OKLAHOMA HEALTH CARE AUTHORITY
SPECIAL SCHEDULED BOARD MEETING
August 21, 2019 at 1:00 P.M.
Oklahoma Health Care Authority
4345 N. Lincoln Blvd.
OKC, OK

A G E N D A

Items to be presented by Stan Hupfeld, Chairman

1. Call to Order / Determination of Quorum

2. Action Item – Approval of the June 25, 2019 OHCA Board Meeting Minutes

3. Discussion Item – Creation of a Pharmacy Committee

4. Introduction of OHCA Chief Executive Officer

Item to be presented by Maria Maule, Interim Chief of Legal Services

5. Discussion Item – Public Comment on this Meeting's Agenda Items by Attendees Who Gave 24 Hour Prior Written Notice

Agency Update

6. Legislative Update – Audra Cross, Legislative Liaison

Item to be presented by Maria Maule, Interim Chief of Legal Services

7. 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

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

    a) Consideration and Vote for a rate change to increase the most current provider rate and reimbursement structures in the SoonerCare program by 5.00%, with some exceptions. Upon passage of Senate Bill 1044, OHCA was mandated to increase most provider rates by 5.00%. Per Senate Bill 1044, the proposed rate increases excludes: services financed through appropriations to other state agencies; Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS); non-emergency transportation capitation payments; services provided to Insure Oklahoma (IO) members; payments for drug ingredients/physician supplied drugs; Indian Health Services/Tribal/Urban Clinics (I/T/U); Federally Qualified Health Centers (FQHCs); Rural Health Centers (RHCs); and Long-Term Care Facilities, which will be discussed at a later date. Program for the All-Inclusive Care for the Elderly (PACE) was excluded from the legislatively mandated rate increases, however OHCA will increase these rates as well. The estimated budget impact for the remainder of SFY2020 will be an increase of $62,867,943 total; of which $21,362,527 is state share. The estimated budget impact for SFY2021 will be an increase of $85,650,782 total; of which $28,324,714 is state share.

b) Consideration and Vote for a rate method change to negotiate a higher reimbursement than the current Oklahoma Medicaid rate for an out-of-state service that is prior authorized, provided that the service is not available in Oklahoma and the negotiated reimbursement does not exceed the rate paid by Medicare, unless authorized in the Oklahoma State Plan. This proposal is budget neutral as it sets out to standardize out-of-state coverage and payment methodologies as well as align with practice.

c) Consideration and Vote for a rate method change to add a third outlier intensity adjustment requested on a case by case basis for those children who have costs beyond the payments made for the base rate and add-ons. The third add-on is a $210.00 per diem. The estimated total budget impact for the remainder of SFY2020 is $4,310,344; $1,500,000 state share and an annual total cost of $5,747,126; $2,000,000 state share for SFY2021. The state share will be paid by the Oklahoma Department of Mental Health and Substance Abuse Service (ODMHSAS).

Item to be presented by Maria Maule, Interim Chief of Legal Services

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

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

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

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

A. AMENDING agency rules at ***Oklahoma Administrative Code (OAC) 317:30-5-740, 317:30-5-740.1, 317:30-5-740.2, 317:30-5-741, 317:30-5-742, 317:30-5-742.1, 317:30-5-742.2, 317:30-5-743.1, 317:30-5-744, 317:30-5-745, 317:30-5-746*** and ADDING agency rules at ***OAC 317:30-5-750 through 317:30-5-757*** will align therapeutic foster care (TFC) policy with current business practice. Revisions will also add new language establishing a more intensive treatment program for children in Oklahoma Department of Human Services (DHS) and Office of Juvenile Affairs (OJA) custody known as Intensive Treatment Family Care (ITFC). ITFC is a TFC model that addresses children's complex/severe behavioral and emotional health needs and/or disorders. ITFC utilizes a team approach of professionals including therapists, care coordinators, and foster parents to provide the intensive treatment services in a family care setting. The proposed revisions will define ITFC, member criteria for the provision of ITFC services, provider participation and credentialing requirements, program coverage, and program limitations. Lastly, the proposed revisions will establish reimbursement methodology and applicable rates for ITFC services.
Budget Impact: The proposed changes will potentially result in an estimated annual total cost for SFY20 of $1,731,183 with a state share of $594,557 and an SFY21 total cost of $2,324,813 with a state share of $768,816. The state share will be paid by the Oklahoma Department of Human Services with the current TFC budget.

(Reference APA WF # 19-05)

B. AMENDING agency rules at ***OAC 317:1-1-4, 317:1-1-6, and 317:1-1-7*** to comply with Oklahoma Senate Bill (SB) 456, which was signed into law on March 13, 2019 and directed the reorganization of the OHCA Board. The seven-member Board was replaced with a nine-member Board. Further revisions will establish that the chair and vice-chair elections are held at the last regular meeting before January 1 of each year. Other revisions are needed to correct outdated language.

Budget Impact: Budget neutral.

(Reference APA WF # 19-11)

C. AMENDING agency rules at ***OAC 317:30-5-22.1 and 317:30-5-42.11*** will add "family practice physician - obstetrics (FP/OB)" as a new provider type under the enhanced services for medically high risk pregnancy policy. This policy change will address and improve access to care for obstetrical-related services in rural Oklahoma. Further revisions will update policy to reflect current business practices.
Budget Impact: The proposed changes will potentially result in a combined total federal and state budget impact of $154,549.10; with $52,515.78 in state share for SFY2020.

(Reference APA WF # 19-12)

Item to be presented by Member Randy Curry, Pharmacy Committee Chair

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

a) Jornay PM™ [Methylphenidate Extended-Release (ER) Capsule], Evekeo ODT™ [Amphetamine Orally Disintegrating Tablet (ODT)], Adhansia XR™ (Methylphenidate ER Capsule), and Sunosi™ (Solriamfetol Tablet) to the utilization and scope prior authorization program under OAC 317:30-5-77.2(e).

b) Balversa™ (Erdafitinib) to the utilization and scope prior authorization program under OAC 317:30-5-77.2(e).

c) Various Special Formulations: Annovera™ (Segesterone Acetate/Ethinyl Estradiol Vaginal System), Bijuva™ (Estradiol/Progesterone Capsule), Cequa™ (Cyclosporine 0.09% Ophthalmic Solution), Corlanor® (Ivabradine Oral Solution), Crotan™ (Crotamiton 10% Lotion), Gloperba® (Colchicine Oral Solution), Glycate® (Glycopyrrolate Tablet), Khapzory™ (Levoleucovorin Injection), Qmiiz™ ODT [Meloxicam Orally Disintegrating Tablet (ODT)], Seconal Sodium™ (Secobarbital Sodium Capsule), TaperDex™ (Dexamethasone Tablet), Tiglutik™ (Riluzole Oral Suspension), TobraDex® ST (Tobramycin/Dexamethasone 0.3%/0.05% Ophthalmic Suspension), Tolsura™ (Itraconazole Capsule), and Yutiq™ (Fluocinolone Acetonide Intravitreal Implant) to the utilization and scope prior authorization program under OAC 317:30-5-77.2(e).

d) Abilify MyCite® (Aripiprazole Tablets with Sensor), Aristada Initio® [Aripiprazole Lauroxil Extended-Release (ER) Injectable Suspension], and Perseris™ [Risperidone ER Subcutaneous (Sub-Q) Injectable Suspension]to the utilization and scope prior authorization program under OAC 317:30-5-77.2(e).

e) Cassipa® (Buprenorphine/ Naloxone) and Levorphanol to the utilization and scope prior authorization program under OAC 317:30-5-77.2(e).

The Drug Utilization Review Board, recommends that select medication assisted treatment (MAT) products no longer require prior authorization.

Item to be presented by Stan Hupfeld, Chairman

11. ADJOURNMENT

NEXT BOARD MEETING
September 18, 2019
Oklahoma Health Care Authority
Oklahoma City, OK

MINUTES OF A SPECIAL BOARD MEETING
OF THE HEALTH CARE AUTHORITY BOARD
June 25, 2019
Oklahoma Health Care Authority Boardroom
Oklahoma City, Oklahoma

Manner and Time of Notice of Meeting: A statutorily required public meeting notice was placed on the front door of the Oklahoma Health Care Authority on May 24, 2019 at 12:50 p.m. Advance public meeting notice was provided to the Oklahoma Secretary of State. In addition to the posting of the statutory public notice, the agency placed its agenda on its website on June 20, 2019 at 7:56 a.m.

Pursuant to a roll call of the members, a quorum was declared to be present, and Becky Pasternik-Ikard called the meeting to order at 1:02 p.m.

BOARD MEMBERS PRESENT: Chairman Hupfeld, Member Case, Member Curry, Member Hausheer, Member Kennedy, Member Nuttle, Member Shamblin

BOARD MEMBERS ABSENT: Vice Chairman Yaffe, Member Boyd

OTHERS PRESENT:

Anthony Armstrong
Lindsey Bateman, OHCA
Yasmine Barve, OHCA
Lisa Montgomery, OHCA
Fred Mensah, OHCA
Shantice Atkins, OHCA
Marie Moore, DDS
Sheryl Gibson, OHCA
Daryn Kirkpatrick, OHCA
Jill Ratterman, OHCA
Rose Pina, OHCA
Folake Adedeji, OHCA
Brent Wilborn, OKPCA
Beverly Couch, OHCA
Kevin Kelley, OHCA
Trudy Johnson, OHCA
Mary Triplet, OHCA
Tiffanie Moore, BlueSprig/OKABA
Sandra Puebla, OHCA
Josh Richards, OHCA
Lisa Spain, DXC
Carmen Forman, The Oklahoman
Connie Cook, OHCA
Rick Snyder, OHA
Melanie Lawrence, OHCA
Rhonda Mitchell, OHCA
Kyle Janzen, OHCA
LeKenya Antwine, OHCA
Kimrey McGinnis, OHCA
Gloria LaFitte, OHCA
Catina Baker, OHCA
Shannon Wilkinson, OHCA

OTHERS PRESENT:

Jo Stainsby, OHCA
Aaron Morris, OHCA
Kambra Reddick, OHCA
Eric Polak, OSU-CHS
Garth Splinter, MD
Shelly Patterson, OHCA
Jason Ince, OHCA
Carolynn Reconnu-Shoffner, OHCA
Tyler Talley, eCap
Stephanie Mavredes, OHCA
Braden Mitchell, OHCA
Bill Garrison, OHCA
Jennifer King, OHCA
David Ward, OHCA
Marlene Asmussen, OHCA
Joe Dorman, OICA
MaryAnn Martin, OHCA
Katelynn Burns, OHCA
Jimmy Witcosky, OHCA
Nico Gomez, Care Providers Oklahoma
Summer Adami, BlueSprig Pediatrics/Autism Speaks
Aimee Merick, OHCA
Melinda Thomason, OHCA
Mike Herndon, OHCA
Patrick Schlecht, OHCA
Lynn Mitchell, OU Physicians
Devin Lockard, OHCA
Nichole Burland, OHCA
Kathryn McNutt, The Oklahoman
Carmen Johnson, OHCA
Bert Bailey, OHCA

DISCUSSION AND POSSIBLE VOTE ON APPROVAL OF BOARD MINUTES OF THE SPECIAL BOARD MEETING HELD MAY 21, 2019.

The Board routinely reviews and approves a synopsis of all its meetings. The full-length recordings of the meetings of the Board are retained at the Board Offices and may be reviewed upon written request.

MOTION:	Member Hausheer moved for approval of the May 21, 2019 board meeting minutes with the change to Item 7b.c and spelling error on page 4. The motion was seconded by Member Kennedy.
FOR THE MOTION:	Chairman Hupfeld, Member Case, Member Curry, Member Nuttle, Member Shamblin
BOARD MEMBERS ABSENT:	Vice-Chairman Yaffe, Member Boyd

ITEM 3 / PUBLIC COMMENT ON THIS MEETING'S AGENDA ITEMS BY ATTENDEES WHO GAVE 24 HOUR PRIOR WRITTEN NOTICE
Nicole Nantois, Chief of Legal Services

Speakers:
- Tiffany Moore, OKABA & Blue Sprig
- Summer Adami, BlueSprig Pediatrics/Autism Speaks

ITEM 4A / EMPLOYEE RECOGNITION

Chairman Hupfeld recognized Anthony Armstrong as the 2019 Brickner Award recipient.

ITEM 4B / ALL-STAR RECOGNITION

- April All-Star – Judith Jones
- May All-Star – Devin Lockard

ITEM 4C / INTRODUCTION OF DEPUTY SECRETARY OF HEALTH AND MENTAL HEALTH

Becky introduced Carter Kimble as the Deputy Secretary of Health and Mental Health

ITEM 4D / FINANCIAL UPDATE
Aaron Morris, Chief Financial Officer

Mr. Morris gave a brief update on OHCA's May financials. OHCA's revenues were under budget with Drug Rebate under budget by $1.3 million state dollars, Medical Refunds over budget by $0.4 million state dollars and taxes and fees under budget by $5 million state dollars. Outpatient hospital is over budget by $20 million state dollars, OHCA staff is looking into why there was an increase. OHCA drug spending in under budget by $16 million state dollars. Administration spending is under budget by $5.6 million state dollars. OHCA's total budget variance is a negative $195,693 million state dollars over budget, about 0.004%. For more detailed information, see Item 4d in the board packet.

ITEM 4E / MEDICAID DIRECTOR'S UPDATE
Melody Anthony, Deputy State Medicaid Director

Ms. Anthony provided an update with April 2019 data that included a report on the number of SoonerCare enrollees in different areas of the Medicaid program and total in-state providers. Ms. Anthony also presented charts showing monthly trend for providers, monthly enrollment and a monthly trend in enrollment for Choice, Traditional and Insure Oklahoma. She further provided trends for total members and how it relates to the unemployment rate and enrollment by state fiscal year. This month's board packet also included graphs showing monthly and yearly trend for the uninsured population. For more detailed information, see Item 4e in the board packet.

ITEM 4F / OKLAHOMA RESIDENCY VERIFICATION PROCESS
Melody Anthony, Deputy State Medicaid Officer

Ms. Anthony gave a brief overview of the Oklahoma Residency Verification Process, which included information on the workgroup members, current process for returned mail, discussion items, current and planned new process, planned new improvements to process, and broadening outreach. For more detailed information, see item 4f in the board packet.

ITEM 4G / LEGISLATIVE UPDATE
Lindsey Bateman, Assistant Director of Government Relations

Gave a brief legislative overview, which included information on the 57th legislature, number of bills being tracked through session, bills signed by the Governor, dormant legislation, themes, OHCA budget, SB 280, other considerations and SINE DIE, the interim, and rules. For more detailed information, see item 4g in the board packet.

ITEM 4H / CHIEF MEDICAL OFFICER UPDATE
Mike Herndon, Chief Medical Officer

Dr. Herndon gave a brief overview of Medical Professional Services, which included information on Medical/Dental Directors, Medical Authorization and Review, Quality Assurance/Quality Improvement and Medical Administrative Support Services. For more detailed information, see Item 4h in the board packet.

ITEM 4I / HEALTH SERVICES INITIATIVE UPDATE
Shelly Patterson, Director of Community Relations and Performance & Health Improvement

Ms. Patterson gave a brief overview of the Health Services Initiatives (HSI), which included information on what an HSI is, HSI development, programs and patterns, reducing sleep-related infant mortality, OSDH and local hospitals, projected outcomes and progress, increase developmental screening and Reach Out and Read (ROR). For more detailed information, see item 4i in the board packet.

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

There were no recommendations regarding conflicts

ITEM 6A-I / CONSIDERATION AND VOTE UPON THE RECOMMENDATIONS OF THE STATE PLAN AMENDMENT RATE COMMITTEE
Josh Richards, Director of Program Integrity

a) Consideration and Vote for a rate change to increase the base rate component to $108.31 for Regular Nursing Facilities and update the pool amount for these facilities in the state plan for the "Other" and "Direct Care" components to $186,146,037. If SFY 2020, this change has an estimated increase of $3,391,494 total; of which $1,183,292 is state share coming from the increased Quality of Care Fee, which is paid by the facilities.

MOTION:	Member Hausheer moved for approval of Item 6a as published. The motion was seconded by Member Curry.
FOR THE MOTION:	Chairman Hupfeld, Member Case, Member Kennedy, Member Nuttle, Member Shamblin
BOARD MEMBERS ABSENT:	Vice-Chairman Yaffe, Member Boyd

b) Consideration and Vote for a rate change to increase the base rate component to $209.50 for the Acquired Immune Deficiency Syndrome (AIDS) rate for Nursing Facilities. In SFY2020, this change has an estimated increase of $7,299 total; of which $2,546 is state share coming from the increased Quality of Care Fee, which is paid by the facilities.

MOTION:	Member Hausheer moved for approval of Item 6b as published. The motion was seconded by Member Shamblin.
FOR THE MOTION:	Chairman Hupfeld, Member Case, Member Curry, Member Kennedy, Member Nuttle,
BOARD MEMBERS ABSENT:	Vice-Chairman Yaffe, Member Boyd

c) Consideration and Vote for a rate change to increase the Qualified Behavioral Health Aid I (QBHA I)/Treatment Parent Specialist (TPS) rate for Therapeutic Foster Care (TFC) to $9.81 per 15 minute unit with a maximum of 6 units per day. The estimated annual budget impact in SFY 2020 will be an increase of $625,464 total; of which $218,225 is state share. The state share will be paid by DHS with the current TFC budget.

MOTION: Member Case moved for approval of Item 6c as published. The motion was seconded by Member Hausheer.

