AGENDA

September 15, 2016
1:00 p.m. – 3:30pm

Charles Ed McFall Board Room

I. Welcome, Roll Call, and Public Comment Instructions: **Chairman, Steven Crawford, M.D.**

   A. Introduction of new delegate Dr. Gail Poyner (Oklahoma Psychological Association)

II. Action Item: Approval of Minutes of the July 21, 2016: **Medical Advisory Committee Meeting**

III. Public Comments (2 minute limit)

IV. MAC Member Comments/Discussion

V. Financial Report: **Gloria Hudson, Director of General Accounting**

VI. SoonerCare Operations Update: **Marlene Asmussen, Director of Population Care Management**

VII. Proposed Rule Changes: Presentation, Discussion, and Vote: **Demetria Bennett, Policy Development Coordinator**

VIII. Action Item: Vote on Proposed Rule Changes: **Chairman, Steven Crawford, M.D.**

   A. APA WF #16-08 Screening Procedures and Fitness Plan for Certain Providers and Owners Designated High Risk
   B. APA WF #16-12 Medical Residents' Licensure Requirements and Policy Clean Up
   C. APA WF #16-15 A&B Obstetrical Reimbursement

IX. New Business: **Chairman, Steven Crawford, M.D**

X. Future Meetings

November 17, 2016 at 1:00 PM

XI. Adjourn

Agenda

MAC Minutes for July 21, 2016

Welcome and Roll Call

Chairman Crawford called the meeting to order at 1:00 PM. He explained about the sensitivity of the mics and to guard conversation. ***Delegates present were*:** Ms. Renee Banks, Ms. Debra Billingsley, Dr. Joe Catalano, Dr. Steve Crawford, Ms. Wanda Felty, Ms. Terrie Fritz, Ms. Annette Mays, Mr. James Patterson, Dr. J. Daniel Post, Ms. Toni Pratt-Reid, Dr. Edd Rhoades, Dr. Jason Rhynes, Mr. Rick Snyder and Mr. Jeff Tallent.

Alternates present were: Ms. Sarah Baker, Dr. Lori Holmquist-Day, Mr. Traylor Rains-Sims, and Dr. Mike Talley providing a quorum.

***Delegates absent without an alternate were*:** Ms. Mary Brinkley, Dr. David Cavallaro, Ms. Samantha Galloway, Dr. Stanley Grogg, Mr. Steve Goforth, Dr. Melissa Gastorf, Mr. Mark Jones, Ms. Liz Moran, Dr. Kanwal Obhrai Dr. Ashley Orynich and Mr. David Rising

Introduction of new delegates

Chairman Crawford introduced new members of the MAC. First Chairman Crawford introduced, Ms. Debra Billingsley, JD who will be representing the Oklahoma Pharmacists Association. Chairman Crawford then introduced Ms. Renee Banks who will be representing the Oklahoma Department of Human Services.

Approval of May 19, 2016 Minutes

Chairman Crawford did a call to vote to approve the meeting minutes for May 19, 2016.
It was accepted by Mr. Jeff Tallent and Dr. Joe Catalano gave the second for the motion. All members voted to approve the minutes with no opposition. Chairman noted that new delegate Dr. Gail Poyner was not present and would be introduced at the August Meeting.

Public Comments

There were no public comments made at this meeting.

MAC Member Comments

Dr. Crawford asked if any member of the MAC had a comment but there were none at this time. Chairman Crawford also noted, Dr. Leon Bragg was not present who was to be recognized for contributions in Dental Services.

SFY 2017 Agency Appropriation Update

Nico Gomez, CEO of the Oklahoma Health Care Authority came forward to discuss the SFY2017 agency appropriation. Mr. Gomez expressed his appreciation of the committee for their efforts and people speaking up across the state of Oklahoma for providers and members regarding the budget crisis. The Oklahoma Health Care Authority was able to come in short of that was needed, but we have additional revenue in this year allowing the agency to file a budget with no further provider rate cuts. Mr. Gomez expressed his appreciation for the people that understand how important these types of programs are and he is optimistic there will be no mid-year provider rate cuts. Mr. Gomez stressed the importance of looking at things from a long term perspective,

but the SoonerCare Program appears to be stable for next year. He stated that all we have been able to do for now is "stop the bleeding", but hopefully we can start to do more long term planning for programs that is best for the state of Oklahoma. Dr. J Daniel Post then asked if some things cut over the last year still be cut and are we making plans to reinstate these amounts? In response, Mr. Gomez stated that he was correct. January 1, 2016 there was a 3% across the board provider rate cut that will stay in place. The agency will work to restore cuts in the budget for next year. However, Mr. Gomez stated he is unable to speak to cuts by the Department of Mental Health and Substance Abuse, as well as, other state agencies. Mr. Traylor Rains-Sims stated the Department of Mental Health did get some money compared to other agencies, but used many onetime funds to help close the last revenue failure. With those funds no longer in place, they are unable to reinstate any rates at this time. Mr. Rains-Sims sated that there is a little less than a million dollars extra, but it is undetermined what will be done with that money. He did state they are not looking to make any further cuts currently. Chairman Crawford made vocal that the restriction of the type of provider rate cuts causes room for many questions and comments. There were no other comments or questions.

