplemental Security Income (SSI) criteria state for determination of eligibility for SSI related eligibility groups such as the Aged, Blind, and Disabled (ABD).
Budget Impact: Budget neutral

(Reference APA WF # 18-14)

G. AMENDING agency rules at ***OAC 317:2-1-2, 317:2-1-6, 317:2-1-7, 317:2-1-10, 317:2-1-11, 317:2-1-12, 317:2-1-13, 317:2-1-14 and 317:2-1-16*** will change all of the agency's appeals rules to extend the length of time that appeals can be submitted from twenty (20) days to thirty (30) days of the date of an adverse agency action. Additionally, the revisions will add Supplemental Hospital Offset Payment Program (SHOPP) appeals to the list of other grievance procedures and processes.
Budget Impact: Budget neutral

(Reference APA WF # 18-15A)

H. AMENDING agency rules at ***OAC 317:30-3-2.1, 317:30-5-95.31, 317:30-5-136, 317:30-5-136.1 and 317:30-5-746*** will change all of the agency's appeals rules to extend the length of time that appeals can be submitted from twenty (20) days to thirty (30) days of the date of an adverse agency action.
Budget Impact: Budget neutral

(Reference APA WF # 18-15B)

I. AMENDING agency rules at ***OAC 317:35-19-16*** will change all of the agency's appeals rules to extend the length of time that appeals can be submitted from twenty (20) days to thirty (30) days of the date of an adverse agency action.
Budget Impact: Budget neutral

(Reference APA WF # 18-15C)

J. AMENDING agency rules at ***OAC 317:35-22-2.1*** will provide non-emergency transportation (NET) to pregnant women covered under the Title XXI State Plan (Soon-to-be-Sooners and Soon-to-be-Sooners Maintenance of Effort populations). Under federal parity law requirements, children covered by the Children's Health Insurance Program (CHIP), including those in the unborn child category, must have the same access to secretary-approved coverage of all Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefits including health care, diagnostic services, treatment, and other measures to correct or ameliorate defects and physical and mental illness and conditions as per the approved State Plan.
Budget Impact: The agency anticipates that the proposed changes would potentially result in a budget impact of approximately $15,094 total, with $5,266 in state share for SFY 2020.

(Reference APA WF # 18-16)

K. AMENDING agency rules at ***OAC 317:30-3-65.4*** will add coverage and reimbursement language for maternal depression screenings at Early and Periodic Screening, Diagnostic and Treatment (EPSDT) at well-child visits. Providers will be reimbursed for conducting a maternal depression screening at the child's well-child visit. The policy will also reiterate how the Oklahoma Health Care Authority adopts and utilizes the American Academy of Pediatrics' Bright Futures periodicity schedule including for the maternal depression screenings. Additionally, the proposed revisions will update the child abuse section to provide a more thorough explanation of how to report abuse and neglect including

clarifying text, and updating outdated citations.
Budget Impact: The agency anticipates that the proposed changes would potentially result in a budget impact of approximately $128,748 total with $43,749 in state share for SFY2020.

(Reference APA WF # 18-17)

L. AMENDING agency rules at ***OAC 317:30-5-2 and 317:30-5-11*** will clarify that when rendering a direct physician service visit in a nursing facility, a psychiatrist or a physician with appropriate behavioral health training is required to perform such service. Additionally, revisions will clarify that other than the two (2) allowable direct physician services visit in a nursing facility, reimbursement for psychiatric services to members residing in a nursing facility is not allowed. Revisions will also reflect WF 18-17 policy changes to update the child abuse section to provide a more thorough explanation of how to report abuse and neglect, including clarifying text, and updating outdated citations. Further revisions will also reference WF 18-24 out-of-state policy.
Budget Impact: The proposed rule will result in small savings to the agency as it will place limits on the overutilization of services.

(Reference APA WF # 18-23)

M. AMENDING agency rules at ***OAC 317:30-3-31 and 317:30-5-95.24;*** ADDING agency rules at ***OAC 317:30-3-89, 317:30-3-90, and 317:30-3-91;*** AMENDING and RENUMBERING ***OAC 317:30-3-64 to OAC 317:30-3-92*** will add a Part 6 to Chapter 30 in policy titled "Out-of-State Services." The new part will define and clarify coverage and reimbursement for services rendered by providers that are physically located outside of Oklahoma. Additions will delineate out-of-state services, provider participation requirements, prior authorizations, and documentation/medical records requirements; and will outline reimbursement criteria for out-of-state providers who do not accept the payment rate established through the State Plan. Additionally, the "payment for lodging and meals" section will be moved under the new Part 6. Finally, revisions will strike out old out-of-state policy then replace with references directing to the new part.
Budget Impact: It is expected that the new policy's reimbursement methodology will achieve significant savings, the exact amount of which cannot be quantified at this time.

(Reference APA WF # 18-24)

N. AMENDING agency rules at ***OAC 317:30-3-19.5 and 317:30-5-664.8*** will eliminate references to sections that have been revoked. The sections were revoked in past rulemaking sessions; however language, in other parts of the Chapter, referring to these sections, were inadvertently missed. Further revisions will correct misspelled words and grammatical mistakes for better flow and understanding.
Budget Impact: Budget neutral

(Reference APA WF # 18-25)

O. AMENDING agency rules at ***OAC 317:30-5-96.6*** will streamline crossover payments of Medicare/Medicaid dual eligible individuals for Part A and B services. Further revisions will also involve limited rewriting aimed at clarifying text, eliminating redundancies, and updating outdated terminology.

Budget Impact: Budget neutral

(Reference APA WF # 18-27)

P. AMENDING agency rules at ***OAC 317:30-5-95.33*** will comply with federal regulations by assuring that members under twenty-one (21) years of age, who are residing in qualified inpatient psychiatric settings, have access to a full range of medically necessary Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services. Revisions will also emphasize that EPSDT services are accessible, regardless of whether such services are listed on the member's individual plan of care.
Budget Impact: Budget neutral

(Reference APA WF # 18-28)

Q. AMENDING agency rules at ***OAC 317:30-5-664.3*** and ADDING agency rules at ***OAC 317:30-5-664.4*** will reinstate administrative rules to allow and better define multiple encounters at Federally Qualified Health Centers (FQHCs). Additional revisions will establish guidelines for these multiple encounters. Finally, revisions will update/remove outdated language in order to reflect current business practices and to provide consistency throughout policy.
Budget Impact: The impact to the budget is difficult to determine, and the agency predicts would be nominal, thus we are estimating this change to be budget neutral.

(Reference APA WF # 18-30)

DHS Initiated

R. AMENDING agency rules at ***OAC 317:40-7-5, 317:40-7-6, 317:40-7-15 and 317:40-7-21*** will add new language to provide general clarification that when a home-based business is established through the Oklahoma Department of Rehabilitation (OKDRS) services, Developmental Disabilities Services (DDS) stabilization services are utilized when the OKDRS end. In addition, new language will provide guidelines for the Personal Support Team to follow when the required thirty (30) hours of employment services through Home and Community-Based Service (HCBS) waivers is not met. Examples of these services include community-based services, center-based services, employment training specialist intensive training services, and job coaching services. Finally revisions will include removal of outdated language relating to the exception process for employment services through the HCBS waiver and will update obsolete acronyms.
Budget Impact: Budget neutral

(Reference APA WF # 18-22B)

S. AMENDING agency rules at ***OAC 317:30-5-1041 through 30-5-1044 and 317:30-5-1046*** will streamline group home coverage and reimbursement policy language and develop consistency with current practice. The proposed revisions will outline and clarify provider requirements and remove references to any services provided in wilderness camps and Diagnostic and Evaluation (D&E) centers. Finally, revisions will involve limited rewriting aimed at updating outdated terminology.
Budget Impact: The proposed changes would potentially result in a combined federal and state spending of $7,048,848 total with $2,663,063 in state share for SFY2020. The state share will be paid by the Oklahoma Department of Human

Services (DHS) and Oklahoma Juvenile Affairs (OJA) for their respective homes.

(Reference APA WF # 18-26)

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 1. PHYSICIANS

317:30-5-20. Laboratory services

This Section covers the guidelines for payment of laboratory services by a provider in his/her office, a certified laboratory and for a pathologist's interpretation of laboratory procedures.

(1) **Compensable services.** Providers may be reimbursed for compensable clinical diagnostic laboratory services only when they personally perform or supervise the performance of the test. If a provider refers specimen to a certified laboratory or a hospital laboratory serving outpatients, the certified laboratory or the hospital must bill for performing the test.

(A) Reimbursement for lab services is made in accordance with the Clinical Laboratory Improvement Amendment of 1988 (CLIA). These regulations provide that payment may be made only for services furnished by a laboratory that meets CLIA conditions, including those furnished in physicians' offices. Eligible providers must be certified under the CLIA program and have obtained a CLIA ID number from ~~CMS~~Centers for Medicare and Medicaid Services and have a current contract on file with the ~~OHCA~~Oklahoma Health Care Authority (OHCA). Providers performing laboratory services must have the appropriate CLIA certification specific to the level of testing performed.

(B) Only medically necessary laboratory services are compensable.

(i) Testing must be medically indicated as evidenced by patient-specific indications in the medical record.

(ii) Testing is only compensable if the results will affect patient care and are performed to diagnose conditions and illnesses with specific symptoms.

(iii) Testing is only compensable if the services are performed in furtherance of the diagnosis and/or treatment of conditions that are covered under SoonerCare.

(C) Laboratory testing must be ordered by the physician or non-physician provider, and must be individualized to the patient and the patient's medical history or assessment indicators as evidenced in the medical documentation.

(2) **Non-compensable laboratory services.**

(A) Laboratory testing for routine diagnostic or screening tests performed without apparent relationship to treatment or diagnosis of a specific illness, symptom, complaint or

injury is not covered.
(B) Non-specific, blanket panel or standing orders for laboratory testing, custom panels particular to the ordering provider, or lab panels which have no impact on the patient's plan of care are not covered.
(C) Split billing, or dividing the billed services for the same patient for the same date of service by the same rendering laboratory into two or more claims is not allowed.
~~(A)~~(D) Separate payment is not made for blood specimens obtained by venipuncture or urine specimens collected by a laboratory. These services are considered part of the laboratory analysis.
~~(B)~~(E) Claims for inpatient full service laboratory procedures are not covered since this is considered a part of the hospital rate.
~~(C)~~(F) Billing multiple units of nucleic acid detection for individual infectious organisms when testing for more than one (1) infectious organism in a specimen is not permissible. Instead, OHCA considers it appropriate to bill a single unit of a procedure code indicated for multiple organism testing.
~~(D)~~(G) Billing multiple Current Procedural Terminology (CPT) codes or units for molecular pathology tests that examine multiple genes or incorporate multiple types of genetic analysis in a single run or report is not permissible. Instead, OHCA considers it appropriate to bill a single CPT code for such test. If an appropriate code does not exist, then one (1) unit for an unlisted molecular pathology procedure may be billed.

(3) **Covered services by a pathologist.**
(A) A pathologist may be paid for the interpretation of inpatient surgical pathology specimen when the appropriate CPT procedure code and modifier is used.
(B) Full service or interpretation of surgical pathology for outpatient surgery performed in an outpatient hospital or ~~Ambulatory Surgery Center~~ambulatory surgery center setting.

(4) **Non-compensable services by a pathologist.** The following are non-compensable pathologist services:
(A) Experimental or investigational procedures.
(B) Interpretation of clinical laboratory procedures.

PART 3. HOSPITALS

317:30-5-40.1. General information

(a) This Chapter applies to coverage in an inpatient and/or outpatient setting. Coverage is the same for adults and children unless otherwise indicated.

(b) **Professional Services**. Payment is made to a participating hospital group or corporation for hospital based physician's

services. The hospital must have a Hospital Group Physician's Contract with OHCA for this method of billing.
(c) **Prior Authorization**. OHCA requires prior authorization for certain procedures to validate the medical need for the service.
(d) **Medical necessity.** Medical necessity requirements are listed at OAC 317:30-3-1(f) and 317:30-5-20.

317:30-5-42.10. Laboratory

~~Payment is made for all laboratory tests listed in the Clinical Diagnostic Laboratory fee schedule from CMS.~~ To be eligible for payment as a laboratory/pathology service, the service must be:

(1) Ordered and provided by or under the direction of a physician or other licensed practitioner within the scope of practice as defined by state law;

(2) Provided in a hospital or independent laboratory;

(3) Directly related to the diagnosis and treatment of a medical condition;~~and~~

(4) Authorized under the laboratory's CLIA certification~~.~~; and

(5) Considered medically necessary as defined in OAC 317:30-3-1(f) and 317:30-5-20.

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 9. LONG-TERM CARE FACILITIES

317:30-5-123. Member certification for ~~long term~~long-term care

(a) **Medical eligibility.** Initial approval of medical eligibility for long-term care is determined by the Oklahoma Department of Human Services ~~(OKDHS)~~(DHS) area nurse, or nurse designee. The certification is obtained by the facility at the time of admission.

(1) **~~Pre-admission~~Preadmission screening.** Federal regulations govern the State's responsibility for Preadmission Screening and Resident Review (PASRR) for individuals with mental illness and intellectual disability. ~~PASRR applies to the screening or reviewing of all individuals for mental illness or intellectual disability or related conditions who apply to or reside in Title XIX certified nursing facilities regardless of the source of payment for the nursing facility (NF) services and regardless of the individual's or resident's known diagnoses.~~ PASRR applies to the screening or reviewing of all individuals for mental illness, intellectual disability, or related conditions who apply to or reside in a Title XIX certified nursing facility (NF), regardless of the source of payment for the NF services and/or the individual's or resident's known diagnoses. Individuals referred for admission to a NF must be screened for a major mental disorder, diagnosable under the most current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM). The NF must independently evaluate the Level I PASRR ~~Screen~~screen regardless of who completes the form and determine whether or not to admit an individual to the facility. Nursing facilities which inappropriately admit a person without a PASRR ~~Screen~~screen are subject to recoupment of funds. PASRR is a requirement for nursing facilities with dually certified (both Medicare and Medicaid) beds. There are no PASRR requirements for Medicare skilled beds that are not dually certified, nor is PASRR required for individuals seeking residency in an intermediate care facility for individuals with intellectual disabilities (ICF/IID).

(2) **PASRR Level I screen.**

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

(i) The NF administrator or co-administrator;

(ii) A licensed nurse, social service director, or social worker from the NF; or

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

(B) Prior to admission, the authorized NF official must evaluate the properly completed ~~OHCA~~Oklahoma Health Care Authority (OHCA) Form LTC-300R and the Minimum Data Set (MDS), if available. Any other readily available medical and social information is also used to determine if there currently exists any indication of mental illness, an intellectual disability, or other related condition, or if such condition existed in the applicant's past history. Form LTC-300R constitutes the Level I PASRR ~~Screen~~screen and is utilized in determining whether or not a Level II ~~Assessment~~assessment is necessary prior to allowing the member to be admitted. The NF is also responsible for consulting with the Level of Care Evaluation Unit (LOCEU) regarding any ~~mental illness, or an intellectual disability related condition information that becomes known either from completion of the MDS or throughout the resident's stay.~~information on a mental illness, intellectual disability or related condition that becomes known either from completion of the MDS or throughout the resident's stay.

(C) The NF is responsible for determining from the evaluation whether or not the member can be admitted to the facility. A "yes" response to any question from Form LTC-300R, Section E, will require the facility to contact the LOCEU for a consultation to determine if a Level II ~~Assessment~~assessment is needed. If there is any question as to whether or not there is evidence of mental illness, an intellectual disability, or related condition, LOCEU should be contacted prior to admission. The original Form LTC-300R must be submitted electronically or by mail to the LOCEU within ~~10~~ten (10) days of the resident admission. SoonerCare payment may not be made for a resident whose LTC-300R requirements have not been satisfied in a timely manner.

(D) Upon receipt and review of the Form LTC-300R, the LOCEU may, in coordination with the ~~OKDHS~~DHS area nurse, re-evaluate whether a Level II PASRR assessment may be required. If a Level II ~~Assessment~~assessment is not required, the process of determining medical eligibility continues. If a Level II is required, a medical decision is not made until the results of the Level II ~~Assessment~~assessment are known.

(3) **Level II Assessment for PASRR.**

(A) Any one of the following three (3) circumstances will allow a member to enter the NF without being subjected to a Level II PASRR ~~Assessment~~assessment.

(i) The member has no current indication of mental illness, ~~or~~ intellectual disability, or other related

condition and there is no history of such condition in the member's past.

(ii) The member does not have a diagnosis of intellectual disability or related condition.

(iii) An individual may be admitted to ~~an~~a NF if he/she has indications of mental illness ~~or an~~, intellectual disability, or other related condition, but is not a danger to self and/or others, and is being released from an acute care hospital as part of a medically prescribed period of recovery (~~Exempted Hospital Discharge~~exempted hospital discharge). If an individual is admitted to ~~an~~a NF based on ~~Exempted Hospital Discharge~~an exempted hospital discharge, it is the responsibility of the NF to ensure that the individual is either discharged by the 30th day or that a Level II has been requested and is in process. ~~Exempted Hospital Discharge~~An exempted hospital discharge is allowed only if all three (3) of the following conditions are met:

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

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

(III) The attending physician must certify in writing before admission to the facility that the individual is likely to require less than ~~30~~thirty (30) days of NF services. The NF will be required to furnish this documentation to OHCA upon request.

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

(C) The OHCA LOCEU authorizes ~~Advance Group Determinations~~advance group determinations for the mental illness and intellectual disability authorities in the following categories listed in (i) through (iii) of this subparagraph. Preliminary screening by the LOCEU may indicate eligibility for NF level of care prior to consideration of the provisional admission.

(i) **Provisional admission in cases of delirium.** Any person with mental illness, intellectual disability, or

related condition that is not a danger to self and/or others, may be admitted to a Title XIX certified NF if the individual is experiencing a condition that precludes screening, i.e., effects of anesthesia, medication, unfamiliar environment, severity of illness, or electrolyte imbalance.

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

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

(ii) **Provisional admission in emergency situations.** ~~Any person with a mental illness, an intellectual disability~~Any person with mental illness, intellectual disability, or related condition, who is not a danger to self and/or others, may be admitted to a Title XIX certified NF for a period not to exceed seven (7) days pending further assessment in emergency situations requiring protective services. The request for Level II evaluation must be made immediately upon admission to the NF if a longer stay is anticipated. The LOCEU must be provided with written documentation from ~~OKDHS~~DHS Adult Protective Services which supports the individual's emergency admission. Payment for NF services will not be made beyond the emergency admission ending date.

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

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

(II) Respite care must be approved by LOCEU staff prior to the individual's admission to the NF. The NF provides the LOCEU with written documentation

concerning circumstances surrounding the need for respite care, the date the individual wishes to be admitted to the facility, and the date the individual is expected to return to the caregiver. Payment for NF services will not be made after the respite care ending date.

(4) **Resident Review.**

(A) The facility's routine resident assessment will identify those individuals previously undiagnosed as intellectually disabled or mentally ill. A new condition of intellectual disability or mental illness must be referred to LOCEU by the NF for determination of the need for the Level II ~~Assessment~~assessment. The facility's failure to refer such individuals for a Level II ~~Assessment~~assessment may result in recoupment of funds.

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

(C) A significant change in a resident's mental condition could trigger a Level II ~~Resident Review~~resident review. If such a change should occur in a resident's condition, it is the responsibility of the NF to notify the LOCEU of the need to conduct a resident review.

(5) **Results of Level II ~~Pre-Admission~~Preadmission Assessment and Resident Review.** Through contractual arrangements between the OHCA and the mental illness or intellectual disability authorities, individualized assessments are conducted and findings presented in written evaluations. The evaluations determine if NF services are needed, if specialized services or less than specialized services are needed, and if the individual meets the federal PASRR definition of mental illness ~~or~~, intellectual disability, or related conditions. Evaluations are delivered to the LOCEU to process formal, written notification to member, guardian, NF, and interested parties.

(6) **Readmissions and interfacility transfers.** The ~~Preadmission Screening~~preadmission screening process does not apply to readmission of an individual to a NF after transfer for a continuous hospital stay, and then back to the NF. There is no specific time limit on the length of absence from the NF for the hospitalization. ~~Inter-facility~~Interfacility transfers are also subject to preadmission screening. In the case of transfer of a resident from a NF to a hospital or to another NF, the transferring NF is responsible for ensuring that copies of the

resident's most recent LTC-300R and any PASRR evaluations accompany the transferring resident. The receiving NF must submit an updated LTC-300R that reflects the resident's current status to LOCEU within ten (10) days of the transfer. Failure to do so could result in possible recoupment of funds. LOCEU should also be contacted prior to admitting out-of-state NF applicants with mental illness ~~or~~, intellectual disability, or related condition, so that PASRR needs can be ascertained. Any PASRR evaluations previously completed by the referring state should be forwarded to LOCEU as part of this PASRR consultation.

(7) **PASRR appeals process.**

(A) Any individual who has been adversely affected by any PASRR determination made by the State in the context of either a preadmission screening or an annual resident review may appeal that determination by requesting a fair hearing. If the individual does not consider the PASRR decision a proper one, the individual or their authorized representative must contact the local county ~~OKDHS~~DHS office to discuss a hearing. Forms for requesting a fair hearing (~~OKDHS~~DHS Form 13MP001E, Request for a Fair Hearing), as well as assistance in completing the forms, can be obtained at the local county ~~OKDHS~~DHS office. Any request for a hearing must be ~~made no later than 20 days following the date of written notice.~~received by OHCA within thirty (30) days of the date of written notice. Appeals of these decisions are available under ~~OAC~~Oklahoma Administrative Code (OAC) 317:2-1-2. All individuals seeking an appeal have the same rights, regardless of source of payment. Level I determinations are not subject to appeal.

(B) When the individual is found to experience mental illness, ~~an~~ intellectual disability, or related condition through the Level II ~~Assessment~~assessment, the PASRR determination made by the mental illness or intellectual disability authorities cannot be countermanded by the OHCA, either in the claims process or through other utilization control/review processes, or by the State Department of Health. Only appeals determinations made through the fair hearing process may overturn a PASRR determination made by the mental illness or intellectual disability authorities.

(b) **Determination of Title XIX medical eligibility for ~~long term~~long-term care.** The determination of medical eligibility for care in a NF is made by the ~~OKDHS~~DHS area nurse, or nurse designee. The procedures for determining NF program medical eligibility are found in OAC 317:35-19. Determination of ICF/IID medical eligibility is made by LOCEU. The procedures for obtaining and submitting information required for a decision are outlined below.

(1) **Pre-approval of medical eligibility.** Pre-approval of medical eligibility for private ICF/IID care is based on results

of a current comprehensive psychological evaluation by a licensed psychologist or state staff psychologist, documentation of intellectual disability or related condition prior to age ~~22~~twenty-two (22), and the need for active treatment according to federal standards. Pre-approval is made by LOCEU analysts.

(2) **Medical eligibility for ICF/IID services.** Within ~~30~~thirty (30) calendar days after services begin, the facility must submit the original of the Nursing Facility Level of Care Assessment ~~(Form LTC-300R)~~(Form LTC 300) to LOCEU. Required attachments include current (within ~~90~~ninety (90) days of requested approval date) medical information signed by a physician, a current (within ~~12~~twelve (12) months of requested approval date) psychological evaluation, a copy of the pertinent section of the ~~Individual Developmental Plan~~individual development plan or other appropriate documentation relative to discharge planning and the need for ICF/IID level of care, and a statement that the member is not an imminent threat of harm to self or others (i.e., suicidal or homicidal). If pre-approval was determined by LOCEU and the above information is received, medical approval will be entered on ~~MEDATS~~Medical Eligibility Determination Application Tracking System (MEDATS).

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

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

SUBCHAPTER 19. NURSING FACILITY SERVICES

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

(a) Federal regulations govern the State's responsibility for Preadmission Screening and Resident Review (PASRR) of individuals with mental illness and intellectual disabilities. ~~PASRR applies to the screening or reviewing of all individuals for mental illness, an intellectual disability, or related conditions who apply to or reside in Medicaid certified nursing facilities regardless of the source of payment for the nursing facility (NF) services and regardless of the individual's or resident's known diagnoses.~~ PASRR applies to the screening or reviewing of all individuals for mental illness, intellectual disability, or related conditions who apply to or reside in a Title XIX certified nursing facility (NF), regardless of the source of payment for the NF services and/or the individual's or resident's known diagnoses. Individuals referred for admission to a NF must be screened for a major mental disorder, diagnosable under the most current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM). The NF must independently evaluate the Level I PASRR ~~Screen~~screen regardless of who completes the form and determine whether or not to admit an individual to the facility. If an individual is admitted inappropriately, the NF is subject to recoupment of Medicaid funds and penalties imposed by ~~CMS~~the Centers for Medicare and Medicaid Services (CMS). Federal financial participation (FFP) may not be paid until results of any needed PASRR Level II evaluations are received. PASRR is a requirement for nursing facilities with dually certified (both Medicare and Medicaid) beds. There are no PASRR requirements for Medicare skilled beds that are not dually certified, nor is PASRR required for individuals seeking residency in an intermediate care facility for individuals with intellectual disabilities (ICF/IID).

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

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

SUBCHAPTER 3. GENERAL PROVIDER POLICIES

PART 1. GENERAL SCOPE AND ADMINISTRATION

317:30-3-33. Suspended claims review and/or prepayment review

Suspended claims review and/or prepayment review occurs after a healthcare good or service has been furnished and a claim for payment has been filed with the Oklahoma Health Care Authority (OHCA) by the provider, but before the claim has been paid. Suspended claims review and/or prepayment review may be performed by the OHCA or its contractor or designee, and may take the form of different types of reviews, including, but not limited to:

(1) Any claims review process(es) required by federal and/or state law, including Section 447.45(f) of Title 42 of the Code of Federal Regulations (C.F.R.);

(2) The suspended claims review process to confirm, prior to payment, the medical necessity of the healthcare good or service provided and use of the appropriate modifier, based on, among other things, the claim's diagnosis, code, and/or modifier, as well as any attached medical record(s) or other supporting documentation; and

(3) Any provider-specific prepayment review, in which a provider's claims are temporarily held in the payment system, pending review of medical records and/or other supporting documentation, in order to confirm that the submitted claims were billed appropriately and relate to healthcare goods or services that are covered and medically necessary.

(A) OHCA shall notify the provider in writing within ten (10) business days before the effective start date of any provider-specific prepayment review, informing the provider as to the:

(i) Implementation date, scope, and nature of the review;

(ii) Process for submitting claims and supporting documentation; and

(iii) Any accuracy goals that must be met before removal from the provider-specific prepayment review status can occur.

(4) Suspended claims review and/or prepayment review is not a sanction and cannot be appealed, nor is it subject to an informal hearing. However, any claim that is denied for payment by OHCA as a result of suspended claims review and/or prepayment review may be resubmitted to OHCA for reconsideration, in accordance with Oklahoma Administrative Code 317:30-3-11.1 and/or 317:30-3-20.

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

SUBCHAPTER 3. GENERAL PROVIDER POLICIES

PART 1. GENERAL SCOPE AND ADMINISTRATION

317:30-3-19.4. ~~Applicants subject to a fingerprint-based criminal background check~~Application fee, provider screening, and applicants subject to a fingerprint-based criminal background check

~~(a) Applicants designated as "'high' categorical risk" in accordance with Federal law, including, but not limited to, 42 C.F.R. § 424.518 and 42 C.F.R. Part 455, Subpart E, or if otherwise required by State and/or Federal law, shall be subject to a fingerprint-based criminal background check as a condition of new or renewed contract enrollment.~~

~~(b) Any applicant subject to a fingerprint-based criminal background check as provided in subsection (a) of this Section, shall be denied enrollment if he/she has a felonious criminal conviction and may be denied enrollment for a misdemeanor criminal conviction relating, but not limited, to:~~

~~(1) The provision of services under Medicare, Medicaid, or any other Federal or State health care program;~~
~~(2) Homicide, murder, or non-negligent manslaughter;~~
~~(3) Aggravated assault;~~
~~(4) Kidnapping;~~
~~(5) Robbery;~~
~~(6) Abuse, neglect, or exploitation of a child or vulnerable adult;~~
~~(7) Human trafficking;~~
~~(8) Negligence and/or abuse of a patient;~~
~~(9) Forcible rape and/or sexual assault;~~
~~(10) Terrorism;~~
~~(11) Embezzlement, fraud, theft, breach of fiduciary duty, or other financial misconduct; and/or~~
~~(12) Controlled substances, provided the conviction was entered within the preceding ten-year period.~~

~~(c) Any OHCA decision denying an application for contract enrollment based on the applicant's criminal history pursuant to OAC 317:30-3-19.4 shall be a final agency decision that is not administratively appealable. However, nothing in this section shall preclude an applicant whose criminal conviction has been overturned on final appeal, and for whom no other appeals are pending or may be brought, from reapplying for enrollment.~~

Pursuant to Subpart E of Part 455 of Title 42 of the Code of Federal Regulations (C.F.R.), an enrolling or re-enrolling SoonerCare provider must meet the screening requirements described

in this rule and pay an application fee if required in the appendix to this rule. See Appendix A at the end of this chapter.

(1) Application fees. The amount of the application fee is the amount established by the Center for Medicare and Medicaid Services (CMS) in accordance with 42 United States Code § 1395cc (j)(2)(C)(i), adjusted for inflation.