FOR THE MOTION: Chairman Hupfeld, Member Curry, Member Kennedy, Member Nuttle, Member Shamblin

BOARD MEMBERS ABSENT: Vice-Chairman Yaffe, Member Boyd

d) Consideration and Vote for a rate change to increase the rate for Qualified Behavioral Health Aid II (QHBA II)/Treatment Parent Specialist (TPS) for Intensive Treatment Family Care (ITFC) providers to $21.43 per 15 minute unit with a 6 unit max per day. The providers have additional training and certifications, serve children with more intense behavioral issues than TFC, and is a stay at home parent with a maximum of one child receiving services. The estimated annual budget impact for the remainder of SFY 2020 will be an increase of $1,731,183 total; of which $594,557 is state share. The SFY 2021 budget impact will be an increase of $2,324,813 total; of which $768,816 is state share. The state share will be paid by DHS with the current TFC budget.

MOTION: Member Hausheer moved for approval of Item 6d as published. The motion was seconded by Member Kennedy.

FOR THE MOTION: Chairman Hupfeld, Member Case, Member Curry, Member Nuttle, Member Shamblin

BOARD MEMBERS ABSENT: Vice-Chairman Yaffe, Member Boyd

e) Consideration and Vote for a method change to correct and update the Developmental Disabilities Services (DDS) Agency Companion procedure codes to reflect procedure code reassignment and current authorization practice. Rates will be adjusted on the following agenda item.

MOTION: Member Hausheer moved for approval of Item 6e as published. The motion was seconded by Member Kennedy.

FOR THE MOTION: Chairman Hupfeld, Member Case, Member Curry, Member Nuttle, Member Shamblin

BOARD MEMBERS ABSENT: Vice-Chairman Yaffe, Member Boyd

f) Consideration and Vote for a rate change to increase the Developmental Disabilities Services (DDS) Waiver rate paid for Waiver Services. The services are available to service recipients on the Homeward Bound Waiver, Community Based Waiver, In-Home Supports Waiver for Adults, and In-Home Supports Waiver for Children. This is an across the board rate increase of 4.00% for all services that the DDS Waiver has established a fixed rate. The estimated budget impact for the remainder of SFY 2020 will be an increase of $9,863,029 total; of which $3,351,457 is state share. The SFY 2021 budget impact will be an increase of $13,150,705 total; of which $4,607,221 is state share. DHS attests that it has adequate funds to cover the state share of the projected cost of services.

MOTION: Member Hausheer moved for approval of Item 6f as published. The motion was seconded by Member Shamblin.

FOR THE MOTION: Chairman Hupfeld, Member Case, Member Curry, Member Kennedy, Member Nuttle,

BOARD MEMBERS ABSENT: Vice-Chairman Yaffe, Member Boyd

g) Consideration and Vote for a rate change to increase the rate paid for Personal Care Services for recipients on the Advantage Waiver and State Plan Personal Care Programs by 4.00%. The estimated budget impact for the remainder of SFY 2020 for State Plan Personal Care Services will be an increase of $185,081 total; of which $62,891 is state share. The SFY 2021 budget impact for State Plan Personal Care Services will be an increase of $246,775 total; of which $80,843 is state share. The estimated budget impact for the remainder of SFY 2020 for the Advantage Waiver Personal Care Services will be an increase of $4,479,449 total; of which $1,522,117 is state share. The SFY 2021 budget impact for State Plan Personal Care Services will be an increase of $5,972,599 total; of which $1,956,623 is state share. DHS attests that it has adequate funds to cover the state share of the projected cost of services.

MOTION: Member Hausheer moved for approval of Item 6g as published. The motion was seconded by Member Case.

FOR THE MOTION: Chairman Hupfeld, Member Curry, Member Kennedy, Member Nuttle, Member Shamblin

BOARD MEMBERS ABSENT: Vice-Chairman Yaffe, Member Boyd

h) Consideration and Vote to establish new rates for Applied Behavioral Analysis (ABA) services. ABA will be using an existing rate methodology for Physician Services. The payment amount for each service paid under the fee schedule is the product of a uniform relative value unit (RVU) for each service and the Medicare conversion factor (CF). The Medicare CF converts the relative values into payment amount. CMS updates the RVU and CF annually. Procedure codes 97151, 97155, and 97156 will be paid at $23.55 per 15 minutes. Procedure Code 97153 will be paid at $17.35 per 15 minutes. The estimated budget impact for SFY2020 will be an increase of $11,455,015 total; of which $3,996,655 is state share.

MOTION: Member Hausheer moved for approval of Item 6h as published. The motion was seconded by Member Case.

FOR THE MOTION: Chairman Hupfeld, Member Curry, Member Kennedy, Member Nuttle, Member Shamblin

BOARD MEMBERS ABSENT: Vice-Chairman Yaffe, Member Boyd

i) Consideration and Vote for a rate method change for Enhanced Payments for State University Employed or Contracted Physicians. The proposed payment methodology for State University Employed or Contracted Physicians is 175% of the Medicare Physician Fee Schedule. The estimated annual budget impact will be an increase of $51,067,779 total; of which $17,817,548 is state share. The state share will be paid by the University of Oklahoma and Oklahoma State University.

MOTION: Member Hausheer moved for approval of Item 6i as published. The motion was seconded by Member Case.

FOR THE MOTION: Chairman Hupfeld, Member Curry, Member Kennedy, Member Nuttle, Member Shamblin

BOARD MEMBERS ABSENT: Vice-Chairman Yaffe, Member Boyd

ITEM 7 / CONSIDERATION AND VOTE OF THE SFY 20 BUDGET WORK PROGRAM

Tasha Black, Senior Director of Financial Services

For more detailed information, see item 7 in the board packet.

MOTION: Member Hausheer moved for approval of Item 7 as published. The motion was seconded by Member Case.

FOR THE MOTION: Chairman Hupfeld, Member Curry, Member Kennedy, Member Nuttle, Member Shamblin

BOARD MEMBERS ABSENT: Vice-Chairman Yaffe, Member Boyd

ITEM 8A-I / CONSIDERATION AND VOTE REGARDING RECOMMENDATIONS MADE BY THE DRUG UTILIZATION REVIEW BOARD UNDER 63 OKLAHOMA STATUES 5030.3.

Jill Ratterman, Clinical Pharmacist

a) Aldurazyme® (Laronidase) and Naglazyme® (Galsulfase) to the utilization and scope prior authorization program under OAC 317:30-5-77.2(e).

b) Plenvu® [Polyethylene Glycol (PEG)-3350/Sodium Ascorbate/Sodium Sulfate/Ascorbic Acid/ Sodium Chloride/Potassium Chloride]to the utilization and scope prior authorization program under OAC 317:30-5-77.2(e).

c) Consensi® (Amlodipine/Celecoxib) and Kapspargo™ Sprinkle [Metoprolol Succinate Extended-Release (ER)] to the utilization and scope prior authorization program under OAC 317:30-5-77.2(e).

d) H.P. Acthar® Gel (Repository Corticotropin Injection) update *criteria* in the utilization and scope prior authorization program under OAC 317:30-5-77.2(e).

e) Fulphila® (Pegfilgrastim-jmdb), Nivestym™ (Filgrastim-aafi), and Udenyca™ (Pegfilgrastim-cbqv) to the utilization and scope prior authorization program under OAC 317:30-5-77.2(e).

f) Xyosted™ [Testosterone Enanthate Subcutaneous (Sub-Q) Auto-Injector] and Jatenzo® (Testosterone Undecanoate Oral Capsule) to the utilization and scope prior authorization program under OAC 317:30-5-77.2(e).

g) Cablivi® (Caplacizumab-yhdp) to the utilization and scope prior authorization program under OAC 317:30-5-77.2(e).

h) Dextenza® (Dexamethasone Ophthalmic Insert), Inveltys™ (Loteprednol Etabonate Suspension), Lotemax® SM (Loteprednol Etabonate Gel), and Oxervate™ (Cenegermin-bkbj) to the utilization and scope prior authorization program under OAC 317:30-5-77.2(e).

i) Lorbrena® (Lorlatinib), Mvasi® (Bevacizumab-awwb), and Vizimpro® (Dacomitinib) to the utilization and scope prior authorization program under OAC 317:30-5-77.2(e).

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

FOR THE MOTION: Chairman Hupfeld, Member Curry, Member Kennedy, Member Nuttle, Member Shamblin

BOARD MEMBERS ABSENT: Vice-Chairman Yaffe, Member Boyd

ITEM 9 / PROPOSED EXECUTIVE SESSION AS RECOMMENDED BY THE CHIEF OF LEGAL SERVICES AND AUTHORIZED BY THE OPEN MEETINGS ACT, 25 OKLAHOMA STATUTES §307(B) (4)

Nicole Nantois, Chief of Legal Services

Chairman Hupfeld entertained a motion to go into Executive Session at this time.

MOTION: Member Hausheer moved for approval of Item 7 as published. The motion was seconded by Member Curry.

FOR THE MOTION: Chairman Hupfeld, Member Case, Member Kennedy, Member Nuttle, Member Shamblin

BOARD MEMBERS ABSENT: Vice-Chairman Yaffe, Member Boyd

ITEM 10 / CONSIDERATION AND VOTE FOR THE FORMATION OF A SEPARATE AUDIT COMMITTEE

No action was taken on this item.

ITEM 11 / ADJOURNMENT

MOTION:	Member Hausheer moved for approval for adjournment. The motion was seconded by Member Kennedy.
FOR THE MOTION:	Chairman Hupfeld, Member Case, Member Curry, Member Nuttle, Member Shamblin
BOARD MEMBERS ABSENT:	Vice-Chairman Yaffe, Member Boyd

Meeting adjourned at 4:30 p.m., 6/25/2019

NEXT BOARD MEETING
August 21, 2019
Oklahoma Health Care Authority
Oklahoma City, OK

Martina Ordonez
Board Secretary

Minutes Approved: _____

*Initials:*_____

5.00% ACROSS-THE-BOARD PROVIDER RATE INCREASE

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

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

3. **PRESENTATION OF ISSUE – WHY IS THIS CHANGE BEING MADE?**
   The Oklahoma Health Care Authority (OHCA) recommends a revision, in the amount of a 5.00% increase, to the current rate and reimbursement structures in the SoonerCare program. Upon passage of Senate Bill 1044, OHCA was mandated to increase most provider rates by 5.00%.

   Federal Requirements:
   State Medicaid programs generally have considerable flexibility in determining the reimbursement methodology and resulting rate for services, within federally-imposed upper limits and specific restrictions. Section 1902(a)(30)(A) of the Social Security Act requires that State Medicaid programs must assure that payment rates :
   - Be consistent with efficiency, economy and quality of care;
   - Are sufficient to enlist enough providers so that Medicaid care and services are available under the state plan at least to the extent that such care and services are available to the general population in that geographic area.

4. **CURRENT METHODOLOGY AND/OR RATE STRUCTURE.**
   OHCA currently reimburses providers under a variety of different rate structures; diagnostic-related group (DRG), per diem, max fee, percent of Medicare, and a percent of costs are some examples. Our current rates for most providers reflect a 3.25% reduction, a 7.75% reduction, a 3.00% reduction, and a 3.00% increase from the applicable rate structures, implemented in April of 2010, July 2014, January 2016, and October 2018. Some provider rates were not impacted by all rate reductions/increases.

5. **NEW METHODOLOGY OR RATE STRUCTURE.**
   OHCA seeks to increase provider rates by 5.00% of the applicable rate structures. Per Senate Bill 1044, the proposed rate increases excludes: services financed through appropriations to other state agencies; Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS); non-emergency transportation capitation payments; services provided to Insure Oklahoma (IO) members; payments for drug ingredients/physician supplied drugs; Indian Health Services/Tribal/Urban Clinics (I/T/U); Federally Qualified Health Centers (FQHCs); Rural Health

Centers (RHCs); and Long-Term Care Facilities, which will be discussed at a later hearing date. Program for the All-Inclusive Care for the Elderly (PACE) was excluded from the legislatively mandated rate increases, however OHCA will increase these rates by 5.00% as well.

6. BUDGET ESTIMATE.

The estimated budget impact for the remainder of SFY2020 will be an increase of $62,867,943 total; of which $21,362,527 is state share. The estimated budget impact for SFY2021 will be an increase of $85,650,782 total; of which $28,324,714 is state share.

7. AGENCY ESTIMATED IMPACT ON ACCESS TO CARE.

The Oklahoma Health Care Authority anticipates a positive impact on access to care. The Oklahoma Health Care Authority has appropriate measures in place to monitor any positive or negative impact to access or quality of care, in accordance with requirements at 42 CFR 447.203(b)(6).

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

The Oklahoma Health Care Authority requests the State Plan Amendment Rate Committee to approve the 5.00% across-the-board provider rate increase of the applicable rate structures for all providers excluding those providers/services mentioned.

9. EFFECTIVE DATE OF CHANGE.

October 1, 2019, contingent upon CMS approval.

OUT-OF-STATE SERVICES

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 to clarify coverage and reimbursement methodology for services rendered by providers that are physically located outside of Oklahoma.

4. **CURRENT METHODOLOGY AND/OR RATE STRUCTURE.**
   Reimbursement for out-of-state will be made in the following manner:
   - Inpatient hospital:
     - Services shall be reimbursed the lesser of the billed charges or the Diagnosis Related Group (DRG) amount.
     - In addition to the billed charges or DRG payment, whichever is less, an outlier payment may be made to the hospital for very high cost stays.
     - The lesser of the billed charges or DRG amount and outlier, if applicable, represent full reimbursement for all non-physician services provided during the inpatient stay. Covered inpatient services provided to eligible members of the Oklahoma SoonerCare program, when treated in out-of-state hospitals, will be reimbursed in the same manner as in-state hospitals.
     - Covered inpatient services provided in out-of-state specialty hospitals may be reimbursed at a negotiated rate not to exceed 100% of the cost to provide the service. Negotiation of rates will only be allowed when the OHCA determines that the specialty hospital or specialty unit provides a unique (non-experimental) service required by SoonerCare members and the provider will not accept the DRG payment rate. Prior authorization is required.
   - Outpatient hospital:
     - Hospital outpatient services shall be reimbursed on a rate-per-service basis that varies according to the Ambulatory Payment Classification (APC) group to which the services are assigned. If not assigned to an APC group and otherwise covered by SoonerCare, services may be reimbursed as determined by OHCA.

- Physician services:
    - 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.
    - 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.

5. NEW METHODOLOGY OR RATE STRUCTURE.

The only change is to add the following clarifying language to the State Plan: The OHCA may negotiate a higher reimbursement than the current Oklahoma Medicaid rate for an out-of-state service that is prior authorized, provided that the service is not available in Oklahoma and the negotiated reimbursement does not exceed the rate paid by Medicare, unless authorized in the Oklahoma State Plan.

6. BUDGET ESTIMATE.

This proposal is budget neutral as it sets out to standardize out-of-state coverage and payment methodologies as well as align with practice.

7. AGENCY ESTIMATED IMPACT ON ACCESS TO CARE.

The Oklahoma Health Care Authority anticipates no impact on access to care. The Oklahoma Health Care Authority has appropriate measures in place to monitor any positive or negative impact to access or quality of care, in accordance with requirements at 42 CFR 447.203(b)(6).

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

The Oklahoma Health Care Authority requests the State Plan Amendment Rate Committee to approve the proposed coverage and reimbursement methodology for services rendered by providers that are physically located outside of Oklahoma.

9. EFFECTIVE DATE OF CHANGE.

September 1, 2019, contingent upon CMS approval.

INPATIENT PSYCHIATRIC SERVICES FOR INDIVIDUALS UNDER AGE 21

1. **IS THIS A RATE CHANGE OR A METHOD CHANGE?**
   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 Service (ODMHSAS) proposes to revise the payment methodology in Acute Level 2 settings of Private Psychiatric Hospitals and General Hospitals with Psychiatric Units and in Psychiatric Residential Treatment Facilities (PRTFs), to allow an additional patient-specific specialty add-on per diem rate. The state has seen a recent increase in children requiring treatment out-of-state. This change being to incentivize the development of in-state specialty programs or units that are high quality and outcome-based.

4. **CURRENT METHODOLOGY AND/OR RATE STRUCTURE.**
   The current methodology consists of prospective per diem base rates for Acute Level 2 settings and for PRTFs. The rates are $367.42 and $340.04, respectively. Depending on the needs of the child, a facility may also receive a patient-specific add-on per diem payment of $110.99 for Intensive Treatment Services (ITS), or $77.51 for Non-Verbal Children. An outlier intensity adjustment may also be requested on a case by case basis for those children who have costs beyond the payments made for the base rate and add-ons.

5. **NEW METHODOLOGY OR RATE STRUCTURE.**
   This new methodology creates a third add-on, a specialty payment of $210 per diem. The add-on payments will not be mutually exclusive. For example, depending on the needs of the child and prior authorization, a facility may receive the base rate + ITS + non-verbal + a specialty add-on payment per day.

6. **BUDGET ESTIMATE.**
   The estimated total budget impact for the remainder of SFY2020 is $4,310,344; $1,500,000 state share and an annual total cost of $5,747,126; $2,000,000 state share for SFY2021. The state share will be paid by the Oklahoma Department of Mental Health and Substance Abuse Service (ODMHSAS).

7. AGENCY ESTIMATED IMPACT ON ACCESS TO CARE.

Increase in access to care. We expect to provide access to 150 children, reduce lengths of stay and readmissions.

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

ODMHSAS requests the SPARC to approve the proposed specialty add-on rate of $210 per day in Acute Level 2 settings of Private Psychiatric Hospitals, General Hospitals with Psychiatric Units and PRTFs.

9. EFFECTIVE DATE OF CHANGE.

September 1, 2019, contingent upon CMS approval.