Financial Update

Gloria Hudson, Director of General Accounting, reported on the state's Fiscal Year 2016 financial transactions through the month of April 2016. She reported that the total for FY 2016 variance is a positive $7.3 million dollars. On the expenditure side, we were over budget with the Medicaid Program by 0.5% for negative $3.1 million state dollars and on the administration side under budget 10.1% for positive $5.9 million state dollars. On the revenue side, we were over budget on Drug Rebates and Collections by 3.8% for $3.1 million state dollars and under budget in Overpayments/Settlements by 8.7% for $1.2 million state dollars and in Tobacco Tax Collections and Fees .5% for $.2 million state dollars. With preliminary data in through the end of the state fiscal year it looks like our agency will continue to be over budget in Medicaid program expenditures. However, we are projecting to end the year with a positive state dollar variance due to under spending in administration and an increase in drug rebates. Ms. Hudson asked for questions, but there were no questions.

Fiscal Year 2017 Budget Update

Vickie Kersey, Director of Fiscal Planning & Procurement expressed great appreciation to providers and members. Ms. Kersey then made vocal that the FY 16 column on the 2 page agency budget report is our revised budget after two revenue failures were declared. Growth shows to be 2.5% as far as increase decrease, but is actually closer to 1%. In examining the areas with greatest decrease, our lab and radiology line decreased by 9.8% in part due to special prior authorizations put in place. In our clinical services line, we continue to see growth so we budgeted an additional $8.7 million dollars or 7.2%. The costs of prescription meds continue to rise so we have increased the budget there. In our miscellaneous line, that is really a huge change because it is a smaller dollar amount. On our Medicare buy in, that is Medicare A and B premiums and we continue to see that increase by a substantial amount. In the agencies Medicare clawback payment we have seen a large increase so we budgeted an additional $13 million dollars or 15.8%. Prescription drug costs have increased and the feds are seeing the same increase so they are upping our share of that. In summary, on Medical Programs there is an overall $92 million dollars increase or 2.5%, but of that amount $56 million is the payment cycle carried over from FY 16 so if you back that out we expect our growth to be about 1%. Ms. Kersey pointed out the next section to be reviewed is our Insure Oklahoma program. The Employee Sponsored program has seen growth and the agency is anticipating more. In FY 16, the size of the Employee Program went from 99 to 250. Ms. Kersey pointed out that the agency did an outreach marketing campaign which could be attributed to the growth. On the individual plan, we did not see growth we had built in to the budget in FY 16 so we have actually decreased

the budget to be more in line with what we are projecting. Ms. Kersey then made vocal that Administration budget over all had a decrease of $13 million dollars and a $2.8 million dollar decrease in our state funds. This is the third year the agency has decreased its overall administration budget. Ms. Kersey noted that for 2017, operations have increased slightly. The budget is actually now so close that we are actually changing methodology to actual costs of insurance and benefits. We have received two new grants for from the Tulsa Community Foundation that caused our grant line to increase. Our largest decrease is in our Information Services department funds due to MMIS and IT projects that have been completed. Regarding other agency programs, those changes are based expenditures we saw in FY 16 and those are really adjustments between our expenditures and our budget amounts. In our total, our budget is $5.58 billion dollars or 1.4% increase over the last FY 16 revised budget. Overall, our revenues increased 1.4% or $78 million dollars. Ms. Kersey noted that most significant was the changes that have occurred in our administration federal funds because we are not spending as much so we are not drawing as much federal dollars. Our prior year carry over has been reduced which is a reflection of the agency reducing its budget overall. There was an increase in state appropriated funds for FY 17, but not quite what the chart reflects. Ms. Kersey stated the agency is very fortunate to have received an increase in appropriation dollars. We needed about $29 million to maintain current level which we did not receive. We did use some one time money to help close the revenue failure. Ms. Kersey then asked for questions. Reference was made to the Insure Oklahoma line, by Mr. Jeff Tallent, that there was a rather dramatic decrease in the individual plan. Mr. Tallent asked the question as to whether some individuals moved to another plan or did they simply fall off? Ms. Kersey stated that when CMS agreed to extend Insure Oklahoma they lowered the FPL which the Oklahoma Health Care Authority believes is the biggest contributing factor. Chairman Crawford asked what will be done with extra money found at the end of the session? Mr. Nico Gomez noted there are really two options, but nothing has been decided. He went on to say that OMES can appropriate the $100 million to restore cuts by certain agencies or have special session to re-appropriate money, but there is a cost for that. Mr. Gomez stated that there are still other agencies working on their budgets. Chairman Crawford asked if it would be put into the "Rainy Day Fund". Mr. Gomez reiterated they will do something with the money, but he is unsure what will be done. Ms. Sarah Baker referred to the Clinic Services line and inquired as to what that includes specifically. Ms. Kersey stated she will need to do research and get back to the committee on that. She believes it refers to free standing clinics, but all this data listed are very broad categories. There were no other questions.

SoonerCare Operations Update

Casey Dunham, Director of Provider & Medical Home Services, reported that this month the focus is on enrollment trends from April 2016. As of April 2016, patient centered medical home members numbered a little over 524,000 which is a decrease of 4,700. SoonerCare Traditional had 228,376 members which is a decrease from last month of approximately 800. SoonerPan has a current enrollment of 32,870 members. Insure Oklahoma enrollment data is not included, but should be available next month. In total, enrollment was at 785,348 which is a 7,000 member decrease excluding Insure Oklahoma. In-state providers numbered 33,182 which is an increase of 487. Mr. Dunham stated that costs on per member per month costs have remained stable. Mr. Dunham then review a chart requested at the last MAC meeting. The chart counts for 11 months as of May 2016. Advanced Practices went from 1,990 to 2,275. Physician Assistants went from 1,271 to 1106 which is a decrease of 165. The decrease is believed to be due to contract renewals and with that over they should be going back up. Dentists went from 1,173 to 1,244 with a subset of Pediatric Dentists going from 51 to 52. Extended Care Facilities decreased from 242 to 240 with the subset of Nursing Homes decreasing from 152 to 150. Mr. Dunham then asked for questions. Dr. Mike Talley asked, what happened to Physician numbers? Was

this in the contract renewal period? Mr. Dunham stated yes it is in line with the physician assistant numbers during the contract renewal period. Ms. Sarah Baker asked about OT, PT and speech as to what category that falls under? Mr. Dunham stated he would need to research to find out where specifically they would fall. Dr. Jason Rhynes noted that he had previously asked for optometry to be divided out and this may be possible for those categories, as well. There were no other questions at this time.