(A) Per 42 C.F.R. § 455.460, the application fee shall not apply to the following providers:

(i) Individual physician or non-physician practitioners;

(ii) Providers who have enrolled or re-enrolled in Medicare, and have met the provider screening requirements and paid an application fee to CMS or its designee; and

(iii) Providers who have enrolled or re-enrolled in another state's Medicaid or CHIP program, and have met the provider screening requirements and paid an application fee to the State Medicaid Agency or its designee.

(iv) A provider must submit documentation to support any claim that it meets the exemption(s) described in paragraph (1)(A)(ii) and/or (1)(A)(iii) of this rule.

(B) The application fee will not be refunded if:

(i) Enrollment or re-enrollment is denied as a result of failure to meet the provider screening requirements described in this rule; or

(ii) Enrollment or re-enrollment is denied based on the results of the provider screening.

(2) Risk categories. Federal law requires the OHCA to screen all providers based on a categorical risk level of "limited," "moderate," or "high." If more than one risk level applies to a provider, the highest level of screening is required.

(A) Limited-risk screens include:

(i) Verification that the provider meets any applicable federal regulations, or state requirements for the provider type;

(ii) License verification, including state licensure verification in states other than Oklahoma; and

(iii) Database checks, including, but not limited to, those required by 42 C.F.R. § 455.436.

(B) Moderate-risk screens include:

(i) All limited-risk screening requirements; and

(ii) Pre- and post-enrollment site visits by OHCA Provider Enrollment staff to confirm the accuracy of the provider's application and to determine compliance with federal and state enrollment requirements.

(iii) Enrolled providers must permit the CMS, its agents, its designated contractors, or OHCA to conduct

unannounced on-site inspections of any and all provider locations.

(C) High-risk screens include:

(i) All limited-risk screening requirements;

(ii) All moderate-risk screening requirements; and

(iii) A fingerprint-based criminal background check of the provider, or of any person with a five percent (5%) or more direct or indirect ownership interest in the provider.

(3) OHCA's risk categories. OHCA has adopted the same risk categories as have been established for Medicare providers in 42 C.F.R. § 424.518. For certain Medicaid providers that are not recognized under Medicare, risk categories have been set forth in OHCA's "Appendix A. Risk Levels for Providers," using criteria similar to that used for Medicare providers, in determining the risk of fraud, waste and abuse.

(4) Changes in risk categories. In accordance with 42 C.F.R. § 455.450(e), limited- and moderate-risk providers are moved to the high-risk category whenever:

(A) OHCA imposes a payment suspension on a provider based on a credible allegation of fraud, waste or abuse;

(B) The provider has an existing Medicaid overpayment;

(C) The provider has been excluded by the Office of the Inspector General for the Department of Health and Human Services or any other state's Medicaid program within the previous ten (10) years; or

(D) OHCA or CMS lifted a temporary moratorium for the particular provider type in the previous six (6) months and a provider that was prevented from enrolling based on the moratorium applies for enrollment within six (6) months from the date the moratorium was lifted.

(5) Fingerprint-based criminal background check. Any applicant subject to a fingerprint-based criminal background check as provided in subsection (2)(C)(iii) of this rule, shall be denied enrollment if he/she has a felonious criminal conviction and may be denied enrollment for a misdemeanor criminal conviction relating, but not limited, to:

(A) The provision of services under Medicare, Medicaid, or any other Federal or State health care program;

(B) Homicide, murder, or non-negligent manslaughter;

(C) Aggravated assault;

(D) Kidnapping;

(E) Robbery;

(F) Abuse, neglect, or exploitation of a child or vulnerable adult;

(G) Human trafficking;

(H) Negligence and/or abuse of a patient;

(I) Forcible rape and/or sexual assault;

(J) Terrorism;

(K) Embezzlement, fraud, theft, breach of fiduciary duty, or other financial misconduct; and/or

(L) Controlled substances, provided the conviction was entered within the preceding ten-year period.

(6) The appropriate screening based on screening risk level must be given to all service locations of an enrolled provider. Providers must disclose all service locations at time of enrollment and notify the agency of changes or additional service locations.

(7) In accordance with 42 C.F.R. § 455.452, the OHCA reserves the right to conduct additional screenings and background checks as is determined necessary.

(8) Any OHCA decision denying an application for contract enrollment based on the applicant's criminal history pursuant to Oklahoma Administrative Code 317:30-3-19.4 shall be a final agency decision that is not administratively appealable. However, nothing in this section shall preclude an applicant whose criminal conviction has been overturned on final appeal, and for whom no other appeals are pending or may be brought, from reapplying for enrollment.

APPENDIX A. RISK LEVELS FOR PROVIDERS [NEW]

Low Risk Provider Types	
41	Adult Day Services
09	Advance Practice Nurse
46	Advantage Home Delivered Meals
39	Agency Companion- DDSD
02	Ambulatory Surgical Center
60	Anesthesiologist Assistant
44	Architectural Modification
36	Assisted Living Services
20	Audiologist
47	Birthing Center
21	Case Management Agency- DDSD
15	Chiropractor
08	Clinic/Group
58	Community Transition Services
27	Dentist
39	Direct Support Services- DDSD
42	Employee Training Specialist
11	Family Training Services- DDSD
08	Federally Qualified Health Center
30	Free Standing Dialysis Clinic
50	Group Home-DDSD
39	Habilitation Training- DDSD
43	Homemaker Services
01	Hospital
63	Inpatient Psychiatric Facility
01	I/T/U Hospital
08	I/T/U Outpatient Clinic
03	Nursing Facility
03	Nursing Facility- Extended Respite
Varies	Medicare Crossover Providers
16	Nurse
23	Nutritionist
17	Occupational Therapy Business-DDSD
19	Optician
18	Optometrist
36	Personal Care
24	Pharmacy
31/52	Physician
10	Physician Assistant
14	Podiatrist
13	Public Health Agency
38	Respite Care
37	Room and Board
8	Rural Health Clinic

Moderate Risk Provider Types	
26	Ambulance Services
53	Behavioral Health Practitioner- Under Supervision
06	Hospice
29	Independent Diagnostic Testing Facility/Mobile X-ray
28	Independent Laboratory
53	Licensed Behavioral Health Practitioner
11	Outpatient Behavioral Health Agency Services
11	Paraprofessionals – Behavioral Health
17	Physical Therapists Group and/or Individual
25	Revalidating DME/Medical Supplies
05	Revalidating Home Health Agencies
High Risk Provider Types	
25	Newly Enrolling DME/Medical Supplies
05	Newly Enrolling Home Health Agencies

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. Determination of capital resources for individuals categorically related to aged, blind and disabled

(a) **General.** The term capital resources is a general term representing any form of real and/or personal property which has an available money value. All available capital resources, except those required to be disregarded by law or by policies of the ~~OHCA~~Oklahoma Health Care Authority (OHCA) or ~~OKDHS~~Oklahoma Department of Human Services (DHS) are considered in determining need. DHS Appendix C-1, Schedule VIII establishes the allowable limit for nonexcludable resources. Available resources are those resources which are in hand or under the control of the individual.

(1) In defining need, OHCA and ~~OKDHS~~DHS recognize the importance of a member retaining a small amount of resources for emergencies or special need and has established a maximum resource standard a member or family may hold and be considered in need.

(2) Capital resources are evaluated on a monthly basis in determining eligibility for an applicant for medical services. An applicant is determined ineligible for any month resources exceed the resource standard at any time during that month. When a member has resources which exceed the resource standard, case closure action is taken for the next possible effective date.

(3) State law is specific on the mutual responsibility of spouses for each other. Therefore, if husband and wife are living together, a capital resource and/or income available to one spouse constitutes a resource and/or income to the other. When there is a break in the family relationship and the husband and wife are separated, but not divorced or legally separated, they constitute a possible resource to each other and this possible resource is explored to determine what, if any, resource can be made available. When a spouse is in a nursing facility, see ~~Subchapter~~Subchapters 9 and 19 of this Chapter.

(4) Only the resources of the child determined eligible for ~~TEFRA~~Tax Equity Fiscal Responsibility Act (TEFRA) are considered in determining eligibility.

(5) ~~Household equipment used for daily living is not considered a resource.~~Household goods and personal effects are not

considered capital resources. Household goods and personal effects are defined as follows:

(A) Household goods are:

(i) Items of personal property, found in or near the home, that are used on a regular basis; and/or

(ii) Items needed by the householder for maintenance, use, and occupancy of the premises as a home.

(B) Personal effects are:

(i) Items of personal property ordinarily worn or carried by the individual; and/or

(ii) Articles otherwise having an intimate relation to the individual.

(C) Personal effects do not include items that were acquired or are held for their value or as an investment. Such items can include but are not limited to gems, jewelry that is not worn or held for family significance, or collectibles.

(6) Each time that need is determined, gross income and the equity of each capital resource are established. Equity equals current market value minus indebtedness. The member may change the form of capital resources from time to time without affecting eligibility so long as the equity is not decreased in doing so or increased in excess of the allowable maximum resource standard. In the event the equity is decreased as the result of a sale or transfer, the reduction in the equity is evaluated in relation to policy applicable to resources disposed of while receiving assistance.

(b) **Eligibility.** In determining eligibility based on resources, only those resources available for current use or those which the member can convert for current use (no legal impediment involved) are considered as countable resources. Examples of legal impediments include, but are not limited to, clearing an estate, probate, petition to sell, or appointment of legal guardian.

(1) Generally, a resource is considered unavailable if there is a legal impediment to overcome. However, the member must agree to pursue all reasonable steps to initiate legal action within ~~30~~thirty (30) days. While the legal action is in process, the resource is considered unavailable.

(2) If a determination is made and documented that the cost of making a resource available exceeds the gain, the member will not be required to pursue action to make it available.

(3) Determination of available and unavailable resources must be well documented in the case record.

(4) The major types of capital resources are listed in Sections ~~OAC 317:35-5-41.1 through 317:35-5-41.7~~Oklahoma Administrative Code (OAC) 317:35-5-41.1 through 317:35-5-41.7, as well as OAC 317:35-5-41.12. The list is not intended to be all inclusive and consideration must be given to all resources.

317:35-5-41.1. Home/real property

(a) Home property is excluded from resources regardless of value unless the individual is applying for long-term care services. [See Oklahoma Administrative Code (OAC) 317:35-5-41.8(a) (relating to eligibility for long-term care services)]. For purposes of the home property resource exclusion, a home is defined as any shelter in which the individual has an ownership interest and which is used by the individual as his/her principal place of residence. The home may be either real or personal property, fixed or mobile.

(1) Home property includes all property which is adjacent to the home. Land is considered adjacent even if separated by a boundary line, street, alley, highway, or waterway.

(2) Property has a value regardless of whether there is an actual offer to purchase. Verification of home/real property value is established by collateral contacts with specialized individuals knowledgeable in the type and location of property being considered. Mineral rights and wind rights associated with the home property are not valued separate from the surface.

(3) The home may be retained without affecting eligibility during periods when it is necessary to be absent for illness or other necessity. When it is determined that the member does not have a feasible plan for and cannot be expected to return to his/her home, the market value of the property is considered in relation to the resource. The member is responsible for taking all steps necessary to convert the resource for use in meeting current needs. If the member is making an effort to make the resource available, a reasonable period of time is given [not to exceed ninety (90) days] to convert the resource. He/she is advised in writing that the ninety-day (90-day) period begins with the determination that the property be considered in relation to the resource. The ninety-day (90-day) period is given only if efforts are in progress to make the resource available. Any extension beyond the initial ninety-day (90-day) period is justified only after interviewing the member, determining that a good faith effort to sell is still being made and failure to sell is due to circumstances beyond the control of the member. A written notification is also provided to the member at any time an extension is allowed. Detailed documentation in the case record is required.

(4) If the member fails or is unwilling to take steps necessary to convert the resource for use in meeting current needs, continuing eligibility cannot be established and the member is advised as to the effective date of closure and of the right to receive assistance when the resources are within the maximum allowable resources provided other conditions of eligibility continue to be met.

(5) When a member sells his/her home with the intention of purchasing another home or when an insurance payment for damage to the home is received, a reasonable period of time is given to reinvest the money in another home. A reasonable period of time is considered to not exceed a ninety-day (90-day) period. Extensions beyond the ninety (90) days may be justified only after interviewing the member; and determining that a good faith effort is still being made; and that completion of the transaction is beyond his/her control. This must be documented in the case record.

(6) At the point a member decides not to reinvest the proceeds from the sale of his/her home in another home, the member's plan for use of the proceeds is evaluated in relation to rules on resources disposed of while receiving assistance.

(7) A home traded for another home of equal value does not affect the member's eligibility status. If the home is traded for a home of lesser value, the difference may be invested in improvement of the new home.

(8) Absences from home for up to ninety (90) days for trips or visits or six (6) months for medical care (other than nursing facilities) do not affect receipt of assistance or the home exclusion as long as the individual intends to return home. Such absences, if they extend beyond those limits, may indicate the home no longer serves as the principal place of residence.

(9) Mineral rights, associated with the home property, are considered along with the surface rights and are excluded as a resource.

~~(b) For purposes of the home property resource exclusion, a home is defined as any shelter in which the individual has an ownership interest and which is used by the individual as his/her principal place of residence. The home may be either real or personal property, fixed or mobile. Home property includes all property which is adjacent to the home. Property has a value regardless of whether there is an actual offer to purchase. Verification of home/real property value is established by collateral contacts with specialized individuals knowledgeable in the type and location of property being considered.~~

~~(1) The home may be retained without affecting eligibility during periods when it is necessary to be absent for illness or other necessity. When it is determined that the member does not have a feasible plan for and cannot be expected to return to his/her home, the market value of the property is considered in relation to the resource. The member is responsible for taking all steps necessary to convert the resource for use in meeting current needs. If the member is making an effort to make the resource available, a reasonable period of time is given (not to exceed 90 days) to convert the resource. He/she is advised~~

~~in writing that the 90-day period begins with the determination that the property be considered in relation to the resource. The 90-day period is given only if efforts are in progress to make the resource available. Any extension beyond the initial 90-day period is justified only after interviewing the member, determining that a good faith effort to sell is still being made and failure to sell is due to circumstances beyond the control of the member. A written notification is also provided to the member at any time an extension is allowed. Detailed documentation in the case record is required.~~

~~(2) If the member fails or is unwilling to take steps necessary to convert the resource for use in meeting current needs, continuing eligibility cannot be established and the member is advised as to the effective date of closure and of the right to receive assistance when the resources are within the maximum allowable resources provided other conditions of eligibility continue to be met.~~

~~(3) When a member sells his/her home with the intention of purchasing another home or when an insurance payment for damage to the home is received, a reasonable period of time is given to reinvest the money in another home. A reasonable period of time is considered to be not in excess of a 90-day period. Extensions beyond the 90 days may be justified only after interviewing the member, determining that a good faith effort is still being made and that completion of the transaction is beyond his/her control. This must be documented in the case record.~~

~~(4) At the point a member decides not to reinvest the proceeds from the sale of his/her home in another home, the member's plan for use of the proceeds is evaluated in relation to rules on resources disposed of while receiving assistance.~~

~~(5) A home traded for another home of equal value does not affect the member's eligibility status. If the home is traded for a home of lesser value, the difference may be invested in improvement of the new home.~~

~~(6) Absences from home for up to 90 days for trips or visits or six months for medical care (other than nursing facilities) do not affect receipt of assistance or the home exclusion as long as the individual intends to return home. Such absences, if they extend beyond those limits, may indicate the home no longer serves as the principal place of residence.~~

~~(7) Mineral rights associated with the home property are considered along with the surface rights and are excluded as a resource. However, mineral rights which are not associated with the home property are considered as a resource. Since evaluation and scalability of mineral rights fluctuate, the establishment of the value of mineral rights are established based on the~~

~~opinion of collateral sources. Actual offers of purchase are used when established as a legitimate offer through a collateral source. Mineral rights not associated with home property which are income producing are considered in the same way as income producing property. Refer to (11)(B) of this subsection for treatment of mineral rights as non-trade or non-business property.~~

~~(8) The market value of real estate other than home property owned by the member or legal dependent and encumbrances against such property are ascertained in determining the equity (including the cost to the member of a merchantable title to be determined when the resource approaches the maximum). The market value of real estate other than the home owned by the applicant is established on the basis of oral or written information which the applicant has on hand and counsel with persons who have specialized knowledge about this kind of resource. Refer to (11) of this subsection for exclusion of real estate that produces income.~~

~~(9) Land which is held by an enrolled member of an Indian tribe is excluded from resources as it cannot be sold or transferred without the permission of other individuals, the tribe, or a federal agency. If permission is needed, the land is excluded as a resource.~~

~~(10) A life estate conveys upon an individual or individuals for his/her lifetime, certain rights in property. Its duration is measured by the lifetime of the tenant or of another person; or by the occurrence of some specific event, such as remarriage of the tenant. The owner of a life estate has the right of possession, the right to use the property, the right to obtain profits from the property and the right to sell his/her life estate interest. However, the contract establishing the life estate may restrain one or more rights of the individual. The individual does not have title to all interest in the property and does not have the right to sell the property other than the interest owned during his/her lifetime. He/she may not usually pass it on to heirs in the form of an inheritance.~~

~~(A) When a life estate in property is not used as the member's home, it is necessary to establish the value. A computer procedure is available to compute the value of a life estate by input of the current market value of the property and the age of the life estate owner.~~

~~(B) The value of a life estate on mortgaged property is based on equity rather than market value and the age of the individual.~~

~~(C) In the event the member does not accept as valid the value of the life estate as established through this method, the member must secure written appraisal by two persons who~~

~~are familiar with current values. If there is substantial unexplained divergence between these appraisals, the worker and the member will jointly arrange for the market value to be established by an appraisal made by a third person who is familiar with current market values and who is acceptable to both the member and the worker.~~

~~(11) Real and/or personal property which produces income is excluded if it meets the following conditions.~~

~~(A) **Trade or business property**. The existence of a trade or business may be established through business tax returns that would be used to compute self-employment earnings. If the current business tax return is unavailable, the existence of the business may be determined through other business forms, records, partnership, a detailed description of the business and its activities, etc. Once it is established that a trade or business exists, any property (real or personal) connected to it and in current use is excluded. This exclusion includes liquid assets, such as a bank account(s) necessary for the business operation. All property used by a trade or business and all property used by an employee in connection with employment is excluded as property essential to self support. The income from the trade or business is determined as any other self-employment income.~~

~~(B) **Non-trade or non-business property**. Property which produces income but is not used in a trade or business is excluded if the total equity value does not exceed $6000, and the net return equals at least 6% of the equity annually. An equity value in excess of $6000 is a countable resource. If the equity exceeds $6000 and 6% return is received on the total equity, only the amount in excess of $6000 is a countable resource. An annual return of less than 6% is acceptable if it is beyond the individual's control, and there is a reasonable expectation of a future 6% return. Liquid resources cannot be excluded as income producing property or meeting the $6000/6% rule (mortgages, including contract for deed, and notes which are income producing are considered as liquid resources). The $6000/6% rule applies to all resources in total, and not separately. Examples of non-business income producing property are rental property, timber rights, mineral rights, etc.~~

(b) Real property other than home property shall be treated as follows:

(1) Mineral rights which are not associated with the home property are considered as a resource. Since evaluation and scalability of mineral rights fluctuate, the establishment of the value of mineral rights are established based on the opinion

of collateral sources. Actual offers of purchase are used when established as a legitimate offer through a collateral source. Mineral rights not associated with home property which are income producing are considered in the same way as income producing property. Refer to OAC 317:35-5-41.12(c)(3) for treatment of mineral rights as non-trade or non-business property.

(2) The market value of real estate other than home property owned by the member or legal dependent and encumbrances against such property are ascertained in determining the equity (including the cost to the member of a merchantable title to be determined when the resource approaches the maximum). The market value of real estate other than the home owned by the applicant is established on the basis of oral or written information which the applicant has on hand and counsel with persons who have specialized knowledge about this kind of resource. Refer to OAC 317:35-5-41.12(c) for exclusion of real estate that produces income.

(3) For any individual (and spouse, if any) who is of Indian descent from a federally recognized Indian tribe, any interest in land which is held in trust by the United States for an individual Indian or tribe, or which is held by an individual Indian or tribe and which can only be sold, transferred, or otherwise disposed of with the approval of other individuals, his or her tribe, or an agency of the federal government, shall be excluded from resource determinations, in accordance with 20 Code of Federal Regulations (C.F.R.) § 416.1234.

(4) A life estate conveys upon an individual or individuals for his/her lifetime, certain rights in property. Its duration is measured by the lifetime of the tenant or of another person; or by the occurrence of some specific event, such as remarriage of the tenant. The owner of a life estate has the right of possession, the right to use the property, the right to obtain profits from the property and the right to sell his/her life estate interest. However, the contract establishing the life estate may restrain one or more rights of the individual. The individual does not have title to all interest in the property and does not have the right to sell the property other than the interest owned during his/her lifetime. He/she may not usually pass it on to heirs in the form of an inheritance.

(A) When a life estate in property is not used as the member's home, it is necessary to establish the value. A computer procedure is available to compute the value of a life estate by input of the current market value of the property and the age of the life estate owner.

(B) The value of a life estate on mortgaged property is based on equity rather than market value and the age of the individual.

(C) In the event the member does not accept as valid the value of the life estate as established through this method, the member must secure written appraisal by two (2) persons who are familiar with current values. If there is substantial unexplained divergence between these appraisals, the worker and the member will jointly arrange for the market value to be established by an appraisal made by a third (3rd) person who is familiar with current market values and who is acceptable to both the member and the worker.

(5) Real and/or personal property which produces income is excluded if it meets the following conditions established in OAC 317:35-5-41.12.

317:35-5-41.2. Miscellaneous Personal property

~~(a) **Property used to produce goods and services**. Personal property necessary to perform daily activities or to produce goods for home consumption is excluded if the equity value does not exceed $6,000. An equity value in excess of $6,000 is a countable resource. The property does not have to produce a 6% annual return. The $6,000 equity maximum includes all such resources in total and does not pertain to each item separately. Examples of property used to produce goods and services are tractors, wildcatting tools, mechanized equipment for gardening, livestock grown for home consumption, etc.~~

~~(b)~~(a) **Cash savings and bank accounts.** ~~Money on hand or in a savings account is considered as a countable resource~~Pursuant to Section 416.1208 of Title 20 of the Code of Federal Regulations (C.F.R.), funds held in a financial institution account (including savings, checking, and time deposits, also known as certificates of deposit) are an individual's resource if the individual has an ownership interest in the account and can use the funds for his or her support and maintenance. Verification of the member's countable income or resources held in bank accounts or at other financial institutions can be established through an Asset Verification System (AVS). ~~Title 56, O.S., Section 1671~~Section 1671 of Title 56 of the Oklahoma Statutes provides that financial records obtained for the purpose of establishing eligibility for assistance or services must be furnished without cost to the member or the Agency. If an individual is designated as sole owner by the account title, and can withdraw funds and use them for his or her support and maintenance, all of the funds, regardless of their source, are that individual's resource. For as long as these conditions are met, it is presumed that the individual owns one-

hundred percent (100%) of the funds in the account. This presumption is non-rebuttable.

(1) ~~Checking accounts may or may not represent savings. Current bank statements are evaluated with the member to establish what, if any, portion of the account represents savings. Any income which has been deposited during the current month is not considered unless it exceeds what is considered as ordinary maintenance expense for the month.~~If there is only one applicant or recipient account holder on a jointly held account, it is presumed that all of the funds in the account belong to that individual. If there is more than one (1) applicant or recipient account holder, it is presumed that all the funds in the account belong to those individuals in equal shares.

(2) ~~Accounts which are owned jointly by the member and a person not receiving SoonerCare are considered available to the member in their entirety unless it can be established what part of the account actually belongs to each of the owners and the money is actually separated and the joint account dissolved. When the member is in a nursing facility and the spouse is in the home or if both are institutionalized, a joint bank account may be maintained with one-half of the account considered available to each.~~If none of the account holders is an applicant or recipient, it is presumed that all of the funds in a jointly-held account belong to the deemor(s), in equal shares if there is more than one (1) deemor. A deemor is a person whose income and resources are required to be considered when determining eligibility and computing the SoonerCare benefit for an eligible individual.

(3) The presumption of ownership, as is established in Oklahoma Administrative Code (OAC) 317:35-5-41.2(a)(1) and (a)(2), above, may be rebutted, as follows, in accordance with 20 C.F.R. § 416.1208. Successful rebuttal may be retroactive as well as prospective.

(A) The individual must submit his/her statement, along with corroborating statements from other account holders, regarding who owns the funds in the joint account, why there is a joint account, who has made deposits to and withdrawals from the account, and how withdrawals have been spent;

(B) The individual must submit account records showing deposits, withdrawals, and interest (if any) in the months for which ownership of funds is at issue; and

(C) The individual must correct the account title to show that the individual is no longer a co-owner if the individual owns none of the funds; or, if the individual owns only a portion of the funds, separate the funds owned by the other account holder(s) from his/her own funds and correct the

account title on the individual's own funds to show they are solely-owned by the individual.

~~(c)~~(b) **Life insurance policies.** ~~If the total face value of all life insurance policies owned by an individual is $1,500 or less, the policies (both face value and cash surrender value) are excluded as resources. Verification of the member's countable income or resources held in bank accounts or at other financial institutions can be established through an AVS.~~Life insurance owned by an individual (and spouse, if any) will be considered a resource to the extent of its cash surrender value. The cash surrender value is the amount which the insurer will pay upon cancellation of the policy before death of the insured or before maturity of the policy.

(1) ~~If the total face value of all policies owned by an individual exceeds $1,500, the net cash surrender value of such policies must be counted as resources. Life insurance policies which do not provide a cash surrender value (e.g., term insurance) are not used in determining whether the total face value of all policies is over $1,500~~If the total face value of all life insurance policies on any person does not exceed $1,500, no part of the cash surrender value of such life insurance will be taken into account in determining the resources of the individual (and spouse, if any).

(2) ~~The face value of a life insurance policy which has been assigned to fund a prepaid burial contract must be evaluated and counted according to the policy on burial funds or, if applicable, the policy on the irrevocable burial contract~~In determining the face value of life insurance on the individual (and spouse, if any), term insurance and burial insurance, as defined in 20 C.F.R. § 416.1230, will not be taken into account.

~~(3) The net cash surrender value of insurance (i.e., cash surrender value less any loans or unpaid interest thereon) usually can be verified by inspection of the insurance policies and documents in the member's possession or by use of the OKDHS Form 08MP061E, Request to Insurance Company.~~

~~(4) Dividends which accrue and which remain with the insurance company increase the amount of resource. Dividends which are paid to the member are considered as income if the life insurance policy is not an excluded resource.~~

~~(5) If an individual has a life insurance policy which allows death benefits to be received while living, and the individual meets the insurance company's requirements for receiving such proceeds, the individual is not required to file for such proceeds. However, if the individual does file for and receive the benefits, the payment will be considered as income in the month it is received and countable as a resource in the following months to the extent it is available. The payment of~~

~~such benefits is not considered a conversion of a resource because the cash surrender value of the insurance policy is still available to the individual. The individual is in effect, receiving the death benefits and not the cash surrender value.~~

~~(d)~~(c) **Burial spaces.** The value of burial spaces for an individual, the individual's spouse or any member of the individual's immediate family will be excluded from resources. ~~"Burial spaces" means conventional grave sites, crypts, mausoleums, urns, and other repositories which are customarily and traditionally used for the remains of deceased persons. "Immediate family" means the individual's minor and adult children, including adopted children and step-children; and the individual's brothers, sisters, parents, adoptive parents, and the spouse of these individuals. Neither dependency nor living in the same household will be a factor in determining whether a person is an immediate family member. Verification of the member's countable income or resources held in bank accounts or at other financial institutions can be established through an AVS.~~

(1) "Burial spaces" means burial plots, gravesites, crypts, mausoleums, urns, niches and other repositories which are customarily and traditionally used for the remains of deceased persons. Additionally, the term includes necessary and reasonable improvements or additions to or upon such burial spaces, including, but not limited to, vaults, headstones, markers, plaques, or burial containers and arrangements for opening and closing the gravesite for burial of the deceased.

(2) "Immediate family" means the individual's minor and adult children, including adopted children and step-children; and the individual's brothers, sisters, parents, adoptive parents, and the spouse of these individuals. Neither dependency nor living in the same household will be a factor in determining whether a person is an immediate family member.

~~(e)~~(d) **Burial funds.** ~~Revocable burial funds not in excess of $1,500 are excluded as a resource if the funds are specifically set aside for the burial arrangements of the individual or the individual's spouse. Any amount in excess of $1,500 is considered as a resource. Burial policies which require premium payments and do not accumulate cash value are not considered to be prepaid burial policies. Verification of the member's countable income or resources held in bank accounts or at other financial institutions can be established through the AVS~~In accordance with 20 C.F.R. § 416.1231, up to $1,500 each of funds specifically set aside for the burial expenses of the individual or the individual's spouse is excluded from resources. This exclusion applies only if the funds set aside for burial expenses are kept separate from all other resources not intended for burial of the individual (or spouse) and are clearly designated as set aside for the

individual's (or spouses) burial expenses. This exclusion is in addition to the burial space exclusion.