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 83. ~~RESIDENTIAL BEHAVIOR MANAGEMENT SERVICES~~THERAPEUTIC FOSTER CARE

317:30-5-740. ~~Eligible providers~~Definitions

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

~~(1) **Therapeutic foster care (TFC) agencies**. A foster care agency is an agency that provides foster care as defined in the Code of Federal Regulations (CFR) as "24-hour substitute care for children outside their own homes." Therapeutic foster care settings are foster family homes.~~

~~(2) **Therapeutic foster care homes**. Agency-supervised private family homes in which foster parents have been trained to provide individualized, structured services in a safe, nurturing family living environment for children and adolescents with significant emotional or behavioral problems who require a higher level of care than is found in a conventional foster home but do not require placement in a more restrictive setting. Therapeutic foster care homes are considered the least restrictive out-of-home placement for children with severe emotional disorders.~~

~~(b) **TFC Agency Requirements.** Eligible TFC agencies must have:~~

~~(1) current certification from the Oklahoma Department of Human services (OKDHS) as a child placing agency;~~

~~(2) a contract with the Division of Children and Family Services of the Oklahoma Department of Human Services, or OJA;~~

~~(3) a contract with the Oklahoma Health Care Authority; and~~

~~(4) a current accreditation status appropriate to provide behavioral health services in a foster care setting from:~~

~~(A) The Joint Commission formerly the Joint Commission on Accreditation (JCAHO), or~~

~~(B) the Rehabilitation Accreditation Commission (CARF), or~~

~~(C) the Council on Accreditation (COA), or~~

~~(D) the American Osteopathic Association (AOA).~~

(1) **"Therapeutic foster care (TFC) agency"** means a foster care agency that provides foster care as defined in Public Welfare, 45 Code of Federal Regulation (CFR), Sec. 1355.20 as twenty-four (24) hour substitute care for children and adolescents placed away from their parents or guardians and for whom the title IV-E agency has placement and care responsibility. TFC settings are foster family homes.

(2) **"TFC home"** means an agency-supervised, private family home

in which foster parents have been trained to provide individualized, structured services in a safe, nurturing family-living environment. The children and adolescents receiving services in this setting have moderate behavioral and emotional health needs, and may also present secondary physical, developmental, intellectual, and/or social disorder that is supported alongside the mental health needs. TFC homes are considered the least restrictive out-of-home placement for these children or adolescents.

(3) "**Therapeutic foster care (TFC) model"** means a model in which children and adolescents in the TFC environment receive increased individualized behavioral health and other support services from qualified staff. Because TFC members require exceptional levels of skill, time, and supervision, the number of unrelated children and/or adolescents placed per home is limited; no more than two (2) TFC members may be placed in a home at any one (1) time unless additional cases are specifically authorized by Child Welfare Services (CWS) of the Oklahoma Department of Human Services (DHS), or Oklahoma Office of Juvenile Affairs (OJA).

317:30-5-740.1. ~~Provider qualifications and requirements~~Eligible providers and requirements

~~(a) **Therapeutic foster care model**. Children in the TFC environment receive intensive individualized behavioral health and other support services from qualified staff. Because TFC children require exceptional levels of skill, time and supervision, the number of unrelated children placed per home is limited; no more than two TFC children in a home at any one time unless additional cases are specifically authorized by OKDHS, Division of Children and Family Services or OJA.~~

~~(b) **Treatment team.** TFC agencies are primarily responsible for treatment planning and coordination of the child's treatment team. This team is typically composed of an OKDHS or OJA caseworker, the child, the child's parents, others closely involved with the child and family. It also includes the following:~~

~~(1) **Certified Behavioral Health Case Manager II (CM).** A bachelors level team member that may provide support services and case management. In addition to the minimum requirements at OAC 317:30-5-240.3 (c), the CM must have:~~

~~(A) a minimum of one year of experience in providing direct care and/or treatment to children and/or families, and~~

~~(B) have access to weekly consultation with a licensed behavioral health professional or Licensure Candidate.~~

~~(C) CM must also follow requirements at OAC 317:30-5-241.3 for providing psychosocial rehabilitation services.~~

~~(2) **Licensed Behavioral Health Professional (LBHP)**. A masters level professional that provides treatment and supervision for~~

~~the treatment staff to maintain clinical standards of care and provide direct clinical services. In addition to the requirements at OAC 317:30-5-240.3(a) and (b), the LBHP or Licensure Candidate in a TFC setting must demonstrate a general professional or educational background in the following areas:~~

~~(A) case management, assessment and treatment planning;~~

~~(B) treatment of victims of physical, emotional, and sexual abuse;~~

~~(C) treatment of children with attachment disorders;~~

~~(D) treatment of children with hyperactivity or attention deficit disorders;~~

~~(E) treatment methodologies for emotionally disturbed children and youth;~~

~~(F) normal childhood development and the effect of abuse and/or neglect on childhood development;~~

~~(G) anger management;~~

~~(H) crisis intervention; and~~

~~(I) trauma informed methodology.~~

~~(3) **Licensed Psychiatrist and/or psychologist**. TFC agencies must provide staff with access to professional psychiatric or psychological consultation as deemed necessary for the planning, implementation and appropriate management of the resident's treatment. See OAC 317:30-5-240.3(a) and OAC 317:25-275.~~

~~(4) **Treatment Parent Specialist (TPS)**. The TPS serve as integral members of the team of professionals providing services for the child. The TPS receives special training in mental health issues, behavior management and parenting techniques; and implements the in-home portion of the treatment plan with close supervision and support. They provide services for the child, get the child to therapy and other treatment appointments, write daily notes about interventions and attend treatment team meetings. The TPS must be under the supervision of a licensed behavioral health professional of the foster care agency and meet the following criteria:~~

~~(A) have a high school diploma or equivalent;~~

~~(B) have an employment relationship with the foster care agency as a foster parent complete with OSBI and OKDHS background screening;~~

~~(C) completion of therapeutic foster parent training outlined in this section;~~

~~(D) have a minimum of twice monthly face to face supervision with the licensed, or under-supervision for licensure, LBHP, independent of the child's family therapy;~~

~~(E) have weekly contact with the foster care agency professional staff; and~~

~~(F) complete required annual trainings.~~

~~(c) **Agency assurances.** The TFC agency must ensure that each~~

~~individual that renders treatment services (whether employed by or contracted by the agency) meets the minimum provider qualifications for the service. Individuals eligible for direct enrollment must have a contract on file with the Oklahoma Health Care Authority.~~

~~(d) **Policies and Procedures.** Eligible TFC agency providers that are defined in section OAC 317:30-5-740(a) shall have written policies and procedures for the orientation of new staff and foster parents which is reviewed and updated annually, for the following:~~

~~(1) pre-service training of foster parents in treatment methodologies and service needs of emotionally and behaviorally disturbed children;~~

~~(2) treatment of victims of physical, emotional, and sexual abuse;~~

~~(3) treatment of children with attachment disorders;~~

~~(4) treatment of children with hyperactive or attention deficit disorders;~~

~~(5) normal childhood development and the effect of abuse and/or neglect on childhood development;~~

~~(6) treatment of children and families with substance use disorders;~~

~~(7) the Inpatient Mental Health and Substance Abuse Treatment of Minors Act;~~

~~(8) anger management;~~

~~(9) inpatient authorization procedures;~~

~~(10) crisis intervention;~~

~~(11) grief and loss issues for children in foster care;~~

~~(12) the significance/value of birth families to children receiving behavioral health services in a foster care setting; and~~

~~(13) trauma informed methodology.~~

(a) **TFC Agency.** Eligible TFC agencies must have:

(1) Current certification from the Oklahoma Department of Human Services (DHS) as a child placing agency;

(2) A contract with the Child Welfare Division of DHS, or Oklahoma Office of Juvenile Affairs (OJA);

(3) A contract with the Oklahoma Health Care Authority (OHCA); and

(4) A current accreditation status appropriate to provide behavioral health services in a foster care setting from:

(A) The Joint Commission; or

(B) The Commission on Accreditation of Rehabilitative Facilities (CARF); or

(C) The Council on Accreditation (COA).

(b) **Treatment team.** TFC agencies are primarily responsible for treatment planning and coordination of the member's treatment team. This team is typically composed of a DHS or OJA caseworker, the member, the member's foster parent(s), as well as others

closely involved with the member and family, including the biological parents when applicable. It also includes the following:

(1) **Certified behavioral health case manager (CM) II.** A bachelor's level team member that may provide support services and case management. In addition to the minimum requirements at Oklahoma Administrative Code (OAC) 317:30-5-240.3(h)(1), the CM II must:

(A) Have a minimum of one (1) year of experience in providing direct care and/or treatment to children/adolescents and/or families; and

(B) Have access to weekly consultation with a licensed behavioral health professional (LBHP) or licensure candidate.

(C) The CM II must also follow requirements at OAC 317:30-5-241.3 for providing psychosocial rehabilitation (PSR) services.

(2) **Certified alcohol and drug counselor (CADC).** A bachelor's level team member with a current certification as a CADC in the state in which services are provided.

(3) **Licensed behavioral health professional (LBHP) and/or licensure candidate**. An LBHP is a master's level professional that provides treatment and supervises other treatment staff in maintaining clinical standards of care and providing direct clinical services. A licensure candidate is a practitioner actively and regularly receiving board-approved supervision, or extended supervision by a fully-licensed clinician if the board's supervision requirement is met but the individual is not yet licensed. In addition to the requirements at OAC 317:30-5-240.3(a) and (b), the LBHP or licensure candidate in a TFC setting must demonstrate a general professional or educational background in the following areas:

(A) Case management, assessment, and treatment planning;

(B) Treatment of victims of physical, emotional, and sexual abuse;

(C) Treatment of children/adolescents with attachment disorders;

(D) Treatment of children/adolescents with hyperactivity or attention deficit disorders;

(E) Treatment methodologies for emotionally disturbed children/adolescents;

(F) Normal childhood development and the effect of abuse and/or neglect on childhood development;

(G) Anger management;

(H) Crisis intervention; and

(I) Trauma-informed methodology.

(4) **Licensed psychiatrist and/or psychologist**. TFC agencies must provide staff with access to professional psychiatric or

psychological consultation as deemed necessary for the planning, implementation, and appropriate management of the member's treatment. See OAC 317:30-5-240.3(a) and 317:25-7-5.

(5) **Treatment parent specialist (TPS).** The TPS serves as an integral member of the team of professionals providing services for the member. The TPS receives extensive training in diagnosed mental health issues, and behavior management/modification and skill-based parenting techniques; and implements the in-home portion of the treatment plan with close supervision and support. The TPS renders services for the member, provides or arranges suitable transportation for therapy and other treatment appointments, writes daily detailed notes regarding interventions and practical applications of learned skills, and attends treatment team meetings. The TPS must be under the supervision of an LBHP or licensure candidate of the foster care agency and meet the following criteria:

(A) **Qualifications.**

(i) Have a high school diploma or equivalent;

(ii) Have an employment and/or contractual relationship with the foster care agency as a foster parent, and have successfully met all required background screening requirements, including, but not limited to, fingerprint screenings conducted by the Oklahoma State Bureau of Investigation (OSBI) and Federal Bureau of Investigation (FBI), and DHS background screenings;

(iii) Complete the initial thirty-six (36) hours of pre-service training, prior to becoming a TFC parent;

(B) **Responsibilities.**

(i) Have a minimum of twice monthly face-to-face supervision with the licensed, or under-supervision for licensure, LBHP, independent of the member's family therapy;

(ii) Have weekly contact with the foster care agency professional staff;

(iii) Complete the required eighteen (18) hours of in-service training per calendar year; and

(iv) Work with the multidisciplinary team and the member's biological family toward reunification, if appropriate, or other permanency plan.

(c) **Agency assurances.** The TFC agency must ensure that each individual who renders treatment services meets the minimum provider qualifications for the service and, if eligible for direct enrollment, is fully contracted with the OHCA. Additionally, the TFC agency must comply with all state and federal Medicaid law, including, but not limited to, OHCA administrative rules, the Code of Federal Regulations (CFR), and the Oklahoma State Medicaid Plan.

(d) **Policies and procedures.** Eligible TFC agency providers shall have written policies and procedures for the orientation of new

staff and foster parents which is reviewed and updated annually, for the following:

(1) Pre-service training of foster parents in treatment methodologies and service needs of emotionally and behaviorally disturbed children/adolescents;

(2) Treatment of victims of physical, emotional, and sexual abuse;

(3) Treatment of children/adolescents with attachment disorders;

(4) Treatment of children/adolescents with hyperactive or attention deficit disorders;

(5) Normal childhood development and the effect of abuse and/or neglect on childhood development;

(6) Treatment of children/adolescents and families with substance use disorders;

(7) The Inpatient Mental Health and Substance Abuse Treatment of Minors Act;

(8) Anger management;

(9) Inpatient authorization procedures;

(10) Crisis intervention;

(11) Grief and loss issues for children/adolescents in foster care;

(12) The significance/value of birth families to children/adolescents receiving behavioral health services in a foster care setting; and

(13) Trauma-informed methodology.

317:30-5-740.2. Provider selection

~~Parents who retain legal custody of a client may select any eligible contractor as the provider of services. In the case of children in the custody of the State of Oklahoma, the State, acting in its custodial role, selects the provider agency.~~Parents who retain legal custody of a TFC child or adolescent may select any eligible TFC agency as the provider of services. In the case of members in the custody of the State of Oklahoma, the State, acting in its custodial role, selects the TFC agency.

317:30-5-741. Coverage by category

~~(a) **Adults.** Behavioral health services in therapeutic foster care settings are not covered for adults.~~

~~(b) **Children.** Behavioral health services are allowed in therapeutic foster care settings for certain children and youth as medically necessary. The children and youth receiving services in this setting have special psychological, social and emotional needs, requiring more intensive, therapeutic care than can be found in the traditional foster care setting. The designated children and youth must continually meet medical necessity criteria to be eligible for coverage in this setting.~~

~~(c) **Medical necessity criteria**. Medical necessity criteria is delineated as follows:~~

~~(1) A diagnosis from the most recent edition of "The Diagnostic and Statistical Manual of Mental Disorders" (DSM), with the exception of V codes and adjustment disorders, with a detailed description of the symptoms supporting the diagnosis. Children with a provisional diagnosis may be admitted for a maximum of 30 days. An assessment must be completed by a Licensed Behavioral Health Professional (LBHP) or Licensure Candidate as defined in OAC 317:30-5-240.3(a) and (b) within the 30 day period resulting in a diagnosis from the most recent edition of "the Diagnostic and Statistical Manual of Mental Disorders"(DSM) with the exception of V codes and adjustments disorders, with a detailed description of the symptoms supporting the diagnosis to continue RBMS in a foster care setting.~~

~~(2) Conditions are directly attributed to a mental illness/serious emotional disturbance as the primary need for professional attention.~~

~~(3) It has been determined by the inpatient authorization reviewer that the current disabling symptoms could not have been or have not been manageable in a less intensive treatment program.~~

~~(4) Evidence that the child's presenting emotional and/or behavioral problems prohibit full integration in a family/home setting without the availability of 24 hour crisis response/behavior management and intensive clinical interventions from professional staff, preventing the child from living in a traditional family home.~~

~~(5) The child is medically stable and not actively suicidal or homicidal and not in need of substance abuse detoxification services.~~

~~(6) The legal guardian/parent of the child (OKDHS/OJA if custody child) agrees to actively participate in the child's treatment needs and planning.~~

(a) **Adults.** Behavioral health services in TFC settings are not covered for adults.

(b) **Children.** Behavioral health services are allowed in TFC settings for children and adolescents as medically necessary. The children and adolescents receiving services in this setting have moderate behavioral and emotional health needs, and may also present secondary physical, developmental, intellectual, and/or social disorder that is supported alongside the mental health needs. The designated children and adolescents must continually meet medical necessity criteria to be eligible for coverage in this setting. Requests for behavioral health services in a TFC setting must be prior authorized and may be approved up to a maximum of three (3) month extensions.

(c) **Medical necessity criteria**. In order to satisfy medical necessity criteria, all of the following conditions must be met:

(1) The member must have a diagnosis from the Diagnostic and Statistical Manual of Mental Disorders (DSM-V), with the exception of V codes and adjustment disorders, with a detailed description of the symptoms supporting the diagnosis. Children and adolescents with a provisional diagnosis may receive TFC services for a maximum of thirty (30) days.

(2) An assessment must be completed by a licensed behavioral health professional (LBHP) or licensure candidate as defined in Oklahoma Administrative Code (OAC) 317:30-5-240.3(a) and (b) within the thirty (30) day provisional period described above, that confirms a diagnosis from the DSM-V with the exception of V codes and adjustments disorders, and that includes a detailed description of the symptoms supporting the diagnosis to continue treatment in a TFC setting.

(3) Conditions are directly attributed to moderate behavioral and emotional needs as the primary need for professional attention.

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

(5) Evidence that the members' needs prohibit full integration in a family/home setting without the availability of twenty-four (24) hour crisis response/behavior management and clinical interventions from professional staff, preventing the member from living in a traditional family home.

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

(7) The legal guardian [Oklahoma Department of Human Services (DHS)/ Oklahoma Office of Juvenile Affairs (OJA) if custody member] or parent of the member agrees to actively participate in the member's treatment needs and planning.

317:30-5-742. Description of services

~~(a) Treatment services must be provided in the least restrictive, non-institutional therapeutic milieu. The foster care setting is restorative in nature, allowing children with emotional and psychological problems to develop the necessary control to function in a less restrictive setting.~~

~~(b) Behavioral health services must include an individual plan of care for each member served. The individual plan of care requirements are set out in OAC 317:30-5-742.2(b)(1). Treatment services in a therapeutic foster care setting may include an array of services listed in (1) - (6) of this subsection as provided in the individual plan of care. Services include, but may not be limited to:~~

~~(1) Individual, family and group therapy;~~
~~(2) Substance abuse/chemical dependency education, prevention, and therapy;~~
~~(3) Psychosocial rehabilitation and support services;~~
~~(4) Behavior management~~
~~(5) Crisis intervention; and~~
~~(6) Case Management.~~

(a) Treatment services must be provided in the least restrictive, non-institutional therapeutic environment. The TFC setting is restorative in nature, allowing children and adolescents with moderate behavioral and emotional health needs who may also have a secondary physical, developmental, intellectual, and/or social disorder that is supported alongside the mental health needs to develop the necessary control to function in a less restrictive setting.

(b) Behavioral health services must include an individual plan of care (IPC) for each member served. The IPC requirements are set out in Oklahoma Administrative Code (OAC) 317:30-5-742.2.