ABD Care Coordination Update

Dana Northrup, Strategic Planning & Reform Project Manager, gave a verbal update on the ABD Care Coordination. She states there has been a slowdown in relationship to ABD over the months of April and May due to getting actuary contracts set and reviewing the budget, as well as, appropriations. This program will now resume its speed. The RFP is targeted to be released at the end of November of 2016. There have been a few revisions to the ABD timeline. She stated in May of 2017 contracts will be awarded and in April 2018 services will begin. There will be stakeholder meetings held every other month staring next week. The next stakeholder meeting will be on July26, 2016. She stated the meetings will be held every other month due to “the cone of silence” surrounding the release of information because there is not that much information we are allowed to share. Ms. Northrup ended with noting that rates are beginning to be developed. There were no other comments or questions at this time.

Proposed Rule Changes

Dr. Crawford invited Demetria Bennett, Policy Development Coordinator to discuss Item #16-02. Demetria presented the emergency rule that is intended to be taken to the August Board Meeting. She noted that a face-to-face Tribal Consultation regarding the proposed change was held Tuesday, March 1, 2016 in the OHCA Board Room. The following rule was also posted from June 17, 2016 through July 18, 2016 for public comment. This rule discusses reimbursement for eyes glasses and the separate reimbursement for the refracting fee, as well as, the fitting fee. This rule previously allowed for the refracting to be bundled under the payment for the eye exam and the fitting fee under eye glass materials. This change in the rule will provide a savings for SoonerCare. Chairman Crawford then asked for any questions. Dr. Rhynes stated he had some comments. Chairman Crawford first did a call to vote on the rule with Mr. Jeff Tallent giving the first for the motion and Dr. Mike Talley proving the second. There was then some discussion regarding this rule change. Dr. J Daniel Post asked the question how are we doing an additional service and saving money? Ms. Bennett stated it was all negotiated when discussing materials for the eye glasses. Dr. J. Daniels Post then asked so you are paying less? Ms. Bennett stated the answer to be yes. Dr. J. Daniel Post then asked how much less? Dr. Mike Herndon, Chief Interim Medical Officer, then came forward and stated that a year ago it was discovered that surrounding states contracted out for all eye glasses and we began to entertain that notion. There were several state Medicaid agencies with open contracts we could have joined allowing us to save money just by joining the contract on the hardware. Dr. Herndon noted that the agency talked with the Optometry Association and came to an agreement to look at lowering reimbursement overall drastically, but to start reimbursement for the refraction and fitting for frames. The question was then asked by Dr. J Daniel Post if members wanted frames that cost more would they be able to get them? Dr. Herndon stated that the answer is yes. He noted that there is a group of frames allowed by Medicaid that do cost less for practitioners. If the members want to go outside of that for frames that cost more they can, but will be responsible for covering the additional cost. Dr. Jason Rhynes stated that he recommends approving the rule change. Dr. Rhynes stated that this a significant effort to provide eye glasses to children of Oklahoma by the Oklahoma Health Care Authority and those who provide eye glasses. This will allow a significant amount of money to stay in Oklahoma that would have otherwise gone to the state of Kentucky

then to Malaysia. Dr. Rhynes noted that because of this agreement on this we are able to provide similar materials at close to the same rate. We have been able to offer above and beyond what SoonerCare will provide to this at risk population thanks to this agreement. This will allow us to do more business with Oklahoma based companies. Ms. Toni Pratt-Reid asked if the lenses are sports safety? Dr. Rhynes stated no, but they are poly carbonate which meets the criteria for sports participation. The glasses provided are not specifically sports glasses. Dr. Rhynes stated he feels "we have bled a lot". At this time last year, the rate was $160 then dropping to $113 and is now $83. Chairman Crawford asked if the $83 quoted includes frames lenses. Dr. Rhynes answered by saying it includes frames, lenses, refraction and fitting. Dr. Rhynes stated that they are working with SoonerCare to move as much as they can to the services area, such as, the refraction and fitting. Dr. Rhynes then verbalized that if we are going to get in a bidding war every year there will always be somewhere and someone that will be able to make eye glasses cheaper. He stated we were bidding against lenses that were $18.75 and he invoiced these at was $53 and it is an economy of scale Dr. Rhynes expressed his appreciation of OHCA allowing them to do their best to continue to provide these services. Dr. Rhynes then verbalized that you must consider turnaround time, sending money out of state, shipping issues if the glasses have to go back because they get damaged etc. Dr. Rhynes stated that we want to be in charge of this as long as we can without involving a third entity. There were no further questions regarding this topic. Chairman Crawford then restated we had a motion to accept with a second to approve the rule and there were no votes against.