~~(1) "Burial funds" means a prepaid funeral contract or burial trust with a funeral home or burial association which is for the individual's or spouse's burial expenses.~~

~~(2) The face value of a life insurance policy, when properly assigned by the owner to a funeral home or burial association, may be used for purchasing "burial funds" as described in (1) of this subsection. The $1,500 burial fund exclusion must also be reduced by the face value of a life insurance policy for which a funeral provider has been made the irrevocable beneficiary, if the life insurance policy owner has irrevocably waived his or her right to, and cannot obtain, any cash surrender value the life insurance policy may generate.~~

~~(3) The burial fund exclusion must be reduced by the face value of life insurance policies owned by the individual or spouse; and amounts in an irrevocable trust or other irrevocable arrangement.~~

~~(4) Interest earned or appreciation on the value of any excluded burial funds is excluded if left to accumulate and become a part of the burial fund.~~

~~(5) If the member did not purchase his/her own prepaid burial, even if his/her money was used for the purchase, the member is not the "owner" and the prepaid burial funds cannot be considered a resource to him/her. However, if the member's money was used by another to purchase the prepaid burial, the rules on transfer of property must be applied since the purchaser (owner) could withdraw the funds any time.~~

(1) Each person's $1,500 exclusion shall be reduced by:

(A) The face value of insurance policies on the life of an individual owned by the individual or spouse (if any), if the cash surrender value of those policies has been excluded from resources; and

(B) Amounts in an irrevocable trust (or other irrevocable arrangement) available to meet the burial expenses.

~~(f)~~(e) **Irrevocable burial contract.** Oklahoma law provides that a purchaser (buyer) of a prepaid funeral contract may elect to make the contract irrevocable. ~~The irrevocability cannot become effective until 30 days after purchase. For an irrevocable contract to be valid, the election to make it irrevocable must be made by the purchaser (owner) or the purchaser's guardian or an individual with power of attorney for the purchaser (owner). In instances where the OKDHS Form 08MA084E, Management of Recipient's Funds, is on file in the nursing facility, the form serves as a power of attorney for the administrator to purchase and/or elect to make irrevocable the burial funds for the member. Verification of the member's countable income or resources held in bank accounts~~

~~or at other financial institutions can be established through an AVS.~~

~~(1) The irrevocable contract shall not be considered a countable resource.~~

~~(2) Effective October 1, 2015, the cash value of any life insurance policies and/or designated accounts shall be excluded as a resource up to a maximum of $1,500. This exclusion shall be reduced dollar for dollar by the face value amount of any irrevocable prepaid burial contract.~~

(1) The irrevocability cannot become effective until thirty (30) days after purchase.

(2) For an irrevocable contract to be valid, the election to make it irrevocable must be made by the purchaser (owner) or the purchaser's guardian or an individual with power of attorney for the purchaser (owner). In instances where the DHS Form 08MA084E, Management of Recipient's Funds, is on file in the nursing facility, the form serves as a power of attorney for the administrator to purchase and/or elect to make irrevocable the burial funds for the member.

(3) The assignment of an insurance policy used to fund an irrevocable contract must also be made irrevocable.

(4) The irrevocable contract shall not be considered a countable resource.

~~(g)~~(f) **Medical insurance.** If a member is covered by insurance other than SoonerCare, then SoonerCare is the payer of last resort and should not be billed until all other payers have paid. If payment is made directly to the member, the member must reimburse OHCA up to the amount paid by SoonerCare. Any amount remaining after payment to OHCA is considered as an available resource.

317:35-5-41.3. Automobiles, pickups, and trucks

~~Automobiles, pickups, and trucks are considered in the eligibility determination for SoonerCare benefits. Verification of the member's countable resources held in bank accounts or at other financial institutions can be established through an AVS~~In accordance with Section 416.1218 of Title 20 of the Code of Federal Regulations (C.F.R.), "automobile" includes cars, pickups, trucks, and other vehicles used to provide necessary transportation.

(1) **Exempt automobiles.** One automobile is totally excluded from counting as a resource, regardless of its value, if it is used for transportation of the individual or a member of the individual's household.

(2) **Other automobiles.** Any other automobiles are considered to be nonliquid resources. The equity in other automobiles~~, pickups, and trucks~~ is considered as a countable resource. The current market value, less encumbrances on the vehicle, is the equity, per 20 C.F.R. § 416.1201(c). Only encumbrances that can be verified are considered in computing equity.

(A) The market value of each year's make and model is established on the basis of the "Avg. Trade In" value as shown in the current publication of the National Automobile Dealers Association (NADA) on "Cars, Trucks, and Imports".

(B) If a vehicle's listing has been discontinued in the NADA book, the household's estimate of the value of the vehicle is accepted unless the worker has reason to believe the estimate is incorrect.

(C) The market value of a vehicle that is no longer operable is ~~the~~its verified salvage value.

(D) In the event the member and worker cannot agree on the value of the vehicle, the member secures written appraisal by two (2) persons who are familiar with current values. If there is substantial unexplained divergence between these appraisals or between the book value and one (1) or more of these appraisals, the worker and the member jointly arrange for the market value to be established by an appraisal made by a third (3rd) person who is familiar with current values and who is acceptable to both the member and the worker.

317:35-5-41.8. Eligibility regarding long-term care services

(a) **Home Property**. In determining eligibility for long-term care services for applications filed on or after January 1, 2006, home property is excluded from resources unless the individual's equity interest in his or her home exceeds ~~$500,000 (increased by the annual percentage increase in the urban component of the consumer price index beginning in 2011, rounded to the nearest $1,000)~~the amount at Oklahoma Department of Human Services (DHS) Appendix C-1, Schedule VIII(D)(2).

(1) Long-term care services include nursing facility (NF) services and other long-term care services. For purposes of this Section, other long-term care services include:

(A) A level of care in any institution equivalent to nursing facility services; and

(B) Home and community-based services furnished under a waiver.

(2) An individual whose equity interest exceeds ~~$500,000 (increased by the annual percentage increase in the urban component of the consumer price index beginning in 2011, rounded to the nearest $1,000)~~the amount at DHS Appendix C-1, Schedule VIII(D)(2) is not eligible for long-term care services unless one of the following circumstances applies:

(A) The individual has a spouse who is lawfully residing in the individual's home;

(B) The individual has a child under the age of twenty-one (21) who is lawfully residing in the individual's home;

(C) The individual has a child of any age who is blind or permanently and totally disabled who is lawfully residing in the individual's home; or

(D) The denial would result in undue hardship. Undue hardship exists when denial of SoonerCare long-term care services based on an individual's home equity exceeding ~~$500,000~~the amount at DHS Appendix C-1, Schedule VIII(D)(2) would deprive the individual of medical care such that the individual's health or life would be endangered; or of food, clothing, shelter, or other necessities of life.

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

(3) Absence from home due to ~~nursing facility~~NF care does not affect the home exclusion as long as the individual intends to return home within ~~12~~twelve (12) months from the time he/she entered the facility. The ~~OKDHS~~DHS Form 08MA010E, Acknowledgment of Temporary Absence/Home Property Policy, is completed at the time of application for ~~nursing facility~~NF care when the applicant has home property. After an explanation of temporary absence, the member, guardian, or responsible person indicates whether there is or is not intent to return to the home and signs the form.

(A) If at the time of application the applicant states he/she does not have plans to return to the home, the home property is considered a countable resource. For members in nursing facilities, a lien may be filed in accordance with ~~OAC~~Oklahoma Administrative Code (OAC) 317:35-9-15 and OAC 317:35-19-4 on any real property owned by the member when it has been determined, after notice and opportunity for a hearing, that the member cannot reasonably be expected to be discharged and return home. However, a lien is not filed on the home property of the member while any of the persons described in OAC 317:35-9-15(b)(1) and OAC 317:35-19-4(b)(1) are lawfully residing in the home:

(B) If the individual intends to return home, he/she is advised that:

(i) the ~~12~~twelve (12) months of home exemption begins effective with the date of entry into the ~~nursing home~~NF regardless of when application is made for SoonerCare benefits, and

(ii) after ~~12~~twelve (12) months of nursing care, it is assumed there is no reasonable expectation the member will be discharged from the facility and return home and a lien may be filed against real property owned by the member for the cost of medical services received.

(C) "Intent" in regard to absence from the home is defined as a clear statement of plans in addition to other evidence and/or corroborative statements of others.

(D) At the end of the ~~12-month~~twelve-month (12-month) period the home property becomes a countable resource unless medical evidence is provided to support the feasibility of the member to return to the home within a reasonable period of time (~~90~~ninety (90) days). This ~~90-day~~ninety-day (90-day) period is allowed only if sufficient medical evidence is presented with an actual date for return to the home.

(E) A member who leaves the ~~nursing facility~~NF must remain in the home at least three (3) months for the home exemption to apply if he/she has to re-enter the facility.

(F) However, if the spouse, minor child under ~~21~~twenty-one (21), or child who is blind or permanently disabled resides in the home during the individual's absence, the home continues to be exempt as a resource so long as the spouse, minor child, or child who is blind or permanently disabled lives there (regardless of whether the absence is temporary).

(G) Once a lien has been filed against the property of an NF resident, the property is no longer considered as a countable resource.

(b) **Promissory notes, loans, or mortgages**. The rules regarding the treatment of funds used to purchase a promissory note, loan, or mortgage on or after February 8, 2006, are found in (1) through (2) of this subsection.

(1) Funds used to purchase a promissory note, loan, or mortgage on or after February 8, 2006, are treated as assets transferred, and the value of such note, loan, or mortgage shall be the amount of the outstanding balance due on the note, loan, or mortgage as of the date of the individual's application for medical assistance unless the note, loan, or mortgage meets all of the conditions in paragraphs (A) through (C) of this paragraph.

(A) The note, loan, or mortgage has a repayment term that is actuarially sound (as determined in accordance with actuarial publications of the Office of the Chief Actuary of the United States Social Security Administration).

(B) The note, loan, or mortgage provides for payments to be made in equal amounts during the term of the loan, with no deferral and no balloon payments made.

(C) The note, loan, or mortgage prohibits the cancellation of the balance upon the death of the lender.

(2) Funds used to purchase a promissory note, loan, or mortgage for less than its fair market value are treated as assets

transferred for less than fair market value regardless of whether:

(A) The note, loan, or mortgage was purchased before February 8, 2006; or

(B) The note, loan, or mortgage was purchased on or after February 8, 2006, and the conditions described in paragraph (1) of this subsection were met.

(c) **Annuities**. Treatment of annuities purchased on or after February 8, 2006.

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

(A) ~~in~~In the first position for at least the total amount of medical assistance paid on behalf of the institutionalized individual; or

(B) ~~in~~In the second position after the community spouse, child under ~~21~~twenty-one (21) years of age, or disabled child and is named in the first position if the spouse or a representative of the child disposes of any such remainder for less than fair market value.

(2) For purposes of determining financial eligibility for long-term care services under this chapter, the term "assets" shall include an annuity purchased by or on behalf of an annuitant who has applied for SoonerCare ~~nursing facility~~NF services or other long-term care services unless the annuity meets one (1) of the following conditions.

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

(B) The annuity is purchased with proceeds from:

(i) An account or trust described in subsection (a), (c), or (p) of Section 408 of the United States Internal Revenue Code of 1986;

(ii) A simplified employee pension as defined in Section 408(k) of the United States Internal Revenue Service Code of 1986; and/or

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

(C) The annuity:

(i) is irrevocable and nonassignable;

(ii) is actuarially sound as determined in accordance with actuarial publications of the Office of the Chief Actuary of the United States Social Security Administration; and

(iii) provides for payments in equal amounts during the term of the annuity, with no deferral and no balloon payments made.

(d) **Life Estates**. This subsection pertains to the purchase of a life estate in another individual's home.

(1) The entire amount used to purchase a life estate in another individual's home on or after February 8, 2006, is treated as assets transferred for less than fair market value, unless the purchaser resides in the home for at least one (1) year after the date of the purchase.

(2) Funds used to purchase a life estate in another individual's home for less than its fair market value are treated as assets transferred for less than fair market value regardless of whether:

(A) The life estate was purchased before February 8, 2006; or

(B) The life estate was purchased on or after February, 8, 2006, and the purchaser resided in the home for one (1) year after the date of purchase.

(e) **Oklahoma Long-Term Care Partnership (LTCP) Program.** This subsection pertains to individuals with Oklahoma Long-Term Care Partnership policies. The Oklahoma Insurance Department approves long-term care insurance policies as Long-term Care Partnership Program policies. The face page of the policy document will indicate if the insurance qualifies as a Long-Term Care Partnership Program policy.

(1) Benefits from the LTCP policy must be exhausted before the individual can be eligible for long-term care under the SoonerCare program.

(2) Assets in an amount equal to the amount paid out under the LTCP policy can be protected for the insured individual once the LTCP policy benefits are exhausted. Protected assets are disregarded when determining eligibility for the SoonerCare program per ~~317:35-5-41.9(26)~~OAC 317:35-5-41.9(b)(26). A record of the amount paid on behalf of the policy holder is available through the ~~OHCA~~Oklahoma Health Care Authority or insurance company holding the LTCP policy.

(A) At the time of application for SoonerCare the individual must determine the asset(s) to be protected. The protected asset(s) cannot be changed. If the value of the protected asset(s) decreases, the individual does not have the option to select additional assets to bring the total up to the protected amount.

(B) If the protected asset(s) are income-producing, the income earned while on SoonerCare is counted in accordance with 317:35-5-42.

(C) The individual can choose to transfer the protected asset without incurring a transfer of assets penalty.

(D) When determining resource eligibility for a couple when one of them enters the nursing home or applies for a HCBS

waiver, the LTCP protected asset(s) are disregarded in determining the total amount of the couple's resources.

317:35-5-41.9. ~~Resource disregards~~Exclusions from resources

~~In determining need, the following are not considered as resources:~~

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

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

~~(3) Education 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 Loan Verification form is 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 Loan Verification form 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) Indian payments or items purchased from 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 the funds after distribution is considered as any other income. Funds and property held in Individual Indian Money (IIM) Accounts are treated as a converted resource and disregarded for purposes of~~

~~eligibility. Disbursements of funds from IIM accounts are to be disregarded as a resource in the month in which the disbursement was made. However, any retained disbursed funds are counted as a resource for purposes of eligibility on the first of the month following the month of disbursement;~~

~~(6) Special allowance for school expenses made available upon petitions (in writing) from funds held in trust for the student;~~

~~(7) Benefits from State and Community Programs on Aging (Title III) are disregarded. Income from the Older American Community Service Employment Act (Title V), including AARP and Green Thumb organizations as well as employment positions allocated at the discretion of the Governor of Oklahoma, is counted as earned income. Both Title III and Title V are under the Older Americans Act of 1965 amended by PL 100-175 to become the Older Americans Act amendments of 1987;~~

~~(8) Payments 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 Services Corps of Retired Executives (SCORE) and Active Corps of Executives (ACE);~~

~~(9) Payment 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;~~

~~(10) The value of supplemental food assistance received under the Child Nutrition Act or the special food services program for children under the National School Lunch Act;~~

~~(11) 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;~~

~~(12) 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;~~

~~(13) 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.);~~

~~(14) 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;~~

~~(15) 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;~~

~~(16) Interests of individual Indians in trust or restricted lands;~~
~~(17) Resources 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 resources 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;~~
~~(18) Payments made to individuals because of their status as victims of Nazi persecution (PL 103-286);~~
~~(19) A migratory farm worker's out-of-state homestead is disregarded if the farm worker's intent is to return to the homestead after the temporary absence;~~
~~(20) 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;~~
~~(21) Dedicated bank accounts established by representative payees to receive and maintain retroactive SSI benefits for disabled/blind children up to the legal age of 18. The dedicated bank account must be in a financial institution, the sole purpose of which is to receive and maintain SSI underpayments which are required or allowed to be deposited into such an account. The account must be set up and verification provided to SSA before the underpayment can be released;~~
~~(22) 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. Payments are not considered as income or resources. A penalty cannot be assessed against the individual if he/she disposes of part or all of the payment. The rules at OAC 317:35-5-41.6 regarding the availability of a trust do not apply if an individual establishes a trust using the settlement payment;~~
~~(23) Payments made to certain Vietnam veterans' children with spina bifida (PL 104-204);~~
~~(24) Payments made to certain Korea service veterans' children with spina bifida (PL 108-183);~~
~~(25) Payments made to the children of women Vietnam veterans who suffer from certain birth defects (PL 106-419);~~
~~(26) For individuals with an Oklahoma Long-Term Care Partnership Program approved policy, resources equal to the amount of benefits paid on the insured's behalf by the long-term care insurer are disregarded at the time of application~~

~~for long-term care services provided by SoonerCare. The Oklahoma Insurance Department approves policies as Long-term Care Partnership Program policies;~~

~~(27) Workers' Compensation Medicare Set Aside Arrangements (WCMSAs), which allocate a portion of the workers' compensation settlement for future medical expenses; and~~

~~(28) 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.~~

(a) The following are excluded resources. In order for payments and benefits listed in paragraph (b) and (c) to be excluded from resources, such funds must be segregated and not commingled with other countable resources so that the excludable funds are identifiable.

(b) Resources excluded by the Social Security Act, in accordance with Section 416.1210 of Title 20 of the Code of Federal Regulations (C.F.R.), unless otherwise noted:

(1) The home that is the principal place of residence, as described at Oklahoma Administrative Code (OAC) 317:35-5-41.1;

(2) Household goods and personal effects, as described at OAC 317:35-5-41(a)(5);

(3) One automobile, as described at OAC 317:35-5-41.3;

(4) Property essential to self-support:

(A) Property of a trade or business which is essential to the means of self-support, as described at OAC 317:35-5-41.12(c);

(B) Nonbusiness property used to produce goods or services essential to self-support, as described at OAC 317:35-5-41.12(c);

(C) Nonbusiness income producing property, as described at OAC 317:35-5-41.12(c);

(5) Resources of a blind or disabled individual which are necessary to fulfill an approved plan for achieving self-support;

(6) Stock in regional or village corporations held by natives of Alaska during the twenty-year (20-year) period in which the stock is inalienable pursuant to the Alaska Native Claims Settlement Act;

(7) Life insurance policies, as described at OAC 317:35-5-41.2(b);

(8) Restricted allotted Indian lands;

(9) Disaster relief assistance provided under Federal law or by state or local government;

(10) Burial spaces, as described at OAC 317:35-5-41.2(c);

(11) Burial funds, as described at OAC 317:35-5-41.2(d);

(12) Irrevocable burial contracts as described at OAC 317:35-5-41.2(e);
(13) Supplemental Security Income (SSI) and Social Security retroactive payments for nine (9) months following the month of receipt;
(14) Housing assistance paid pursuant to:
(A) The United States Housing Act of 1937;
(B) The National Housing Act;
(C) Section 101 of the Housing and Urban Development Act of 1965;
(D) Title V of the Housing Act of 1949;
(E) Section 202(h) of the Housing Act of 1959;
(15) Refunds of Federal income taxes and advances made by an employer relating to an earned income tax credit for nine (9) months following the month of receipt;
(16) Payments received as compensation for expenses incurred or losses suffered as a result of a crime;
(17) Relocation assistance for nine (9) months beginning with the month following the month of receipt. The assistance must be provided by a State or local government that is comparable to assistance provided under Title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 that is subject to the treatment required by Section 216 of that Act;
(18) Money in a dedicated account for SSI-eligible individuals under age eighteen (18) that is required by 20 C.F.R. § 416.640(e);
(19) Gifts to children under age eighteen (18) with life-threatening conditions from an organization described at 26 United States Code (U.S.C.) § 501(c)(3) that is exempt from taxation under 26 U.S.C. § 501(a);
(20) Restitution of Social Security, SSI, or a Special Benefit for World War II Veterans made because of misuse by a representative payee, for nine (9) months following the month of receipt;
(21) Any portion of a grant, scholarship, fellowship, or gift used or set aside for paying tuition, fees, or other necessary educational expenses, for nine (9) months beginning the month after the month of receipt;
(22) Payment of a refundable child tax credit for nine (9) months following the month of receipt;
(23) Any annuity paid by a State to a person (or his or her spouse) based on the State's determination that the person is:
(A) A veteran (as defined in 38 U.S.C. § 101); and
(B) Blind, disabled, or aged;
(24) The principal and income of trusts complying with OAC 317:35-5-41.6(6). See also 42 U.S.C. § 1396p(d)(4);

(25) Workers' Compensation Medicare Set Aside Arrangements (WCMSAs) which allocate a portion of the workers' compensation settlement for future medical expenses; and/or

(26) For individuals with an Oklahoma Long-Term Care Partnership Program approved policy, resources equal to the amount of benefits paid on the insured's behalf by the long-term care insurer. Said disregard is made at the time of application for long-term care services provided by SoonerCare. The Oklahoma Insurance Department approves policies as Long-term Care Partnership Program policies.

(c) Resources excluded by federal laws other than the Social Security Act, in accordance with 20 C.F.R. § 416.1236, unless otherwise noted:

(1) Funds and interest held in an Achieving a Better Life Experience (ABLE) account, pursuant to 26 U.S.C. § 529A:

(A) A contribution to an ABLE account by another individual is neither income nor a resource to the individual with the ABLE account, unless such contribution exceeds the annual federal gift tax exclusion established by 26 U.S.C. § 2503(b), in which case, any contribution in excess of the annual federal gift tax exclusion is a countable resource and income in the month deposited.

(B) A distribution from an ABLE account that is retained after the month of receipt is neither income nor a resource to the individual in any month when spent on a qualified disability expense (QDE).

(C) A QDE is any expense related to the blindness or disability of the individual and made for the benefit of the individual. QDE's include but are not limited to:

(i) Education;

(ii) Housing;

(iii) Transportation;

(iv) Employment training and support;

(v) Assistive technology;

(vi) Health;

(vii) Prevention and wellness;

(viii) Financial management and administrative services;

(ix) Legal fees;

(x) Expenses for ABLE account oversight and monitoring;

(xi) Funeral and burial; and

(xii) Basic living expenses.

(D) A distribution, or portion of a distribution, from an ABLE account that is retained after the month of receipt, and used for a non-QDE in the next or subsequent month, is a countable resource to the individual in the month in which the funds were spent. Any unspent portion of the

distribution the individual continues to retain is not a countable resource.

(E) A distribution, or portion of a distribution, from an ABLE account that is received and used for a non-QDE in the same month, is considered unearned income to the individual in the month of receipt. Any unspent portion of the distribution the individual retains after the month of receipt is not a countable resource;

(2) Payments made under Title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (84 Stat. 1902, 42 U.S.C. § 4636);

(3) Payments made to Native Americans as listed in paragraphs (b) and (c) of section IV of the Appendix to Subpart K of Part 416 of C.F.R. Title 20;

(4) Indian judgment funds held in trust by the Secretary of the Interior or distributed per capita pursuant to a plan prepared by the Secretary of the Interior and not disapproved by a joint resolution of the Congress under Public Law 93-134, as amended by Public Law (Pub.L.) 97-458 (25 U.S.C. § 1407). Indian judgment funds include interest and investment income accrued while the funds are so held in trust. This exclusion extends to initial purchases made with Indian judgment funds, but will not apply to proceeds from sales or conversions of initial purchases or to subsequent purchases;

(5) Supplemental Nutrition Assistance Program benefits;

(6) The value of assistance to children under the National School Lunch Act (60 Stat. 230, 42 U.S.C. §§ 1751 et seq.) as amended by Pub.L. 90-302 [82 Stat. 117, 42 U.S.C. § 1761 (h)(3)];

(7) The value of assistance to children under the Child Nutrition Act of 1966 [80 Stat. 889, 42 U.S.C. § 1780(b)];

(8) Any grant or loan to any undergraduate student for educational purposes made or insured under any program administered by the Commissioner of Education as provided by section 507 of the Higher Education Amendments of 1968, Pub.L. 90-575 (82 Stat. 1063);

(9) Incentive allowances received under Title I of the Comprehensive Employment and Training Act of 1973 [87 Stat. 849, 29 U.S.C. § 821(a)];

(10) Compensation provided to volunteers by the Corporation for National and Community Service (CNCS), unless determined by the CNCS to constitute the minimum wage in effect under the Fair Labor Standards Act of 1938 (29 U.S.C. §§ 201 et seq.) or applicable State law, pursuant to 42 U.S.C. § 5044(f)(1). Programs include:

(A) AmeriCorps;

(B) Special and demonstration volunteer programs;

(C) University year for ACTION;
(D) Retired senior volunteer program;
(E) Foster grandparents program; and
(F) Senior companion program;
(11) Distributions received by an individual Alaska Native or descendant of an Alaska Native from an Alaska Native Regional and Village Corporation pursuant to the Alaska Native Claims Settlement Act, as follows: cash, including cash dividends on stock received from a Native Corporation, is disregarded to the extent that it does not, in the aggregate, exceed two-thousand ($2,000) per individual each year [the $2,000 limit is applied separately each year, and cash distributions up to $2,000 which an individual received in a prior year and retained into subsequent years will not be counted as resources in those years]; stock, including stock issued or distributed by a Native Corporation as a dividend or distribution on stock; a partnership interest; land or an interest in land, including land or an interest in land received from a Native Corporation as a dividend or distribution on stock; and an interest in a settlement trust. This exclusion is pursuant to the exclusion under section 15 of the Alaska Native Claims Settlement Act Amendments of 1987, Pub.L. 100-241 [43 U.S.C. § 1626(c)], effective February 3, 1988;
(12) Value of Federally donated foods distributed pursuant to section 32 of Pub.L. 74–320 or section 416 of the Agriculture Act of 1949 [7 C.F.R. § 250.6(e)(9) as authorized by 5 U.S.C. § 301];
(13) All funds held in trust by the Secretary of the Interior for an Indian tribe and distributed per capita to a member of that tribe under Pub.L. 98-64;
(14) Home energy assistance payments or allowances under the Low-Income Home Energy Assistance Act of 1981, as added by Title XXVI of the Omnibus Budget Reconciliation Act of 1981, Pub.L. 97-35 [42 U.S.C. § 8624(f)];
(15) Student financial assistance for attendance costs received from a program funded in whole or in part under Title IV of the Higher Education Act of 1965, as amended, or under Bureau of Indian Affairs (BIA) Student assistance programs if it is made available for tuition and fees normally assessed a student carrying the same academic workload, as determined by the institution, including costs for rental or purchase of any equipment, materials, or supplies required of all students in the same course of study; and an allowance for books, supplies, transportation, and miscellaneous personal expenses for a student attending the institution on at least a half-time basis, as determined by the institution, under section 14(27) of Pub.L. 100-50, the Higher Education Technical Amendments Act of 1987

(20 U.S.C. § 1087uu) or under BIA student assistance programs. This includes, but is not limited to:

(A) Pell grants;

(B) Student services incentives;

(C) Academic achievement incentive scholarships;

(D) Byrd scholars;

(E) Federal supplemental education opportunity grants;

(F) Federal educational loans (federal PLUS loans, Perkins loans, Stafford loans, Ford loans, etc.);

(G) Upward Bound;

(H) GEAR UP (Gaining Early Awareness and Readiness for Undergraduate Programs);

(I) State educational assistance programs funded by the leveraging educational assistance programs; and

(J) Work-study programs;

(16) Amounts paid as restitution to certain individuals of Japanese ancestry and Aleuts under the Civil Liberties Act of 1988 and the Aleutian and Pribilof Islands Restitution Act, sections 105(f) and 206(d) of Pub.L. 100-383 (50 U.S.C. app. 1989 b and c);

(17) Payments made on or after January 1, 1989, 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.) under Pub.L. 101-201 (103 Stat. 1795) and section 10405 of Pub.L. 101-239 (103 Stat. 2489);

(18) Payments made under section 6 of the Radiation Exposure Compensation Act, Pub.L. 101-426 (104 Stat. 925, 42 U.S.C. § 2210);

(19) Payments made to individuals because of their status as victims of Nazi persecution excluded pursuant to section 1(a) of the Victims of Nazi Persecution Act of 1994, Pub.L. 103-286 (108 Stat. 1450);

(20) Any matching funds and interest earned on matching funds from a demonstration project authorized by Pub.L. 105-285 that are retained in an Individual Development Account, pursuant to section 415 of Pub.L. 105-285 (112 Stat. 2771);

(21) Any earnings, Temporary Assistance for Needy Families matching funds, and accrued interest retained in an Individual Development Account, pursuant to section 103 of Pub.L. 104-193 [42 U.S.C. § 604(h)(4)];

(22) Payments made to individuals who were captured and interned by the Democratic Republic of Vietnam as a result of participation in certain military operations, pursuant to section 606 of Pub.L. 105-78 and section 657 of Pub.L. 104-201 (110 Stat. 2584);

(23) Payments made to certain Vietnam veteran's children with spina bifida, pursuant to section 421 of Pub.L. 104-204 [38 U.S.C. § 1805(d)];
(24) Payments made to the children of women Vietnam veterans who suffer from certain birth defects, pursuant to section 401 of Pub.L. 106-419, [38 U.S.C. § 1833(c)];
(25) Assistance provided for flood mitigation activities under section 1324 of the National Flood Insurance Act of 1968, pursuant to section 1 of Public Law 109-64 (119 Stat. 1997, 42 U.S.C. § 4031); and/or
(26) Payments made to individuals under the Energy Employees Occupational Illness Compensation Program Act of 2000, pursuant to section 1, app. [Div. C. Title XXXVI section 3646] of Public Law 106-398 (114 Stat. 1654A-510, 42 U.S.C. § 7385e).

317:35-5-41.12. Real or personal property essential to self-support

(a) This rule describes exclusions when real or personal property is essential to an individual's means of self-support.
(b) Categories of property essential to self-support.
(1) Property used in a trade or business; property used by an individual as an employee for work; or government permits that represent authority granted by a government agency to engage in an income-producing activity.
(A) Are excluded as a resource regardless of value or rate of return.
(B) Government permits includes any permit, license, or similar instrument issued by a federal, state, or local government agency.
(C) Personal property used by an employee for work includes farm machinery, tools, safety equipment, uniforms, etc.
(2) Nonbusiness real or personal property used to produce goods or services essential to basic daily living needs:
(A) Up to six-thousand dollars ($6,000) of the equity value is excluded, regardless of rate of return.
(B) Any portion of the property's equity value in excess of six-thousand dollars ($6,000) is a countable resource.
(C) Nonbusiness property used to produce goods or services includes, but is not limited to:
(i) Growing produce or livestock solely for personal consumption in the individual's household or performing activities essential to the production of food solely for home consumption.
(ii) Timber lots, wood splitters, and other tools used to produce firewood solely for use in the applicant's or recipient's home.
(3) Nonbusiness income-producing property.