(c) Treatment services in a TFC setting must receive at least one (1) hour of individual, family, and/or group therapy per week, as set forth in OAC 317:30-5-742.2(3). Treatment may also include, but is not limited to, an array of the following services:

(1) Individual, family and group therapy;
(2) Substance abuse/chemical dependency education, prevention, and therapy;
(3) Psychosocial rehabilitation and support services;
(4) Behavior management;
(5) Crisis intervention; and
(6) Case management.

317:30-5-742.1. Reimbursement

~~Services provided to a member without a written individual plan of care as described in OAC 317:30-5-742.2(b)(1) will not be reimbursed.~~

(a) TFC services will be paid at the current fee-for-service (FFS) rate. Services provided to a member without a written individual plan of care (IPC) as described in Oklahoma Administrative Code (OAC) 317:30-5-742.2 will not be reimbursed.

(b) Reimbursement for TFC services is not available for the following:

(1) Room and board;
(2) Educational costs;
(3) Supported employment;
(4) Inpatient psychiatric services; and
(5) Respite care.

(c) Case management services are reimbursed to government providers as per the methodology in the approved Oklahoma Medicaid State Plan.

317:30-5-742.2. Individual plan of care (IPC) ~~and prior authorization of services~~

~~(a) All behavioral health services must be prior authorized by the designated agent of the Oklahoma Health Care Authority (OHCA) before the service is rendered by an eligible service provider. Without prior authorization, payment is not authorized. Requests for behavioral health services in a foster care setting may be approved for a maximum of three (3) months per extension request.~~

~~(b) All behavioral health services in a foster care setting are provided as a result of an individual assessment of the members needs and documented in the individual plan of care.~~

~~(1)~~**~~Assessment~~**~~.~~

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

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

~~(C)~~ **~~Limitations~~**~~. Assessments are compensable on behalf of a member who is seeking services for the first time from the therapeutic foster care agency. This service is not compensable if the member has previously received or is currently receiving services from the agency unless there has been a gap in service of more than six (6) months and it has been more than one (1) year since the previous assessment.~~

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

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

~~(ii) Source of information;~~

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

~~(iv) Gender;~~

~~(v) Birth date;~~

~~(vi) Home address;~~

~~(vii) Telephone number;~~

~~(viii) Referral source;~~

(ix) Reason for referral;
(x) Person to be notified in case of emergency;
(xi) Presenting reason for seeking services;
(xii) Start and stop time for each unit billed;
(xiii) Dated signature of parent or guardian participating in the face-to-face assessment. Signatures are required for members over the age of fourteen (14);
(xiv) Bio-Psychosocial information which must include:
(I) Identification of the member's strengths, needs, abilities and preferences;
(II) History of the presenting problem;
(III) Previous psychiatric treatment history, include treatment for psychiatric; substance use; drug and alcohol addiction; and other addictions;
(IV) Health history and current biomedical conditions and complications;
(V) Alcohol, drug, and/or other addictions history;
(VI) Trauma, abuse, neglect, violence, and/or sexual assault history of self and/or others, including Department of Human Services (DHS) involvement;
(VII) Family and social history including psychiatric, substance use, drug and alcohol addiction, other addictions, and trauma/abuse/neglect;
(VIII) Educational attainment, difficulties and history;
(IX) Cultural and religious orientation;
(X) Vocational, occupational and military history;
(XI) Sexual history, including HIV, AIDS, and STD at-risk behaviors;
(XII) Marital or significant other relationship history;
(XIII) Recreation and leisure history;
(XIV) Legal or criminal record, including the identification of key contacts, (e.g. attorneys, probation officers);
(XV) Present living arrangements;
(XVI) Economic resources; and
(XVII) Current support system, including peer and other recovery supports.
(xv) Mental status and Level of Functioning information, including questions regarding but not limited to the following:
(I) Physical presentation, such as general appearance, motor activity, attention and alertness;
(II) Affective process, such as mood, affect, manner and attitude;
(III) Cognitive process, such as intellectual ability, social-adaptive behavior, thought processes, thought

content, and memory; and

(IV) All related diagnoses from the most recent addition of the DSM.

(xvi) Pharmaceutical information to include the following for both current and past medications;

(I) Name of medication;

(II) Strength and dosage of medication;

(III) Length of time on the medication; and

(IV) Benefit(s) and side effects of medication.

(xvii) LBHP's interpretation of findings and diagnosis;

(xviii) Dated signature and credentials of the qualified practitioner who performed the face-to-face behavioral assessment. If performed by a licensure candidate, it must be countersigned by the licensed behavioral health professional who is responsible for the member's care.

(2) **Individual plan of care requirement.**

(A) **Signature Requirement**. A written individual plan of care following a comprehensive evaluation for each member must be formulated by the provider agency staff within thirty (30) days of admission with documented input from the member, legal guardian(OKDHS/Office of Juvenile Affairs (OJA) staff), the foster parent (when applicable) and the treatment provider(s). An individual plan of care is not valid until all dated signatures are present, including signatures from the member (if fourteen (14) or over), the legal guardian, the foster parent (when applicable) and the treatment provider(s). If necessary, an individual plan of care may be faxed to a required signatory to have them review, sign and fax it back to the provider before its implementation; however, the provider must obtain the original signature for the clinical file within thirty (30) days. No stamped or photocopied signatures are allowed. This plan must be revised and updated every three (3) months with documented involvement of the legal guardian and resident.

(B) **Individualization.** The individual plan of care must be individualized and take into account the member's age, history, diagnosis, assessed functional levels, culture, and the effect of past and current traumatic experiences in the life of the member. It includes the member's documented diagnosis, appropriate goals, and corresponding reasonable and attainable objectives and action steps within the expected time lines. Each member's individual plan of care is to also address the provider agency's plans with regard to the provision of services. Each plan of care must clearly identify the type of services required to meet the child's treatment needs and frequency over a given period of time.

(C) **Qualified professional**. This service is performed by an LBHP or Licensure Candidate.

(D) **Time requirements**. Individual plan of care updates must be conducted face-to-face and are required every three (3) months during active treatment. However, updates can be conducted whenever it is clinically needed as determined by the qualified practitioner and member.

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

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

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

(iii) specific goals for the member;

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

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

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

(vii) any needed referrals for service;

(viii) specific discharge criteria; and

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

(F) **Amendments.** Amendment of an existing individual plan of care to revise or add goals, objectives, service provider, service type, and service frequency, must be documented in either a scheduled three (3) month plan update or within the existing individual plan of care through an addendum until the review/update is due. Any changes must, prior to implementation, be signed and dated by the member (if fourteen (14) or over), the legal guardian, the foster parent (if applicable), as well as the primary LBHP and any new provider(s). Individual plan of care updates must address the following:

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

(ii) progress, or lack of, on previous individual plan of care goals and/or objectives;

(iii) a statement documenting a review of the current individual plan of care and an explanation if no changes are to be made to the individual plan of care and a statement addressing the status of identified problem behaviors that lead to placement must be included;

(iv) change in goals and/or objectives (including target dates) based upon member's progress or identification of new need, challenges and problems;

(v) change in frequency and/or type of services provided;

(vi) change in practitioner(s) who will be responsible for providing services on the plan;
(vii) change in discharge criteria;
(viii) description of the member's involvement in, and responses to, the treatment plan, and his/her signature and date.

(3) **Description of Services.** Agency services include:

(A) **Individual, family and group therapy**. See OAC 317:30-5-241.2(a), (b), and (c).

(B) **Crisis/behavior management and redirection**. The provider agency must provide crisis/behavior redirection by agency staff as needed twenty-four (24) hours per day, seven (7) days per week. The agency must ensure staff availability to respond to the residential foster parents in a crisis to stabilize members' behavior and prevent placement disruption. This service is to be provided to the member by an LBHP.

(C) **Discharge planning.** The provider agency must develop a discharge plan for each member. The discharge plan must be individualized, child-specific and include an after care plan that is appropriate to the member's needs, identifies the member's needs, includes specific recommendations for follow-up care and outlines plans that are in place at the time of discharge. The plan for children in parental custody must include, when appropriate, reunification plans with the parent(s)/legal guardian. The plan for children who remain in the custody of the OKDHS or the OJA must be developed in collaboration with the case worker and in place at the time of discharge. The discharge plan is to include at a minimum, recommendations for continued treatment services, educational services, and other appropriate community resources. Discharge planning provides a transition from foster care placement into a lesser restrictive setting within the community.

(D) **Substance use/chemical dependency use therapy.** Substance use/chemical dependency therapy can be provided if a member is identified by diagnosis or documented social history as having emotional or behavioral problems directly related to substance use and/or chemical dependency. The modalities employed are provided in order to begin, maintain and enhance recovery from alcoholism, problem drinking, addiction or nicotine use and addiction. This service is to be provided to the member by an LBHP or Licensure Candidate.

(E) **Substance Use Rehabilitation Services**. Covered substance use rehabilitation services are provided in non-residential settings in regularly scheduled sessions intended for individuals not requiring a more intensive level of care or those who require continuing services

following more intensive treatment regimes. The purpose of substance use rehabilitation services is to begin, maintain, and/or enhance recovery from alcoholism, problem drinking, drug use, drug dependency addiction or nicotine use and addiction. Rehabilitation services may be provided individually or in group sessions, and they take the format of an agency approved curriculum based education and skills training. This service is to be provided to the member by a CM II.

(F) **Psychosocial rehabilitation (PSR).**

(i) **Definition.** PSR services are face-to-face Behavioral Health Rehabilitation services which are necessary to improve the member's ability to function in the community. They are performed to improve the skills and abilities of members to live interdependently in the community, improve self-care and social skills, and promote lifestyle change and recovery practices. Rehabilitation services may be provided individually or in group sessions, and they take the format of an agency approved curriculum based education and skills training.

(ii) **Clinical Restrictions.** This service is generally performed with only the members and the qualified provider, but may include a member and the member's family/support system group that focuses on the member's diagnosis, symptom management, and recovery based curriculum. A member who at the time of service is not able to cognitively benefit from the treatment due to active hallucinations, substance use, or other impairments is not suitable for this service. Family involvement is allowed for support of the member and education regarding his/her recovery, but does not constitute family therapy, which requires a licensed provider.

(iii) **Qualified Practitioners.** CM II, LBHP or a Licensure Candidate and LBHP may perform PSR, following development of an individual plan of care curriculum approved by an LBHP or Licensure Candidate. PSR staff must be appropriately and currently trained in a recognized behavioral/management intervention program such as MANDT or Controlling Aggressive Patient Environment (CAPE) or trauma informed methodology. The CM II must have immediate access to an LBHP who can provide clinical oversight of the CM II and collaborate with the CM II in the provision of services. A minimum of one (1) monthly face-to-face consultation with an LBHP is required.

(iv) **Group Sizes.** The maximum staffing ratio is eight (8) to one (1) for children under the age of eighteen (18).

(v) **Limitations.**

(I) In order to develop and improve the member's community and interpersonal functioning and self-care abilities, PSR services may take place in settings away from the behavioral health agency site as long as the setting protects and assures confidentiality. When this occurs, the qualified provider must be present and interacting, teaching, or supporting the defined learning objectives of the member for the entire claimed time.

(II) PSR services are intended for children with Serious Emotional Disturbance (SED), and children with other emotional or behavioral disorders. Children under age six (6), unless a prior authorization for children ages four (4) and five (5) has been granted by OHCA or its designated agent based on a finding of medical necessity, are not eligible for PSR services.

(III) PSR services are time-limited services designed to be provided over the briefest and most effective period possible and as adjunct (enhancing) interventions to complement more intensive behavioral health therapies. Service limits are based on the member's needs according to the Client Assessment Record (CAR) or other approved tool, the requested placement based on the level of functioning rating, medical necessity, and best practice. Service limitations are designed to help prevent rehabilitation diminishing return by remaining within reasonable age and developmentally appropriate daily limits.

(vi) **Progress Notes.** In accordance with OAC 317:30-5-241.1, the behavioral health individual plan of care developed by the LBHP must include the member's strengths, functional assets, weaknesses or liabilities, treatment goals, objectives and methodologies that are specific and time-limited, and defines the services to be performed by the practitioners and others who comprise the treatment team. When PSR services are prescribed, the plan must address objectives that are specific, attainable, realistic, measurable, and time-limited. The plan must include the appropriate treatment coordination to achieve the maximum reduction of the mental and/or behavioral health disability and to restore the member to their best possible functional level.

(I) Start and stop times for each day attended and the physical location in which the service was rendered;

(II) Specific goal(s) and objectives addressed during the session/group;

~~(III) Type of Skills Training provided each day and/or during the week including the specific curriculum used with member;~~
~~(IV) Member satisfaction with staff intervention(s);~~
~~(V) Progress, or barriers made towards goals, objectives;~~
~~(VI) New goal(s) or objective(s) identified;~~
~~(VII) Dated signature of the qualified provider; and~~
~~(VIII) Credentials of the qualified provider;~~

~~(vii) **Additional documentation requirements.** Documentation of ongoing consultation and/or collaboration with an LBHP or Licensure Candidate related to the provision of PSR services.~~

~~(viii) **Non-Covered Services**. The following services are not considered PSR and are not reimbursable:~~
~~(I) room and board;~~
~~(II) educational costs;~~
~~(III) supported employment; and~~
~~(IV) respite.~~

~~(G) **Social skills redevelopment.** Goal directed activities for each member to restore, retain and improve the self-help, communication, socialization, and adaptive skills necessary to reside successfully in home and community based settings. These will be daily activities that are age appropriate, culturally sensitive and relevant to the goals of the individual plan of care. These may include self-esteem enhancement, violence alternatives, communication skills or other related skill development. This service is to be provided to the member by the Treatment Parent Specialist (TPS). Services rendered by the TPS are limited to one and one half (1.5) hours daily.~~

All behavioral health services in a TFC setting are provided as a result of an individual assessment of the member's needs and documented in the IPC.

(1)**Assessment**.

(A) **Definition.** Gathering and assessment of historical and current bio-psycho-social information which includes face-to-face contact with the member and the member's foster parent(s) or legal guardian or other person, including biological parent(s) when applicable, who have pertinent information about the member resulting in a written summary report, diagnosis, and recommendations. All TFC agencies must assess each individual to determine whether he or she could be an appropriate candidate for TFC services.

(B) **Qualified professional.** This service is performed by a licensed behavioral health professional (LBHP) or licensure candidate.

(C) **Limitations**. Assessments are compensable on behalf of

a member who is seeking services for the first time from the TFC agency. This service is not compensable if the member has previously received or is currently receiving services from the agency, unless there has been a gap in service of more than six (6) months and it has been more than one (1) year since the previous assessment.

(D) **Documentation requirements.** The assessment must include all elements and tools required by the OHCA. In the case of members under the age of eighteen (18), it is performed with the direct, active, face-to-face participation of the member and foster parent(s) or legal guardian or other persons, including biological parent(s) when applicable. The member's level of participation is based on age, developmental, and clinical appropriateness. The assessment must include all related diagnoses from the DSM-V. The assessment must contain, but is not limited to, the following:

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

(ii) Source of information;

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

(iv) Gender;

(v) Birth date;

(vi) Home address;

(vii) Telephone number;

(viii) Referral source;

(ix) Reason for referral;

(x) Person to be notified in case of emergency;

(xi) Presenting reason for seeking services;

(xii) Start and stop time for each unit billed;

(xiii) Dated signature of foster parent(s) or legal guardian [Oklahoma Department of Human Services (DHS) or Oklahoma Office of Juvenile Affairs (OJA)] or other persons, including biological parents(s) (when applicable) participating in the face-to-face assessment. Signatures are required for members fourteen (14) years of age and over;

(xiv) Bio-psychosocial information which must include:

(I) Identification of the member's strengths, needs, abilities, and preferences;

(II) History of the presenting problem;

(III) Previous psychiatric treatment history, including treatment of psychiatric issues, substance use, drug and alcohol addiction, and other addictions;

(IV) Health history and current biomedical conditions and complications;

(V) Alcohol, drug, and/or other addictions history;

(VI) Trauma, abuse, neglect, violence, and/or sexual assault history of self and/or others, including DHS

involvement;
(VII) Family and social history, including psychiatric, substance use, drug and alcohol addiction, other addictions, and trauma/abuse/neglect;
(VIII) Educational attainment, difficulties, and history;
(IX) Cultural and religious orientation;
(X) Vocational, occupational, and military history;
(XI) Sexual history, including human immunodeficiency virus (HIV), acquired immune deficiency syndrome (AIDS), other sexually transmitted diseases (STDs), and at-risk behaviors;
(XII) Marital or significant other relationship history;
(XIII) Recreation and leisure history;
(XIV) Legal or criminal record, including the identification of key contacts (e.g. attorneys, probation officers);
(XV) Present living arrangements;
(XVI) Economic resources; and
(XVII) Current support system, including peer and other recovery supports.

(xv) Mental status and level of functioning information, including, but not limited to, questions regarding the following:
(I) Physical presentation, such as general appearance, motor activity, attention, and alertness;
(II) Affective process, such as mood, affect, manner, and attitude;
(III) Cognitive process, such as intellectual ability, social-adaptive behavior, thought processes, thought content, and memory; and
(IV) All related diagnoses from the DSM-V.

(xvi) Pharmaceutical information for both current and past medications, to include the following:
(I) Name of medication;
(II) Strength and dosage of medication;
(III) Length of time on the medication; and
(IV) Benefit(s) and side effects of medication.

(xvii) LBHP's interpretation of findings and diagnosis; and

(xviii) Dated signature and credentials of the qualified practitioner who performed the face-to-face behavioral assessment. If performed by a licensure candidate, it must be countersigned by the LBHP who is responsible for the member's care.