Informational Item Only – Access Monitoring Review Plan:

Tywanda Cox, Chief of Federal & State Policy, gave a verbal update regarding this plan. She stated the initial July 1 submission date has now been moved by CMS to October 1. This has allowed us to go back and review our plan and to also discuss the plan with our partners, such as, the Department of Mental Health and Substance Abuse and the State Health Department. Ms. Cox stated that some of the feedback was from specific providers asking to be written into the initial plan. Ms. Cox noted that regulations state those provider types include Primary Care Physicians, Physician Specialists, Behavioral Health, Pre and Postnatal Obstetrics and Home Health. The Oklahoma Health Care Authority then began to initially include those types in the plan and gain feedback. There is no current model given by CMS for this plan. Oklahoma agreed to be one of the first states to work on this plan and serve as a model. Ms. Cox state they are hoping to post the plan the week of August 1 for feedback. The item will then be presented to be Board. Ms. Cox encouraged MAC members to sign up for web alerts to remain current on proposed feedback regarding this plan. Dr. Crawford asked for any other discussion regarding this plan, but there was no further discussion.

New Business / Member Comments

Nico Gomez, CEO stated due to the budget issues and uncertainty there will be no Strategic Planning Conference this year. He proposed that they may hold something January.

Future Meetings

Dr. Crawford stated the September 15 meeting would be moved to August 8th to allow committee members to vote on rules before they are presented to the Board.

Adjournment

Dr. Crawford asked for a motion to adjourn. It was provided by Dr. Jeff Tallent and seconded by Mr. Traylor Rains-Sims. There was no dissent and the meeting was adjourned.

Agenda

FINANCIAL REPORT

For the Fiscal Year Ended June 30, 2016
Submitted to the CEO & Board

- Revenues for OHCA through June, accounting for receivables, were **$3,834,234,757 or .2% under** budget.
- Expenditures for OHCA, accounting for encumbrances, were **$3,852,168,962 or .6% under** budget.
- The state dollar budget variance through June is a **positive $15,219,563.**
- The budget variance is primarily attributable to the following (in millions):

Expenditures:	
Medicaid Program Variance	(1.0)
Administration	6.6
Revenues:	
Drug Rebate	12.0
Taxes and Fees	(3.1)
Overpayments/Settlements	.7
Total FY 16 Variance	**$ 15.2**

ATTACHMENTS

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

OKLAHOMA HEALTH CARE AUTHORITY
Summary of Revenues & Expenditures: OHCA
For the Fiscal Year Ended June 30, 2016

REVENUES	FY16 Budget YTD	FY16 Actual YTD	Variance	% Over/ (Under)
State Appropriations	$ 883,424,477	$ 882,224,477	$ (1,200,000)	(0.1)%
Federal Funds	2,233,356,269	2,198,945,809	(34,410,460)	(1.5)%
Tobacco Tax Collections	50,190,063	49,518,495	(671,568)	(1.3)%
Quality of Care Collections	76,634,335	76,129,937	(504,398)	(0.7)%
Prior Year Carryover	72,016,727	72,016,727	-	0.0%
Federal Deferral - Interest	275,292	275,292	-	0.0%
Drug Rebates	260,639,960	291,466,957	30,826,997	11.8%
Medical Refunds	44,260,276	46,091,204	1,830,928	4.1%
Supplemental Hospital Offset Payment Program	202,973,635	202,973,635	-	0.0%
Other Revenues	16,797,643	14,592,223	(2,205,420)	(13.1)%
TOTAL REVENUES	**$ 3,840,568,677**	**$ 3,834,234,757**	**$ (6,333,920)**	**(0.2)%**

EXPENDITURES	FY16 Budget YTD	FY16 Actual YTD	Variance	% (Over)/ Under
ADMINISTRATION - OPERATING	**$ 58,103,398**	**$ 50,188,995**	**$ 7,914,403**	**13.6%**
ADMINISTRATION - CONTRACTS	**$ 114,550,412**	**$ 98,161,445**	**$ 16,388,967**	**14.3%**
MEDICAID PROGRAMS				
Managed Care:				
SoonerCare Choice	39,323,551	38,625,283	698,268	1.8%
Acute Fee for Service Payments:				
Hospital Services	884,211,413	894,299,084	(10,087,671)	(1.1)%
Behavioral Health	19,351,088	19,337,396	13,692	0.1%
Physicians	461,642,778	458,936,591	2,706,187	0.6%
Dentists	123,695,984	125,385,426	(1,689,442)	(1.4)%
Other Practitioners	40,721,029	42,501,435	(1,780,406)	(4.4)%
Home Health Care	19,165,840	18,834,088	331,752	1.7%
Lab & Radiology	61,585,904	55,023,596	6,562,308	10.7%
Medical Supplies	44,762,567	45,258,210	(495,644)	(1.1)%
Ambulatory/Clinics	127,856,055	130,526,863	(2,670,809)	(2.1)%
Prescription Drugs	511,265,192	509,473,907	1,791,284	0.4%
OHCA Therapeutic Foster Care	553,805	214,773	339,031	61.2%
Other Payments:				
Nursing Facilities	551,632,884	552,957,144	(1,324,260)	(0.2)%
Intermediate Care Facilities for Individuals with Intellectual Disabilities Private	59,395,109	59,798,145	(403,036)	(0.7)%
Medicare Buy-In	145,002,967	142,393,936	2,609,032	1.8%
Transportation	65,804,265	65,459,113	345,152	0.5%
Money Follows the Person-OHCA	701,638	342,713	358,924	0.0%
Electonic Health Records-Incentive Payments	10,611,425	10,611,425	-	0.0%
Part D Phase-In Contribution	85,364,027	85,481,968	(117,941)	(0.1)%
Supplemental Hospital Offset Payment Program	441,657,505	441,657,505	-	0.0%
Telligen	6,674,228	6,674,228	-	0.0%
Total OHCA Medical Programs	**3,700,979,253**	**3,703,792,830**	**(2,813,577)**	**(0.1)%**
OHCA Non-Title XIX Medical Payments	89,382	25,692	63,690	0.0%
TOTAL OHCA	**$ 3,873,722,445**	**$ 3,852,168,962**	**$ 21,553,483**	**0.6%**
REVENUES OVER/(UNDER) EXPENDITURES	**$ (33,153,768)**	**$ (17,934,206)**	**$ 15,219,563**	