(A) Up to six-thousand dollars ($6,000) of the equity value is excluded as a resource if the property produces a net annual return equal to at least six percent (6%) of the excluded equity.

(B) Any portion of the property's equity value in excess of six-thousand dollars ($6,000) is a countable resource.

(C) If the property produces less than a six percent (6%) return, the exclusion can only apply if the lower return is for reasons beyond the individual's control and there is a reasonable expectation that the property will again produce a six percent (6%) return. Otherwise, none of the equity value is excluded under this section.

(D) If the earnings decline was for reasons beyond the individual's control, up to twenty-four (24) months can be allowed for the property to resume producing a six percent (6%) return. The twenty-four (24) month period begins with the first day of the tax year following the one in which the return dropped to below six percent (6%).

(E) If the tax return shows that the activity has operated at a loss for the two (2) most recent years or longer, the property cannot be excluded unless the individual submits current receipts and records to show that it currently is producing a six percent (6%) return.

(F) If an individual owns more than one (1) piece of income-producing property, the six percent (6%) return requirement applies individually to each property and the six-thousand dollar ($6,000) equity value limit applies to the total equity value of all the properties meeting the six percent (6%) return requirement.

(G) If all properties meet the six percent (6%) test but the total equity value exceeds six-thousand dollars ($6,000), that portion of the total equity value in excess of six-thousand dollars ($6,000) is a countable resource.

(c) For any of the exclusions to apply, the property must be in current use in the type of activity that qualifies it as essential.

(d) Property not in current use. If the property is not in current use, it must be for reasons beyond the individual's control and there must be a reasonable expectation that the use will resume within twelve (12) months of last use.

(1) Property not in current use can be excluded for twelve (12) months as essential for self-support if it has been in use and there is reasonable expectation that the use will resume. The individual must provide a signed statement of last date of use, reason the property is not in use, and when the individual expects to resume the self-support activity.

(2) If an individual alleges that self-support property is not in current use because of a disabling condition of the

individual, the individual must provide a signed statement of the nature of the condition, the date the individual ceased the self-support activity, and when the individual intends to resume activity to receive up to an additional twelve (12) months.

(3) If the individual does not intend to resume the self-support activity, the property is a countable resource in the month after the month of last use.

(4) If, after property has been excluded because an individual intends to resume self-support activity, the individual decides not to resume such activity, the exclusion ceases to apply as of the date of the change of intent. The property is a resource in the following month.

(e) Individual responsibilities. The individual shall:

(1) Provide a copy of the tax return for the tax year prior to application or renewal to be used to determine the net income earned for the individual from the income-producing property.

(2) Provide pertinent documents and a signed statement if the individual alleges owning a government license, permit, or other property that represents government authority to engage in an income-producing activity, and has value as a resource. The statement shall include:

(A) The type of license, permit, or other property;

(B) The name of the issuing agency, if appropriate;

(C) Whether the law requires such license, permit, or property for engaging in the income-producing activity at issue; and

(D) How the license, permit, or other property is being used; or

(E) Why it is not being used.

(3) Provide a signed statement if the individual alleges owning items used in his or her work as an employee. The statement shall include:

(A) The name, address, and telephone number of the employer;

(B) A general description of the items;

(C) A general description of the individual's duties; and

(D) Whether the items are currently being used.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY

CHAPTER 2. GRIEVANCE PROCEDURES AND PROCESS

317:2-1-2. Appeals

(a) **Request for Appeal.**

(1) For the purpose of calculating the timeframe for requesting an administrative appeal of an agency action, the date on the written notice shall not be included. The last day of the thirty-day (30-day) timeframe shall be included, unless it is a legal holiday as defined by 25 Oklahoma Statutes (O.S.) § 82.1, or any other day the Oklahoma Health Care Authority (OHCA) is closed or closes early, in which case, the timeframe runs until the close of the next full business day.

(2) An appeals request that an aggrieved member or provider sends via mail is deemed filed on the date that the agency receives it.

~~(a)~~(b) **Member Process Overview.**

(1) The appeals process allows a member to appeal a decision relating to program benefits. Examples are decisions involving medical services, prior authorizations for medical services, or discrimination complaints.

(2) In order to ~~file~~initiate an appeal, the member ~~files~~must file a LD-1 (Member Complaint/Grievance Form) within ~~twenty (20)~~thirty (30) calendar days of the ~~triggering event. The triggering event occurs at the time when the member (the "Appellant") knew or should have known the facts or circumstances serving as the basis for an appeal~~date the OHCA sends written notice of its action, in accordance with Oklahoma Administrative Code (OAC) 317:2-1-2(a), above, or, in matters in which a formal notice is not sent by the agency, within thirty (30) days of the date on which the member knew or should have known the facts or circumstances serving as the basis for appeal.

(3) If the LD-1 form is not received ~~within twenty (20) days of the triggering event~~timely, ~~OHCA~~the Administrative Law Judge (ALJ) will cause to be issued a letter stating the appeal will not be heard ~~because it is untimely~~. In the case of tax warrant intercept appeals, if the LD-1 form is not received by OHCA within the timeframe pursuant to ~~Title 68 Oklahoma Statutes, Sec. 205.2~~68 O.S. § 205.2, OHCA similarly will cause to be issued a letter stating the appeal will not be heard because it is untimely.

(4) If the LD-1 form is not completely filled out or if necessary documentation is not included, then the appeal will not be heard.

(5) OHCA will advise members that if assistance is needed in

reading or completing the grievance form, arrangements will be made to provide such assistance.

(6) Upon receipt of the member's appeal, a fair hearing before the ~~Administrative Law Judge (ALJ)~~ALJ will be scheduled. The member will be notified in writing of the date and time of the hearing. The member must appear at the hearing, either in person or telephonically. Requests for a telephone hearing must be received in writing on OHCA's LD-4(Request for Telephonic Hearing) form no later than ten (10) calendar days prior to the scheduled hearing date. Telephonic hearing requests will only be granted by the OHCA's Chief Executive Officer (CEO) or his/her designee, at his/her sole discretion, for good cause shown, including, for example, the member's physical condition, travel distances, or other limitations that either preclude an in-person appearance or would impose a substantial hardship on the member.

(7) The hearing shall be conducted according to OAC 317:2-1-5. The ALJ's decision may be appealed to the CEO of the OHCA, which is a record review at which the parties do not appear (OAC 317:2-1-13).

(8) Member appeals are ordinarily decided within ninety (90) days from the date on which the member's timely request for a fair hearing is received, unless, in accordance with ~~42 Code of Federal Regulations, Sec. 431.244(f)~~Section 431.244(f) of Title 42 of the Code of Federal Regulations:

(A) The Appellant was granted an expedited appeal pursuant to ~~OAC 317:2-1-2.4~~OAC 317:2-1-2.5;

(B) OHCA cannot reach a decision because the Appellant requests a delay or fails to take a required action, as reflected in the record; or

(C) There is an administrative or other emergency beyond OHCA's control, as reflected in the record.

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

~~(b)~~(c) **Provider Process Overview.**

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

(2) All provider appeals are initially heard by the OHCA ALJ under ~~OAC 317:2-1-2(c)(2)~~OAC 317:2-1-2(d)(2).

(A) In order to initiate an appeal, ~~A~~a provider ~~who wants to contest an adverse OHCA determination (the "Appellant") must initiate an appeal by filing with OHCA the proper~~must file the appropriate LD form within ~~twenty (20)~~thirty (30) calendar days of the date ~~of~~the OHCA sends written notice of

~~an adverse determination or other~~its action ~~taken by OHCA~~, in accordance with OAC 317:2-1-2(a), above. LD-2 forms should be used for Program Integrity audit appeals; LD-3 forms are to be used for all other provider appeals.

(B) Except for OHCA Program Integrity audit appeals, ~~If~~if the appropriate LD form is not received ~~within twenty (20) days of the date of notice~~timely, ~~OHCA~~the ALJ will cause a letter to be issued stating that the appeal will not be heard ~~because it is untimely~~.

(C) A decision ordinarily will be issued by the ALJ within forty-five (45) days of the close of all evidence in the appeal.

(D) Unless otherwise limited by OAC 317:2-1-7 or 317:2-1-13, the ALJ's decision is appealable to OHCA's CEO.

~~(c)~~(d) **ALJ jurisdiction.** The ALJ has jurisdiction of the following matters:

(1) **Member Appeals.**

(A) Discrimination complaints regarding the SoonerCare program;

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

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

(D) Appeals which relate to the tax warrant intercept system through the OHCA. Tax warrant intercept appeals will be heard directly by the ALJ. A decision will be rendered by the ALJ within twenty (20) days of the hearing;

(E) Proposed administrative sanction appeals pursuant to OAC 317:35-13-7. Proposed administrative sanction appeals will be heard directly by the ALJ. A decision by the ALJ will ordinarily be rendered within twenty (20) days of the hearing before the ALJ. This is the final and only appeals process for proposed administrative sanctions;

(F) Appeals which relate to eligibility determinations made by OHCA; and

(G) Appeals of insureds participating in Insure Oklahoma which are authorized by OAC 317:45-9-8~~(a); and~~.

(2) **Provider Appeals.**

(A) Whether Pre-admission Screening and Resident Review (PASRR) was completed as required by law;

(B) Denial of request to disenroll member from provider's SoonerCare Choice panel;

(C) Appeals by Long Term Care facilities for administrative penalty determinations as a result of findings made under OAC 317:30-5-131.2(b)(5)(B) and (d)(8);

(D) Appeals of Professional Service Contract awards and other matters related to the Central Purchasing Act pursuant to ~~Title 74 O. S. § 85.1~~Title 74 O.S. § 85.1 et seq.;
(E) Drug rebate appeals;
(F) Provider appeals of OHCA Program Integrity audit findings pursuant to OAC 317:2-1-7. This is the final and only appeals process for appeals of OHCA Program Integrity audit findings;
(G) Oklahoma Electronic Health Records Incentive program appeals related only to incentive payments, incentive payment amounts, provider eligibility determinations, and demonstration of adopting, implementing, upgrading, and meaningful use eligibility for incentives;
(H) Supplemental Hospital Offset Payment Program (SHOPP) annual assessment, Supplemental Payment, fees or penalties as specifically provided in OAC 317:2-1-15; and
(I) The Nursing Facility Supplemental Payment Program (NFSPP) and its issues consisting of the amount of each component of the Intergovernmental transfer, the Upper Payment Limit payment, the Upper Payment Limit gap, and the penalties specifically provided in OAC 317:30-5-136. This is the final and only process for appeals regarding NFSPP.

317:2-1-6. Other grievance procedures and processes

Other grievance procedures and processes include those set out in Oklahoma Administrative Code (OAC) 317:2-1-7 ~~(Provider Appeals of OHCA Audit Findings)~~(Program Integrity Audit Appeals); ~~317:2-1-8 (Nursing Home Provider Contract Appeals); and~~ OAC 317:2-1-9 (OHCA's Designated Agent's Appeal Process for QIO Services); OAC 317:2-1-10 (Drug Rebate Appeal Process); OAC 317:2-1-11 [Medicaid Drug Utilization Review Board (DUR) Appeal Process]; OAC 317:2-1-12 ~~(For Cause Provider Contract Suspension/Termination Appeals Process)~~(For Cause and Immediate Provider Contract Termination Appeals Process); ~~and~~ OAC 317:2-1-14 (Contract Award Protest Process)~~.~~; and OAC 317:2-1-15 (Supplemental Hospital Offset Payment Program (SHOPP) Appeals).

317:2-1-7. Program Integrity Audit Appeals

All appeals related to audits originating from Program Integrity resulting in overpayments are heard by an Administrative Law Judge (ALJ) pursuant to ~~56 O.S. § 1011.9~~56 Oklahoma Statutes (O.S.) § 1011.9.

(1) If the ~~OHCA~~Oklahoma Health Care Authority (OHCA) determines a provider received an overpayment based upon audit ~~findings~~findings/report issued pursuant to ~~OAC~~Oklahoma Administrative Code (OAC) 317:30-3-2.1, the provider may appeal the audit ~~findings~~findings/report. If a provider elects to

appeal the audit ~~findings~~findings/report, the provider must file its appeal with the OHCA's Legal Docket Clerk, using Form LD-2. The LD-2 must be received by the OHCA Legal Docket Clerk within ~~20~~thirty (30) calendar days of the date of the initial audit ~~findings~~findings/report or within ~~20~~thirty (30) calendar days of the date of the reconsideration audit ~~findings following reconsideration~~findings/report. The computation of time shall be calculated in accordance with ~~12 O.S. § 2006~~OAC 317:2-1-2(a).

(2) The provider must attach a statement to the LD-2 that specifies what findings and/or claims are being appealed, as well as all factual and legal bases for the appeal. The provider shall attach the following to the LD-2 form:

(A) Citations for any statute or rule that the provider contends has been violated;

(B) The provider's name, address, e-mail address, and telephone number;

(C) The name, address, e-mail address, and telephone number of the provider's authorized representative, if any; and

(D) The LD-2 must be signed by the provider or provider's authorized representative.

(i) For purposes of this section, "provider" means the person or entity against whom the overpayment is sought.

(ii) Consistent with Oklahoma rules of practice, an individual provider may appear on his/her own behalf or may be represented by an attorney licensed to practice law within the State of Oklahoma. In the case of an entity, the provider entity must be represented by an attorney licensed to practice within the State of Oklahoma. Attorneys not licensed to practice in Oklahoma must comply with 5 O.S. Art II, Sec. 5, and rules of the Oklahoma Bar Association.

(3) A provider or the provider's authorized representative shall immediately report any change in contact information during the course of the appeal to the OHCA Legal Docket Clerk.

(4) The OHCA, on its own initiative or upon written request of a party, may consolidate or join appeals if to do so will expedite the processing of the appeals and not adversely affect the interest of the parties.

(5) The provider has the burden of proof to prove that the overpayment determination and the errors identified in the audit ~~findings~~findings/report are inaccurate. The provider must prove the relief sought by a preponderance of the evidence standard, as defined by the Oklahoma Supreme Court. In adjudicating an appeal under the preponderance of the evidence standard, the ALJ will examine each piece of evidence for relevance, probative value, and credibility, to determine

whether the fact to be proven is proved by the greater weight of the evidence.

(6) Within approximately ~~45~~forty-five (45) days of receiving the LD-2, the Legal Docket Clerk will schedule a prehearing conference before an ALJ. This period of time is intended to provide the parties an opportunity to settle the dispute prior to the prehearing. Settlement of audit appeals is encouraged and can begin at any time of the audit appeal process between the provider and OHCA's Legal Division. If a settlement is reached, the terms shall be set out in writing and signed by both parties and/or their authorized representatives. Unless otherwise warranted, an Agreed Order setting out the terms of the settlement shall be presented to the ALJ for approval. In limited situations, a settlement may be agreed to be a confidential settlement by the parties and will not be submitted as an Agreed Order to the ALJ. In the case of confidential settlements, the Appellant shall file a motion to dismiss the appeal with prejudice which informs the ALJ that the matter has been settled and that the audit appeal is moot.

(7) Audit appeals which are not settled will commence with a prehearing conference before the assigned ALJ as follows:

(A) The prehearing conference shall be informal, structured by the ALJ, and not open to the public. The ALJ shall record the prehearing conference by digital recording.

(i) Each party shall be notified of the date of the prehearing conference at least ~~30~~thirty (30) calendar days prior to the scheduled prehearing conference.

(ii) Each party shall appear in person or through their authorized representative.

(iii) Witnesses, not including a named party, shall not appear at the prehearing conference. Nor shall any witness testimony be presented at the prehearing conference.

(B) A request for continuance of a prehearing conference can be made up to three (3) business days prior to the scheduled prehearing conference date. A lesser period of time may be permitted for good cause shown. The ALJ shall rule on the request and in no case shall a combination of continuance exceed a total of ~~30~~thirty (30) calendar days except for good cause shown.

(C) Within ~~20~~twenty (20) days prior to the prehearing conference, the Appellant provider shall file a prehearing conference statement with the Legal Docket Clerk and provide a copy to the other party; and within ~~10~~ten (10) days prior to the prehearing conference, the OHCA shall file a prehearing conference statement with the docket clerk and

provide a copy to the other party. Each party's prehearing conference statement shall include:

(i) A brief statement of its case, including a list of stipulations and legal and factual issues to be heard;

(ii) A list of any witnesses who have direct knowledge of the facts surrounding the issues of the appeal and who are expected to be called at the hearing. The list shall include a brief statement of the testimony each witness will offer;

(iii) A list of all exhibits, together with a copy thereof, which each party intends to offer into evidence at the hearing; and

(iv) Any requests for discovery.

(D) At the prehearing conference, the parties shall clarify and isolate the legal and factual issues involved in the audit appeal.

(E) Each party shall be present, on time, and prepared. Failure to do so may result in dismissal of the appeal or other sanctions unless good cause is shown. A prehearing conference shall not be continued if a party fails to be prepared to identify issues, propose witnesses, or provide exhibits, unless the ALJ finds good cause is shown.

(F) Following the prehearing conference, the ALJ shall issue a Scheduling Order setting forth deadlines for parties to complete discovery, submit briefs as directed by the ALJ, submit prehearing motions, and other deadlines as may be needed. The ALJ should attempt to issue the Scheduling Order within two (2) weeks of the prehearing conference. Upon completion of discovery and the submission of any motions or briefs, the ALJ shall issue a Prehearing Order that shall identify all issues to be presented at the hearing; a final list of witnesses to be called by each party; a final list of exhibits to be used by each party; and the hearing date and anticipated duration of the hearing. The Prehearing Order should be filed by the ALJ no later than ~~10~~ten (10) days prior to the hearing.

(8) The ALJ shall:

(A) Limit all decisions, rulings, and orders to matters directly related to the contested overpayment determination resulting from the audit findings issued pursuant to OAC 317:30-3-2.1 and procedural matters set forth within OAC 317:2-1-7;

(B) Hear and rule on pending requests or motions as expeditiously as possible. This includes setting filing and responsive deadlines in accordance with Title 12 of the Oklahoma Statutes and the Rules for District Courts of Oklahoma. To preserve judicial efficiency, a reply to a

response to a motion shall not be filed by a party without leave of Court to do so and such permission shall not be routinely granted;

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

(D) Rule on whether discovery requests and other motions and requests are relevant;

(E) Rule on whether to grant a party's request to depose a witness. To preserve judicial efficiency, depositions shall not be routinely permitted and shall only be permitted by order of the ALJ;

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

(G) Identify and rule on ~~errors~~the specific audit findings being appealed and ~~issues~~ to be heard at the administrative hearing.

(9) As the purpose of the administrative process is to expedite a limited appellate review of the audit findings, the ALJ shall ensure a timely resolution of the appeal. The ALJ shall schedule a hearing within ~~90~~ninety (90) days of the prehearing conference. A party may request a continuance of the hearing by motion, which shall only be permitted if the ALJ finds good cause exists and neither party shall be prejudiced by the continuation.

(10) At the hearing:

(A) Each party shall appear in person or through their authorized representative.

(B) All witnesses must appear in person to provide testimony.

(C) All relevant exhibits provided with and specifically identified in each party's prehearing conference statement or final exhibit list, that have not been objected to or stricken by the ALJ, shall be deemed admissible at the hearing.

(D) Each party ~~is responsible to~~shall provide a sufficient number of copies of its own exhibits at the hearing. This is in addition to any other copies of exhibits that were previously produced prior to the hearing unless otherwise ordered by the ALJ.

(E) The hearing will be limited to one (1) day. Each side will be allowed four (4) hours to present its case-in-chief, which is inclusive of any time needed for cross-examination of witnesses by the opposing party. For good cause shown, the ALJ may increase or decrease the time limit for each party to present its case-in-chief, taking into account the time limits of the entire appeal process.

(11) The ALJ should attempt to make the final hearing decision within 90 days from the date of the hearing. Any appeal of the final order pursuant to 12 O.S. § 951 must be filed with the District Court of Oklahoma County within ~~30~~thirty (30) days.

(A) The following items shall constitute the record on appeal:

(i) all motions and orders filed with the Legal Docket Clerk;

(ii) all exhibits admitted during the hearing; and

(iii) the transcripts of proceedings, if any.

(B) It shall be the duty of the Appellant in any District Court appeal to order a written transcript of proceedings to be used on appeal. The transcript must be ordered within 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.

(12) All orders and settlements are non-precedential decisions.

(13) The prehearing conference, the hearing, and any supplementary hearings or conferences shall be digitally recorded and closed to the public.

(14) The record of the appeal, confidential settlements, and any audio recordings shall remain confidential.

317:2-1-10. Drug Rebate appeal process

The purpose of this Section is to afford a process to both the manufacturer and the state to administratively resolve drug rebate discrepancies. These rules anticipate discrepancies between the manufacturer and ~~OHCA~~the Oklahoma Health Care Authority (OHCA) which would require the manufacturer to pay a higher rebate or a lower rebate. These regulations provide a mechanism for both informal dispute resolution of drug rebate discrepancies between the manufacturer and OHCA and a mechanism for appeals of drug rebate discrepancies between the manufacturer and OHCA.

(1) The process begins at the end of each calendar quarter when the OHCA mails a copy of the State's past quarter's utilization data to the manufacturer. Utilization data and a billing for rebates will be mailed to the manufacturer within ~~60~~sixty (60) days after the end of each quarter. It is this data which dictates the application of the federal drug rebate formula.

(2) Within ~~30~~thirty (30) days from the date utilization data is sent to the manufacturer, the manufacturer may edit state data and resolve data inconsistencies with the state. The manufacturer may utilize telephone conferences, letters and any other mechanism to resolve data inconsistencies in mutual agreement with the state.

(3) Within ~~30~~thirty (30) days after the utilization data is mailed to the manufacturer, the manufacturer may:

(A) pay the same amount as billed by the state with the quarterly utilization date;

(B) pay an amount which differs from the amount billed by the state with the utilization data and send disputed data information;

(C) pay nothing and send no disputed data information;

(D) pay nothing and send disputed data information.

(4) In the event the state receives the rebate amount billed by the 30th day, the dispute ends.

(5) If after ~~30~~thirty (30) days one of the following events occurs, the state will acknowledge the receipt of the correspondence and review the disputed data:

(A) the receipt of an amount lower than that billed to the manufacturer;

(B) the receipt of disputed data.

(6) In the event no disputed data is received and no payment is received, interest will be computed in accordance with the provisions of federal law found at ~~42 U.S.C. Section 1396b(d)(5)~~42 United States Code (U.S.C.) § 1396b(d)(5) and will be compounded upon the amount billed from ~~38~~thirty-eight days after the date utilization data is sent.

(7) In the event a lower amount than billed is paid or in the event disputed data is sent, and no money is received, interest will be computed in accordance with 42 U.S.C. Section 1396b(d)(5) and will be computed from ~~38~~thirty-eight days from the date utilization data is sent to the manufacturer.

(8) Within ~~70~~seventy (70) days from the date utilization data is sent to the manufacturer, the state will make its final informal review of the disputed data. OHCA will mail a second notice to the manufacturer which will include:

(A) receipt of the rebate, if any;

(B) receipt of the dispute;

(C) a statement regarding the interest amount; and

(D) a statement regarding the appeal rights of the manufacturer with a copy of the appeal form.

(9) Within ~~90~~ninety (90) days of the date utilization data is sent to the manufacturer or within ~~20~~thirty (30) days of the date a second notice is mailed to the manufacturer, whichever is sooner, the state or the manufacturer may request a hearing to administratively resolve the matter.

(10) The administrative appeal of drug rebate discrepancies includes:

(A) The appeal process will begin by the filing of a form LD-2 by the manufacturer or OHCA.

(B) The process afforded the parties will be the process found at ~~OAC 317:2-1-2(b) and (c)~~OAC 317:2-1-2(c) and (d).

(C) With respect to the computation of interest, interest

will continue to be computed from the ~~38~~thirty-eight (38) day based upon the policy contained in the informal dispute resolution rules above.

(D) The ~~ALJ's~~Administrative Law Judge's (ALJ) decision will constitute the final administrative decision of the OHCA.

(E) If the decision of the ALJ affirms the decision of OHCA in whole or in part, payment from the manufacturer must be made within ~~30~~thirty (30) days of the decision. If the decision of the ALJ reverses the decision of the OHCA, the OHCA will make such credit or action within ~~30~~(30) days of the decision of the ALJ.

(F) The nonpayment of the rebate by the manufacturer within ~~30~~thirty (30) days after the ALJ's decision will be reported to the Centers for Medicare and Medicaid Services and may be the basis of an exclusion action by the OHCA.

317:2-1-11. Medicaid Drug Utilization Review Board (DUR) appeal process

This Section explains the appeal process, pursuant to ~~63 O.S. §5030.3(B)(Supp. 1999)~~Title 63 Oklahoma Statutes (O.S.) § 5030.3(B), accorded any party aggrieved by a decision of the ~~OHCA~~Oklahoma Health Care Authority (OHCA) Board or ~~Administrator (CEO)~~Chief Executive Officer (CEO) concerning a proposed recommendation of the Medicaid Drug Utilization Review Board (DUR).

(1) The aggrieved party may appeal pursuant to ~~OAC~~Oklahoma Administrative Code (OAC) 317:2-1-2 et seq. (OHCA Appeals).

(2) The Board finds that the prescription of Title 63 O.S. § 5030.3(B) is somewhat contradictory with the functions of the DUR Board. More specifically, in most instances, the DUR Board suggests policies that must be rule made. Rules promulgated by the OHCA Board do not lend to an "individual proceeding notice" as contemplated by Article II of the Oklahoma Administrative Procedures Act, specifically, ~~Title 75 O.S. §309~~Title 75 O.S. § 309. Thus, in instances where the OHCA Board promulgates rules as a result of policy recommendations by the DUR Board, this Board will consider a party aggrieved by these rules to have filed a Petition for Rulemaking under ~~75 O.S. §305~~75 O.S. § 305. In making this interpretation of ~~63 O.S. §5030.1~~63 O.S. § 5030, the Board will not enforce the last sentence of ~~75 O.S. §305~~75 O.S. § 305. In making this interpretation, the Board finds that it is taking two somewhat conflicting provisions, and combining them to effectuate the intent of the legislature - to provide a hearing to those aggrieved by recommendations by the DUR Board and accepted by the OHCA Board.

(3) In instances where the DUR Board makes a recommendation accepted by the Board against an individual provider [for

example, a recommendation under 42 ~~U.S.C.~~United States Code 1396r-8(g)(3)(C)(iii)(IV)], OHCA will provide an individual proceeding under the Oklahoma Administrative Procedures Act.

(4) In any appeal under (1) and (2) of this subsection, the OHCA Board delegates the OHCA ALJ to preside over the above hearing and present the Board with proposed findings of fact and conclusions of law in accordance with Article II of the Administrative Procedures Act. The OHCA Board may accept the ALJ's written decision, reject it, or amend the recommendations.

(5) Appeals filed pursuant to (1) and (2) of this subsection, will be made within ~~20~~thirty (30) days of the OHCA Board's acceptance of the recommendation by the DUR Board.

(6) After Proposed Findings of Fact and Conclusions of Law are presented to the OHCA Board, the Board will have a period of 120 days to issue a final administrative order.

(7) The Agency's Legal Services Division will construct a form called the LD-3, which will be used for parties to file an action under (1) and (2) of this subsection.

317:2-1-12. For cause and immediate provider contract termination appeals process

This section explains the appeals process for providers whose SoonerCare contracts have been terminated by the ~~OHCA~~Oklahoma Health Care Authority (OHCA) for cause.

(1) **~~30~~Thirty (30) day for cause termination.** Pursuant to the terms of all provider contracts with the OHCA, either party may terminate the contract for cause with a ~~30~~thirty (30) day written notice to the other party.

(A) **Notice of proposed termination.** The OHCA will provide notice to the provider of the proposed termination of the provider's contract. The written notice of termination will state:

(i) the reasons for the proposed termination;

(ii) the date upon which the termination will be effective; and

(iii) a statement that the provider has a right to OHCA review prior to the termination of the provider's contract.

(B) **Right to OHCA review prior to termination of provider contract.** Before the provider's contract is terminated, the OHCA will give the provider the opportunity to submit documents and written arguments against the termination of the provider's contract. The provider's written response requesting a review must be submitted within ~~20~~thirty (30) days from the date of the notice. If a written response is not received within ~~20~~thirty (30) days, the notice of

termination will become final and there will be no further right to review or appeal post-termination.

(C) **Notice of termination.**

(i) After the OHCA review of the provider's written response, the OHCA will make a final administrative decision regarding the contract termination.

(ii) Should the OHCA decide that the provider's contract should not be terminated, the provider will be notified in writing of the reasons for the OHCA's decision.

(iii) Should the OHCA make a decision to terminate the provider's contract, the OHCA will send a subsequent notice stating:

(I) the reasons for the decision;

(II) the effective date of the termination of the contract; and

(III) the provider's right to request a post termination panel committee desk review within ~~20~~thirty (30) days of the date of the termination letter.