(2) **IPC requirements.**

(A) **Signature requirement**. A written IPC following a comprehensive evaluation for each member must be formulated by the TFC agency staff within thirty (30) days of admission to the program with documented input from the member, the legal guardian (DHS/ OJA), the foster parent(s), the treatment provider(s), and the biological parent(s) when applicable. An IPC is not valid until all dated signatures are present, including signatures from the member [if fourteen (14) years of age and over], the legal guardian, the foster parent, and the treatment provider (s). This plan must be revised and updated every three (3) months with documented involvement of the legal guardian and member.

(B) **Individualization.** The IPC must be individualized and take into account the member's age, history, diagnosis, assessed functional levels, culture, and the effect of past and current traumatic experiences in the life of the member. It includes the member's documented diagnosis, appropriate goals, and corresponding reasonable and attainable treatment objectives, and action steps within the expected timelines. Each member's IPC needs to address the TFC agency's plans with regard to the provision of services. Each plan of care must clearly identify the type of services required to meet the member's treatment needs and frequency over a given period of time.

(C) **Qualified professional**. This service is performed by an LBHP or licensure candidate.

(D) **Time requirements**. IPC updates must be conducted face-to-face and are required at least every ninety (90) days during active treatment. However, updates can be conducted whenever it is clinically needed, as determined by the qualified practitioner and member.

(E) **Documentation requirements.** Comprehensive and integrated service plan content must identify:

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

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

(iii) Specific goals for the member;

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

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

(vi) The name and credentials of all the practitioners who will be providing and responsible for each service;

(vii) Any needed referrals for service;

(viii) Specific discharge criteria; and

(ix) Member's involvement in, and responses to, the treatment plan, and his/her signature and date [if

fourteen (14) years of age and over].

(F) **Amendments.** Amendment of an existing IPC to revise or add goals, objectives, service provider(s), service type, and service frequency, must be documented in either a scheduled three (3) month plan update or within the existing IPC through an addendum until the review/update is due. Any changes must, prior to implementation, be signed and dated by the member [if fourteen (14) years of age and over], the legal guardian, the foster parent, as well as the primary LBHP and any new provider(s). IPC updates must address the following:

(i) Update to the bio-psychosocial assessment, re-evaluation of diagnosis, and IPC goals and/ or objectives;

(ii) Progress, or lack of, on previous IPC goals and/or objectives;

(iii) A statement documenting a review of the current IPC, and, if no changes are needed, an explanation and a statement addressing the status of the identified problem behavior that led to TFC placement must be included;

(iv) Change in goals and/or objectives (including target dates) based upon member's progress or identification of new needs, challenges, and problems;

(v) Change in frequency and/or type of services provided;

(vi) Change in practitioner(s) who will be responsible for providing services on the plan;

(vii) Change in discharge criteria; and

(viii) Description of the member's involvement in, and responses to, the treatment plan, and his/her signature and date [if fourteen (14) years of age and over].

(3) **Description of services.** Agency services include:

(A) **Individual, family, and/or group therapy**. See Oklahoma Administrative Code (OAC) 317:30-5-241.2(a), (b), and (c). A member must receive one (1) hour of individual, family, and/or group therapy each week that is provided by an LBHP or licensure candidate, and may receive up to two (2) hours each week, if medically needed.

(B) **Crisis intervention**. The provider agency must provide crisis intervention by agency staff as needed twenty-four (24) hours per day, seven (7) days per week. The agency must ensure staff availability to respond to the residential foster parent(s) in a crisis to stabilize a member's behavior and prevent placement disruption. This service is to be provided to the member by an LBHP or a licensure candidate. The licensure candidate must have immediate access to an LBHP who can provide oversight of the licensure candidate and conduct an emergency detention evaluation.

(C) **Discharge planning.** The TFC agency must develop a

discharge plan for each member. The discharge plan must be individualized, member-specific, and include an after care plan that is appropriate to the member's needs, identifies the member's needs, includes specific recommendations for follow-up care, and outlines plans that are in place at the time of discharge. The plan for members in parental custody must include, when appropriate, reunification plans with the parent(s)/legal guardian. The plan for members who remain in the custody of DHS or OJA must be developed in collaboration with the case worker and finalized at the time of discharge. The discharge plan is to include, at a minimum, recommendations for continued treatment services, educational services, and other appropriate community resources. Appointments for outpatient therapy and medication management (when applicable) should be scheduled prior to discharge. Discharge planning provides a transition from TFC placement into a less restrictive setting within the community. Discharge planning is performed in partnership between Child Welfare Services (CWS) of the DHS and an LBHP within the TFC agency.

(D) **Substance use/chemical dependency use therapy.** Substance use/chemical dependency therapy can be provided if a member is identified by diagnosis or documented social history as having emotional or behavioral problems directly related to substance use and/or chemical dependency. The modalities employed are provided in order to begin, maintain, and enhance recovery from problem drinking, alcoholism, nicotine use and addiction, and/or drug use, drug dependency, and/or drug addiction. This service is to be provided to the member by an LBHP or licensure candidate.

(E) **Substance use rehabilitation services**. Covered substance use rehabilitation services are provided in non-residential settings in regularly scheduled sessions intended for individuals not requiring a more intensive level of care or those who require continuing services following more intensive treatment regimes. The purpose of substance use rehabilitation services is to begin, maintain, and/or enhance recovery from problem drinking, alcoholism, nicotine use and addiction, and/or drug use, drug dependency, and/or drug addiction. Rehabilitation services may be provided individually or in group sessions, and they take the format of an agency-approved, curriculum-based education and skills training. This service is to be provided to the member by a certified behavioral health case manager (CM) II, certified alcohol drug counselor (CADC) or LBHP.

(F) **Psychosocial rehabilitation (PSR).**

(i) **Definition.** PSR services are face-to-face behavioral health rehabilitation services which are necessary to

improve the member's ability to function in the community. They are performed to improve the skills and abilities of members to live independently in the community, improve self-care and social skills, and promote lifestyle change and recovery practices. Rehabilitation services may be provided individually or in group sessions, and they take the format of an agency-approved, curriculum-based education, and skills training.

(ii) **Clinical restrictions.** This service is generally performed with only the member and the qualified provider, but may also include a member and the member's family/support system group that focuses on the member's diagnosis, symptom management, and recovery based curriculum. A member who, at the time of service, is not able to cognitively benefit from the treatment due to active hallucinations and/or substance use, or other impairments is not suitable for this service. Family involvement is allowed for support of the member and education regarding his/her recovery, but does not constitute family therapy, which requires an LBHP or licensure candidate.

(iii) **Qualified practitioners.** A CM II, an LBHP, or a licensure candidate may perform PSR, following development of an IPC curriculum approved by an LBHP or licensure candidate. The CM II must have immediate access to an LBHP who can provide clinical oversight of the CM II and collaborate with the CM II in the provision of services. A minimum of one (1) monthly face-to-face consultation with an LBHP is required.

(iv) **Group sizes.** The maximum staffing ratio is eight (8) members to one (1) practitioner for members under the age of twenty-one (21).

(v) **Limitations.**

(I) In order to develop and improve the member's community and interpersonal functioning and self-care abilities, PSR services may take place in settings away from the behavioral health agency site as long as the setting protects and assures confidentiality. When this occurs, the qualified provider must be present and interacting, teaching, or supporting the defined learning objectives of the member for the entire claimed time.

(II) PSR services are intended for children/adolescents with Serious Emotional Disturbance (SED), and children/adolescents with moderate behavioral and emotional health needs who may also have a secondary physical, developmental,

intellectual, and/or social disorder that is supported alongside the mental health needs. Members, ages four (4) and five (5), are not eligible for PSR services unless a prior authorization has been granted by OHCA or its designated agent based on a finding of medical necessity.

(III) PSR services are time-limited services designed to be provided over the briefest and most effective period possible and as adjunct (enhancing) interventions to complement more intensive behavioral health therapies. Service limits are based on the member's needs according to the Client Assessment Record (CAR) or other approved tools. Service limitations are designed to maximize efficacy by remaining within reasonable age and developmentally appropriate daily limits.

(vi) **Progress notes.** In accordance with OAC 317:30-5-241.1, the behavioral health IPC developed by the LBHP or licensure candidate must include the member's strengths, functional assets, weaknesses or liabilities, treatment goals, objectives, and methodologies that are specific and time-limited, and defines the services to be performed by the practitioners and others who comprise the treatment team. When PSR services are prescribed, the plan must address objectives that are specific, attainable, realistic, measurable, and time-limited. The plan must include the appropriate treatment coordination to achieve the maximum reduction of the moderate behavioral and emotional health conditions, and any other secondary physical, developmental, intellectual, and/or social disorder and to restore the member to his or her best possible functional level. Progress notes for PSR services must include:

(I) Start and stop times for each day attended and the physical location in which the service was rendered;

(II) Specific goal(s) and objectives addressed during the session/group;

(III) Type of skills training provided each day and/or during the week including the specific curriculum used with the member;

(IV) Member satisfaction with staff intervention(s);

(V) Progress, towards attaining, or barriers affecting the attainment of, goals and objectives;

(VI) New goal(s) or objective(s) identified;

(VII) Dated signature of the qualified provider; and

(VIII) Credentials of the qualified provider.

(vii) **Additional documentation requirements.** Documentation of ongoing consultation and/or

collaboration with an LBHP or licensure candidate related to the provision of PSR services.

(G) **Therapeutic behavioral services (TBS).** Goal directed social skills redevelopment activities for each member to restore, retain, and improve the self-help, communication, socialization, and adaptive skills necessary to reside successfully in home and community based settings. These will be daily activities that are age appropriate, culturally sensitive, and relevant to the goals of the IPC. These may include self-esteem enhancement, violence alternatives, communication skills, or other related skill development. This service is to be provided to the member by the treatment parent specialist (TPS). Services rendered by the TPS are limited to one and one half (1.5) hours daily.

317:30-5-743.1. Service ~~Quality Review~~quality review (SQR)

There will be an ~~on-site Service Quality Review (SQR)~~SQR performed by the ~~OHCA~~Oklahoma Health Care Authority (OHCA) or its designated agent of each ~~Therapeutic Foster Care (TFC)~~TFC agency that provides care to members. The OHCA will designate the members of the SQR ~~Team~~team. This team will consist of at least two (2) team members and will be comprised of ~~Licensed Behavioral Health Professionals and/or Registered Nurses~~licensed behavioral health professionals (LBHPs) and/or registered nurses (RNs). The SQR will consist of a survey of current members receiving services, as well as members for which claims have been filed with OHCA for TFC services. Observation and contact with members may be incorporated. The review includes validation of certain factors, all of which must be met for the services to be compensable. Following the ~~on-site inspection~~review, the SQR ~~Team~~team will report its findings to the TFC agency. The TFC agency will be provided with written notification if the findings of the SQR have resulted in any deficiencies. A copy of the final report will be sent to the TFC agency's accrediting body. Deficiencies found during the SQR may result in a recoupment of the compensation received for that service. The individual plan of care (IPC) is considered to be critical to the integrity of care and treatment and must be completed within the ~~time lines~~timelines designated at ~~OAC~~Oklahoma Administrative Code (OAC) 317:30-5-742.2. If the ~~individual plan of care~~IPC is missing, or it is found that the ~~child~~member did not meet medical necessity criteria at any time, all paid services will be recouped for each day the ~~individual plan of care~~IPC was missing from the date the plan of care was due for completion or the date from which medical necessity criteria was no longer met.

317:30-5-744. Billing

(a) Claims must be submitted in accordance with guidelines found

at ~~OAC~~Oklahoma Administrative Code (OAC) 317:30-3-11 ~~and~~, 317:30-3-11.1, and 317:30-3-20.
(b) Claims for dually eligible individuals (Medicare/Medicaid) should be filed directly with the ~~OHCA~~Oklahoma Health Care Authority (OHCA).

317:30-5-745. Documentation of records

~~All services must be reflected by documentation in the records including the date the service was provided, the beginning and ending time the service was provided, the location in which the service was provided, a description of the resident's response to the service and whether the service provided was an individual, group or family session, group rehabilitative treatment, social skills (re)development, basic living skills (re)development, crisis behavior management and redirection, or discharge planning, and the dated signature with credentials of the person providing the service.~~

Providers must maintain an appropriate records system. Current individual plans of care, case files, and progress notes are maintained in the provider's files during the time the member is receiving services. All services must be reflected by documentation in the records. Documentation of services must include all of the following:

(1) The date the service was provided;

(2) The beginning and ending time the service was provided;

(3) A description of the member's response to the service;

(4) The type of service provided (individual, group, or family session; group rehabilitative treatment; social skills (re)development; basic living skills (re)development; crisis behavior management and redirection; or discharge planning); and

(5) The dated signature with credentials of the person providing the service.

317:30-5-746. ~~Appeal of Prior Authorization Decision~~Prior authorization and 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 calendar days of the receipt of the notification of the denial by the OHCA or its designated agent.~~

(a) All behavioral health services must be prior authorized by the Oklahoma Health Care Authority (OHCA) or its designated agent before the service is rendered by an eligible provider. Without prior authorization, payment is not authorized.

(b) 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 OHCA within thirty (30) calendar days of the

receipt of the notification of the denial by the OHCA or its designated agent.

PART 84. INTENSIVE TREATMENT FAMILY CARE

317:30-5-750. Definitions.

The following words or terms used in this Part shall have the following meaning, unless the context clearly indicates otherwise:

(1) **"Intensive treatment family care (ITFC) agency"** means an agency that provides foster care as defined in Public Welfare, 45 Code of Federal Regulation (CFR), Sec. 1355.20 as twenty-four (24) hour substitute care for children and adolescents placed away from their parents or guardians and for whom the title IV-E agency has placement and care responsibility. ITFC settings are foster family homes.

(2) **"Intensive treatment family care (ITFC) home"** means an agency-supervised, private family home in which foster parents [at least one (1) parent must be a stay-at home parent] have been trained to provide individualized, structured services in a safe, nurturing family-living environment. These services are provided to children and adolescents with severe behavioral and emotional health needs. They may also present a secondary physical, developmental, intellectual, and/or social disorder that is supported alongside the mental health needs of the member. These members require a higher level of care that cannot be provided in the traditional foster care or TFC home. ITFC homes provide the higher level of care needed for these children and adolescents, and help prevent placement in a more restrictive setting, including an inpatient setting.

(3) **"Intensive treatment family care (ITFC) model"** means a model in which children and adolescents in the ITFC environment receive intensive individualized behavioral health and other support services from qualified staff. Because ITFC members require exceptional levels of skill, time, and supervision, the number of unrelated children and adolescents placed per home is limited; no more than one (1) ITFC member may be placed in a home at any one (1) time unless additional cases are specifically authorized by Child Welfare Services (CWS) of the Oklahoma Department of Human Services (DHS), or Oklahoma Office of Juvenile Affairs (OJA).

317:30-5-750.1. Eligible providers and requirements

(a) **ITFC agency**. Eligible ITFC agencies must have:

(1) Current certification from the Oklahoma Department of Human services (DHS) as a child placing agency;

(2) A contract with the Child Welfare Division of DHS, or Oklahoma Office of Juvenile Affairs (OJA);

(3) A contract with the Oklahoma Health Care Authority (OHCA);

and

(4) A current accreditation status appropriate to provide behavioral health services in a foster care setting from:

(A) The Joint Commission; or

(B) The Commission on Accreditation of Rehabilitative Facilities (CARF); or

(C) The Council on Accreditation (COA).

(b) **Treatment team.** ITFC agencies are primarily responsible for treatment planning and coordination of the member's treatment team. This team is typically composed of a DHS or OJA caseworker, the member, the member's foster parent(s), as well as others closely involved with the member and family, including the biological parents when applicable. It also includes the following:

(1) **Certified behavioral health case manager (CM) II.** A bachelor's level team member who may provide support services and case management. In addition to the minimum requirements at Oklahoma Administrative Code (OAC) 317:30-5-240.3(h)(1), the CM II must:

(A) Have a minimum of one (1) year of experience in providing direct care and/or treatment to children/adolescents and/or families; and

(B) Have access to weekly consultation with a licensed behavioral health professional (LBHP).

(C) The CM II must also follow requirements at OAC 317:30-5-241.3 for providing psychosocial rehabilitation (PSR) services.

(2) **Certified alcohol and drug counselor (CADC).** A bachelor's level team member with a current certification as a CADC in the state in which services are provided.

(3) **Licensed behavioral health professional (LBHP)**. A master's level professional who provides treatment and supervises other treatment staff in maintaining clinical standards of care and providing direct clinical services. In addition to the requirements at OAC 317:30-5-240.3(a), the LBHP in an ITFC setting must demonstrate a general professional or educational background in the following areas:

(A) Case management, assessment, and treatment planning;

(B) Treatment of victims of physical, emotional, and sexual abuse;

(C) Treatment of children/adolescents with attachment disorders;

(D) Treatment of children/adolescents with hyperactivity or attention deficit disorders;

(E) Treatment methodologies for emotionally disturbed children/adolescents;

(F) Normal childhood development and the effect of abuse and/or neglect on childhood development;

(G) Anger management;
(H) Crisis intervention; and
(I) Trauma-informed methodology.
(4) **Licensed psychiatrist and/or psychologist**. ITFC agencies must provide staff with access to professional psychiatric or psychological consultation as deemed necessary for the planning, implementation, and appropriate management of the member's treatment. See OAC 317:30-5-240.3(a) and 317:25-7-5.
(5) **Treatment parent specialist (TPS)**. The TPS serves as an integral member of the team of professionals providing services for the children and adolescents. The TPS receives extensive training in diagnosed mental health issues, and behavior management/modification and skill-based parenting techniques; and implements the in-home portion of the treatment plan with close supervision and support. The TPS renders services for the member, provides or arranges suitable transportation for therapy and other treatment appointments, writes daily detailed notes regarding interventions and practical applications of learned skills, and attends treatment team meetings. The TPS must be under the supervision of an LBHP of the ITFC agency and meet the following criteria:
(A) **Qualifications**.
(i) Have a high school diploma or equivalent, and either some post-secondary education and/or a combination of at least two (2) years of personal/professional experience working with children/adolescents with significant needs;
(ii) Have an employment and/or contractual relationship with the ITFC agency as a foster parent, and have successfully met all required background screening requirements, including, but not limited to, fingerprint screenings conducted by the Oklahoma State Bureau of Investigation (OSBI) and Federal Bureau of Investigation (FBI), and DHS background screenings;
(iii) Completed all evidence-informed ITFC foster parent training, as outlined in this section;
(iv) Complete a minimum of twenty (20) hours of required annual continuing education trainings. Six (6) hours of the twenty (20) training hours must be clinical in nature;
(v) Agree to have at least one (1) parent in the ITFC home serve as a full-time, stay-at-home parent in order to sufficiently meet the significant needs of the member placed in the ITFC home; and
(B) **Responsibilities.**
(i) Have a minimum of twice monthly face-to-face supervision with the LBHP, independent of the member's family therapy;
(ii) Have weekly contact with the ITFC agency professional staff;

(iii) Utilize individualized curriculum-based education and support materials with the member to support the member's skill development outside of the clinical setting;

(iv) Agree, by contract with the ITFC agency, to serve the member in his or her ITFC home through completion of the treatment designated on his or her individual plan of care, and without disruption to the service array; and

(v) Work with the multidisciplinary team and the member's biological family toward reunification, if appropriate, or other permanency plan.