Agenda

Soonercare Operations Update

(July 2016 Data)

SOONERCARE ENROLLMENT/EXPENDITURES

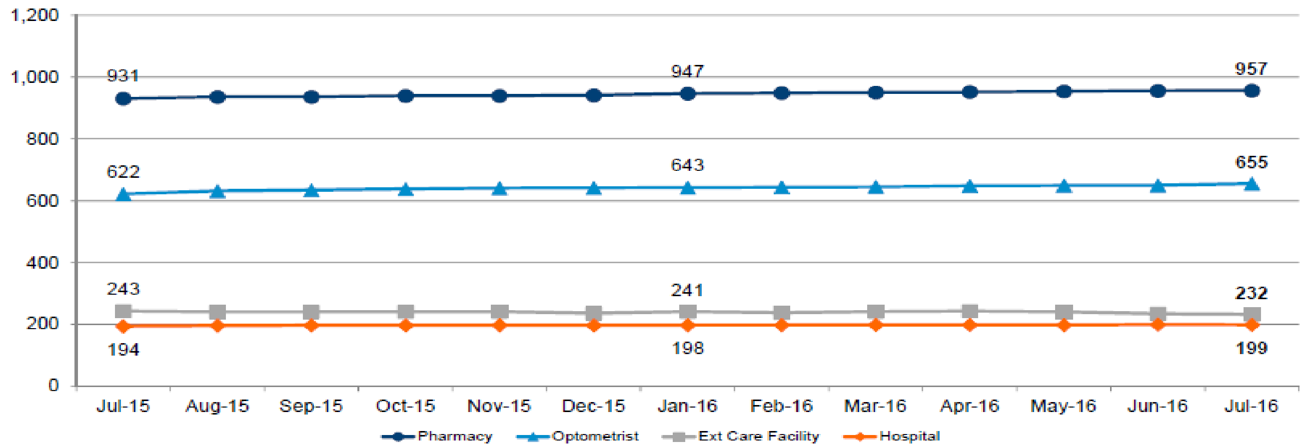
Delivery System		Enrollment July 2016	Children July 2016	Adults July 2016	Enrollment Change	Total Expenditures July 2016	PMPM July 2016	Forecasted Jul 2016 Trend PMPM
SoonerCare Choice Patient-Centered Medical Home		531,903	437,490	94,413	1,986	$153,720,159		
Lower Cost	*(Children/Parents; Other)*	488,491	423,844	64,647	2,339	$109,468,829	$224	$213
Higher Cost	*(Aged, Blind or Disabled; TEFRA; BCC)*	43,412	13,646	29,766	-353	$44,251,330	$1,019	$943
SoonerCare Traditional		227,955	83,507	144,448	2,248	$196,464,581		
Lower Cost	*(Children/Parents; Other)*	115,918	78,436	37,482	1,658	$44,894,334	$387	$369
Higher Cost	*(Aged, Blind or Disabled; TEFRA; BCC & HCBS Waiver)*	112,037	5,071	106,966	590	$151,570,247	$1,353	$1,225
SoonerPlan		32,529	2,758	29,771	37	$275,102	$8	$7
Insure Oklahoma		18,883	492	18,391	707	$6,742,376		
Employer-Sponsored Insurance		14,516	315	14,201	525	$4,686,396	$323*	$291
Individual Plan		4,367	177	4,190	182	$2,055,980	$471	$421
TOTAL		811,270	524,247	287,023	4,978	$357,202,217		

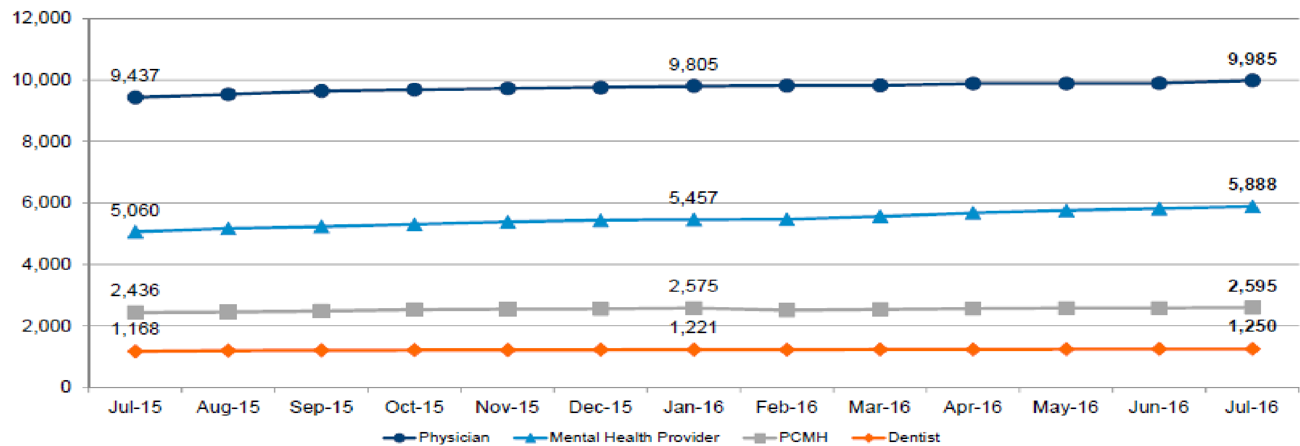
Enrollment totals include all members enrolled during the report month. Members may not have expenditure data. Children are members aged 0 - 20 or for Insure Oklahoma enrolled as Students or Dependents.
*Decrease in Insure Oklahoma ESI PMPM is due to March payments being delayed as IO is transitioned to a new eligibility system.