(2) **Immediate termination.** The OHCA will provide notice to the provider of the termination of the provider's contract. The written notice of termination will state:

(A) the reasons for the proposed termination;

(B) the date upon which the termination will be effective; and

(C) a statement that the provider has a right to appeal the termination of the provider's contract in a post-termination panel committee desk review within ~~20~~thirty (30) days of the date of the termination letter.

(3) **Post-termination panel committee desk review**. After the effective date of the termination of the provider's contract, the provider is entitled to receive a post-termination panel committee desk review. The panel review committee for the OHCA will be comprised of three (3) employees of the OHCA as designated by the Chief Executive Officer or his/her designee. Any OHCA employee who was involved with the underlying investigation of the provider's case for purpose of the termination will not be a panel review committee member. The purpose and scope of the panel committee desk review will be limited to issues raised in the OHCA's letter of termination as the basis of terminating the provider's contract. The panel committee does not have jurisdiction to hear issues not addressed in the termination notice.

(A) The provider must request a panel committee desk review within ~~20~~thirty (30) days of the date of the termination letter. The provider must submit a brief written statement detailing the facts which are refuted by the provider. Any

documentation the provider requests consideration of by the panel review committee must also be submitted with the written statement.

(B) The OHCA may submit any additional documents to the panel committee for the desk review that may contradict the documents submitted by the provider for the purposes of the desk review. Any additional information that OHCA submits to the panel review committee will also be provided to the provider.

(C) The panel review committee will issue a written decision regarding the provider's contract termination approximately ~~60~~sixty (60) days from receipt of the provider's written statement and documentation.

(4) **~~60~~Sixty (60) day without cause termination**. Pursuant to the terms of all provider contracts with the OHCA, either party may terminate the contract without cause with a ~~60~~sixty (60) day written notice to the other party. As such, there is no right to appeal or review of a ~~60~~sixty (60) day contract termination.

317:2-1-13. Appeal to the Chief Executive Officer

(a) The Oklahoma Health Care Authority offers approximately ~~40~~forty (40) different types of administrative appeals. Some of the appeals are appealable to the Chief Executive Officer (CEO) and some are not. The following appeals may be heard by the ~~Chief Executive Officer~~CEO following the decision of an Administrative Law Judge:

(1) Appeals under ~~317:2-1-2(c)(1)(A)~~Oklahoma Administrative Code (OAC)317:2-1-2(d)(1)(A) to ~~(c)(1)(G)~~(d)(1)(G), with the exception of subsection ~~(c)(1)(E)~~(d)(1)(E);

(2) Appeals under ~~317:2-1-2(c)(2)(A)~~OAC 317:2-1-2(d)(2)(A) to ~~(c)(2)(I)~~(d)(2)(I), with the exceptions of subsections ~~(c)(2)(F) and(G)~~(d)(2)(F) and (G); and

(3) Appeals under ~~317:2-1-8 and~~ 317:2-1-10.

(b) Appeals to the ~~Chief Executive Officer~~CEO must be filed with the OHCA within ~~20~~thirty (30) days of the date of the Order, or decision by OHCA.

(c) No new evidence may be presented to the ~~Chief Executive Officer~~CEO.

(d) Appeals to the ~~Chief Executive Officer~~CEO under (a) of this Section may be filed by the provider, member, or agency. The ~~Chief Executive Officer~~CEO will ordinarily render decisions within ~~60~~sixty (60) days of the receipt of the appeal.

317:2-1-14. Contract award protest process

Suppliers who respond to a solicitation issued and awarded by the Authority pursuant to ~~74 Okla. Stat. 85.5 T~~74 Oklahoma Statutes(O.S.) § 85.5 (T) may protest the award of a contract

under such solicitation.

(1) A supplier shall submit written notice to the ~~Director of Legal Operations~~OHCA Legal Division of a protest of an award of a contract by OHCA ~~pursuant to 74 Okla. Stat. 85.5 T~~ within ten (10) business days of contract award. The protest shall state supplier facts and reasons for protest.

(2) The ~~Legal Operations Director~~OHCA Legal Division shall review the supplier's protest and contract award documents. Written notice of the decision ~~by the Legal Operations Director~~ to sustain or deny the supplier's protest will be sent to the supplier within ten (10) business days of receipt of supplier's written notice.

(3) If the ~~Legal Operations Director~~OHCA Legal Division denies the supplier's protest, the supplier may request a hearing to administratively resolve the matter within ~~twenty (20)~~thirty (30) ~~business~~calendar days of receipt of the ~~Legal Operations Director's~~ written denial by filing a form LD-2 with the Docket Clerk.

(4) The process afforded the supplier will be the process found at ~~OAC 317:2-1-2(b)(1)~~Oklahoma Administrative Code 317:2-1-2(c) ~~through (2)(D)~~.

(5) The ~~ALJ's~~Administrative Law Judge's decision will constitute the final administrative decision of the ~~OHCA~~Oklahoma Health Care Authority.

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

In accordance with Oklahoma Administrative Code (OAC) 317:30-5-136, 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 describe those appeal rights.

(1) The following are appealable issues of the program: the assessed amount for each component of the intergovernmental transfer (IGT), the Upper Payment Limit (UPL) payment, the UPL Gap payment, and penalties for the 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 NSGO (appellant is the NSGO who files an appeal) shall file an LD-2 form within ~~twenty (20)~~thirty (30) days from the date of the OHCA letter which advises the NSGO of component of IGT, UPL payment, UPL 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 notice of program reimbursement (NPR) shall be subject to penalty and

suspension from the program. Any applicable penalties 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 SoonerCare payments.
(4) The LD-2 shall only be filed by the NSGO or the NSGO's attorney in accordance with (5) below.
(5) Consistent with Oklahoma rules of practice, the non-state government-owned (NSGO) entity shall be represented by an attorney licensed to practice within the State of Oklahoma. Attorneys not licensed to practice in Oklahoma shall comply with Article II, Section ~~(§)~~ 5 of Title 5 of the Oklahoma Statutes (O.S.), and rules of the Oklahoma Bar Association.
(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.
(7) The appellant has the burden of proof by the preponderance of the evidence standard as defined by the Oklahoma Supreme Court.
(8) The docket clerk will send the appellant and any other necessary party a notice which states the hearing location, date, and time.
(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 ~~Oklahoma Administrative Code 317:30-5-136~~OAC 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.

(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 shall be filed with the District Court of Oklahoma County within ~~30~~thirty (30) days.
(B) It shall be the duty of the 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.

(11) All orders and settlements are non-precedential decisions.
(12) The hearing shall be digitally recorded and closed to the public.
(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 3. GENERAL PROVIDER POLICIES

PART 1. GENERAL SCOPE AND ADMINISTRATION

317:30-3-2.1. Program Integrity Audits/Reviews

(a) This section applies to all contracted providers. The following words and terms, when used in this Section, shall have the following meaning:

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

(2) "**Error Rate"** means the percentage of dollars of audited claims found to be billed in error.

~~(2)~~(3) **"Extrapolation"** means the methodology of estimating an unknown value by projecting, with a calculated precision (i.e., margin of error), the results of a probability sample to the universe from which the sample was drawn.

~~(3)~~(4) **"Probability sample"** means the standard statistical methodology in which a sample is selected based on the theory of probability (a mathematical theory used to study the occurrence of random events).

(5) "**Sample"** means a statistically valid number of claims obtained from the universe of claims audited/reviewed.

~~(4)~~(6) "**Universe"** means all paid claims or types of paid claims audited/reviewed during a specified timeframe.

~~(5) "**Sample"** means a statistically valid number of claims obtained from the universe of claims audited/reviewed.~~

~~(6) "**Error Rate"** means the percentage of dollars of audited claims found to be billed in error.~~

(b) An OHCA audit/review includes an examination of provider records, by either an on-site or desk audit. Claims may be examined for compliance with provider contracts and/or relevant Federal and State laws and regulations, as well as for practices indicative of fraud, waste, and/or abuse of the SoonerCare program, including, but not limited to, inappropriate coding and consistent patterns of overcharging.

(c) An initial audit/review report contains preliminary findings. Within ~~twenty (20)~~thirty (30) calendar days of the date of notice regarding the audit/review report, a provider may elect to:

(1) Remit the identified overpayment to the OHCA;

(2) Request informal reconsideration of the initial audit report ~~per~~pursuant to ~~OAC 317:30-3-2.1(d)~~Oklahoma Administrative Code (OAC) 317:30-3-2.1(d); or

(3) Request a formal appeal of the initial audit report ~~per~~pursuant to OAC 317:30-3-2.1(e).

(d) If a provider requests an informal reconsideration, the provider, within ~~twenty (20)~~thirty (30) calendar days of the date of notice of the audit/review report, shall:

(1) Produce any and all written existing documentation that is relevant to, and could reasonably be used to clarify or rebut, the findings ~~as~~ identified in the initial report. Documents submitted for reconsideration shall not be altered or created for purposes of the audit; and

(2) Specifically identify those claims and findings to be reviewed for reconsideration. Any claims or findings not specifically identified by the provider for reconsideration will be deemed to have been waived by the provider for purposes of both the informal reconsideration and the formal appeal, if requested. The reconsideration findings will replace the initial findings and be identified as the final audit report.

(e) A request for an informal reconsideration does not limit a provider's right to a formal appeal as long as any formal appeal of the final audit report is received by the OHCA Legal Docket Clerk within ~~twenty (20)~~thirty (30) calendar days of the date of notice of the final audit report. However, all claims and findings not specifically identified by the provider upon an informal reconsideration request will be deemed to have been waived by the provider for purposes of a subsequent formal audit appeal. Additionally, the provider must specifically identify each claim to be contested on appeal, and any remaining appealable claim that has not already been waived during the informal reconsideration and is not specifically identified in the initial appeal filing, will be deemed waived on appeal.

(f) If the provider does not request either an informal reconsideration or a formal appeal within the specified timeframe, the initial report will become the final audit report and the provider will be obligated to reimburse OHCA for any identified overpayment, which amount shall be immediately due and payable to OHCA. OHCA may, at its discretion, withhold the overpayment amount from the provider's future payments.

(g) When OHCA conducts a probability sample audit, the sample claims are selected on the basis of recognized and generally accepted sampling methods. If an audit reveals an error rate exceeding ~~10%~~ten percent (10%), OHCA shall extrapolate the error rate to the universe of the dollar amount of the audited paid claims.

(1) When using statistical sampling, OHCA uses a sample that is sufficient to ensure a minimum confidence level of ~~95%~~ninety-five percent (95%).

(2) When calculating the amount to be recovered, OHCA ensures

that all overpayments and underpayments reflected in the probability sample are totaled and extrapolated to the universe from which the sample was drawn.

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

(h) If a probability sample audit reveals an error rate of ~~10%~~ten percent (10%) or less, the provider will be required to reimburse OHCA for any overpayments noted during the audit/review.

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 6. INPATIENT PSYCHIATRIC SERVICES

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

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

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

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

(d) In the event a member disagrees with the decision by OHCA, or its designated agent, the member receives an evidentiary hearing under ~~OAC 317:2-1-2(a)~~Oklahoma Administrative Code 317:2-1-2(b). The member's request for such an appeal must ~~commence~~be received within ~~20~~thirty (30) calendar days of the initial decision.

PART 9. 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 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 Public Funds as the State Share of Financial Participation, 42 Code of Federal Regulation (C.F.R.), 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 entity to the Oklahoma Health Care Authority (OHCA).

(3) **"Non-state government-owned (NSGO)"** means an entity owned and/or operated by a unit of government other than the state and the application packet is accepted and determined complete by OHCA as a qualified NSGO.

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

(5) **"Supplemental payment calculation period"** 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 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 the application packet is accepted and determined complete by OHCA;

(4) the facility is an active participant in the Focus on Excellence program and has earned at minimum ~~100~~one-hundred (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

(5) the facility and NSGO comply with care criteria requirements. All facilities 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) 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) **Care Criteria Evaluation and Audit.** 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~~C.F.R., 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.

(h) **Disbursement of payment.** NSGOs shall secure allowable 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 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. 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 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.**

(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 Oklahoma Administrative Code ~~317:2-1-2(b)~~317:2-1-2(c) and 317:2-1-16.

317:30-5-136.1. Focus on Excellence

(a) **Purpose.** The Focus on Excellence (FOE) program was established through Oklahoma State Statute, Title 56, Section 56-1011.5. FOE's mission is to enhance the quality of life for target citizens by delivering effective programs and facilitating partnerships with providers and the community they serve. The program has a full commitment to the very best in quality, service and value which will lead to measurably improved quality outcomes, healthier lifestyles; greater satisfaction and confidence for our members.

(b) **Eligible Providers.** Any Oklahoma long-term care nursing facilities that are licensed and certified by the Oklahoma State Department of Health and accommodate SoonerCare members at their facility as defined in Oklahoma Administrative Code (OAC) 317:30-5-120.

(c) **Quality measure care criteria.** To maintain status in the FOE program, each nursing facility must enter quality data either monthly, quarterly, annually for the following care criteria metrics. All metrics in detail can be found on the Oklahoma Health Care Authority's (OHCA) FOE website or on FOE/QOC (Quality of Care) Data Collection Portal.

(1) **Person-Centered Care.** Facility must meet six (6) out of ten (10) of the established measurement criteria for this metric to receive the points. This metric is measured quarterly and must be completed by the 15th of the month following the close of the quarter.

(2) **Direct-Care Staffing**. Facility must maintain a direct care staffing ratio of three and a half (3.5) hours per patient day to receive the points for this metric. This metric must be completed monthly by the 15th of each month.

(3) **Resident/Family Satisfaction.** Facility must maintain a score of 76 of a possible 100 points on overall satisfaction to receive the points for this metric. This metric is collected in a survey format and must be completed once a year in the fall. Surveys are to be completed by the resident, power of attorney and/or with staff assistance.

(4) **Employee Satisfaction.** Facility must maintain a score of 70 points or higher in order to receive the points for this metric. Surveys are completed by FOE facility employees and must be completed once a year in the fall.

(5) **Licensed-Nurse Retention.** Facility must maintain a one-year tenure rate of 60 percent (60%) or higher of its licensed nursing staff to receive the points for this metric. This metric must be completed monthly by the 15th of the month.

(6) **Certified Nurse Assistant (CNA) Retention.** Facility must maintain a one-year tenure rate of 50 percent (50%) or higher of its CNA staff to receive the points for this metric. This metric must be completed monthly by the 15th of the month.

(7) **Distance Learning Program Participation.** Facility must contract and use an approved distance learning vendor for its frontline staff in order to receive points for this metric. This metric is measured quarterly and must be completed by the 15th of the month following the close of the quarter.

(8) **Peer Mentoring.** Facility must establish a peer-mentoring program in accordance with OHCA guidelines. This metric is measured quarterly and must be completed by the 15th of the month following the close of the quarter.

(9) **Leadership Commitment.** Facility must meet six (6) out of ten (10) of the established measurement criteria for this metric to receive the points. This metric is measured quarterly and must be completed by the 15th of the month following the close of the quarter.

(d) **Payment.** The amount of eligible dollars is reimbursable based on the SoonerCare FOE nursing facility meeting the quality metric thresholds listed in (b). Facilities must meet a minimal of 100 points to even be eligible for reimbursement.

(1) **Distribution of Payment.** OHCA will notify the FOE facility of the quality reimbursement amount on a quarterly basis.

(2) **Penalties.** Facilities that do not submit on the appropriate due dates will not receive reimbursable dollars. Facilities that do not submit quality measures will not receive reimbursable dollars for those specific measures. Due dates can be found on the OHCA FOE webpage.

(e) **Appeals.** Facilities can file an appeal with the Quality Review Committee and in accordance, with the grievance procedures found at OAC ~~317:2-1-2(b)~~317:2-1-2(c) and 317:2-1-16.

PART 83. RESIDENTIAL BEHAVIOR MANAGEMENT SERVICES

317:30-5-746. Appeal of Prior Authorization Decision

If a denial decision is made, an appeal may be initiated by the member or the member's legal guardian. The denial can be appealed to the Oklahoma Health Care Authority within ~~20~~thirty (30) calendar days of the receipt of the notification of the denial by the OHCA or its designated agent.

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

SUBCHAPTER 19. NURSING FACILITY SERVICES

317:35-19-16. PASRR appeals process

(a) Any individual who has been adversely affected by any ~~PASRR~~Preadmission Screening and Resident Review (PASRR) determination made by the State in the context of either a preadmission screening or an annual resident review may appeal that determination by requesting a fair hearing. If the individual does not consider the PASRR decision a proper one, the individual or their authorized representative must contact the local county ~~OKDHS~~Oklahoma Department of Human Services (DHS) office to discuss a hearing. Forms for requesting a fair hearing (~~OKDHS~~DHS Form 13MP001E, Request for a Fair Hearing), as well as assistance in completing the forms, can be obtained at the local county ~~OKDHS~~DHS office. Any request for a hearing must be made no later than ~~20~~thirty (30) days following the date of written notice. Appeals of these decisions are available under ~~OAC 317:2-1-2~~Oklahoma Administrative Code (OAC) 317:2-1-2. There is no distinction between the SoonerCare and non-SoonerCare patient; therefore, all individuals seeking an appeal have the same rights, regardless of source of payment. Level I determinations are not subject to appeal.

(b) When the individual is found to experience ~~MI~~Mental Illness (MI), ~~MR~~Intellectual Disability (ID), or related condition through the Level II screen, the PASRR determination made by the ~~MR/MI~~ID/MI authorities cannot be countermanded by the Oklahoma Health Care Authority, either in the claims process or through other utilization control/review processes, or by the Oklahoma State Department of Health. Only appeals determinations made through the fair hearing process may overturn a PASRR determination made by the ~~MR/MI~~ID/MI authorities.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY

CHAPTER 35. MEDICAL ASSISTANCE FOR ADULTS AND CHILDREN-ELIGIBILITY

SUBCHAPTER 22. PREGNANCY RELATED BENEFITS COVERED UNDER TITLE XXI

317:35-22-2.1. Non-covered services

(a) Services and benefits provided to evaluate and/or treat maternal conditions that are not related to or impact the pregnancy outcome.

~~(a) Non-emergency transportation.~~

~~(c)~~(b) Dental.

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

SUBCHAPTER 3. GENERAL PROVIDER POLICIES

PART 4. EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (EPSDT) PROGRAM/CHILD-HEALTH SERVICES

317:30-3-65.4. Screening components

Comprehensive Early and Periodic Screening, Diagnosis and Treatment (EPSDT) screenings are performed by, or under the supervision of, a SoonerCare physician or other SoonerCare practitioner. SoonerCare physicians are defined as all licensed allopathic and osteopathic physicians in accordance with the rules and regulations covering the Oklahoma Health Care Authority's (OHCA) SoonerCare program. Other SoonerCare practitioners are defined as all contracted physician assistants and advanced practice registered nurses in accordance with the rules and regulations covering the OHCA's SoonerCare program. At a minimum, screening examinations must include, but not be limited to, the following components:

(1) **Comprehensive health and developmental history**. Health and developmental history information may be obtained from the parent or other responsible adult who is familiar with the member's history and include an assessment of both physical and mental health development. Coupled with the physical examination, this includes:

(A) **Developmental assessment**. Developmental assessment includes a range of activities to determine whether an individual's developmental processes fall within a normal range of achievement according to age group and cultural background. Screening for development assessment is a part of every routine, initial and periodic screening examination. Acquire information on the member's usual functioning as reported by the member, teacher, health professional or other familiar person. Review developmental progress as a component of overall health and well-being given the member's age and culture. As appropriate, assess the following elements:

(i) Gross and fine motor development;
(ii) Communication skills, language and speech development;
(iii) Self-help, self-care skills;
(iv) Social-emotional development;
(v) Cognitive skills;
(vi) Visual-motor skills;
(vii) Learning disabilities;

(viii) Psychological/psychiatric problems;
(ix) Peer relations; and
(x) Vocational skills.

(B) **Assessment of nutritional status**. Nutritional assessment may include preventive treatment and follow-up services including dietary counseling and nutrition education if appropriate. This is accomplished in the basic examination through:

(i) Questions about dietary practices;
(ii) Complete physical examination, including an oral dental examination;
(iii) Height and weight measurements;
(iv) Laboratory test for iron deficiency; and
(v) Serum cholesterol screening, if feasible and appropriate.

(2) **Comprehensive unclothed physical examination**. Comprehensive unclothed physical examination includes the following:

(A) **Physical growth**. Record and compare height and weight with those considered normal for that age. Record head circumference for children under one year of age. Report height and weight over time on a graphic recording sheet.

(B) **Unclothed physical inspection**. Check the general appearance of the member to determine overall health status and detect obvious physical defects. Physical inspection includes an examination of all organ systems such as pulmonary, cardiac, and gastrointestinal.

(3) **Immunizations.** Legislation created the Vaccine for Children Program effective October 1, 1994. Vaccines are provided free of charge to all enrolled providers for SoonerCare eligible children and adolescents. Participating providers may bill for an administration fee set by the Centers for Medicare and Medicaid Services (CMS) on a regional basis. They may not refuse to immunize based on inability to pay the administration fee.

(4) **Appropriate laboratory tests**. A blood lead screening test (by either finger stick or venipuncture) must be performed between the ages of nine and 12 months and at 24 months. A blood lead test is required for any child up to age 72 months who had not been previously screened. A blood lead test equal to or greater than 10 micrograms per deciliter (ug/dL) obtained by capillary specimen (fingerstick) must be confirmed using a venous blood sample. If a child is found to have blood lead levels equal to or greater than 10 ug/dL, the Oklahoma Childhood Lead Poison Prevention Program (OCLPPP) must be notified according to rules set forth by the Oklahoma State Board of Health defined in Oklahoma Administrative Code (OAC) 310:512-3-5.

(A) The OCLPPP schedules an environmental inspection to identify the source of the lead for children who have a persistent blood lead level 15 ug/dL or greater. Environmental inspections are provided through the Oklahoma State Department of Health (OSDH) upon notification from laboratories or providers and reimbursed through the OSDH cost allocation plan approved by OHCA.

(B) Medical judgment is used in determining the applicability of all other laboratory tests or analyses to be performed unless otherwise indicated on the periodicity schedule. If any laboratory tests or analyses are medically contraindicated at the time of the screening, they are provided when no longer medically contraindicated. Laboratory tests should only be given when medical judgment determines they are appropriate. However, laboratory tests should not be routinely administered.

(5) **Health education**. Health education is a required component of screening services and includes anticipatory guidance. At the outset, the physical and dental assessment, or screening, gives the initial context for providing health education. Health education and counseling to parents, guardians or members is required. It is designed to assist in understanding expectations of the member's development and provide information about the benefits of healthy lifestyles and practices as well as accident and disease prevention.

(6) **Vision and hearing screens**. Vision and hearing services are subject to their own periodicity schedules. However, age-appropriate vision and hearing assessments may be performed as a part of the screening as outlined at OAC 317:30-3-65.7 and 317:30-3-65.9.

(7) **Dental screening services**. An oral screening may be included in the EPSDT screening and as a part of the nutritional status assessment. Federal regulations require a direct dental referral for every member in accordance with the American Academy of Pediatric Dentistry periodicity schedule and at other intervals as medically necessary. Therefore, when an oral screening is done at the time of the EPSDT screening, the member may be referred directly to a dentist for further screening and/or treatment. Specific dental services are outlined in OAC 317:30-3-65.8.

~~(8) **Child abuse.** Instances of child abuse and/or neglect are to be reported in accordance with state law, including, but not limited to, 10A of Oklahoma Statutes, Section 1-2-101. Any person suspecting child abuse or neglect shall immediately report it to the Oklahoma Department of Human Services (DHS) Hotline at 1-800-522-3511.~~

(8) **Maternal depression screens.** A maternal depression screening may be provided to the child's mother during the child's EPSDT screening as per the established guidelines in the American Academy of Pediatrics Bright Futures' periodicity schedule.

(9) **Reporting suspected abuse and/or neglect.** Instances of child abuse and/or neglect are to be reported in accordance with state law, including, but not limited to, 10A Oklahoma Statute (O.S.) § 1-2-101 and 43A O.S. § 10-104. Any person suspecting child abuse or neglect shall immediately report it to the Oklahoma Department of Human Services (DHS) hotline, at 1-800-522-3511; any person suspecting abuse, neglect, or exploitation of a vulnerable adult shall immediately report it to the local DHS County Office, municipal or county law enforcement authorities, or, if the report occurs after normal business hours, the DHS hotline. Health care professionals who are requested to report incidents of domestic abuse by adult victims with legal capacity shall promptly make a report to the nearest law enforcement agency, per 22 O.S. § 58.

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 1. PHYSICIANS

317:30-5-2. General coverage by category

(a) **Adults**. Payment for adults is made to physicians for medical and surgical services within the scope of the Oklahoma Health Care Authority's (OHCA) SoonerCare program, provided the services are reasonable and necessary for the diagnosis and treatment of illness or injury, or to improve the functioning of a malformed body member. Coverage of certain services must be based on a determination made by the OHCA's medical consultant in individual circumstances.

(1) Coverage includes the following medically necessary services:

(A) Inpatient hospital visits for all SoonerCare covered stays. All inpatient services are subject to post-payment review by the OHCA, or its designated agent.

(B) Inpatient psychotherapy by a physician.

(C) Inpatient psychological testing by a physician.

(D) One (1) inpatient visit per day, per physician.

(E) Certain surgical procedures performed in a Medicare certified free-standing ambulatory surgery center (ASC) or a Medicare certified hospital that offers outpatient surgical services.

(F) Therapeutic radiology or chemotherapy on an outpatient basis without limitation to the number of treatments per month for members with proven malignancies.

(G) Physician services on an outpatient basis include:

(i) A maximum of four (4) primary care visits per member per month, with the exception of SoonerCare Choice members, or

(ii) A maximum of four (4) specialty visits per member per month.

(iii) Additional visits are allowed per month for treatment related to emergency medical conditions and ~~Family Planning~~ family planning services.

~~(H) Direct physician services in a nursing facility for those members residing in a long-term care facility. A maximum of two nursing facility visits per month are allowed. To receive payment for a second nursing facility visit in a month denied by Medicare for a Medicare/SoonerCare member, attach the EOMB from Medicare showing denial and mark "carrier denied coverage".~~

(H) Direct physician services in a nursing facility.

(i) A maximum of two (2) nursing facility visits per month are allowed; and if the visit (s) is for psychiatric services, it must be provided by a psychiatrist or a physician with appropriate behavioral health training.

(ii) To receive payment for a second nursing facility visit in a month denied by Medicare for a Medicare/SoonerCare member, attach the explanation of Medicare benefits (EOMB) showing denial and mark "carrier denied coverage."

(I) Diagnostic x-ray and laboratory services.

(J) Mammography screening and additional follow-up mammograms as per current guidelines.

(K) Obstetrical care.

(L) Pacemakers and prostheses inserted during the course of a surgical procedure.

(M) Prior authorized examinations for the purpose of determining medical eligibility for programs administered by OHCA. A copy of the authorization, ~~OKDHS~~ Oklahoma Department of Human Services (DHS) form 08MA016E, Authorization for Examination and Billing, must accompany the claim.

(N) If a physician renders direct care to a member on the same day as a dialysis treatment, payment is allowed for a separately identifiable service unrelated to the dialysis.

(O) Family planning includes sterilization procedures for legally competent members ~~21~~twenty-one (21) years of age and over who voluntarily request such a procedure and execute the federally mandated consent form with his/her physician. A copy of the consent form must be attached to the claim form. Separate payment is allowed for the insertion and/or implantation of contraceptive devices during an office visit. Certain family planning products may be obtained through the Vendor Drug Program. Reversal of sterilization procedures for the purposes of conception is not allowed. Reversal of sterilization procedures are allowed when medically indicated and substantiating documentation is attached to the claim.

(P) Genetic counseling.

(Q) Laboratory testing.

(R) Payment for ultrasounds for pregnant women as specified in ~~OAC~~Oklahoma Administrative Code (OAC) 317:30-5-22.

(S) Payment to the attending physician in a teaching medical facility for compensable services when the physician signs as claimant and renders personal and identifiable services to the member in conformity with federal regulations.

(T) Payment to the attending physician for the services of a currently Oklahoma licensed physician in training when the following conditions are met~~;~~:

(i) Attending physician performs chart review and signs off on the billed encounter;

(ii) Attending physician is present in the clinic/or hospital setting and available for consultation; and

(iii) Documentation of written policy and applicable training of physicians in the training program regarding when to seek the consultation of the attending physician.

(U) Payment for services rendered by medical residents in an outpatient academic setting when the following conditions are met:

(i) ~~the~~The resident has obtained a medical license or a special license for training from the appropriate regulatory state medical board; and

(ii) has the appropriate contract on file with the OHCA to render services within the scope of their licensure.

(V) The payment to a physician for medically directing the services of a ~~CRNA~~certified registered nurse anesthetist (CRNA) or for the direct supervision of the services of an ~~Anesthesiologist Assistant~~anesthesiologist assistant (AA) is limited. The maximum allowable fee for the services of both providers combined is limited to the maximum allowable had the service been performed solely by the anesthesiologist.

(W) Screening and follow up ~~Pap Smears~~pap smears as per current guidelines.

(X) Medically necessary solid organ and bone marrow/stem cell transplantation services for children and adults are covered services based upon the conditions listed in (i)-(iv) of this subparagraph:

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

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

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

(iv) Procedures considered experimental or investigational are not covered.

(Y) Donor search and procurement services are covered for transplants consistent with the methods used by the Medicare program for organ acquisition costs.

(Z) Donor expenses incurred for complications are covered only if they are directly and immediately attributable to

the donation procedure. Donor expenses that occur after the ~~90~~ninety (90) day global reimbursement period must be submitted to the OHCA for review.