(c) **Agency assurances.** The ITFC agency must ensure that each individual who renders treatment services meets the minimum provider qualifications for the service and is fully contracted with the OHCA. Additionally, the ITFC agency must comply with all state and federal Medicaid law, including, but not limited to, OHCA administrative rules, the Code of Federal Regulations (CFR), and the Oklahoma State Medicaid Plan.

(d) **Policies and procedures.** Eligible ITFC agencies shall have written policies and procedures for the orientation of new staff and foster parents which is reviewed and updated annually, for the following:

(1) Pre-service training of foster parents in treatment methodologies and service needs of emotionally and behaviorally disturbed children/adolescents;

(2) Treatment of victims of physical, emotional, and sexual abuse;

(3) Treatment of children/adolescents with attachment disorders;

(4) Treatment of children/adolescents with hyperactive or attention deficit disorders;

(5) Normal childhood development and the effect of abuse and/or neglect on childhood development;

(6) Treatment of children/adolescents and families with substance use disorders;

(7) The Inpatient Mental Health and Substance Abuse Treatment of Minors Act;

(8) Anger management;

(9) Inpatient authorization procedures;

(10) Crisis intervention;

(11) Grief and loss issues for children/adolescents in foster care;

(12) The significance/value of birth families to children/adolescents receiving behavioral health services in a foster care setting; and

(13) Trauma-informed methodology.

317:30-5-750.2. Provider selection

Parents who retain legal custody of an ITFC member may select any eligible ITFC agency as the provider of services. In the case of members in the custody of the State of Oklahoma, the State, acting in its custodial role, selects the ITFC agency.

317:30-5-751. Coverage by category

(a) **Adults.** Behavioral health services in ITFC settings are not covered for adults.

(b) **Children.** Behavioral health services are allowed in ITFC settings for children and adolescents as medically necessary. The children and adolescents receiving services in this setting have severe behavioral and emotional health needs and may also present a secondary physical, developmental, intellectual, and/or social disorder that is supported alongside the mental health needs. ITFC homes provide the higher level of care needed for these children or adolescents and help prevent placement in an inpatient or more restrictive setting. The designated children and adolescents must continually meet medical necessity criteria to be eligible for coverage in this setting. Requests for behavioral health services in an ITFC setting must be prior authorized and may be approved up to a maximum of three (3) month extensions.

(c) **Medical necessity criteria**. In order to satisfy medical necessity criteria, all of the following conditions must be met:

(1) The member must have a diagnosis from the Diagnostic and Statistical Manual of Mental Disorders (DSM-V), with the exception of V codes and adjustment disorders, with a detailed description of the symptoms supporting the diagnosis. Children and adolescents with a provisional diagnosis may receive ITFC services for a maximum of thirty (30) days.

(2) An assessment must be completed by a licensed behavioral health professional (LBHP) as defined in Oklahoma Administrative Code (OAC) 317:30-5-240.3(a) within the thirty (30) day provisional period described above, that confirms a diagnosis from the DSM-V with the exception of V codes and adjustments disorders, and that includes a detailed description of the symptoms supporting the diagnosis to continue treatment in an ITFC setting.

(3) Conditions are directly attributed to a primary medical diagnosis of a severe behavioral and emotional health need, and may also be attributed to a secondary medical diagnosis of a physical, developmental, intellectual and/or social disorder that is supported alongside the mental health needs.

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

(5) Evidence that the members' needs prohibit full integration in a family/home setting without the availability of twenty-four (24) hour crisis response/behavior management and

intensive clinical interventions from professional staff, preventing the member from living in a traditional or therapeutic foster home.

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

(7) The legal guardian [Oklahoma Department of Human Services (DHS)/ Oklahoma Office of Juvenile Affairs (OJA) if custody member] or parent of the member agrees to actively participate in the member's treatment needs and planning.

317:30-5-752. Description of services

(a) Treatment services must be provided in the least restrictive, non-institutional therapeutic environment. The ITFC setting is restorative in nature, allowing children and adolescents with severe behavioral and emotional health needs, who may also present a secondary physical, developmental, intellectual, and/or social disorder that is supported alongside the mental health needs, to develop the necessary control to function in a less restrictive setting.

(b) Behavioral health services must include an individual plan of care (IPC) for each member served. The IPC requirements are set out in Oklahoma Administrative Code (OAC) 317:30-5-753.

(c) Treatment services in an ITFC must include at least two (2) hours of individual, family, and/or group therapy per week, as set forth in OAC 317:30-5-753(3). Treatment may also include, but is not limited to, an array of the following services:

(1) Substance abuse/chemical dependency education, prevention, and therapy;

(2) Psychosocial rehabilitation and support services;

(3) Behavior management;

(4) Crisis intervention; and

(5) Case management.

317:30-5-753. Individual plan of care (IPC) requirements

All behavioral health services in an ITFC setting are provided as a result of an individual assessment of the member's needs and documented in the IPC.

(1)**Assessment**.

(A) **Definition.** Gathering and assessment of historical and current bio-psychosocial information which includes face-to-face contact with the member and the member's foster parent(s) or legal guardian or other person, including biological parent(s) when applicable, who have pertinent information about the member resulting in a written summary report, diagnosis, and recommendations. All ITFC agencies must assess each individual to determine whether they could be an appropriate candidate for ITFC services.

(B) **Qualified professional.** This service is performed by a licensed behavioral health professional (LBHP).
(C) **Limitations**. Assessments are compensable on behalf of a member who is seeking services for the first time from the ITFC agency. This service is not compensable if the member has previously received or is currently receiving services from the agency, unless there has been a gap in service of more than six (6) months and it has been more than one (1) year since the previous assessment.
(D) **Documentation requirements.** The assessment must include all elements and tools required by the Oklahoma Health Care Authority (OHCA). In the case of members under the age of eighteen (18), it is performed with the direct, active, face-to-face participation of the member and foster parent(s) or legal guardian or other persons, including biological parent(s) when applicable. The member's level of participation is based on age, developmental, and clinical appropriateness. The assessment must include all related diagnoses from the Diagnostic and Statistical Manual of Mental Disorders (DSM-V). The assessment must contain, but is not limited to, the following:

(i) Date, including month, day, and year of the assessment session(s);
(ii) Source of information;
(iii) Member's first name, middle initial, and last name;
(iv) Gender;
(v) Birth date;
(vi) Home address;
(vii) Telephone number;
(viii) Referral source;
(ix) Reason for referral;
(x) Person to be notified in case of emergency;
(xi) Presenting reason for seeking services;
(xii) Start and stop time for each unit billed;
(xiii) Dated signature of foster parent(s) or legal guardian [Oklahoma Department of Human Services (DHS) or Oklahoma Office of Juvenile Affairs (OJA)] or other persons, including biological parent(s) (when applicable) participating in the face-to-face assessment. Signatures are required for members fourteen (14) years of age and over;
(xiv) Bio-psychosocial information, which must include:

(I) Identification of the member's strengths, needs, abilities, and preferences;
(II) History of the presenting problem;
(III) Previous psychiatric treatment history, including treatment of psychiatric issues, substance use, drug and alcohol addiction, and other addictions;

(IV) Health history and current biomedical conditions and complications;
(V) Trauma, abuse, neglect, violence, and/or sexual assault history of self and/or others, including DHS involvement;
(VI) Family and social history, including psychiatric, substance use, drug and alcohol addiction, other addictions, and trauma/abuse/neglect;
(VII) Educational attainment, difficulties, and history;
(VIII) Cultural and religious orientation;
(IX) Vocational, occupational, and military history;
(X) Sexual history, including human immunodeficiency virus (HIV), acquired immune deficiency syndrome (AIDS), other sexually transmitted diseases (STDs), and at-risk behaviors;
(XI) Marital or significant other relationship history;
(XII) Recreation and leisure history;
(XIII) Legal or criminal record, including the identification of key contacts (e.g. attorneys, probation officers);
(XIV) Present living arrangements;
(XV) Economic resources; and
(XVI) Current support system, including peer and other recovery supports.

(xv) Mental status and level of functioning information, including, but not limited to, questions regarding the following:
(I) Physical presentation, such as general appearance, motor activity, attention, and alertness;
(II) Affective process, such as mood, affect, manner, and attitude;
(III) Cognitive process, such as intellectual ability, social-adaptive behavior, thought processes, thought content, and memory; and
(IV) All related diagnoses from the DSM-V.

(xvi) Pharmaceutical information for both current and past medications, to include the following;
(I) Name of medication;
(II) Strength and dosage of medication;
(III) Length of time on the medication; and
(IV) Benefit(s) and side effects of medication.

(xvii) LBHP's interpretation of findings and diagnosis; and

(xviii) Dated signature and credentials of the LBHP who performed the face-to-face behavioral assessment.

(2) **IPC requirements.**

(A) **Signature requirement**. A written IPC following a comprehensive evaluation for each member must be formulated by the ITFC agency staff within thirty (30) days of admission to the program with documented input from the member, the legal guardian (DHS/OJA), the foster parent(s), the treatment provider(s), and the biological parent(s) when applicable. An IPC is not valid until all dated signatures are present, including signatures from the member [if fourteen (14) years of age and over], the legal guardian, the foster parent, and the treatment provider(s). This plan must be reviewed every thirty (30) days with documented involvement of the legal guardian and member. The review includes an evaluation of the member's progress in the treatment setting, as well as in other environments, such as home, school, social engagements, etc.

(B) **Individualization.** The IPC must be individualized and take into account the member's age, history, diagnosis, functional levels, culture, and the effect of past and current traumatic experiences in the life of the member. It includes the member's documented diagnosis, appropriate goals, corresponding reasonable and attainable treatment objectives, and action steps within the expected timelines. Each member's IPC needs to address the ITFC agency's plans with regard to the provision of services. Each plan of care must clearly identify the type of services required to meet the member's treatment needs and frequency over a given period of time.

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

(D) **Time requirements**. IPC updates must be conducted face-to-face and are required at least every ninety (90) days during active treatment. However, updates can be conducted whenever it is clinically needed, as determined by an LBHP. Updates should reflect changes to treatment based on the members' progress or lack thereof.

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

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

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

(iii) Specific goals for the member;

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

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

(vi) The name and credentials of all the practitioners who will be providing and responsible for each service;

(vii) Any needed referrals for service;
(viii) Specific discharge criteria; and
(ix) Description of the member's involvement in, and responses to, the treatment plan, and his/her signature and date [if fourteen (14) years of age and older].

(F) **Amendments.** Amendment of an existing IPC to revise or add goals, objectives, service provider(s), service type, and service frequency must be documented in the existing IPC through an addendum until the review/update is due. Any changes must, prior to implementation, be signed and dated by the member [if fourteen (14) years of age and over], the legal guardian, the foster parent, as well as the primary LBHP and any new provider(s). IPC updates must address the following:

(i) Update to the bio-psychosocial assessment, re-evaluation of diagnosis, and IPC goals and/ or objectives;
(ii) Progress, or lack of, on previous IPC goals and/or objectives;
(iii) A statement documenting a review of the current IPC, and, if no changes are needed, an explanation and a statement addressing the status of identified problem behaviors that led to ITFC placement must be included;
(iv) Change in goals and/or objectives (including target dates) based upon member's progress or identification of new needs, challenges, and problems;
(v) Change in frequency and/or type of services provided;
(vi) Change in practitioner(s) who will be responsible for providing services on the plan;
(vii) Change in discharge criteria; and
(viii) Description of the member's involvement in, and responses to, the treatment plan, and his/her signature and date [if fourteen (14) years of age and older].

(3) **Description of services.** Agency services include:

(A) **Individual, family, and/or group therapy**. See OAC 317:30-5-241.2(a), (b), and (c). The number of units of individual, family, and/or group therapy within the ITFC setting differ from the number of units available in the outpatient setting. A member must receive two (2) hours of individual, family, and/or group therapy each week that is provided by an LBHP, and may receive up to three (3) hours each week, if medically needed.

(B) **Crisis intervention**. The provider agency must provide crisis intervention by ITFC agency staff as needed twenty-four (24) hours per day, seven (7) days per week. The agency must ensure staff is available to respond to the ITFC foster parent(s) in a crisis to stabilize a member's behavior and prevent placement disruption. This service is to be provided

to the member by an LBHP.

(C) **Discharge planning.** The ITFC agency must develop a discharge plan for each member. The discharge plan must be individualized, member-specific, and include an after-care plan that is appropriate to the member's needs, identifies the member's needs, includes specific recommendations for follow-up care, and outlines plans that are in place at the time of discharge. The plan for members in parental custody must include, when appropriate, reunification plans with the parent(s)/legal guardian. The plan for members who remain in the custody of DHS or OJA must be developed in collaboration with the case worker and be finalized at the time of discharge. The discharge plan is to include, at a minimum, recommendations for continued treatment services, educational services, and other appropriate community resources. Appointments for outpatient therapy and medication management (when applicable) should be scheduled prior to discharge. Discharge planning provides a transition from ITFC placement into a lesser restrictive setting within the community. Discharge planning is performed in partnership between Child Welfare Services (CWS) of the Oklahoma Department of Human Services (DHS) and an LBHP within the ITFC agency.

(D) **Substance use/chemical dependency use therapy.** Substance use/chemical dependency therapy can be provided if a member is identified by diagnosis or documented social history as having emotional or behavioral problems directly related to substance use and/or chemical dependency. The modalities employed are provided in order to begin, maintain, and/or enhance recovery from problem drinking, alcoholism, nicotine use and addiction, and/or drug use, drug dependency, and/or drug addiction. This service is provided to the member by an LBHP.

(E) **Substance use rehabilitation services**. Covered substance use rehabilitation services are provided in non-residential settings in regularly scheduled sessions intended for individuals not requiring a more intensive level of care or those who require continuing services following more intensive treatment regimes. The purpose of substance use rehabilitation services is to begin, maintain, and/or enhance recovery from problem drinking, alcoholism, nicotine use and addiction, and/or drug use, drug dependency, and/or drug addiction. Rehabilitation services may be provided individually or in group sessions, and they take the format of an agency-approved, curriculum-based education and skills training. This service is provided to the member by a certified behavioral health case manager (CM) II, a certified alcohol drug counselor (CADC), or an

LBHP.

(F) **Psychosocial rehabilitation (PSR).**

(i) **Definition.** PSR services are face-to-face behavioral health rehabilitation services which are necessary to improve the member's ability to function in the community. They are performed to improve the skills and abilities of members to live independently in the community, improve self-care and social skills, and promote lifestyle change and recovery practices. Rehabilitation services may be provided individually or in group sessions, and they take the format of an agency-approved, curriculum-based education and skills training.

(ii) **Clinical restrictions.** This service is generally performed with only the member and the qualified provider, but may also include the member's family/support system group that focuses on the member's diagnosis, symptom management, and recovery-based curriculum. A member who, at the time of service, is not able to benefit from the treatment due to active hallucinations and/or substance use, or other impairment, is not suitable for this service. Family involvement is allowed for support of the member and education regarding his/her recovery, but does not constitute family therapy, which requires an LBHP.

(iii) **Qualified practitioners.** A CM II or an LBHP may perform PSR, following development of an IPC curriculum. The CM II must have immediate access to an LBHP who can provide clinical oversight of the CM II and collaborate with the CM II in the provision of services. A minimum of one (1) monthly face-to-face consultation with an LBHP is required.

(iv) **Group sizes.** The maximum staffing ratio is eight (8) members to one (1) service provider for members under the age of twenty-one (21).

(v) **Limitations.**

(I) In order to develop and improve the member's community and interpersonal functioning and self-care abilities, PSR services may take place in settings away from the behavioral health agency site as long as the setting protects and assures confidentiality. When this occurs, the qualified provider must be present and interacting, teaching, or supporting the defined learning objectives of the member for the entire claimed time.

(II) PSR services are intended for children/adolescents with Serious Emotional Disturbance (SED), and children/adolescents with severe behavioral and emotional health needs who may

also have a secondary physical, developmental, intellectual, and/or social disorder that is supported alongside the mental health needs. Members, ages four (4) and five (5), are not eligible for PSR services unless a prior authorization has been granted by OHCA or its designated agent, based on a finding of medical necessity.

(III) PSR services are time-limited services designed to be provided over the briefest and most effective period possible and as adjunct (enhancing) interventions to complement more intensive behavioral health therapies. Service limits are based on the member's needs according to the Client Assessment Record (CAR) or other approved tools. Service limitations are designed to maximize efficacy by remaining within reasonable age and developmentally appropriate daily limits.