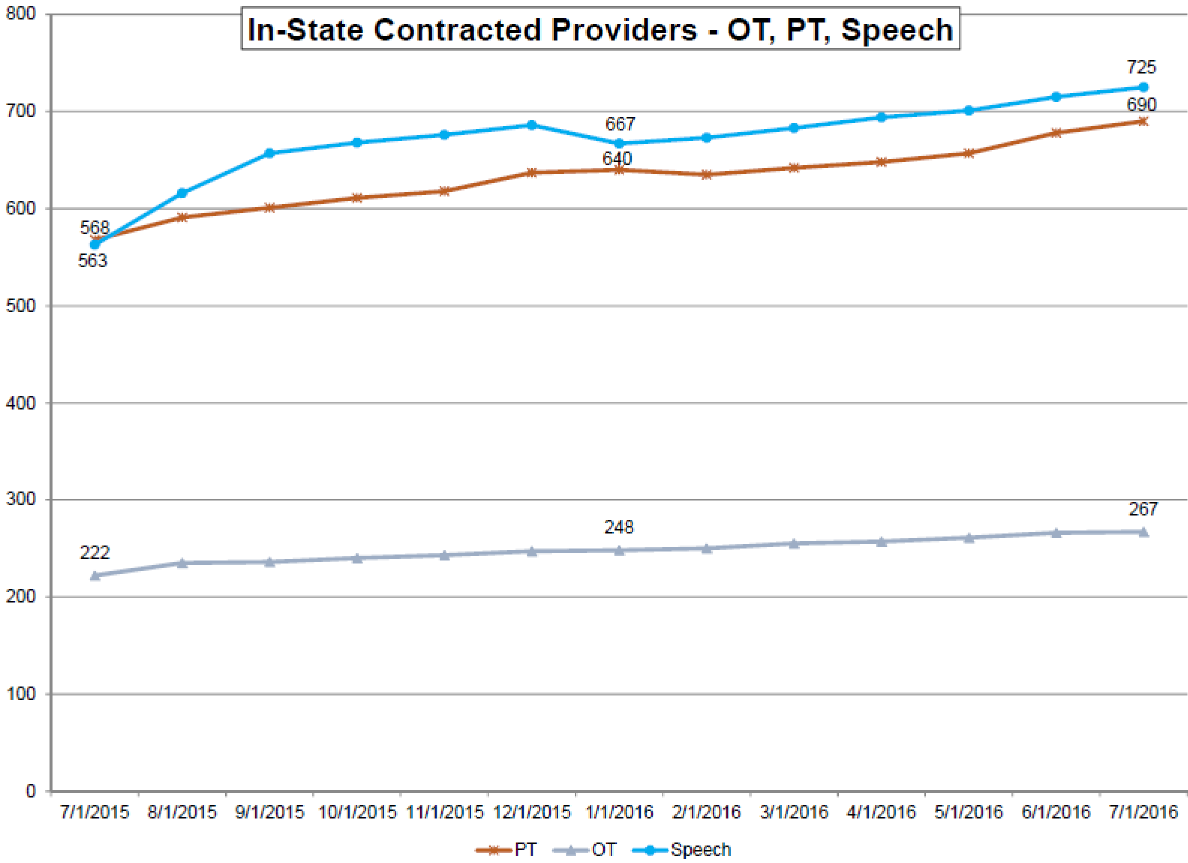
IN-STATE CONTRACTED PROVIDERS

Total In-State Providers: 33,218 (+403) **(In-State Providers counted multiple times due to multiple locations, programs, types, and specialties)**

*Decrease in Total Provider count is due to Physician Assistant renewal starting in Feb 2016 and Behavioral Health Provider in Mar 2016. Decrease during contract renewal period is typical during all renewal periods.