(AA) Total parenteral nutritional ~~therapy (TPN)~~(TPN) therapy for identified diagnoses and when prior authorized.

(BB) Ventilator equipment.

(CC) Home dialysis equipment and supplies.

(DD) Ambulatory services for treatment of members with tuberculosis (TB). This includes, but is not limited to, physician visits, outpatient hospital services, rural health clinic visits and prescriptions. Drugs prescribed for the treatment of TB beyond the prescriptions covered under SoonerCare require prior authorization by the University of Oklahoma College of Pharmacy Help Desk using form ~~"Petition for TB Related Therapy".~~"Petition for TB Related Therapy." Ambulatory services to members infected with TB are not limited to the scope of the SoonerCare program, but require prior authorization when the scope is exceeded.

(EE) Smoking and ~~Tobacco Use Cessation Counseling~~tobacco use cessation counseling for treatment of members using tobacco.

(i) Smoking and ~~Tobacco Use Cessation Counseling~~tobacco use cessation counseling consists of the 5As:

(I) Asking the member to describe their smoking use;

(II) Advising the member to quit;

(III) Assessing the willingness of the member to quit;

(IV) Assisting the member with referrals and plans to quit; and

(V) Arranging for follow-up.

(ii) Up to eight (8) sessions are covered per year per individual.

(iii) Smoking and ~~Tobacco Use Cessation Counseling~~tobacco use cessation counseling is a covered service when performed by physicians, physician assistants (PA), advanced registered nurse practitioners (ARNP), certified nurse midwives (CNM), dentists, Oklahoma State Health Department (OSDH) and ~~FQHC~~Federally Qualified Health Center (FQHC) nursing staff, and ~~Maternal/Child Health Licensed Clinical Social Workers with a certification as a Tobacco Treatment Specialist Certification (CTTS).~~maternal/child health licensed clinical social worker trained as a certified tobacco treatment specialist (CTTS). It is reimbursed in addition to any other appropriate global payments for obstetrical care, ~~PCP~~primary care provider (PCP) care coordination payments, evaluation and management codes, or other appropriate services rendered. It must be a significant,

separately identifiable service, unique from any other service provided on the same day.

(iv) Chart documentation must include a separate note that addresses the 5A's and office note signature along with the member specific information addressed in the five (5) steps and the time spent by the practitioner performing the counseling. Anything under three (3) minutes is considered part of a routine visit and not separately billable.

(FF) Immunizations as specified by the Advisory Committee on Immunization Practices (ACIP) guidelines.

(GG) Genetic testing and other molecular pathology services are covered when medically necessary. Genetic testing may be considered medically necessary when the following conditions are met:

(i) The member displays clinical features of a suspected genetic condition, is at direct risk of inheriting the genetic condition in question (e.g., a causative familial variant has been identified) or has been diagnosed with a condition where identification of specific genetic changes will impact treatment or management; and

(ii) Clinical studies published in peer-reviewed literature have established strong evidence that the result of the test will positively impact the clinical decision-making or clinical outcome for the member; and

(iii) The testing method is proven to be scientifically valid for the identification of a specific genetically-linked inheritable disease or clinically important molecular marker; and

(iv) A medical geneticist, physician, or licensed genetic counselor provides documentation that supports the recommendation for testing based on a review of risk factors, clinical scenario, and family history.

(2) General coverage exclusions include the following:

(A) Inpatient admission for diagnostic studies that could be performed on an outpatient basis.

(B) Services or any expense incurred for cosmetic surgery.

(C) Services of two (2) physicians for the same type of service to the same member on the same day, except when supplemental skills are required and different specialties are involved.

(D) Routine eye examinations for the sole purpose of prescribing glasses or visual aids, determination of refractive state, treatment of refractive errors or purchase of lenses, frames or visual aids.

(E) Pre-operative care within 24twenty-four (24) hours of the day of admission for surgery and routine post-operative

care as defined under the global surgery guidelines promulgated by Current Procedural Terminology (CPT) and the Centers for Medicare and Medicaid Services (CMS).
(F) Payment to the same physician for both an outpatient visit and admission to hospital on the same date.
(G) Sterilization of members who are under ~~21~~twenty-one (21) years of age, mentally incompetent, or institutionalized or reversal of sterilization procedures for the purposes of conception.
(H) Non-therapeutic hysterectomies.
(I) Medical services considered experimental or investigational.
(J) Payment for more than four (4) outpatient visits per member (home or office) per month, except visits in connection with family planning, services related to emergency medical conditions, or primary care services provided to SoonerCare Choice members.
(K) Payment for more than two (2) nursing facility visits per month.
(L) More than one (1) inpatient visit per day per physician.
(M) Physician services which are administrative in nature and not a direct service to the member including such items as quality assurance, utilization review, treatment staffing, tumor board review or multidisciplinary opinion, dictation, and similar functions.
(N) Charges for completion of insurance forms, abstracts, narrative reports or telephone calls.
(O) Payment for the services of social workers, licensed family counselors, registered nurses or other ancillary staff, except as specifically set out in OHCA rules.
(P) Induced abortions, except when certified in writing by a physician that the abortion was necessary due to a physical disorder, injury or illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would place the woman in danger of death unless an abortion is performed, or that the pregnancy is the result of an act of rape or incest. (Refer to OAC 317:30-5-6 or 317:30-5-50~~.~~).
(Q) Speech and ~~Hearing~~hearing services.
(R) Mileage.
(S) A routine hospital visit on the date of discharge unless the member expired.
(T) Direct payment to perfusionist as this is considered part of the hospital reimbursement.
(U) Inpatient chemical dependency treatment.
(V) Fertility treatment.
(W) Payment for removal of benign skin lesions.
(X) Sleep studies.

(b) **Children**. Payment is made to physicians for medical and surgical services for members under the age of ~~21~~twenty-one (21) within the scope of the ~~Authority's~~ SoonerCare program, provided the services are medically necessary for the diagnosis and treatment of illness or injury, or to improve the functioning of a malformed body member. Medical and surgical services for children are comparable to those listed for adults. For services rendered to a minor child, the child's parent or court-appointed legal guardian must provide written authorization prior to the service being rendered, unless there is an explicit state or federal exception to this requirement. In addition to those services listed for adults, the following services are covered for children.

(1) **Pre-authorization of inpatient psychiatric services**. All inpatient psychiatric services for members under ~~21~~twenty-one (21) years of age must be prior authorized by an agency designated by the ~~Oklahoma Health Care Authority~~OHCA. All psychiatric services are prior authorized for an approved length of stay. Non-authorized inpatient psychiatric services are not SoonerCare compensable.

(A) All residential and acute psychiatric services are authorized based on the medical necessity criteria as described in OAC 317:30-5-95.25,317:30-5-95.27 and 317:30-5-95.29.

(B) ~~Out of state placements are not authorized unless it is determined that the needed medical services are more readily available in another state or it is a general practice for members in a particular border locality to use resources in another state. If a medical emergency occurs while a member is out of the State, treatment for medical services is covered as if provided within the State. A prime consideration for placements is proximity to the family or guardian in order to involve the family or guardian in discharge and reintegration planning.~~For out of state placements refer to OAC 317:30-3-89 through 317:30-3-92.

(2) **General acute care inpatient service limitations**. All general acute care inpatient hospital services for members under the age of ~~21~~twenty-one (21) are not limited. All inpatient care must be medically necessary.

(3) **Procedures for requesting extensions for inpatient services**. The physician and/or facility must provide necessary justification to enable OHCA, or its designated agent, to make a determination of medical necessity and appropriateness of treatment options. Extension requests for psychiatric admissions must be submitted to the OHCA or its designated agent. Extension requests must contain the appropriate documentation validating the need for continued treatment in accordance with the medical necessity criteria described in OAC

317:30-5-95.26, 317:30-5-95.28 and 317:30-5-95.30. Requests must be made prior to the expiration of the approved inpatient stay. All decisions of OHCA or its designated agent are final.

(4) **Utilization control requirements for psychiatric beds.** Utilization control requirements for inpatient psychiatric services for members under ~~21~~twenty-one (21) years of age apply to all hospitals and residential psychiatric treatment facilities.

(5) **Early and periodic screening diagnosis and treatment (EPSDT) program.** Payment is made to eligible providers for ~~Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)~~EPDST of members under age ~~21~~twenty-one (21). These services include medical, dental, vision, hearing and other necessary health care. Refer to OAC 317:30-3-65.2 through 317:30-3-65.11 for specific guidelines.

~~(6) **Child abuse/neglect findings.** Instances of child abuse and/or neglect discovered through screenings and regular exams are to be reported in accordance with State Law. Section 7103 of Title 10 of the Oklahoma Statutes mandates reporting suspected abuse or neglect to the Oklahoma Department of Human Services. Section 7104 of Title 10 of the Oklahoma Statutes further requires reporting of criminally injurious conduct to the nearest law enforcement agency.~~

(6) **Reporting suspected abuse and/or neglect**. Instances of child abuse and/or neglect are to be reported in accordance with state law, including, but not limited to, 10A Oklahoma Statute (O.S.) § 1-2-101 and 43A O.S. § 10-104. Any person suspecting child abuse or neglect shall immediately report it to the Oklahoma Department of Human Services (DHS) hotline, at 1-800-522-3511; any person suspecting abuse, neglect, or exploitation of a vulnerable adult shall immediately report it to the local DHS county office, municipal or county law enforcement authorities, or, if the report occurs after normal business hours, the DHS hotline. Health care professionals who are requested to report incidents of domestic abuse by adult victims with legal capacity shall promptly make a report to the nearest law enforcement agency, per 22 O.S. § 58.

(7) **General exclusions.** The following are excluded from coverage for members under the age of ~~21~~twenty-one (21):

(A) Inpatient admission for diagnostic studies that could be performed on an outpatient basis.

(B) Services or any expense incurred for cosmetic surgery unless the physician certifies the procedure emotionally necessary.

(C) Services of two (2) physicians for the same type of service to the same member on the same day, except when supplemental skills are required and different specialties are involved.

(D) Pre-operative care within ~~24~~twenty-four (24) hours of the day of admission for surgery and routine post-operative care as defined under the global surgery guidelines promulgated by ~~Current Procedural Terminology (CPT)~~CPT and ~~the Centers for Medicare and Medicaid Services (CMS)~~CMS.
(E) Payment to the same physician for both an outpatient visit and admission to hospital on the same date.
(F) Sterilization of members who are under ~~21~~twenty-one (21) years of age, mentally incompetent, or institutionalized or reversal of sterilization procedures for the purposes of conception.
(G) Non-therapeutic hysterectomies.
(H) Medical ~~Services~~services considered experimental or investigational.
(I) More than one (1) inpatient visit per day per physician.
(J) Induced abortions, except when certified in writing by a physician that the abortion was necessary due to a physical disorder, injury or illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would place the woman in danger of death unless an abortion is performed, or that the pregnancy is the result of an act of rape or incest. (Refer to OAC 317:30-5-6 or 317:30-5-50~~.~~).
(K) Physician services which are administrative in nature and not a direct service to the member including such items as quality assurance, utilization review, treatment staffing, tumor board review or multidisciplinary opinion, dictation, and similar functions.
(L) Payment for the services of social workers, licensed family counselors, registered nurses or other ancillary staff, except as specifically set out in OHCA rules.
(M) Direct payment to perfusionist as this is considered part of the hospital reimbursement.
(N) Charges for completion of insurance forms, abstracts, narrative reports or telephone calls.
(O) Mileage.
(P) A routine hospital visit on date of discharge unless the member expired.

(c) **Individuals eligible for Part B of Medicare.** Payment is made utilizing the OHCA allowable for comparable services. Claims filed with Medicare Part B should automatically cross over to OHCA. The ~~explanation of Medicare Benefits (EOMB)~~EOMB reflects a message that the claim was referred to SoonerCare. If such a message is not present, a claim for coinsurance and deductible must be filed with the OHCA within ~~90~~ninety (90) days of the date of Medicare payment and within one (1) year of the date of service in order to be considered timely filed.

(1) In certain circumstances, some claims do not automatically ~~"cross over".~~"cross over." Providers must file a claim for coinsurance and/or deductible to SoonerCare within ~~90~~ninety (90) days of the Medicare payment and within one (1) year from the date of service.

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

317:30-5-11. Psychiatric services

(a) Payment is made for procedure codes listed in the ~~Psychiatry~~psychiatry section of the most recent edition of the American Medical Association Current Procedural Terminology (CPT) codebook. The codes in this service range are accepted services within the SoonerCare program for children and adults with the following exceptions:

(1) Psychiatric evaluation of hospital records, other psychiatric reports, psychometric and/or projective tests, and other accumulated data for medical diagnostic purposes.

(2) Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist the patient.

(3) Preparation of report of patient's psychiatric status, history, treatment, or progress (other than for legal or consultative purposes) for other physicians, agencies, or insurance carriers.

(4) Unlisted psychiatric service or procedure.

(b) All services must be medically necessary and appropriate and include at least one (1) ~~Diagnostic and Statistical Manual (DSM)~~ diagnosis from the most recent version of the ~~DSM.~~Diagnosis and Statistical Manual of Mental Disorders (DSM).

(c) Services in the psychiatry section of the CPT manual must be provided by a board eligible or board certified psychiatrist or a physician, physician assistant, or nurse practitioner with additional training that demonstrates the knowledge to conduct the service performed.

(d) Psychiatric services performed via telemedicine are subject to the requirements found in ~~OAC~~Oklahoma Administrative Code (OAC) 317:30-3-27.

(e) With the exception of the two (2) allowable direct physician services in a nursing facility (refer to OAC 317:30-5-2), reimbursement for psychiatric services to members residing in a nursing facility is not allowed. Provision of these services is the responsibility of the nursing facility and reimbursement is included within the all-inclusive per diem payment that nursing facilities receive for the member's care.

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

SUBCHAPTER 3. GENERAL PROVIDER POLICIES

PART 1. GENERAL SCOPE AND ADMINISTRATION

317:30-3-31. Prior authorization for health care-related goods and services

(a) Under the Oklahoma SoonerCare program, there are health care-related goods and services that require prior authorization (PA) by the Oklahoma Health Care Authority (OHCA). PA is a process to determine if a prescribed good or service is medically necessary; it is not, however, a guarantee of member eligibility or of SoonerCare payment. All goods or services requiring PA will be authorized on the basis of information submitted to OHCA, including:

(1) the relevant code, as is appropriate for the good or service requested (for example, Current Procedural Terminology (CPT) codes for services; Healthcare Common Procedure Coding System (HCPCS) codes, for durable medical equipment; or National Drug Codes (NDC), for drugs); and/or

(2) any other information required by OHCA, in the format as prescribed. The OHCA authorization file will reflect the codes that have been authorized.

(b) The OHCA staff will issue a determination for each requested good or service requiring a PA. The provider will be advised of that determination, either through the provider portal, or for requests made for out-of-state services, meals, mileage, transportation and lodging, by letter or other written communication. The member will be advised by letter. Policy regarding member appeal of a denied PA is available at ~~OAC~~Oklahoma Administrative Code (OAC) 317:2-1-2.

(c) The following is an inexhaustive list of the goods and services that may require a PA, for at least some SoonerCare member populations, under some circumstances. This list is subject to change, with OHCA expressly reserving the right to add a PA requirement to a covered good or service or to remove a PA requirement from a covered good or service.

(1) Physical therapy for children
(2) Speech therapy for children
(3) Occupational therapy for children
(4) High Tech Imaging (for ex. CT, MRA, MRI, PET)
(5) Some dental procedures, including, but not limited to orthodontics (orthodontics are covered for children only)
(6) Inpatient psychiatric services
(7) Some prescription drugs and/or physician administered drugs

(8) Ventilators
(9) Hearing aids (covered for children only)
(10) Prosthetics
(11) High risk OB services
(12) ~~Urine drug testing~~Drug testing
(13) Enteral therapy (covered for children only)
(14) Hyperalimentation
(15) Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services, supplies, or equipment that are determined to be medically necessary for a child or adolescent, and which are included within the categories of mandatory and optional services in Section 1905(a) of Title XIX, regardless of whether such services, supplies, or equipment are listed as covered in Oklahoma's State Plan
(16) Adaptive equipment for persons residing in private Intermediate Care Facilities for Individuals with Intellectual Disabilities
(17) Some ancillary services provided in a long term care hospital or in a long term care facility
(18) Rental of hospital beds, support surfaces, oxygen and oxygen related products, continuous positive airway pressure devices (CPAP and BiPAP), pneumatic compression devices, and lifts
(19) Allergy testing and immunotherapy
(20) Bariatric surgery
(21) Genetic testing
(22) Out-of-state services
(23) Meals, travel, and lodging

(d) Providers should refer to the relevant Part of OAC 317:30-5 for additional, provider-specific guidance on PA requirements. Providers may also refer to the OHCA Provider Billing and Procedure Manual, available on OHCA's website, and the SoonerCare Medical Necessity Criteria for Inpatient Behavioral Health Services Manual to see how and/or where to submit PA requests, as well as to find information about documentation.

PART 3. GENERAL MEDICAL PROGRAM INFORMATION

317:30-3-64. Payment for lodging and meals [AMENDED AND RENUMBERED TO 317:30-3-92]

~~(a) Payment for lodging and/or meals assistance for an eligible member and/or an approved medical escort is provided only when medically necessary in connection with transportation to and from SoonerCare compensable services. The member and/or medical escort must make a reasonable effort to secure lodging at a hospital or non-profit organization. The Oklahoma Health Care Authority (OHCA)~~

has discretion and final authority to approve or deny any lodging and/or meal services.

(1) Lodging and/or meals are reimbursable when prior approved. Payment for lodging and/or meals is limited to a period of up to 24 hours prior to the start of member's medical services and up to 24 hours after the services end. Lodging is approved for the member and/or one approved medical escort. The following factors may be considered by the OHCA when approving reimbursement for a member and/or one medical escort:

(A) travel is to obtain specialty care; and

(B) the trip cannot be completed during SoonerRide operating hours; and/or

(C) the trip is 100 miles or more from the member's residence, as listed in the OHCA system, to the medical facility; and/or

(D) the member's medical treatment requires an overnight stay, or the condition of the member discourages traveling.

(2) When a member is not required to have a PCP or when a PCP referral is not required to obtain a SoonerCare covered service, a member may go to any provider they choose but SoonerCare will not reimburse for transportation, lodging, or meals if the distance is beyond what is considered the nearest appropriate facility.

(3) Meals will be reimbursed if lodging criteria is met. Duration of the trip must be 18 hours or greater.

(4) Reimbursement for meals is based on a daily per diem and may be used for breakfast, lunch or dinner, or all three meals, whichever is required.

(5) During inpatient or outpatient medical stays, lodging and/or meals services are reimbursed for a period of up to 14 days without prior approval; stays exceeding the 14 day period must be prior approved. A member may not receive reimbursement for lodging and/or meals services for days the member is an inpatient in a hospital or medical facility.

(6) For eligible members in the Neonatal Intensive Care Unit (NICU) a minimum visitation of 6 hours per day for the approved medical escort is required for reimbursement of lodging and/or meals services. Non-emergency transportation services for medically necessary visitation may be provided for eligible medical escorts.

(b) Lodging must be with a SoonerCare contracted Room and Board provider, when available, before direct reimbursement to a member and/or medical escort can be approved. If lodging and/or meals assistance with contracted Room and Board providers are not available, the member and/or medical escort may request reimbursement assistance by submitting the appropriate travel reimbursement forms. The travel reimbursement forms may be

~~obtained by contacting SoonerCare Care Management division. Any lodging and/or meal expenses claimed on the travel reimbursement forms must be documented with the required receipts and medical records to document the lodging criteria have been met. Reimbursement must not exceed state per diem amounts. The OHCA has discretion and the final authority to approve or deny lodging and/or meals reimbursement.~~

~~(c) Payment for transportation and lodging and/or meals of one medical escort may be approved if the service is required.~~

~~(d) If the Oklahoma Department of Human Services (OKDHS) removes a child from his/her home, a court must appoint a temporary guardian. During this time the temporary guardian is eligible for medical escort related lodging and/or meals services. It is the responsibility of the OHCA to determine this necessity. The decision should be based on the following circumstances:~~

~~(1) when the individual's health or disability does not permit traveling alone; and~~

~~(2) when the individual seeking medical services is a minor child.~~

PART 6. OUT-OF-STATE SERVICES

317:30-3-89. Definitions

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

"Emergency" means a serious situation or occurrence that happens unexpectedly and demands immediate action such as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected, by a reasonable and prudent layperson, to result in placing the member's health in serious jeopardy, serious impairment to bodily function, or serious dysfunction of any bodily organ or part.

"Out-of-state provider" means a provider contracted with SoonerCare in accordance with Oklahoma Administrative Code (OAC) 317:30-3-2, if:

(A) The physical address where services are or will be rendered is located outside the Oklahoma border and within the United States; or

(B) The physical address where services are or will be rendered is located within the Oklahoma border, but:

(i) The out-of-state provider maintains all member and/or billing records outside the Oklahoma border; and

(ii) The out-of-state provider is unable to produce the originals or exact copies of the member and/or billing records from the location in Oklahoma where services are rendered.

"Temporary" means lasting for a limited period of time, such as when a member is on vacation, but does not include situations in which a SoonerCare member leaves Oklahoma for the purpose of receiving medical care and treatment.

317:30-3-90. Out-of-state services

(a) Consistent with Section 431.52 of Title 42 of the Code of Federal Regulations (C.F.R.), an eligible SoonerCare member who is a resident of Oklahoma but who is temporarily out of state, may receive services from an out-of-state provider to the same extent that he or she would receive such services in Oklahoma, if:

(1) Medical services are needed for a medical emergency, as determined by the attending physician or other provider (M.D., D.O., P.A., or A.P.R.N).

(A) For any provider, who is not contracted at the time the services are provided, documentation as requested from the Oklahoma Health Care Authority (OHCA) of the emergency must be submitted, including, but not limited to, emergency room reports, medical histories, discharge summaries, and all other relevant medical reports.

(2) Medical services are needed and the member's health would be endangered if he or she were required to return to Oklahoma for medical care and treatment, as determined by the attending physician or other provider (M.D., D.O., P.A., or A.P.R.N).

(A) For any provider, who is not contracted at the time the services are provided, documentation of the nature and possible extent of the endangerment must be submitted as requested from the OHCA.

(3) The Oklahoma Health Care Authority's (OHCA) Chief Medical Officer (CMO), or his or her designee, determines, on the basis of medical advice, that the needed medical services, or necessary supplemental resources, are more readily available in the state where the member is located at the time of needing medical treatment.

(A) Prior authorization must be obtained from the OHCA's CMO, or his or her designee, before the services are rendered; or

(4) The customary or general practice for members residing in a particular locality within Oklahoma is to use medical resources in another state, and the member is using a provider that is contracted with the OHCA.

(A) Except for out-of-state inpatient psychiatric services, no prior authorization is necessary for services provided in accordance with paragraph (a)(4), above, if the member obtains them from an out-of-state provider that is:

(i) Located in a border state (Arkansas, Colorado, Kansas, Missouri, New Mexico, or Texas) within fifty (50) miles of the Oklahoma border; and

(ii) Contracted with the OHCA;

(iii) Provided, however, that nothing in this paragraph shall be interpreted to eliminate or otherwise affect a prior authorization requirement established by any other OHCA rule, including, but not limited to, Oklahoma Administrative Code (OAC) 317:30-3-31, that would have to be met if the health care-related good and/or service were provided in Oklahoma.

(B) In all other instances, prior authorization must be obtained from the OHCA's CMO, or his or her designee, before the services are rendered.

(b) Except as provided in subsections (a)(1),(a)(2) and (a)(4)(A), above, SoonerCare will not pay for any services furnished by an out-of-state provider unless prior authorization has been obtained from the OHCA's CMO, or his or her designee, before the services are rendered. Prior authorization must be obtained in all instances in which the member is located in Oklahoma at the time the services are determined to be medically necessary.

(1) As part of this authorization process, the following documents must be submitted to the OHCA's CMO, or his or her designee:

(A) Documents sufficient to establish the "medical necessity" of the services requested, as that term is defined by OAC 317:30-3-1(f). See also OAC 317:30-3-31, Prior authorization for health care-related goods and services. Examples of such documents may include, but are not limited to, Histories of Present Illnesses (HPIs), physical exams, laboratory reports, imaging reports, progress notes, hospital charts, and/or other relevant medical records; and

(B) Documents sufficient to establish that the health care needs of the member cannot be met in Oklahoma. Such documents shall include, but not be limited to, a letter from the referring provider that contains:

(i) A clear presentation of the member's medical condition and diagnosis for which out-of-state treatment is requested, including a summary of treatment to date that is supported by the documents in paragraph (b)(1)(A), above;

(ii) Names of physicians and/or facilities in Oklahoma that the member has previously been referred to for diagnosis and/or treatment;

(iii) Physicians consulted by the attending physician relative to diagnosis and/or availability of recommended treatment in Oklahoma;

(iv) Recommended treatment or further diagnostic work; and

(v) Reasons why medical care cannot be provided in Oklahoma or the next closest location outside Oklahoma.

(C) Except for emergency medical or behavioral health cases, prior authorization requests for out-of-state services must be made in writing with all the necessary documents that show medical necessity and details of the services provided, including but not limited to, relevant medical history, description of services and procedures to be performed, Histories of Present Illnesses (HPIs), physical exams, laboratory reports, imaging reports, and received by the OHCA at least ten (10) calendar days prior to the date services are to be provided in another state or at the discretion of the CMO or his/her designee.

(i) Emergency medical or behavioral health cases must be identified as such by the physician or provider in the prior authorization request. Any telephone request for prior authorization of out-of-state services will only be accepted in emergency situations, and must be promptly followed by a written request.

(2) Prior authorization requirements for medically necessary lodging, transportation, and/or meals assistance associated with out-of-state services are established in other OHCA rules, including, but not limited to, OAC 317:30-3-92, 317:30-5-327.1, and 317:35-3-2.

(c) The restrictions established in subsections (a) through (b), above, shall not apply to children who reside outside Oklahoma and for whom the Oklahoma Department of Human Services makes Title IV-E adoption assistance payments or Title IV-E foster care maintenance payments.

(d) Denials of requests for prior authorization may be appealed in accordance with OAC 317:2-1-2(d)(1)(C).

(e) Out-of-state providers shall, upon request by authorized OHCA representatives, make available fiscal and medical records as required by applicable federal regulations, OHCA rules, and the Provider Agreement. Such records shall be made available for review by authorized OHCA representatives at the OHCA's address in Oklahoma City, Oklahoma.

317:30-3-91. Reimbursement of services rendered by out-of-state providers

(a) Before an out-of-state provider can receive reimbursement, it shall contract with SoonerCare and be subject to enrollment, including, but not limited to, providing information requested by the Oklahoma Health Care Authority (OHCA) such as name, address, Social Security Number or Tax Identification Number, and

verification of licensure and insurance. Out-of-state providers are also subject to the same screening rules, policies, and procedures as in-state providers, including, but not limited to Oklahoma Administrative Code (OAC) 317:30-3-2, and 317:30-3-19.3 through 317:30-3-19.4. Once the OHCA approves enrollment, the provider will receive a SoonerCare provider number that will allow claims to be processed.

(b) While the member's physician may suggest where the member be sent, the OHCA's Chief Medical Officer (CMO), or his or her designee, is responsible for making the final determination based on the most cost effective institution and treatment consistent with the recognized standards of care. Reimbursement for services rendered by out-of-state providers shall be as follows:

(1) Reimbursement for inpatient hospital services shall be made in accordance with OAC 317:30-5-47.

(2) Reimbursement for outpatient hospital services shall be made in accordance with OAC 317:30-5-42.14 and 317:30-5-566.

(3) Reimbursement for physician services shall be the lower of the SoonerCare maximum allowable fee as of the date the service was rendered, available at www.okhca.org (SoonerCare Fee Schedules), or the provider's actual charge.

(A) Exceptions to the above reimbursement method are payments for outpatient clinical diagnostic laboratory tests performed by a physician or independent laboratory. These tests will be reimbursed at the lower of the provider's actual charge or a rate of reimbursement equal to the rate paid by Medicare.

(4) Unless authorized by the Oklahoma State Plan, any reimbursement shall not exceed the rate paid by Medicare.

(c) The OHCA may negotiate a higher reimbursement rate for an out-of-state service that is prior authorized, provided that:

(1) The service is not available in Oklahoma; and

(2) The negotiated reimbursement does not exceed the rate paid by Medicare, unless as authorized by the Oklahoma State Plan. Services not covered by Medicare but covered by SoonerCare may be reimbursed as determined by the OHCA.

(d) Individual cases which are adversely affected by these reimbursement procedures may be presented to the OHCA's CMO, or his or her designee, for consideration as an exception to this rule on a case-by-case basis. The CMO's decision, or that of his or her designee, shall be the agency's final decision and is not otherwise appealable under these rules.

(e) Reimbursement of medically necessary lodging, transportation, and/or meals assistance associated with out-of-state services is governed by other OHCA rules, including, but not limited to, OAC 317:30-3-92, 317:30-5-327.1, and 317:35-3-2, as well as Part 31 of OAC 317:30-5.

317:30-3-92.Payment for lodging and meals

(a) Payment for lodging and/or meals assistance for an eligible member and an approved medical escort, if needed, is provided only when medically necessary in connection with transportation to and from SoonerCare compensable services. The member and any medical escort must make a reasonable effort to secure lodging at a hospital or non-profit organization. The Oklahoma Health Care Authority (OHCA) has discretion and final authority to approve or deny any lodging and/or meal services.