(vi) **Progress notes.** In accordance with OAC 317:30-5-241.1, the behavioral health IPC developed by the LBHP must include the member's strengths, functional assets, weaknesses or liabilities, treatment goals, objectives, and methodologies that are specific and time-limited, and defines the services to be performed by the practitioners and others who comprise the treatment team. When PSR services are prescribed, the plan must address objectives that are specific, attainable, realistic, measurable, and time-limited. The plan must include the appropriate treatment coordination to achieve the maximum reduction of the physical, developmental, emotional, and/or social disorders and to restore the member to his or her best possible functional level. Progress notes for PSR services must include:

(I) Start and stop times for each day attended and the physical location in which the service was rendered;

(II) Specific goal(s) and objectives addressed during the session/group;

(III) Type of skills training provided each day and/or during the week including the specific curriculum used with the member;

(IV) Member satisfaction with staff intervention(s);

(V) Progress towards attaining, or barriers affecting the attainment of, goals and objectives;

(VI) New goal(s) or objective(s) identified;

(VII) Dated signature of the qualified provider; and

(VIII) Credentials of the qualified provider.

(vii) **Additional documentation requirements.** Documentation of ongoing consultation and/or collaboration with an LBHP related to the provision of

PSR services.

(G) **Therapeutic behavioral services (TBS).** Goal-directed social skills redevelopment activities for each member to restore, retain, and improve the self-help, communication, socialization, and adaptive skills necessary to reside successfully in home and community based settings. These will be daily activities that are age appropriate, culturally sensitive, and relevant to the goals of the IPC. These may include self-esteem enhancement, violence alternatives, communication skills, or other related skill development. This service is to be provided to the member by the treatment parent specialist (TPS). Services rendered by the TPS are limited to one and a half (1.5) hours daily.

317:30-5-754. Service quality review (SQR)

(a) Providers must maintain an appropriate records system. Current individual plans of care, case files, and progress notes are maintained in the provider's files during the time the member is receiving services. All services must be reflected by documentation in the records. Documentation of services must include all of the following:

(1) The date the service was provided;

(2) The beginning and ending time the service was provided;

(3) A description of the member's response to the service;

(4) The type of service provided (individual, group, or family session; group rehabilitative treatment; social skills (re)development; basic living skills (re)development; crisis behavior management and redirection; or discharge planning); and

(5) The dated signature with credentials of the person providing the service.

(b) There will be an SQR review performed by the Oklahoma Health Care Authority (OHCA) or its designated agent of each ITFC agency that provides care to members. The OHCA will designate the members of the SQR team. This team will consist of at least two (2) team members and will be comprised of licensed behavioral health professionals (LBHPs) and/or registered nurses (RNs). The SQR will consist of a survey of current members receiving services, as well as members for which claims have been filed with OHCA for ITFC services. Observation and contact with members may be incorporated. The review includes validation of certain factors, all of which must be met for the services to be compensable. Following the review, the SQR team will report its findings to the ITFC agency. The ITFC agency will be provided with written notification if the findings of the SQR have resulted in any deficiencies. A copy of the final report will be sent to the ITFC agency's accrediting body. Deficiencies found during the SQR may result in a recoupment of the compensation received for that

service. The individual plan of care (IPC) is considered to be critical to the integrity of care and treatment and must be completed within the timelines designated at Oklahoma Administrative Code (OAC) 317:30-5-753. If the IPC is missing, or it is found that the member did not meet medical necessity criteria at any time, all paid services will be recouped for each day the IPC was missing from the date the plan of care was due for completion or the date from which medical necessity criteria was no longer met.

317:30-5-755. Billing

(a) Claims must be submitted in accordance with guidelines found at Oklahoma Administrative Code (OAC) 317:30-3-11, 317:30-3-11.1 and 317:30-3-20.

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

317:30-5-756. Reimbursement

(a) ITFC services will be paid at the current fee-for-service (FFS) rate. Services provided to a member without a written individual plan of care (IPC) as described in Oklahoma Administrative Code (OAC) 317:30-5-753 will not be reimbursed.

(b) In the case of a member who needs additional specialized behavioral health services, prior authorization by the Oklahoma Health Care Authority (OHCA) is required. See OAC 317:30-3-31. Only specialized rehabilitation or psychological treatment services to address unique, unusual, or severe symptoms or disorders will be authorized. Documentation must be provided to ensure that services are not duplicative.

(c) If additional services are approved for a member in state custody, the Oklahoma Department of Human Services (DHS), or Oklahoma Office of Juvenile Affairs (OJA) will collaborate with the provider of such services as directed by the OHCA. Any additional specialized behavioral health services provided to members in state custody are funded in the normal manner.

(d) Reimbursement for ITFC services is not available for the following:

(1) Room and board;
(2) Educational costs;
(3) Supported employment;
(4) Inpatient psychiatric services; and
(5) Respite care.

(e) Case management services are reimbursed to government providers as per the methodology in the approved Medicaid State Plan.

317:30-5-757. Prior authorization and appeal of prior

authorization decision

(a) All behavioral health services must be prior authorized by the Oklahoma Health Care Authority (OHCA) or its designated agent before the service is rendered by an eligible provider. Without prior authorization, payment is not authorized.

(b) 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 OHCA within 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 1. ADMINISTRATIVE OPERATIONS

SUBCHAPTER 1. ORGANIZATION AND ADMINISTRATION

317:1-1-4. Organization and meetings

(a) The Authority Board consists of ~~seven (7)~~nine (9) members. Section 5007 of Title 63 of the Oklahoma Statutes (O.S.) provides for their appointment and service.

(b) A chair and a ~~Vice-Chair~~vice-chair shall be elected by a majority of the members of the Board. The terms of office of the ~~Chair and Vice-Chair~~chair and vice-chair shall be one (1) year beginning ~~July~~January 1 of each year. A member elected to serve as ~~Chair or Vice-Chair~~chair or vice-chair may be elected to serve more than one (1) term. Elections will be held at the last regular meeting before ~~July~~January 1. However, in the event the last regular meeting before ~~July~~January 1 shall be canceled for any reason, the election may be held at a specially-scheduled meeting or, if it is not possible to schedule a special meeting, at the next ~~regularly-scheduled~~regularly-scheduled meeting. In the event an election ~~can not~~cannot be conducted prior to ~~July~~January 1 of any year, the ~~Chair and Vice-Chair~~chair and vice-chair who are in office ~~June 30~~December 31 shall continue their terms until an election is held.

(c) The chair will preside over meetings and perform other duties as required by the Authority ~~[65:5008(A)]~~.

(d) A majority of the members of the Board shall constitute a quorum for the transaction of business and for taking any official action. Any action or decision of the Board requires an affirmative vote of at least a majority of the members present ~~[63:5007(D)]~~[63 O.S. § 5007(D)].

(e) All meetings of the Authority Board will be conducted in accordance with the Open ~~Meetings~~Meeting Act, ~~Sections 301 through 314 of Title 25 of the Oklahoma Statutes~~25 O.S. §§ 301 - 314.

317:1-1-6. ~~Cancellation~~Emergency cancellation of meetings

The ~~Chairman~~chair, or the vice-chair in the chair's absence, shall have the power to cancel or reschedule any regular or special meeting of the Authority due to anticipated lack of quorum, inclement weather, or other emergency. Notice ~~of cancellation of said meeting~~thereof shall be ~~posted~~filed with the Secretary of State and publicly posted as soon as reasonably possible ~~and in the same manner as the agenda~~.

317:1-1-7. Minutes of the Authority

A summary shall be made of all proceedings before the Authority which shall show those members present and absent, all matters considered, all actions taken, and the vote of each member on any

motion, and shall be made public~~, as prescribed in OAC 317:1-1-10(e)~~on the Authority's website.

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 1. PHYSICIANS

317:30-5-22.1. Enhanced services for medically high risk pregnancies

(a) **Enhanced services.** Enhanced services are available for pregnant women eligible for SoonerCare and are in addition to services for uncomplicated maternity cases. Women deemed high risk based on criteria established by the ~~OHCA~~Oklahoma Health Care Authority (OHCA) must receive prior authorization for medically necessary enhanced benefits which include:

(1) prenatal at risk antepartum management;

(2) a combined maximum of five (5) fetal non stress test(s) and biophysical profiles (additional units can be prior authorized for multiple fetuses)with one (1) test per week beginning at ~~32~~thirty-two (32) weeks gestation and continuing to ~~38~~thirty-eight (38) weeks; and

(3) a maximum of three (3) follow-up ultrasounds not covered under OAC 317:30-5-22(b)(2).

(b) **Prior authorization**. To receive enhanced services, the following documentation must be received by the OHCA Medical Authorizations Unit for review and approval:

(1) ~~ACOG~~A comprehensive prenatal assessment from the American College of Obstetricians and Gynecologist (ACOG) or other comparable comprehensive prenatal assessment; and

(2) ~~appropriate~~Appropiate documentation supporting medical necessity from a ~~Board Eligible/Board Certified~~board eligible/board certified Maternal Fetal Medicine (MFM) specialist, ~~or~~a ~~Board Eligible/Board Certified~~board eligible/board certified Obstetrician-Gynecologist (OB-GYN)~~.~~, or a board eligible/board certified Family Practice Physician who has completed an Accreditation Council for Graduate Medical Education (ACGME) approved residency. The medical residency program must include appropriate obstetric training and the physician must be credentialed by the hospital at which they provide obstetrical services in order to perform such services. The documentation must include information identifying and detailing the qualifying high risk condition. Non-MFM obstetrical providers requesting enhanced services are limited to a specific set of diagnoses as outlined on the OHCA Medical Authorizations Unit webpage.

(c) **Reimbursement**. When prior authorized, enhanced benefits will be reimbursed as follows:

(1) Antepartum management for high risk is reimbursed to the primary obstetrical provider. If the primary provider of obstetrical care is not the MFM and wishes to request authorization of the antepartum management fee, the treatment plan must be signed by the primary provider of OB care. Additionally, reimbursement for enhanced at risk antepartum management is not made during an in-patient hospital stay.

(2) Non stress tests, biophysical profiles and ultrasounds [in addition to those covered under OAC 317:30-5-22(a)(2) subparagraphs (A) through (C)] are reimbursed when prior authorized.

(3) Reimbursement for enhanced at risk antepartum management is not available to physicians who already qualify for enhanced reimbursement as state employed physicians.

PART 3. HOSPITALS

317:30-5-42.11. Observation/treatment

(a) Payment is made for the use of a treatment room associated with outpatient observation services. Observation services must be ordered by a physician or other individual authorized by state law. Observation services are furnished by the hospital on the hospital's premises and include use of the bed and periodic monitoring by hospital staff. Observation services must include a minimum of ~~8~~eight (8) hours of continuous care. Outpatient observation services are not covered when they are provided:

(1) On the same day as an emergency department visit.

(2) Prior to an inpatient admission, as those observation services are considered part of the inpatient DRG.

(3) For the convenience of the member, member's family or provider.

(4) When specific diagnoses are not present on the claim.

(5) As part of another service, i.e. for post operative monitoring; recovery after diagnostic testing or concurrently with therapeutic services such as chemotherapy.

(b) Payment is made for observation services in a labor or delivery room. Observation services must include a minimum of eight (8) hours of continuous care. Specific pregnancy-related diagnoses are required. ~~During active labor, a fetal non-stress test is covered in addition to the labor and delivery room charge.~~

Oklahoma Health Care Authority Board Meeting – Drug Summary

Drug Utilization Review Board Meeting – July 10, 2019

Recommendation/ Vote	Drug	Used for	Cost*	Notes
1	Jornay PM™ Evekeo ODT™ Adhansia XR™ and Sunosi™	Attention deficit hyperactivity disorder (ADHD) Narcolepsy	• $369.90- month • $6.36 per OTD • N/A • $22.00 per tablet	Different formulations of ADHD medications New med for narcolepsy
2	Balversa™	Urothelial (bladder) cancer	$21,600.00 - $24,300.00 - month	Oral capsule
3	Various Special Formulations (#15)**	Various conditions	See table "Various Special Formulations"**	See table "Special Formulations"
4	Abilify MyCite® Aristada Initio® Perseris™	Atypical antipsychotic medications (schizophrenia)	• $1,650.00 – month $19,800.00 – year • $1,981.73 - one time dose • $1,710.00-$2,280.00 –month • $20,520.00 - $27,360.00 - year	tablets with sensor Extended-Release (ER) Injectable Suspension Sub-Q Injectable
5	Cassipa® and Levorphanol	Medication assisted treatment (MAT) Pain	• N/A – FDA approved Set 2018 • $44.50 per unit/tablet $178.00 per day	Higher strength (16mg) buprenorphine/ naloxone) not on market, yet. Dosing varies for pain (1-2 mg every 6 hours)

*Costs do not reflect rebated prices or net costs. Costs based on National Average Drug Acquisition Costs (NADAC) or Wholesale Acquisition Costs (WAC) if NADAC unavailable. N/A = not available at the time of publication.

Oklahoma Health Care Authority Board Meeting –Various Special Formulations**

Drug Utilization Review Board Meeting

Recommendation #3 (15)	Drug	Generic Name	Cost – 30 days or Treatment *	Comparable to/Notes:
a)	Annovera™	Segesterone Acetate/Ethinyl Estradiol Vaginal System	N/A	Nuvaring®
b)	Bijuva™	Estradiol/Progesterone Capsule	$214.50 vs $65.00	Activella® & generic
c)	Cequa™	Cyclosporine 0.09% Ophthalmic Solution	$507.00 - parity	Restasis®
d)	Corlanor®	Ivabradine Oral Solution	N/A	New formulation – oral solution
e)	Crotan™	Crotamiton 10% Lotion	$1838.70 - parity	Permethrin @ $26.40
f)	Gloperba®	Colchicine Oral Solution	N/A	Oral solution for gout
g)	Glycate®	Glycopyrrolate Tablet	$467.10 vs. $27.90	PUD
h)	Khapzory™	Levoleucovorin Injection	$3500.00 vs $570.00	Less expensive alternatives available ($570.00)
i)	Qmiiz™ ODT	Meloxicam Orally Disintegrating Tablet (ODT)	$202.50 vs $0.60	Disintegrating tablet dosage form
j)	Seconal Sodium™	Secobarbital Sodium Capsule	$498.68/ 14 capsules	Rebranding of an old drug Less expensive alternatives available $0.42-$2.63
k)	TaperDex™	Dexamethasone Tablet	$231.77 vs $17.64	Dose pack, can use individual tablets to taper dose
l)	Tiglutik™	Riluzole Oral Suspension	$3150.00 vs. $53.40 - tabs	Liquid dose form
m)	TobraDex® ST	Tobramycin/Dexamethasone 0.3%/0.05% Ophthalmic Suspension	$198.10 vs $151.55	Other formulations available
n)	Tolsura™	Itraconazole Capsule	$6200.00 vs $320.00 -tabs	Capsule verses generic tablets @$320.00
o)	Yutiq™	Fluocinolone Acetonide Intravitreal Implant	$8340.00	All require prior authorization

*Costs do not reflect rebated prices or net costs. Costs based on National Average Drug Acquisition Costs (NADAC) or Wholesale Acquisition Costs (WAC) if NADAC unavailable.

N/A = not available at the time of publication.

Recommendation 1: Vote to Prior Authorize Jornay PM™ [Methylphenidate Extended-Release (ER) Capsule], Evekeo ODT™ [Amphetamine Orally Disintegrating Tablet (ODT)], Adhansia XR™ (Methylphenidate ER Capsule), and Sunosi™ (Solriamfetol Tablet)

The Drug Utilization Review Board recommends the following changes to the ADHD and Narcolepsy Medications Product Based Prior Authorization (PBPA) category:

1. The placement of Jornay PM™ (methylphenidate ER capsule) and Adhansia XR™ (methylphenidate ER capsule) into Tier-3. Current Tier-3 criteria will apply.
2. The placement of Evekeo ODT™ (amphetamine ODT) into the Special Prior Authorization (PA) Tier. Current Special PA criteria will apply.
3. Updating the current Special PA approval criteria for Methylin® chewable tablets and solution to prefer the brand formulation of Methylin® solution based on net costs.
4. The prior authorization of Sunosi™ (solriamfetol tablet) in the Narcolepsy Medications category. Criteria similar to the current approval criteria for Xyrem® (sodium oxybate) will apply.

Recommendation 2: Vote to Prior Authorize Balversa™ (Erdafitinib)

The Drug Utilization Review Board recommends the prior authorization of Vote to Prior Authorize Balversa™ (Erdafitinib)with the following criteria:

Balversa™ (Erdafitinib) Approval Criteria [Urothelial Carcinoma Diagnosis]:

1. A diagnosis of locally advanced or metastatic urothelial carcinoma; and
2. Tumor positive for FGFR2 or FGFR3 genetic mutation; and
3. Use in second-line or greater treatments including:
    a. Following at least 1 line of platinum-containing chemotherapy; and
    b. Within 12 months of neoadjuvant or adjuvant platinum-containing chemotherapy.