In-State Contracted Providers - OT, PT, Speech
800
700
600
500
400
300
200
100
0
725
690
667
640
568
563
267
248
222
7/1/2015
8/1/2015
9/1/2015
10/1/2015
11/1/2015
12/1/2015
1/1/2016
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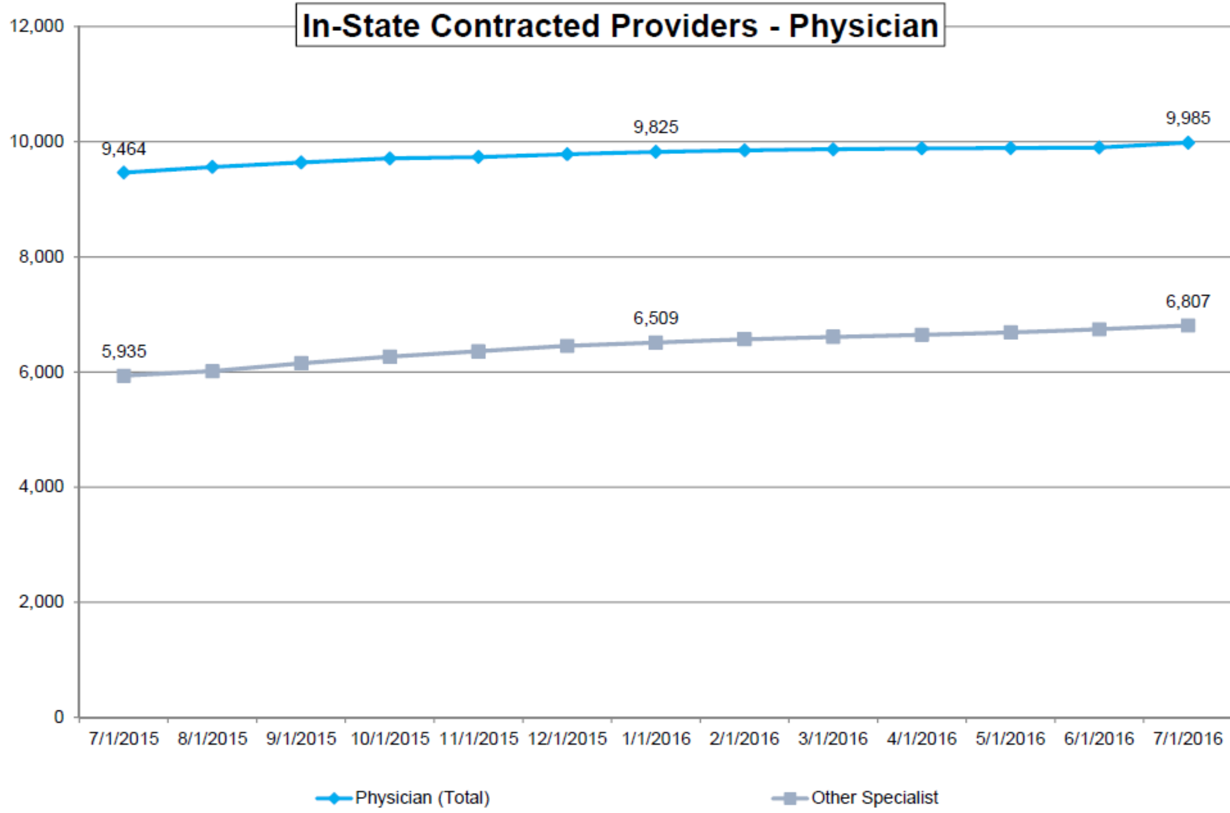
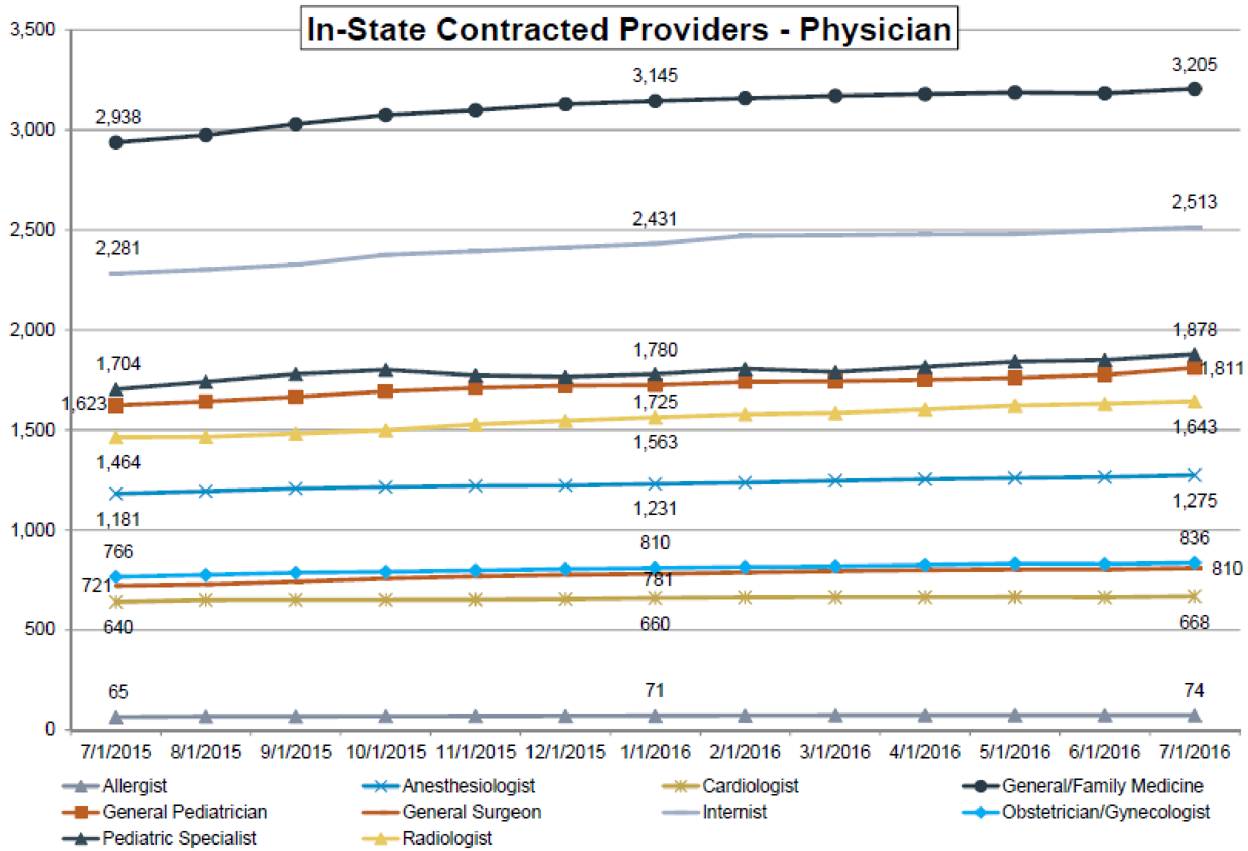
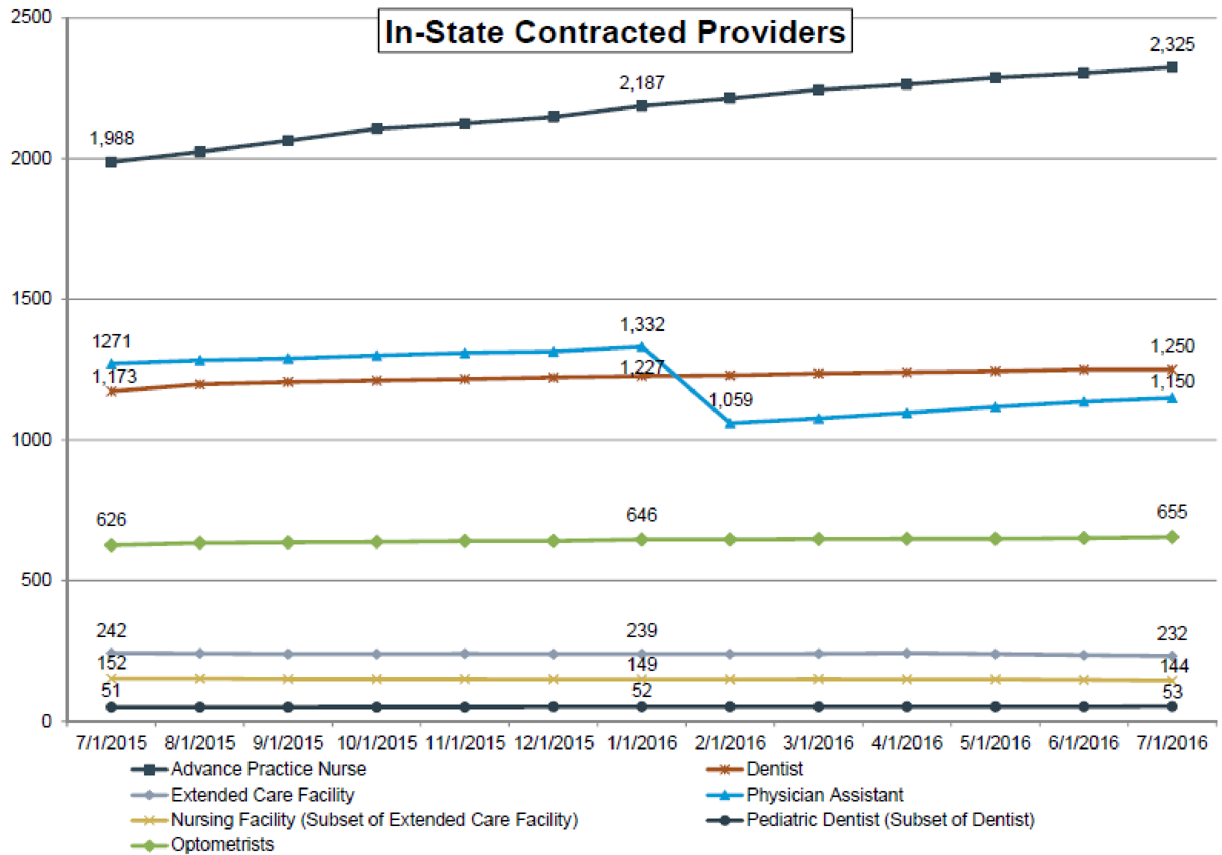
6/1/2016
7/1/2016
PT
OT
Speech