(1) Lodging and/or meals are reimbursable when prior authorized. Payment for lodging and/or meals is limited to a period of up to twenty-four (24) hours prior to the start of member's medical services and up to twenty-four (24) hours after the services end. Lodging is authorized for the member and one approved medical escort, if needed. The following factors may be considered by the OHCA when approving reimbursement for a member and any medical escort:

(A) Travel is to obtain specialty care; and

(B) The trip cannot be completed during SoonerRide operating hours; and/or

(C) The trip is one hundred (100) miles or more from the member's residence, as listed in the OHCA system, to the medical facility; and/or

(D) The member's medical treatment requires an overnight stay, or the condition of the member discourages traveling.

(2) When a member is not required to have a Primary Care Provider (PCP) or when a PCP referral is not required to obtain a SoonerCare covered service, a member may go to any provider they choose, but SoonerCare will not reimburse for transportation, lodging, or meals if the distance is beyond what is considered the nearest appropriate facility.

(3) Meals will be reimbursed if lodging criteria is met. Duration of the trip must be eighteen (18) hours or greater.

(4) Reimbursement for meals is based on a daily per diem and may be used for breakfast, lunch or dinner, or all three (3) meals, as required.

(5) During inpatient or outpatient medical stays, lodging and/or meals services are reimbursed for a period of up to fourteen (14) days without prior authorization; stays exceeding the fourteen (14) day period must be prior authorized. A member may not receive reimbursement for lodging and/or meals services for days the member is an inpatient in a hospital or medical facility.

(6) For eligible members in the Neonatal Intensive Care Unit (NICU), a minimum visitation of six (6) hours per day for the approved medical escort is required for reimbursement of

lodging and/or meals services. Non-emergency transportation services for medically necessary visitation may be provided for eligible medical escorts.

(b) Lodging must be with a SoonerCare contracted Room and Board provider, when available, before direct reimbursement to a member and/or medical escort can be authorized. If lodging and/or meals assistance with contracted Room and Board providers are not available, the member and any medical escort may request reimbursement assistance by submitting the appropriate travel reimbursement forms. The travel reimbursement forms may be obtained by contacting SoonerCare Care Management division. Any lodging and/or meal expenses claimed on the travel reimbursement forms must be documented with the required receipts and medical records to document the lodging criteria have been met. Reimbursement must not exceed state per diem amounts. The OHCA has discretion and the final authority to approve or deny lodging and/or meals reimbursement.

(c) Payment for transportation and lodging and/or meals of one medical escort may be authorized if the service is required.

(d) If the Oklahoma Department of Human Services (DHS) removes a child from his/her home, a court must appoint a temporary guardian. During this time the temporary guardian is eligible for medical escort-related lodging and/or meals services. It is the responsibility of the OHCA to determine this necessity. The decision should be based on the following circumstances:

(1) When the individual's health or disability does not permit traveling alone; and

(2) When the individual seeking medical services is a minor child.

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 6. INPATIENT PSYCHIATRIC SERVICES

317:30-5-95.24. Prior authorization of inpatient psychiatric services for children

(a) All inpatient psychiatric services for members under ~~21~~twenty-one (21) years of age must be prior authorized by the ~~OHCA~~Oklahoma Health Care Authority (OHCA) or its designated agent. All inpatient acute and residential psychiatric services will be prior authorized for an approved length of stay. Admission requirements for services must be provided in accordance with Code of Federal Regulations, Title 42 Public Health, Part 441 and 456. Additional information will be required for a SoonerCare compensable approval on enhanced treatment units or in special population programs.

(b) Staffing ratios shall always be present for each individual unit not by facility or program. Patients shall be grouped for

accommodation by gender, age, and treatment needs. At a minimum, children, adolescent, and adult treatment programs shall be separate with distinct units for each population. A unit is determined by separate and distinct sleeping, living, and treatment areas often separated by walls and/or doors. A unit that does not allow clear line of sight due to the presence of walls or doors is considered a separate unit. Each individual unit shall have assigned staff to allow for appropriate and safe monitoring of patients and to provide active treatment.

(c) In an acute care setting, at least one Registered Nurse (RN) must be on duty per unit at all times, with additional RNs to meet program needs. RNs must adhere to Oklahoma Department of Health policy at Oklahoma Administrative Code (OAC) 310:667-15-3 and OAC 310:667-33-2(a)(3).

(d) Regular residential treatment programs require a staffing ratio of 1:6 during routine waking hours and 1:8 during time residents are asleep with ~~24~~twenty-four (24) hour nursing care supervised by an RN for management of behaviors and medical complications. At a minimum, the supervising RN must be available by phone and on-site within one (1) hour. If the supervising RN is off-site, then an RN or LPN must be on-site to adhere to a ~~24~~twenty-four (24) hour nursing care coverage ratio of 1:30 during routine waking hours and 1:40 during time residents are asleep.

(e) Specialty residential treatment at this level is a longer term treatment that requires a higher staff to member ratio because of the need for constant, intense, and immediate reinforcement of new behaviors to develop an understanding of the behaviors. The environment of specialized residential treatment centers requires special structure and configuration (e.g., sensory centers for autistic members) and specialized training for the staff in the area of the identified specialty. The physician will see the child at least one (1) time a week.

(f) A ~~PRTF~~Psychiatric Residential Treatment Facility (PRTF) will not be considered a specialty treatment program for SoonerCare without prior approval of the OHCA behavioral health unit.

(g) A treatment program that has been approved as a specialized treatment program must maintain medical records that document the degree and intensity of the psychiatric care delivered to the children.

(h) Criteria for classification as a specialized PRTF will require a staffing ratio of 1:3 at a minimum during routine waking hours and 1:6 during time residents are asleep with ~~24~~twenty-four (24) hour nursing care supervised by a RN for management of behaviors and medical complications. The PRTF will be a secure unit, due to the complexity of needs and safety considerations. Admissions will be restricted to children that meet the medical necessity criteria

for ~~RTC~~Residential Treatment Center (RTC) and also meet at least two or more of the following:

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

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

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

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

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

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

(E) Lack of social or emotional reciprocity;

(F) Lack of attachment to caretakers;

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

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

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

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

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

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

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

(N) Stereotyped and repetitive motor mannerisms (e.g., hand or finger flapping or twisting or complex whole body movements);

(O) Persistent occupation with parts of objects;

(3) Member is medically stable, but has co-morbid medical conditions which require specialized medical care during treatment;

(4) Full scale IQ below 40 (profound mental retardation intellectual disability).

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

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

(k) ~~Out of state placements must be approved by the agent designated by the OHCA and subsequently approved by the OHCA, Medical Services Behavioral Health Division. Requests for admission to Psychiatric Residential Treatment Facilities or acute care units will be reviewed for consideration of level of care, availability, suitability, and proximity of suitable services.~~For out-of-state placement policy, refer to OAC 317:30-3-89 through 317:30-3-92. A prime consideration for placements will be proximity to the family or guardian in order to involve the family or guardian in Active Treatment, including discharge and reintegration planning. Out of state facilities are responsible for insuring appropriate medical care as needed under SoonerCare provisions as part of the per-diem rate.

(l) Inpatient psychiatric services in all acute hospitals and psychiatric residential treatment facilities are limited to the approved length of stay. OHCA, or its designated agent, will approve lengths of stay using the current OHCA Behavioral Health medical necessity criteria as described in OAC 317:30-5-95.25 through OAC 317:30-5-95.31. The approved length of stay applies to both hospital and physician services. The Child and Adolescent Level of Care Utilization System (CALOCUS7) is a level of care assessment that will be used as a tool to determine the most appropriate level of care treatment for a member by LBHPs in the community.

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

SUBCHAPTER 3. GENERAL PROVIDER POLICIES

PART 1. GENERAL SCOPE AND ADMINISTRATION

317:30-3-19.5. Termination of provider agreements

Pursuant to the terms of ~~OHCA's~~the Oklahoma Health Care Authority's (OHCA) Standard Provider Agreement, both OHCA and a provider may terminate the agreement without cause on sixty (60) days' notice, or for-cause on thirty (30) days' notice. In addition, OHCA can terminate the agreement immediately in order to protect the health and safety of members, or upon evidence of fraud (including, but not limited to, a credible allegation of fraud as defined by 42 C.F.R. § 455.2). Conduct that may serve as a basis for a for-cause termination of a provider includes, but is not limited to, any of the following:

(1) **Noncompliance.** The provider is determined not to be in compliance with the enrollment requirements described in ~~OAC~~Oklahoma Administrative Code (OAC) 317:30-3-2~~, OAC 317:30-3-19~~and 317:30-3-19.3, or in the enrollment application applicable for its provider type. OHCA may, but is not required to, request additional documentation from the provider to determine compliance.

(2) **Provider exclusion, debarment, or suspension.** The provider or any owner, managing employee, authorized or delegated official, medical director, supervising physician, or other health care personnel thereof is:

(A) Excluded from the Medicare, Medicaid, or any other Federal health care program, as defined in 42 C.F.R § 1001.2; or

(B) Debarred, suspended, or otherwise excluded from participating in any other Federal procurement or nonprocurement program or activity.

(3) **Convictions.** Conviction of the provider or any of its affiliates for a Federal or State offense that OHCA has determined to be detrimental to the best interests of the program and its members. Such offenses may include, but are not limited to, those offenses enumerated in OAC 317:30-3-19.3 and OAC 317:30-3-19.4.

(4) **False or misleading information.** The provider submitted or caused to be submitted misleading or false information on its enrollment application to be enrolled or to maintain enrollment in the SoonerCare program. In addition to termination of a contract, offenders may be referred for prosecution, which could result in fines or imprisonment, or both, in accordance

with current law and regulations.

(5) **On-site review.** OHCA determines, upon on-site review, that the provider is no longer operational, able to furnish SoonerCare covered items, or able to safely and adequately render services; or is not meeting SoonerCare enrollment requirements under statute or regulation to supervise treatment of, or to provide SoonerCare covered items or services for SoonerCare members.

(6) **Misuse of billing number.** The provider knowingly sells to or allows another individual or entity to use its billing number. This does not include those providers who enter into a valid reassignment of benefits as specified in 42 U.S.C. § 1396a(a)(32) or a change of ownership as outlined in 42 C.F.R. § 455.104(c) (within thirty-five (35) days of a change in ownership).

(7) **Abuse of billing privileges.** The provider submits a claim or claims for services that reasonably could not have been rendered, or that do not accurately reflect those services actually rendered, to a specific individual on the date of service. These instances include, but are not limited to: upcoding; unbundling of services; services that are purportedly provided to a member who has died prior to the date of service; services that are purportedly provided on a date on which the directing physician or member is not in the State or country or is otherwise physically incapable of providing or receiving the service; or the equipment necessary for testing was not present where the testing is said to have occurred, or was incapable of operating correctly at the supposed time of testing.

(8) **Failure to report.** The provider did not comply with the reporting requirements specified in the SoonerCare Provider Agreement or any applicable State and/or Federal statutes or regulations, including without limitation, changes in the provider's licenses, certifications, and/or accreditations provided at the time of enrollment. Providers shall report and update a change in mailing address within fourteen (14) days of such change.

(9) **Failure to document or provide OHCA access to documentation.**

(A) The provider did not comply with the documentation or OHCA access requirements specified in the SoonerCare Provider Agreement.

(B) OHCA may suspend all SoonerCare payments to a provider who refuses or fails to produce for inspection those financial and other records as are required by 42 C.F.R. § 431.107 and the executed SoonerCare Provider Agreement, until such time as all requested records have been submitted to OHCA for review.

(10) **Adverse audit determinations.** The provider receives an

adverse Program Integrity audit that demonstrates fraud, waste, abuse, and/or repeated failure or inability to comply with SoonerCare billing and provision of service requirements.

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 75. FEDERALLY QUALIFIED HEALTH CENTERS

317:30-5-664.8. Obstetrical care provided by Health Centers

(a) **Billing written agreement.** In order to avoid duplicative billing situations, a Health Center must have a written agreement with its physician, certified nurse midwife, advanced practice nurse, or physician assistant that specifically identifies how obstetrical care will be billed. The agreement must specifically identify the service provider's compensation for Health Center core services and other health services that may be provided by the Health Center.

(b) **Prenatal or postpartum services.**

(1) If the Health Center compensates the physician, certified nurse midwife or advanced practice nurse for the provision of obstetrical care, then the Health Center bills the ~~OHCA~~Oklahoma Health Care Authority (OHCA) for each prenatal and postpartum visit separately using the appropriate ~~CPT~~Current Procedural Terminology (CPT) evaluation and management code(s) as provided in the Health Center billing manual.

(2) If the clinic does not compensate the provider for the provision of obstetrical care, then the provider must bill the OHCA for prenatal care according to the global method described in the SoonerCare Traditional provider specific rules for physicians, certified nurse midwives, physician assistants, and advanced practice nurses ~~(~~[refer to ~~OAC~~Oklahoma Administrative Code (OAC) 317:30-5-22~~)~~].

(3) Under both billing methods, payment for prenatal care includes all routine or minor medical problems. No additional payment is made to the prenatal provider except in the case of a major illness distinctly unrelated to pregnancy.

(c) **Delivery services**. Delivery services are billed using the appropriate CPT codes for delivery. If the clinic does not compensate the provider for the provision of obstetrical care, then the provider must be individually enrolled and bill for those services using his or her assigned provider number. The costs associated with the delivery must be excluded from the cost settlement/encounter rate setting process ~~(see OAC 317:30-5-664.11)~~.

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 6. INPATIENT PSYCHIATRIC SERVICES

317:30-5-96.6. Payment for Medicare/Medicaid dual ~~eligibles~~eligible individuals

~~Payment is made to hospitals for services to Medicare eligible individuals as set forth in this section. Payment is not made to freestanding psychiatric hospitals for inpatient coinsurance and/or deductible for individuals between 21 and 65 years of age.~~

~~(1) **Individuals eligible for Part A and Part B.**~~

~~(A) Payment is made utilizing the Medicaid allowable for comparable Part B services.~~

~~(B) Payment is made for the inpatient deductible for Part A services for categorically needy individuals under the age of 21 and age 65 and over.~~

~~(2) **Individuals who are not eligible for Part A services.** For individuals who have exhausted Medicare Part A benefits, claims must be accompanied by a statement from the Medicare Part A intermediary showing the date benefits were exhausted.~~

(a) **For dual eligible members**. Payment is made for Medicare-related deductibles and/or coinsurance.

(b) **For individuals who are not eligible for Part A services**. For individuals who have exhausted Medicare Part A benefits, claims must be accompanied by a statement from the Medicare Part A Regional Administrative Contractor showing the date benefits were exhausted.

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 6. INPATIENT PSYCHIATRIC SERVICES

317:30-5-95.33. Individual plan of care for members under the age of twenty-one (21)

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

(1) **"Licensed ~~Behavioral Health Professional~~behavioral health professional (LBHP)"** means licensed psychologists, licensed clinical social workers (LCSW), licensed marital and family therapists (LMFT), licensed professional counselors (LPC), licensed behavioral practitioners (LBP), licensed alcohol and drug counselors (LADC), and ~~Advanced Practice Registered Nurses~~advanced practice registered nurses (APRN).

(2) **"Licensure ~~Candidate~~candidate"** means practitioners actively and regularly receiving board approved supervision, and extended supervision by a fully licensed clinician if board's supervision requirement is met but the individual is not yet licensed, to become licensed by one of the following licensing boards:

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

(3) **"Individual ~~Plan of Care~~plan of care (IPC)"** means a written plan developed for each member within four (4) calendar days of admission to an acute psychiatric facility or a PRTF that directs the care and treatment of that member. The IPC must be recovery focused, trauma informed, and specific to culture, age, and gender and include:

(A) A primary diagnosis from the most recent edition of ~~"The Diagnostic and Statistical Manual of Mental Disorders"~~the Diagnostic and Statistical Manual of Mental Disorders (DSM) with the exception of V-Codes, adjustment disorders, and substance abuse related disorders, accompanied by a detailed description of the symptoms supporting the diagnosis. Members eighteen (18) to twenty (20) years of age may have a diagnosis of any personality disorder. Adjustment or substance related disorders may be a secondary diagnosis;
(B) ~~the~~The current functional level of the individual;

(C) ~~treatment~~Treatment goals and measurable, time-limited objectives;

(D) ~~any~~Any orders for psychotropic medications, treatments, restorative and rehabilitative services, activities, therapies, social services, diet, and special procedures recommended for the health and safety of the member;

(E) ~~plans~~Plans for continuing care, including review and modification to the IPC; and

(F) ~~plan~~Plan for discharge, all of which is developed to improve the member's condition to the extent that the inpatient care is no longer necessary.

(b) The IPC:

(1) ~~must~~Must be based on a diagnostic evaluation that includes examination of the medical, psychological, social, behavioral, and developmental aspects of the individual member and reflects the need for inpatient psychiatric care;

(2) ~~must~~Must be developed by a team of professionals in consultation with the member, his or her parents or legal guardians [for members under the age of eighteen (18)], or others in whose care he or she will be released after discharge. This team must consist of professionals as specified below:

(A) ~~for~~For a member admitted to a psychiatric hospital or PRTF, by the "interdisciplinary team" as defined by ~~OAC~~Oklahoma Administrative Code (OAC) 317:30-5-95.35(b)(2), per 42 C.F.R. '' 441.155 and 483.354; or

(B) ~~for~~For a member admitted to a psychiatric unit of a general hospital, by a team comprised of at least:

(i) ~~an Allopathic or Osteopathic Physician~~An allopathic or osteopathic physician with a current license and a board certification/eligible in psychiatry, or a current resident in psychiatry practicing as described in OAC 317:30-5-2(a)(1)(U); and

(ii) ~~a Registered Nurse~~A registered nurse (RN) with a minimum of two (2) years of experience in a mental health treatment setting; and

(iii) ~~an~~An LBHP.

(3) ~~must~~Must establish treatment goals that are general outcome statements and reflective of informed choices of the member served. Additionally, the treatment goals must be appropriate to the member's age, culture, strengths, needs, abilities, preferences, and limitations;

(4) ~~must~~Must establish measurable and time-limited treatment objectives that reflect the expectations of the member served and parents/legal guardians (when applicable), as well as being age, developmentally, and culturally appropriate. When modifications are being made to accommodate age, developmental level, or a cultural issue, the documentation must be reflected

on the IPC. The treatment objectives must be achievable and understandable to the member and the parents/legal guardians (when applicable). The treatment objectives also must be appropriate to the treatment setting and list the frequency of the service;
(5) ~~must~~Must t prescribe an integrated program of therapies, activities, and experiences designed to meet the objectives;
(6) ~~must~~Must include specific discharge and after care plans that are appropriate to the member's needs and effective on the day of discharge. At the time of discharge, after care plans will include referral to medication management, outpatient behavioral health counseling, and case management, to include the specific appointment date(s), names, and addresses of service provider(s) and related community services to ensure continuity of care and reintegration for the member into his or her family, school, and community;
(7) ~~must~~Must be reviewed, at a minimum, every five (5) to nine (9) calendar days for members admitted to an acute care setting; every fourteen (14) calendar days for members admitted to a regular PRTF; every twenty-one (21) calendar days for members admitted to an OHCA-approved longer-term treatment program or specialty PRTF; and every thirty (30) calendar days for members admitted to a Community Based Transitional PRTF. Review must be undertaken by the appropriate team specified in OAC 317:30-5-95.33(b)(2), above, to determine that services being provided are or were required on an inpatient basis, and to recommend changes in the IPC as indicated by the member's overall adjustment, progress, symptoms, behavior, and response to treatment;
(8) ~~development~~Development and review must satisfy the utilization control requirements for recertification [42 C.F.R. '' 456.60(b), 456.160(b), and 456.360(b)], and establishment and periodic review of the IPC (42 C.F.R. '' 456.80, 456.180, and 456.380); and,
(9) ~~each~~Each IPC and IPC review must be clearly identified as such and be signed and dated individually by the member, parents/legal guardians [for members under the age of eighteen (18)], and required team members. All IPCs and IPC reviews must be signed by the member upon completion, except when a member is too physically ill or the member's acuity level precludes him or her from signing. If the member is too physically ill or the member's acuity level precludes him or her from signing the IPC and/or the IPC review at the time of completion, the member must sign the plan when his or her condition improves, but before discharge. The documentation should indicate the reason the member was unable to sign and when the next review will occur to obtain the signature. IPCs and IPC reviews are not valid until completed and appropriately signed and dated. All

requirements for the IPCs and IPC reviews must be met; otherwise, a partial per diem recoupment will be merited. If the member's parent/legal guardian is unable to sign the IPC or IPC review on the date it is completed, then within seventy-two (72) hours the provider must in good faith and with due diligence attempt to telephonically notify the parent/legal guardian of the document's completion and review it with them. Documentation of reasonable efforts to make contact with the member's parent/legal guardian must be included in the clinical file. In those instances where it is necessary to mail or fax an IPC or IPC review to a parent/legal guardian or Oklahoma Department of Human Services/Oklahoma Office of Juvenile Affairs (DHS/OJA) worker for review, the parent/legal guardian and/or DHS/OJA worker may fax back his or her signature. The provider must obtain the original signature for the clinical file within thirty (30) days. Stamped or photocopied signatures are not allowed for any parent/legal guardian or member of the treatment team.

(10) Medically necessary Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services shall be provided to members, under the age of twenty-one (21), who are residing in an inpatient psychiatric facility, regardless of whether such services are listed on the IPC. Reimbursement for the provision of medically necessary EPSDT services to individuals under age twenty-one (21), while the member is residing in an inpatient psychiatric facility, will be provided in accordance with the Oklahoma Medicaid State Plan.

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 75. FEDERALLY QUALIFIED HEALTH CENTERS

317:30-5-664.3. ~~Health Center encounters~~Federally Qualified Health Center (FQHC) encounters

(a) ~~Health Center~~FQHC encounters that are billed to the ~~OHCA~~Oklahoma Health Care Authority (OHCA) must meet the definition in this Section and are limited to services covered by OHCA. Only encounters provided by the authorized health care professional on the approved FQHC state plan pages within the scope of their licensure trigger a ~~PPS~~prospective payment system encounter rate.

(b) An encounter is defined as a face-to-face contact between a health care professional and a member for the provision of defined services through a ~~Health Center~~FQHC within a 24-hour period ending at midnight, as documented in the member's medical record.

(c) ~~A Health Center~~An FQHC may bill for one medically necessary encounter per 24 hour period~~.~~ when the appropriate modifier is applied. Medical review will be required for additional visits for children. For information about multiple encounters, refer to Oklahoma Administrative Code (OAC) 317:30-5-664.4. Payment is limited to four (4) visits per member per month for adults.

(d) Services considered reimbursable encounters (including any related medical supplies provided during the course of the encounter) include:

(1) medical;
(2) diagnostic;
(3) dental, medical and behavioral health screenings;
(4) vision;
(5) physical therapy;
(6) occupational therapy;
(7) podiatry;
(8) behavioral health;
(9) speech;
(10) hearing;
(11) medically necessary ~~Health Center~~FQHC encounters with a ~~RN~~registered nurse or ~~LPN~~licensed practical nurse and related medical supplies (other than drugs and biologicals) furnished on a part-time or intermittent basis to home-bound members (refer to OAC 317:30-5-661.3); and
(12) any other medically necessary health services (i.e. optometry and podiatry) are also reimbursable as permitted within the ~~Health Center's~~FQHCs scope of services when medically reasonable and necessary for the diagnosis or

treatment of illness or injury, and must meet all applicable coverage requirements.

(e) Services and supplies incident to a physician's professional service are reimbursable within the encounter if the service or supply is:

(1) of a type commonly furnished in physicians' offices;

(2) of a type commonly rendered either without a charge or included in the health clinic's bill;

(3) furnished as an incidental, although integral, part of a physician's professional services;

(4) furnished under the direct, personal supervision of a physician; and

(5) in the case of a service, furnished by a member of the clinic's health care staff who is an employee of the clinic.

(f) Only drugs and biologicals which cannot be self-administered are included within the scope of this benefit.

317:30-5-664.4. Multiple encounters at Federally Qualified Health Centers (FQHC)

An FQHC may bill for more than one (1) medically necessary encounter per 24-hour period under certain conditions when the appropriate modifier is applied.

(1) It is intended that multiple medically necessary encounters will occur on an infrequent basis.

(2) An FQHC may not develop FQHC procedures that routinely involve multiple encounters for a single date of service, unless medical necessity warrants multiple encounters.

(3) Each service must have distinctly different diagnoses in order to meet the criteria for multiple encounters. For example, a medical visit and a dental visit on the same day are considered different services with distinctly different diagnoses.

(4) Similar services, even when provided by two (2) different health care practitioners, are not considered multiple encounters.

(5) Encounters with more than one (1) FQHC practitioner on the same day, regardless of the length or complexity of the visit, would constitute a single visit. An exception is when the patient has either or both of these:

(A) An illness or injury requiring additional diagnosis or treatment subsequent to the first encounter; and/or

(B) A qualified medical visit, a qualified mental health and/or dental visit on the same day.

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

SUBCHAPTER 7. EMPLOYMENT SERVICES THROUGH HOME AND COMMUNITY-BASED SERVICES WAIVERS

317:40-7-5. ~~Community-Based Services~~Community-based services

~~Community-Based Services~~Community-based services are provided in sites and at times typically used by others in the community and promote independence, ~~inclusion within the~~ community~~,~~ inclusion, and the creation of natural supports. Community-based services must reflect the member's choice and values in typical age and cultural situations~~ that are typical for age and culture~~.

(1) Approved ~~Community-Based Services~~community-based services are individualized work-related supports targeting inclusion into integrated experiences~~. Community-Based Services~~ and are pre-planned, documented activities supported by a schedule relating to the member's identified employment outcomes. Approved community-based services activities include:

(A) active participation in formalized volunteer activities;

(B) active participation in paid or unpaid work experience sites in community settings;

(C) training through generic entities such as trade schools, ~~Vo Techs,~~technology centers, ~~junior~~community colleges, or other community groups. The provider is paid for the time ~~during which~~when direct supports are necessary and provided;

(D) stamina-enhancing programs~~ that occur~~ in integrated settings;

(E) transportation to and from employment or community-based activities;

(F) meals and breaks~~ which must occur~~ during~~ the conduct of~~ the member's employment activities~~;~~ that occur in the community at a location used for the same purpose, with others without disabilities;

(G) job tours or job shadowing scheduled with and provided by a ~~community business~~community-business entity;

(H) using Workforce OK services; and

(I) attending job fairs.

(2) Any other work-related, community-based activities must be approved through the exception process, ~~described in OAC~~ per Oklahoma Administrative Code (OAC) 317:40-7-21.

(3) ~~Community-Based Services~~Community-based services continue ~~if~~when the member ~~has to go~~goes to a center-based facility for support, such as repositioning or personal care, as long as the member returns immediately to a planned community-based activity. The amount of time for the repositioning and personal care are based upon a Team-approved health care positioning plan~~ approved by the Team~~.

(4) ~~Community-Based Services~~Community-based services are available for individual and group placements.

(A) Individual placement means the member is provided supports that enable him or her to participate in ~~approved~~individual community-based activities described in this Section~~ individually~~ and not as part of a group placement.

(B) Group ~~Placement~~placement means ~~two to five~~two-to-five members are provided supports that enable ~~him or her to participate~~participation in the approved community-based activities described in this Section.

317:40-7-6. Center-based services

(a) Center-based services are~~ any~~ employment ~~service~~services provided where ~~a~~the majority of the people at the site ~~are persons with a disability.~~have disabilities. These settings facilitate opportunities to seek employment in competitive settings and support access to the greater community.

(b) Center-based services are pre-planned, documented activities that relate to the member's identified employment outcomes.

(c) Examples of ~~Center-based~~center-based services are active participation in:

(1) learning and work experiences where the individual can develop general, non-job-task specific strengths and skills that contribute to employability in paid employment in integrated community settings;

(2) team-prescribed therapy programs, such as speech, physical therapy, or a switch activation program implemented by employment provider staff in the workshop or other center-based setting;~~ and~~

(3) computer classes, General Education Development preparation, job club, interviewing skills, or other classes ~~whose~~where all participants~~ all~~ have disabilities, even when the location is in the community~~.~~; and

(4) mealtimes where the majority of people with disabilities are employed.

(d) Paid contract work is usually subcontracted, and the ~~persons~~member receiving services ~~earn~~earns commensurate wage according to Department of Labor regulations.

(e) Participation in ~~Center-based~~center-based services is limited to ~~15~~fifteen (15) hours per week for ~~persons~~members receiving services through the Homeward Bound Waiver, unless approved through the exception process, ~~explained in (OAC)~~per Oklahoma Administrative Code (OAC) 317:40-7-21.

(f) The provider agency must meet physical plant expectations, ~~of (OAC)~~per OAC 340:100-17-13.

(g) During periods in which no paid work is available~~ for members,~~ despite the provider's documented good faith efforts to secure

work, the employment-provider agency ensures each member participates in training activities that are age appropriate, work related, and consistent with the Individual Plan. Such activities may include, but are not limited to:

(1) resume development and application writing;
(2) work attire selection;
(3) job interview training and practice;
(4) job safety and evacuation training;
(5) personal or social skills training; and
(6) stamina and wellness classes.

317:40-7-15. Service requirements for employment services through Home and Community-Based Services (HCBS) Waivers

(a) The Oklahoma Department of Human Services (DHS) Developmental Disabilities Services (DDS) case manager, the member, ~~a~~the member's family or, when applicable, the member's legal guardian, and the member's provider develop a preliminary plan of services including the:

(1) site and amount of the services ~~to be~~ offered;
(2) types of services to be delivered; and
(3) expected outcomes.