Recommendation 3: Vote to Prior Authorize Various Special Formulations Annovera™ (Segesterone Acetate/Ethinyl Estradiol Vaginal System), Bijuva™ (Estradiol/Progesterone Capsule), Cequa™ (Cyclosporine 0.09% Ophthalmic Solution), Corlanor® (Ivabradine Oral Solution), Crotan™ (Crotamiton 10% Lotion), Gloperba® (Colchicine Oral Solution), Glycate® (Glycopyrrolate Tablet), Khapzory™ (Levoleucovorin Injection), Qmiiz™ ODT [Meloxicam Orally Disintegrating Tablet (ODT)], Seconal Sodium™ (Secobarbital Sodium Capsule), TaperDex™ (Dexamethasone Tablet), Tiglutik™ (Riluzole Oral Suspension), TobraDex® ST (Tobramycin/Dexamethasone 0.3%/0.05% Ophthalmic Suspension), Tolsura™ (Itraconazole Capsule), and Yutiq™ (Fluocinolone Acetonide Intravitreal Implant)with the following criteria:

The Drug Utilization Review Board recommends the prior authorization of Annovera™ (segesterone acetate/ethinyl estradiol vaginal system), Bijuva™ (estradiol/progesterone capsule), and Cequa™ (cyclosporine 0.09% ophthalmic solution) with the following criteria:

a) Annovera™ (Segesterone Acetate/Ethinyl Estradiol Vaginal System) Approval Criteria:

1. An FDA approved indication to prevent pregnancy in women; and
2. A patient-specific, clinically significant reason why the member cannot use NuvaRing® (etonogestrel/ethinyl estradiol vaginal ring) or all other available formulations of estrogen/progestin contraception must be provided; and
3. A quantity limit of 1 vaginal system per year will apply.

b) Bijuva™ (Estradiol/Progesterone Capsule) Approval Criteria:

1. An FDA approved indication for the treatment of moderate-to-severe vasomotor symptoms due to menopause in women with an intact uterus; and
2. A patient-specific, clinically significant reason why the member cannot use all other available estrogen/progestin products indicated for vasomotor symptoms of menopause must be provided; and
3. A quantity limit of 30 capsules (1 pack) per 30 days will apply.

c) Cequa™ (Cyclosporine 0.09% Ophthalmic Solution) Approval Criteria:

1. An FDA approved indication to increase tear production in patients with keratoconjunctivitis sicca (dry eye); and
2. A patient-specific, clinically significant reason why the member cannot use Restasis® (cyclosporine 0.05% ophthalmic emulsion), which is available without a prior authorization, must be provided; and
3. A quantity limit of 60 single-use vials (1 box) per 30 days will apply.

The Drug Utilization Review Board also recommends the prior authorization of Corlanor® (ivabradine oral solution) and to update the current Corlanor® (ivabradine tablet) approval criteria to be consistent with package labeling.

d) **Corlanor® (Ivabradine** Tablet and **Oral Solution**) Approval Criteria:

1. An FDA approved indication of 1 of the following:
    a. To reduce the risk of hospitalization for worsening heart failure (HF) in adult patients with stable, symptomatic chronic HF with reduced left ventricular ejection fraction; or
    b. For the treatment of stable, symptomatic HF due to dilated cardiomyopathy (DCM) in patients 6 months of age and older; and
2. For a diagnosis of worsening HF in adults:
    a. The prescriber must verify that the member has left ventricular ejection fraction ≤35%; and
    b. The prescriber must verify that the member is in sinus rhythm with a resting heart rate ≥70 beats per minute; and

   c. The member must be on maximal/maximally tolerated doses of beta-blockers or have a contraindication to beta-blockers; and
3. For a diagnosis of DCM in patients 6 months of age or older:
   a. The prescriber must verify that the member has left ventricular ejection fraction ≤45%; and
   b. The prescriber must verify that the member is in sinus rhythm with a resting heart rate (HR) as follows:
      i. Age 6 to 12 months, HR ≥105 beats per minute (bpm); or
      ii. Age 1 to 3 years, HR ≥95 bpm; or
      iii. Age 3 to 5 years, HR ≥75 bpm; or
      iv. Age 5 to 18 years, HR ≥70 bpm; and
   c. The prescriber must verify that dose titration will be followed according to package labeling; and
   d. 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
4. Authorization of Corlanor® solution for members >40kg requires a patient-specific, clinically significant reason why Corlanor® tablets cannot be used; and
5. For Corlanor® tablets, a quantity limit of 60 tablets per 30 days will apply; and
6. For Corlanor® solution, a quantity limit of 56 ampules (2 boxes) per 28 days will apply.

The Drug Utilization Review Board also recommends the addition of Crotan™ (crotamiton 10% lotion) to the current Eurax® (crotamiton lotion/cream) criteria and the addition of Gloperba® (colchicine oral solution) to the current Colcrys® (colchicine tablet) and Mitigare® (colchicine capsule) criteria.

e) Eurax® (Crotamiton 10% Lotion/Cream) and **Crotan™ (Crotamiton 10% Lotion)** Approval Criteria:

1. An FDA approved diagnosis of scabies or pruritic skin; and
2. Member must be at least 18 years of age; and
3. For a diagnosis of scabies, member must have used permethrin 5% cream in the past 7 to 14 days with inadequate results; and
4. For a diagnosis of pruritic skin, a patient-specific, clinically significant reason why the member cannot use other available topical treatments used for pruritic skin must be provided; and
5. For authorization of Crotan™, a patient-specific, clinically significant reason why the member cannot use Eurax® must be provided; and
6. A quantity limit of 1 tube or bottle per 30 days will apply.

f) Colcrys® (Colchicine Tablet), ~~and~~ Mitigare® (Colchicine Capsule), and **Gloperba® (Colchicine Oral Solution)** Approval Criteria:

1. A quantity of 6 tablets/capsules for a 3-day supply is available without prior authorization for treatment of acute gouty attacks; and
2. Failure of allopurinol after 6 months of treatment defined by persistent gouty attacks with serum urate levels greater than 6.0mg/dL; and

3. A patient-specific, clinically significant reason why colchicine/probenecid would not be a viable option for the member must be provided; and
4. For authorization of Gloperba®, a patient-specific, clinically significant reason why the member cannot use colchicine tablets or capsules must be provided; and
5. A quantity limit of 60 tablets/capsules per 30 days or 300mL per 30 days will apply for gout; and
6. Members with the diagnosis of Familial Mediterranean Fever verified by genetic testing will be approved for up to 2.4mg per day.

The Drug Utilization Review Board recommends the prior authorization of Glycate® (glycopyrrolate tablet) and Khapzory™ (levoleucovorin injection) with the following criteria:

g) Glycate® (Glycopyrrolate Tablet) Approval Criteria:

1. An FDA approved indication of adjunctive therapy in the treatment of peptic ulcer disease (PUD) in patients 12 years of age and older; and
2. A patient-specific, clinically significant reason why the member cannot use glycopyrrolate 1mg and 2mg tablets, which are available without a prior authorization, must be provided.

h) Khapzory™ (Levoleucovorin Injection) Approval Criteria:

1. An FDA approved indication of 1 of the following:
    a. Rescue after high-dose methotrexate (MTX) therapy in patients with osteosarcoma; or
    b. Diminishing the toxicity associated with overdosage of folic acid antagonists or impaired MTX elimination; or
    c. Treatment of patients with metastatic colorectal cancer in combination with fluorouracil; and
2. A patient-specific, clinically significant reason why the member cannot use generic leucovorin injection or generic levoleucovorin calcium injection must be provided.

i) Qmiiz™ ODT (meloxicam ODT) into the Special Prior Authorization (PA) Tier

The Drug Utilization Review Board recommends the placement of Qmiiz™ ODT (meloxicam ODT) into the Special Prior Authorization (PA) Tier of the Nonsteroidal Anti-Inflammatory Drugs (NSAIDs) Product Based Prior Authorization (PBPA) category. Current Special PA Criteria will apply. The change is will be shown in the NSAIDs Tier Chart located here: http://www.okhca.org/providers.aspx?id=12091

The Drug Utilization Review Board recommends the prior authorization of Seconal Sodium™ (secobarbital sodium capsule), TaperDex™ (dexamethasone tablet), and Tiglutik™ (riluzole suspension) with the following criteria:

j) Seconal Sodium™ (Secobarbital Sodium Capsule) Approval Criteria:

1. An FDA approved indication for 1 of the following:
    a. The short-term treatment of insomnia; or

   b. A preanesthetic; and
2. A patient-specific, clinically significant reason why the member cannot use other cost-effective therapeutic alternatives must be provided; and
3. For the short-term treatment of insomnia, a quantity limit of 1 capsule per day not to exceed 14 capsules per 30 days will apply.

k) TaperDex™ (Dexamethasone Tablet) Approval Criteria:

1. A patient-specific, clinically significant reason why the member cannot use dexamethasone 1.5mg individual tablets, which are available without a prior authorization, must be provided.

l) Tiglutik™ (Riluzole Suspension) Approval Criteria:

1. An FDA approved indication for the treatment of amyotrophic lateral sclerosis (ALS); and
2. A patient-specific, clinically significant reason why the member cannot use riluzole tablets, even when tablets are crushed, must be provided; and
3. A quantity limit of 20mL per day or 600mL per 30 days will apply.

m) TobraDex® ST (tobramycin/dexamethasone 0.3%/0.05% ophthalmic suspension)

The Drug Utilization Review Board recommends the placement of TobraDex® ST (tobramycin/ dexamethasone 0.3%/0.05% ophthalmic suspension) into Tier-2 of the Ophthalmic Antibiotics/Steroid Combination Products PBPA category. Current Tier-2 criteria will apply.

The Drug Utilization Review Board recommends the prior authorization of Tolsura™ (itraconazole capsule) and Yutiq™ (fluocinolone acetonide intravitreal implant) with the following criteria:

n) Tolsura™ (Itraconazole Capsule) Approval Criteria:

1. An FDA approved indication of 1 of the following fungal infections in immunocompromised and non-immunocompromised adult patients:
   a. Blastomycosis, pulmonary and extrapulmonary; or
   b. Histoplasmosis, including chronic cavitary pulmonary disease and disseminated, non-meningeal histoplasmosis; or
   c. Aspergillosis, pulmonary and extrapulmonary, in patients who are intolerant of or who are refractory to amphotericin B therapy; and
2. A patient-specific, clinically significant reason why the member cannot use itraconazole 100mg capsules, which are available without prior authorization, must be provided.

o) Yutiq™ (Fluocinolone Acetonide Intravitreal Implant) Approval Criteria:

1. An FDA approved diagnosis of chronic, non-infectious uveitis affecting the posterior segment of the eye; and
2. Yutiq™ must be administered by an ophthalmologist; and
3. Prescriber must verify that the member will be monitored for increased intraocular pressure and cataract development; and
4. A patient-specific, clinically significant reason why the member requires Yutiq™ in place of local corticosteroids must be provided; and
5. A quantity limit of 1 implant per eye every 36 months will apply.

Recommendation 4: Vote to Prior Authorize Abilify MyCite® (Aripiprazole Tablet with Sensor), Aristada Initio® [Aripiprazole Lauroxil Extended-Release (ER) Injectable Suspension], and Perseris™ [Risperidone ER Subcutaneous (Sub-Q) Injectable Suspension] with the following criteria:

The Drug Utilization Review Board recommends the following changes to the Atypical Antipsychotic Medications Product Based Prior Authorization (PBPA) category:

1. The placement of Aristada Initio® (aripiprazole lauroxil) into Tier-3. Aristada Initio® (aripiprazole lauroxil) is currently in Tier-1 due to supplemental rebate participation. If the manufacturer chooses not to participate in supplemental rebates, Aristada Initio® may be moved up to the higher tier.
2. The placement of Perseris™ (risperidone ER sub-Q injection) into Tier-3. Current Tier-3 criteria will apply.
3. The placement of Abilify MyCite® (aripiprazole tablets with sensor) into Tier-3 with the following criteria:

Abilify MyCite® (Aripiprazole Tablet with Sensor) Approval Criteria:

1. An FDA approved diagnosis; and
2. Member must not have dementia-related psychosis; and
3. A patient-specific, clinically significant reason why the member cannot use all oral or injectable Tier-1 or Tier-2 medications. Tier structure rules continue to apply. Please note, the ability of Abilify MyCite® to improve patient compliance or modify aripiprazole dosage has not been established; and
4. Previous use of aripiprazole tablets and a reason why the Tier-1 aripiprazole tablets are no longer appropriate for the member must be provided; and
5. The prescriber agrees to closely monitor patient adherence; and
6. Patients should be capable and willing to use the MyCite® App and follow the *Instructions for Use* and ensure the MyCite® App is compatible with their specific smartphone; and
7. ~~Initial~~ Approvals will be for the duration of 3 months. For continuation consideration, documentation demonstrating positive clinical response and patient compliance greater than 80% with prescribed therapy must be provided. In addition, a patient-specific, clinically significant reason why the member cannot transition to oral aripiprazole tablets or to any of the oral or injectable Tier-1 or Tier-2 medications must be provided. Tier structure rules continue to apply.

Recommendation 5: Vote to Prior Authorize Cassipa® (Buprenorphine/Naloxone) and Levorphanol

The Drug Utilization Review Board recommends the implementation of a daily morphine milligram equivalent (MME) limit of 90 to coincide with Centers for Medicare and Medicaid (CMS) safety alerts.

1. Prior authorization would be required for members exceeding the 90 MME limit per day. Prior authorizations would require patient-specific, clinically significant reasoning for daily doses of 90 MME or greater. Prescribers must provide reasoning for why tapering to below the MME limit is not appropriate for the member.
2. Requests for members exceeding the 90 MME limit per day can be approved when there is documentation of pain associated with end-of-life care, palliative care, or hospice. Oncology, sickle cell disease, and hemophilia diagnoses would also be excluded from the MME limit.

Furthermore, the Drug Utilization Review Board, recommends that select medication assisted treatment (MAT) products no longer require prior authorization. In addition, it is recommended to update the quantity limit for buprenorphine-containing medications used for MAT to 16mg bioequivalent buprenorphine per day. Each request for greater than 16mg bioequivalent buprenorphine per day will be evaluated on a case-by-case basis.

The Drug Utilization Review Board recommends the following:

1. The placement of levorphanol tartrate into the Special Prior Authorization (PA) Tier of the Opioid Analgesics Product Based Prior Authorization (PBPA) category.
2. The prior authorization of Cassipa® (buprenorphine/naloxone SL films) with the following criteria.

Levorphanol Tartrate Approval Criteria:

1. A patient-specific, clinically significant reason why the member cannot use alternative ~~lower tiered short-acting~~ treatment options for pain (e.g., non-opioid products, lower-tiered opioid analgesics) must be provided.

Suboxone® [Buprenorphine/Naloxone Sublingual (SL) Tablets and Films], Subutex® (Buprenorphine SL Tablets), Zubsolv® (Buprenorphine/Naloxone SL Tablets), Bunavail® (Buprenorphine/Naloxone Buccal Films), and Cassipa® (Buprenorphine/Naloxone SL Films) Approval Criteria:

1. Brand formulation Suboxone® SL films and generic buprenorphine/naloxone SL tablets are the preferred products. Authorization of Bunavail®, Zubsolv®, Cassipa®, and generic Suboxone® SL films requires a patient-specific, clinically significant reason why brand formulation Suboxone® SL films or generic buprenorphine/naloxone SL tablets are not appropriate.
2. Subutex® (buprenorphine) 2mg and 8mg SL tablets will only be approved if the member is pregnant or has a documented serious allergy or adverse reaction to naloxone.

3. For Cassipa®, the member must have been titrated to a dose of 16mg buprenorphine using another buprenorphine product prior to approval.
4. Buprenorphine products FDA approved for a diagnosis of opioid abuse/dependence must be prescribed by a licensed practitioner who qualifies for a waiver under the Drug Addiction Treatment Act (DATA) and has notified the Center for Substance Abuse Treatment of the intention to treat addiction patients and has been assigned a Drug Enforcement Agency (DEA) X number; and
5. Member must have an FDA approved diagnosis of opioid abuse/dependence; and
6. Concomitant treatment with opioids (including tramadol) will be denied; and
7. Approvals will be for the duration of 90 days to allow for concurrent medication monitoring; and
8. The following limitations will apply:
    a. **Suboxone®** 2mg/0.5mg, 4mg/1mg~~, and 8mg/2mg~~ SL tablets and films: A quantity limit of 90 SL units per 30 days will apply.
    b. **Suboxone®** 8mg/2mg SL tablets and films: A quantity limit of 60 SL units per 30 days will apply.
    c. **Suboxone®** 12mg/3mg SL films: A quantity limit of 30 ~~60~~ SL films per 30 days will apply.
    d. **Subutex®** 2mg ~~and 8mg~~ SL tablets: A quantity limit of 90 SL tablets per 30 days will apply.
    e. **Subutex®** 8mg SL tablets: A quantity limit of 60 SL tablets per 30 days will apply.
    f. **Zubsolv®** 0.7mg/0.18mg, 1.4mg/0.36mg, 2.9mg/0.71mg~~, and 5.7mg/1.4mg~~ SL tablets: A quantity limit of 90 SL tablets per 30 days will apply.
    g. **Zubsolv®** 5.7mg/1.4mg ~~and 8.6mg/2.1mg~~ SL tablets: A quantity limit of 60 SL tablets per 30 days will apply.
    h. **Zubsolv®** 8.6mg/2.1mg and 11.4mg/2.9mg SL tablets: A quantity limit of 30 SL tablets per 30 days will apply.
    i. **Bunavail®** 2.1mg/0.3mg ~~and 4.2mg/0.7mg~~ buccal films: A quantity limit of 90 buccal films per 30 days will apply.
    j. **Bunavail®** 4.2mg/0.7mg buccal films: A quantity limit of 60 buccal films per 30 days will apply.
    k. **Bunavail®** 6.3mg/1mg buccal films: A quantity limit of 30 ~~60~~ buccal films per 30 days will apply.
    l. **Cassipa®** 16mg/4mg SL films: A quantity limit of 30 SL films per 30 days will apply.

High-Dose Buprenorphine Products Approval Criteria:

1. Each request for >16 ~~24~~mg bioequivalent buprenorphine per day will be evaluated on a case-by-case basis; and
2. A taper schedule, dates of an attempted taper with reason for failure, or a patient-specific, clinically significant reason why a taper schedule or attempt is not appropriate for the member should be documented on the prior authorization request; and

3. Opioid urine drug screens should be submitted with high-dose requests that plan to continue high-dose treatment longer than the duration of 1 month; and
    a. Urine drug screens must show the absence of opioid medications other than buprenorphine products for continued approval; or
    b. Prescriber must document a patient-specific reason the member should continue therapy, reason for opioid use, and document a plan for member to discontinue opioid use; and
4. Symptoms associated with withdrawal at lower doses or symptoms requiring high doses should be listed on the prior authorization request; and
5. Each approval will be for the duration of 1 month. If urine drug screen and other documentation are submitted indicating high-dose therapy is necessary, an approval can be granted for the duration of 3 months; and
6. Continued high-dose authorization after the 3-month approval will require a new (recent) urine drug screen.