(b) To promote community integration and inclusion, employment services are ~~only~~ delivered in non-residential sites.

(1) Employment services through ~~Home and Community-Based Services (HCBS) Waivers~~HCBS waivers cannot be reimbursed when those services occur in the residence or property of the member or provider-paid staff, including garages and sheds, whether the garage or shed is attached to the home or not.

(2) No exceptions to Oklahoma Administrative Code (OAC) 317:40-7-15(b) are authorized~~.~~ except when a home-based business is established and supported through the Oklahoma Department of Rehabilitation Services (OKDRS). Once OKDRS stabilization services end, DDS stabilization services are then utilized.

(c) The service provider is required to notify the DDS case manager in writing when the member:

(1) is placed in a new job;
(2) loses his or her job. A ~~Personal Support Team~~personal support team (Team) meeting must be held when the member loses the job;
(3) experiences significant changes in the community-based or employment schedule; or
(4) ~~experiences other circumstances,~~is involved in critical and non-critical incidents per OAC 340:100-3-34.

(d) The provider submits a DHS Provider Progress Report, per OAC 340:100-5-52, for each member receiving services.

(e) The cost of a member's employment services, excluding transportation and state-funded services per OAC 340:100-17-30, cannot exceed $27,000 per Plan of Care year.

(f) Each member receiving ~~residential supports per OAC 340:100-5-22.1, or group home services is employed for 30 hours per week or receives a minimum of 30 hours of employment services, each week, excluding transportation to and from the member's residence.~~HCBS is supported in opportunities to seek employment and work in competitive integrated settings. When the member is not employed in a competitive integrated job, the Team identifies outcomes and/or action steps to create opportunities that move the member toward competitive integrated employment.

(g) Each member receiving residential supports, per OAC 340:100-5-22.1, or group-home services is employed for thirty (30) hours per week or receives a minimum of thirty (30) hours of employment services each week, excluding transportation to and from his or her residence.

(1) ~~Thirty-hours~~Thirty (30) hours of employment service each week may be a combination of community-based services, center-based services, employment training specialist (ETS) intensive training services, stabilization services, ~~and~~or job coaching services. Center-based services cannot exceed ~~15~~fifteen (15) hours per week for members receiving services through the Homeward Bound Waiver.

(2) ~~Less than 30 hours of employment activities per week requires approval per OAC 317:40-7-21.~~When the member does not participate in thirty (30) hours per week of employment services, the Team:

(A) documents the outcomes and/or action steps to create a pathway that moves toward employment activities;

(B) describes a plan to provide a meaningful day in the community; or

(C) increases the member's employment activities to thirty (30) hours per week.

317:40-7-21. Exception process for employment services through Home and Community-Based Services Waivers

(a) All exceptions to rules in ~~OAC~~Oklahoma Administrative Code (OAC) 317:40-7 are:

(1) approved, per OAC 317:40-7-21 prior to service implementation;

(2) intended to result in the ~~Personal Support Team~~personal support team (Team) development of an employment plan tailored to meet the member's needs;

(3) identified in the Individual Plan (Plan) process, per OAC 340:100-5-50 through 340:100-5-58; and

(4) documented and recorded in the Individual Plan by the Developmental Disabilities Services Division ~~(DDSD)~~(DDS) case manager after Team approval.

(b) ~~A request for an exception to the minimum of 30 hours per week of employment services, per OAC 317:40-7-15, includes documentation of the Team's:~~

~~(1) discussion of:~~

~~(A) current specific situation that requires an exception;~~

~~(B) all employment efforts, successful and unsuccessful, made by the member and Team in the past year; and~~

~~(C) progress toward previous exception strategies or plans;~~

~~(2) plan with specific steps and target dates to address the situation throughout the Plan of Care year so the exception may be lessened or no longer necessary at the end of the Plan of Care year; and~~

~~(3) specific residential schedule to provide integrated activities outside the home while the plan to increase to 30 hours is implemented.~~

~~(c)~~ A request for an exception to the maximum limit of ~~15~~fifteen (15) hours per week for center-based services, per OAC 317:40-7-6, or continuous supplemental supports, per OAC 317:40-7-13, for a member receiving services through the Homeward Bound Waiver includes documentation of the Team's:

(1) discussion of:

(A) a current, specific situation that requires an exception;

(B) all employment efforts, successful and unsuccessful, made by the member and Team in the past year; and

(C) progress toward previous exception strategies or plans; and

(2) plan, with specific steps and target dates to address the situation throughout the Plan of Care year, so the exception may be lessened or no longer necessary at the end of the Plan of Care year.

~~(d)~~(c) A request for an alternative to required community-based activities per OAC 317:40-7-5 includes documentation of the Team's:

(1) discussion of:

(A) current specific situation that requires an exception;

(B) all employment efforts, successful and unsuccessful, made by the member and Team in the past year; and

(C) progress toward previous exception strategies or plans; and

(2) plan, with specific steps and target dates to address the situation throughout the Plan of Care year, so the exception may be lessened or no longer necessary at the end of the Plan of Care year.

~~(e)~~(d) Exception requests, per OAC 340:40-7-21~~(f)~~(e), are documented by the ~~DDSD~~DDS case manager after Team consensus, and submitted to the ~~DDSD area manager~~DDS field administrator or designee within ~~ten working~~ten-business (10-business) days after

the annual IP or interim Team meeting. The ~~area manager~~field administrator approves or denies the request~~ with a copy to the DDSD area office claims staff and case manager~~ based on the thoroughness of the Team's discussion of possible alternatives and reasons for rejection of the other possible alternatives. A copy of the field administrator's decision is provided to the assigned case manager. A request for any other exception to rules in OAC 317:40-7-21 requires documentation of the Team's discussion of:

(1) a current, specific situation that requires an exception;

(2) all employment efforts, successful and unsuccessful, made by the member and Team in the past year; and

(3) progress toward previous exception strategies or plans.

~~(1) State dollar reimbursement for absences of a member receiving services through the Community Waiver in excess of 10% of authorized units up to 150 units is approved for medical reasons only. The request includes:~~

~~(A) Team's discussion of current specific situation that requires an exception;~~

~~(B) specific medical issues necessitating the exception request; and~~

~~(C) a projection of units needed to complete the State fiscal year.~~

~~(2) A request for any other exception to rules in OAC 317:40-7-21 requires documentation of the Team's discussion of:~~

~~(A) current specific situation that requires an exception;~~

~~(B) all employment efforts, successful and unsuccessful, made by the member and Team in the past year; and~~

~~(C) progress toward previous exception strategies or plans.~~

~~(f)~~(e) The ~~DDSD~~DDS director or designee may review exceptions granted per OAC 317:40-7-21, directing the Team to provide additional information, ~~if~~when necessary, to comply with OAC 340:100-3-33.1 and other applicable rules

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

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

317:30-5-1041. Eligible providers

Payment is made for Residential Behavior Management Services (RBMS) in group settings ~~and non-secure Diagnostic and Evaluation (D&E) Centers~~ to any ~~OHCDS who~~Organized Heath Care Delivery System (OHCDS) that is a child placing agency ~~who~~, that has a statutory authority for the care of children in the custody of the State of Oklahoma and which enters into a contract with the State Medicaid program. The OHCDS must certify to the ~~OHCA~~Oklahoma Health Care Authority (OHCA) that all direct providers of services (whether furnished through its own employees or under contract) meet the minimum program qualifications. ~~Residential Behavior Management Services and Diagnostic and Evaluation services~~ RBMS are covered only for those beds contracted by the OHCDS.

317:30-5-1042. Memorandum of agreement

A Memorandum of Agreement between the Oklahoma Health Care Authority (OHCA) and the Organized Heath Care Delivery System (OHCDS) must be in effect before reimbursement can be made for compensable services. The agreement outlines the contractual and subcontractual requirements for reimbursement. This agreement provides that the OHCDS is responsible for the Medicaid ~~State~~state share required for federal financial participation for all ~~RBMS~~Residential Behavior Management Services (RBMS) provided to custody children in residential ~~group home and diagnostic and evaluation settings.~~group homes.

317:30-5-1043. Coverage by category

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

(b) **Children.** ~~Residential Behavioral Management Services (RBMS) in Group Settings and Non-Secure Diagnostic and Evaluation Centers~~ RBMS in group settings are covered for children as set forth in this subsection.

(1) **Description**. ~~Residential Behavior Management Services~~RBMS are provided by Organized Health Care Delivery Systems (OHCDS) for children in the care and custody of the State who have special psychological, behavioral, emotional and social needs that require more intensive care than can be provided in a family or foster home setting. The behavior management services

are provided in the least restrictive environment and within a therapeutic milieu. The group setting is restorative in nature, allowing children with emotional and psychological problems to develop the necessary control to function in a less restrictive setting. ~~Residential Behavior Management Services are reimbursed in accordance with the intensity of supervision and treatment required for the group setting in which the child is placed. Members residing in a Level E and Intensive Treatment Services (ITS) Group Homes receive maximum supervision and treatment. In addition, ITS group homes provide crisis and stabilization intervention and treatment. Members residing in a Level D+ Group Home receive highly intensive supervision and treatment. Members residing in a Level D Group home or in a wilderness camp receive close supervision and moderate treatment. Members residing in a Level C Group Home receive minimum supervision and treatment. Members residing in Residential Diagnostic and Evaluation Centers receive intensive supervision and a 20 day comprehensive assessment. Members residing in a Sanctions Home receive highly intensive supervision and treatment. Members residing in an Independent Living Group Home receive intensive supervision and treatment.~~RBMS are reimbursed in accordance with established rate methodology as described in the Oklahoma Medicaid State Plan. It is expected that RBMS in group settings are an all-inclusive array of treatment services provided in one (1) day. In the case of a child who needs additional specialized services, under the Rehabilitation Option or by a psychologist, prior authorization by the OHCA or designated agent is required. Only specialized rehabilitation or psychological treatment services to address unique, unusual or severe symptoms or disorders will be authorized. If additional services are approved, the OHCDS collaborates with the provider of such services as directed by the OHCA or its agent. Any additional specialized behavioral health services provided to children in state custody are funded in the normal manner. The OHCDS must provide concurrent documentation that these services are not duplicative. The OHCDS determines the need for RBMS.

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

(A) Any ~~DSM~~Diagnostic and Statistical Manual of Mental Disorders (DSM) primary diagnosis, with the exception of V codes, with a detailed description of the symptoms supporting the diagnosis. A detailed description of the child's emotional, behavioral and psychological condition must be on file. ~~A diagnosis is not required for behavior management services provided in Diagnostic and Evaluation centers.~~

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

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

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

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

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

(3) **Treatment components.**

(A) **Individual plan of care development.** A comprehensive individualized plan of care for each resident shall be formulated by the provider agency staff within ~~30~~thirty (30) days of admission, for ~~ITS~~intensive treatment services (ITS) level within ~~72~~seventy-two (72) hours, with documented input from the agency which has permanent or temporary custody of the child and when possible, the parent. This plan must be revised and updated at least every three (3) months, every seven (7) days for ITS, with documented involvement of the agency which has permanent or temporary custody of the child. Documented involvement can be written approval of the individual plan of care by the agency which has permanent or temporary custody of the child and indicated by the signature of the agency case worker or liaison on the individual plan of care. It is acceptable in circumstances where it is necessary to fax a service plan to someone for review and then have ~~them~~him/her fax back ~~their~~his/her signature; however, the provider obtains the original signature for the clinical file within ~~30~~thirty (30) days. No stamped or Xeroxed signatures are allowed. An individual plan of care is considered inherent in the provision of therapy and is not covered as a separate item of behavior management services. The individual plan of care is individualized taking into account the child's age, history, diagnosis, functional levels, and culture. It includes appropriate goals and time limited and measurable objectives. Each member's individual plan of care must also address the provider agency's plans with regard to the provision of services in each of the following areas:

(i) ~~group~~Group therapy;

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

(B) **Individual therapy.** The provider agency must provide individual therapy on a weekly basis with a minimum of one (1) or more sessions totaling one (1) hour or more of treatment per week to children and youth receiving RBMS in ~~Wilderness Camps, Level D, Level D+ homes, Level E Homes, Independent Living Homes, and Sanctions Homes. ITS Level residents will receive a minimum of five or more sessions totaling a minimum of five or more hours of individual therapy per week. Members residing in Diagnostic and Evaluation Centers and Level C Group Homes receive Individual Therapy on an as needed basis.~~ group homes. Individual therapy must be age appropriate and the techniques and modalities employed relevant to the goals and objectives of the individual's plan of care. Individual counseling is a ~~face to face, one to one~~face-to-face, one-to-one service, and must be provided in a confidential setting.

(C) **Group therapy.** The provider agency must provide group therapy to children and youth receiving ~~residential behavioral management services~~RBMS. Group therapy must be a ~~face to face~~face-to-face interaction, age appropriate and the techniques and modalities employed relevant to the goals and objectives of the individual's plan of care. The minimum expected occurrence would be one (1) hour per week in ~~Level D, Level C, Wilderness Camps and Independent Living. Two hours per week are required in Levels D+ and E. Ten hours per week are required in Sanctions Homes, Intensive Treatment Service Level. Group therapy is not required for Diagnostic and Evaluation Centers.~~ group homes. Group size should not exceed six (6) members and group therapy sessions must be provided in a confidential setting. One half hour (30 min) of individual therapy may be substituted for one (1) hour of group therapy.

(D) **Family therapy.** Family therapy is a ~~face to face~~face-to-face interaction between the therapist/counselor and family, to facilitate emotional, psychological or behavioral changes and promote successful communication and understanding. The provider agency must provide family

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

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

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

(G) **Social skills redevelopment.** The provider agency must provide ~~goal directed~~goal-directed activities designed for each resident to restore, retain and improve the ~~self help~~self-help, communication, socialization, and adaptive skills necessary to reside successfully in home and community based settings. These are age appropriate, culturally sensitive and relevant to the goals of the individual plan of care. For ITS level of care, the minimum skill redevelopment per day is three (3) hours. Any combination of basic living skills and social skills

redevelopment that is appropriate to the need and developmental abilities of the child is acceptable.

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

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

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

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

~~(i) Psychology,~~

~~(ii) Social work (clinical specialty only),~~

~~(iii) Licensed professional counselor,~~

~~(iv) Licensed marriage and family therapist, or~~

~~(v) Licensed behavioral practitioner; or~~

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

~~(D) be a registered psychiatric nurse; AND~~

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

~~(i) case management, assessment and treatment planning;~~

~~(ii) treatment of victims of physical, emotional, and sexual abuse;~~

~~(iii) treatment of children with attachment disorders;~~

~~(iv) treatment of children with hyperactivity or attention deficit disorders;~~

~~(v) treatment methodologies for emotional disturbed children and youth;~~

~~(vi) normal childhood development and the effect of abuse and/or neglect on childhood development;~~
~~(vii) treatment of children and families with substance abuse and chemical dependency disorders;~~
~~(viii) anger management; and~~
~~(ix) crisis intervention.~~

~~(5)~~(4) **Providers.** For eligible RBMS agencies to bill the ~~Oklahoma Health Care Authority~~OHCA for services provided by their staff for behavior management therapies ~~(Individual, Group, Family)~~(individual, group, family) as of July 1, 2007, providers must have the following qualifications:

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

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

(C) ~~demonstrate~~Demonstrate a general professional or educational background in the following areas:

(i) ~~case~~Case management, assessment and treatment planning;

(ii) ~~treatment~~Treatment of victims of physical, emotional, and sexual abuse;

(iii) ~~treatment~~Treatment of children with attachment disorders;

(iv) ~~treatment~~Treatment of children with hyperactivity or attention deficit disorders;

(v) ~~treatment~~Treatment methodologies for emotionally disturbed children and youth;

(vi) ~~normal~~Normal childhood development and the effect of abuse and/or neglect on childhood development;

(vii) ~~treatment~~Treatment of children and families with substance abuse and chemical dependency disorders;

(viii) ~~anger~~Anger management; and

(ix) ~~crisis~~Crisis intervention.

(D) Staff providing basic living skills redevelopment, social skills redevelopment, and alcohol and other substance abuse treatment, must meet one (1) of the following areas:

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

(ii) ~~a~~A current license as ~~a registered nurse~~an RN in Oklahoma; or

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

(iv) ~~current~~Current certification as a ~~Behavioral Health Case Manager~~behavioral health case manager from ~~DMHSAS~~the Oklahoma Department of Mental Health and Substance Abuse (ODMHSAS) and meets OHCA requirements to perform case management services, as described in ~~OAC~~Oklahoma Administrative Code (OAC) 317:30-5-240 through 317:30-5-249.

(E) Staff providing behavior redirection services must have current certification and required updates in nationally recognized behavior management techniques, such as Controlling Aggressive Patient Environment (CAPE) or MANDT. Additionally, staff providing these services must receive initial and ongoing training in at least one (1) of the following areas:

(i) ~~trauma informed~~Trauma-informed methodology~~,~~;

(ii) ~~anger~~Anger management~~,~~;

(iii) ~~crisis~~Crisis intervention~~,~~;

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

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

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

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

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

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

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

(xi) ~~passive~~Passive physical restraint procedures~~,~~; or

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

(F) In addition, ~~Behavioral Management~~behavior management staff must have access to consultation with an appropriately licensed mental health professional.

317:30-5-1044. Payment rates

A per diem rate is established for each residential level of care in which behavior management services are provided. ~~The payment rate is based upon a sample analysis of the average annual allowable cost of providing the program components of behavior management services using facility time study and cost reports of the OHCDS and the facilities under contract to them.~~ The payment is an ~~all inclusive~~all-inclusive daily rate for all behavior management services provided under the auspices of the ~~OHCDS~~Organized Health Care Delivery System (OHCDS). Room and ~~Board~~board costs, educational costs and related administrative costs are not reimbursable and are excluded from the calculation of the daily rate. ~~RBMS services~~Residential Behavioral Management Services (RBMS) are limited to a maximum of one (1) service per day per eligible recipient.

317:30-5-1046. Documentation of records and records review

(a) The ~~OHCDS~~Organized Health Care Delivery System (OHCDS) and the facilities with whom it contracts must maintain appropriate records system. Current individual plans of care, case files, and progress notes are maintained in the facilities' files during the time the child or youth is receiving services. All services rendered must be reflected by documentation in the case records.

(b) ~~OHCA~~The Oklahoma Health Care Authority (OHCA) and the Centers for Medicare and Medicaid Services (CMS) may evaluate through inspection or other means, the quality, appropriateness and timeliness of services provided by the OHCDS or facilities with whom it contracts.

(c) All ~~residential behavioral management services~~Residential Behavioral Management Services (RBMS) in group settings ~~and non-secure diagnostic and evaluation centers~~ must be reflected by documentation in the patients' records. Individual, group, family, and alcohol and other drug counseling and social and basic living skills development services must include all of the following:

(1) ~~date~~Date;

(2) ~~start~~Start and stop time for each session;

(3) ~~signature~~Signature of the therapist/staff providing service;

(4) ~~credentials~~Credentials of therapist/staff providing service;

(5) ~~specific~~Specific problem(s) addressed (problem must be identified on individualized plan of care);

(6) ~~methods~~Methods used to address problem(s);

(7) ~~progress~~Progress made toward goals;

(8) ~~patient~~Patient response to the session or intervention; and

(9) ~~any~~Any new problem(s) identified during the session.

Oklahoma Health Care Authority Board Meeting – Drug Summary

Drug Utilization Review Board – Drug Summary February 13, 2019

Recommendation	Drug	Used for	Cost*	Notes
1	Arikayce®	Mycobacterium avium complex (MAC)	$3,049.20 per dose $85,377.60 per 28-day supply	Inhaled antibiotic. Other aminoglycoside alternatives available.
2	Revcovi™	Adenosine deaminase severe combined immune deficiency (ADA-SCID) in pediatric and adult patients	$197,120.20- $394,240,40 per 28-day therapy	Comparable drug cost $104,140.00 per 28-day therapy.
3	Lokelma™	Hyperkalemia -- impaired urinary potassium excretion	$7,858.80 Cost per Year	Other generics available costs range for SFY18 $416.44, $2,012.70, $3,702.40
4	Tavalisse™ Doptelet® Mulpleta®	Thrombocytopenia	$9,450.00 per month $9,440.00 - $14,160.00 per treatment $8,500.03 per treatment	Long term treatment of immune thrombocytopenia 5 days prior to procedure 7 days prior to procedure
5	Carbaglu®	N-acetylglutamate synthase (NAGS) deficiency	Acute Treatment Cost per 3 days $4616.40-$10,963.95 Maintenance Treatment Cost per 30 Days $5770.35 - $46,164.00	Rare genetic disorder characterized by complete or partial lack of the enzyme NAGS results in excessive ammonia in the blood

*Costs do not reflect rebated prices or net costs. Costs based on National Average Drug Acquisition Costs (NADAC) or Wholesale Acquisition Costs (WAC) in NADAC unavailable.
N/A = not available at the time of publication.

Recommendation 1: Vote to Prior Authorize Arikayce® (Amikacin Liposome Inhalation Suspension)

The Drug Utilization Review Board recommends the prior authorization of Arikayce® (amikacin liposome inhalation suspension) with the following criteria:

Arikayce® (Amikacin Liposome Inhalation Suspension) Approval Criteria:

1. An FDA approved indication for the treatment of *Mycobacterium avium* complex (MAC) lung disease in adults who have limited or no alternative treatment options; and
2. Member must have had a minimum of 6 consecutive months of a multidrug background regimen therapy used compliantly and not achieved negative sputum cultures within the last 12 months. Dates of previous treatments and regimens must be listed on the prior authorization request; and
    a. If claims for a multidrug background regimen are not in the member's claim history, the pharmacy profile should be submitted or detailed information regarding dates and doses should be included along with the signature from the prescriber; and
3. Member must continue a multidrug background regimen therapy while on Arikayce®, unless contraindicated, or provide reasoning why continuation of a multidrug background regimen is not appropriate for the member; and
4. A patient-specific, clinically significant reason why the member requires an inhaled aminoglycoside in place of an intravenous or intramuscular aminoglycoside (e.g., amikacin, streptomycin) must be provided; and
5. Arikayce® will not be approved for patients with non-refractory MAC lung disease; and
6. Arikayce® must be prescribed by or in consultation with a pulmonary disease or infectious disease specialist (or be an advanced care practitioner with a supervising physician who is a pulmonary disease or infectious disease specialist); and
7. Initial approvals will be for the duration of 6 months after which time the prescriber must document the member is responding to treatment for continued approval.
8. A quantity limit of 28 vials per 28 days will apply.

Recommendation 2: Vote to Prior Authorize Revcovi™ (Elapegademase-lvlr)

The Drug Utilization Review Board recommends the prior authorization of Revcovi™ (elapegademase-lvlr) with the following criteria:

Revcovi™ (Elapegademase-lvlr) Approval Criteria:

1. An FDA approved diagnosis of adenosine deaminase severe combined immune deficiency (ADA-SCID) in pediatric and adult patients; and

a. Diagnosis of ADA deficiency should be confirmed by demonstrating biallelic mutations in the *ADA* gene; and

2. Revcovi™ must be prescribed by or in consultation with a physician who specializes in the treatment of immune deficiency disorders; and
3. The member must have failed to respond to a bone marrow transplant or not be a current suitable candidate for a bone marrow transplant; and
4. A patient-specific, clinically significant reason why Adagen® (pegademase bovine) is not appropriate for the member; or
5. Previous failure of Adagen® (pegademase bovine) used compliantly. Failure is defined as the inability to maintain ADA activity or reduce erythrocyte deoxyadenosine nucleotides (dAXP), or the member is experiencing adverse effects associated with Adagen® therapy that are not expected to occur with Revcovi™; and
6. Prescriber must agree to monitor trough plasma ADA activity, trough dAXP levels, and/or total lymphocyte counts to ensure efficacy and compliance and to monitor for neutralizing antibodies when suspected; and
7. The member's recent weight must be provided on the prior authorization request in order to authorize the appropriate amount of drug required according to package labeling; and
8. Initial approvals will be for the duration of 6 months at which time the prescriber must confirm improvement or stabilization in ADA activity or dAXP levels or improvement in immune function. Subsequent approvals will require the prescriber to verify the member is still not a current suitable candidate for a bone marrow transplant.

Recommendation 3: Vote to Prior Authorize Lokelma™ (Sodium Zirconium Cyclosilicate)

The Drug Utilization Review Board recommends the prior authorization of Lokelma™ (sodium zirconium cyclosilicate) with the following criteria:

Lokelma™ (Sodium Zirconium Cyclosilicate) Approval Criteria:

1. An FDA approved diagnosis of hyperkalemia; and
2. Medications known to cause hyperkalemia [e.g., angiotensin-converting enzyme (ACE) inhibitors, angiotensin II receptor blockers (ARBs), aldosterone antagonists, nonsteroidal

anti-inflammatory drugs (NSAIDs)] have been discontinued or reduced to the lowest effective dose where clinically appropriate; and
3. A trial of a potassium-eliminating diuretic or documentation why a diuretic is not appropriate for the member; and
4. Documentation of a low potassium diet; and
5. A quantity limit of 30 packets per month will apply. Quantity limit overrides will be granted to allow for initial 3 times daily dosing.

Recommendation 4: Vote to Prior Authorize Tavalisse™ (Fostamatinib), Doptelet® (Avatrombopag), and Mulpleta® (Lusutrombopag)

The Drug Utilization Review Board recommends the prior authorization of Tavalisse™ (fostamatinib), Doptelet® (Avatrombopag), and Mulpleta® (Lusutrombopag)with the following criteria:

Tavalisse™ (Fostamatinib) Approval Criteria:

1. An FDA approved indication for the treatment of thrombocytopenia in adult patients with chronic immune thrombocytopenia (ITP) who have had an insufficient response to a previous treatment; and
2. Member must be 18 years of age or older (Tavalisse™ is not recommended for use in patients younger than 18 years of age because adverse effects on actively growing bones were observed in nonclinical studies); and
3. Member must have a clinical diagnosis of persistent/chronic ITP for at least 3 months; and
4. Previous insufficient response with at least 2 of the following treatments:
    a. Corticosteroids; or
    b. Immunoglobulins; or
    c. Splenectomy; or
    d. Thrombopoietin receptor agonists; and
5. Degree of thrombocytopenia and clinical condition increase the risk for bleeding; and
6. Must be prescribed by, or in consultation with, a hematologist or oncologist; and
7. Prescriber must verify the member's complete blood count (CBC), including platelet counts, will be monitored monthly until a stable platelet count (at least 50 X 10^9/L) is achieved and will be monitored regularly thereafter; and
8. Prescriber must verify liver function tests (LFTs) (e.g., ALT, AST, bilirubin) will be monitored monthly; and
9. Prescriber must verify member's blood pressure will be monitored every 2 weeks until establishment of a stable dose, then monthly thereafter; and

10. Female members must not be pregnant and must have a negative pregnancy test immediately prior to therapy initiation. Female members of reproductive potential must be willing to use effective contraception while on therapy and for at least 1 month after therapy completion; and
11. Prescriber must verify member is not breastfeeding; and
12. Member must not be taking strong CYP3A4 inducers (e.g., rifampicin) concurrently with Tavalisse™; and
13. Initial approvals will be for the duration of 12 weeks; and
14. Discontinuation criteria:
    a. Platelet count does not increase to a level sufficient to avoid clinically important bleeding after 12 weeks of therapy; and
15. A quantity limit of 2 tablets daily will apply.

Doptelet® (Avatrombopag) Approval Criteria:

1. An FDA approved indication for the treatment of thrombocytopenia in adult patients with chronic liver disease who are scheduled to undergo a procedure; and
2. A patient-specific, clinically significant reason why the member cannot use Mulpleta® (lusutrombopag); and
3. Date of procedure must be listed on the prior authorization request; and
4. Prescriber must verify the member will have the procedure within 5 to 8 days after the member receives the last dose of Doptelet®; and
5. Member must have a baseline platelet count <50 X 10^9/L (recent baseline platelet count must be provided); and
6. Must be prescribed by, or in consultation with, a hematologist, gastroenterologist, or hepatologist; and
7. Doptelet® must not be used in an attempt to normalize platelet counts; and
8. A quantity limit of 15 tablets per scheduled procedure will apply.

Mulpleta® (Lusutrombopag) Approval Criteria:

1. An FDA approved indication for the treatment of thrombocytopenia in adult patients with chronic liver disease who are scheduled to undergo a procedure; and
2. Date of procedure must be listed on the prior authorization request; and
3. Prescriber must verify the member will have the procedure 2 to 8 days after the member receives the last dose of Mulpleta®; and
4. Member must have a baseline platelet count <50 X 10^9/L (recent baseline platelet count must be provided); and
5. Must be prescribed by, or in consultation with, a hematologist, gastroenterologist, or hepatologist; and
6. Mulpleta® must not be used in an attempt to normalize platelet counts; and
7. A quantity limit of 7 tablets per scheduled procedure will apply.

Recommendation 5: Vote to Prior Authorize Carbaglu® (Carglumic Acid)

The Drug Utilization Review Board recommends the prior authorization of Carbaglu® (carglumic acid) with the following criteria:

Carbaglu® (Carglumic Acid) Approval Criteria:

1. An FDA approved diagnosis of N-acetylglutamate synthase (NAGS) deficiency; and
2. Carbaglu® must be prescribed by, or in consultation with, a geneticist; and
3. Documentation of active management with a low protein diet; and
4. Initial approvals will be for the duration of 1 year. After that time, reauthorization will require the prescriber to verify the member is responding well to therapy.