Other Specialist is a subset of the Physician (Total).



All provider groups are subsets of the Physician (Total).


In-State Contracted Providers
2500
2000
1500
1000
500
0
1,988
2,187
2,325
1271
1,332
1,250
1,173
1,227
1,059
1,150
626
646
655
242
239
232
152
149
144
51
52
53
7/1/2015
8/1/2015
9/1/2015
10/1/2015
11/1/2015
12/1/2015
1/1/2016
2/1/2016
3/1/2016
4/1/2016
5/1/2016
6/1/2016
7/1/2016
Advance Practice Nurse
Dentist
Extended Care Facility
Physician Assistant
Nursing Facility (Subset of Extended Care Facility)
Pediatric Dentist (Subset of Dentist)
Optometrists
*Drop in Physician Assistant in Feb 2016 is due to contract renewal period.

POPULATION CARE MANAGEMENT

OHCA Board Meeting
August 11, 2016

POPULATION CARE MANAGEMENT DEPARTMENT

Health Management Program (HMP) – Part of OHCA's chronic disease strategy

Chronic Care Management Unit – Works in tandem with HMP to serve chronic disease population

Case Management Unit – provides episodic, event-based case management services

CASE MANAGEMENT UNIT

Nurses and social service coordinators provide case management for members specifically identified through programs, episodes or events (obstetrics, pediatrics, other populations)

Members are identified through data mining, self-referral, health risk assessment, provider referral, community agency/state partner agency referral, legislative referral, and intra-agency (OHCA) referral

HIGH-RISK OBSTETRICAL (HROB) CASE MANAGEMENT

Members identified for program through medical authorization process (defined list of maternal and fetal diagnoses)

Once approved, members receive enhanced benefit package (ultrasounds, fetal non-stress tests, and biophysical profiles) and case manager follow-up throughout pregnancy

Assistance in accessing resources and services for newborn and patient education

HROB CASE MANAGEMENT OUTCOMES

More than 5,200 women evaluated from 2010 to 2013.

70 percent of the women were ages 21-34

15 percent under age 21

In satisfaction surveys, 93.2 percent would recommend the program to a friend

HROB CASE MANAGEMENT OUTCOMES

	SFY2010	SFY2013
Early gestation/low birth weight deliveries	21.6%	16.2%
Neonatal intensive care unit (NICU) admissions	13.9%	13.0%
30-day readmission (mom)	3.4%	2.3%
60-day readmission (mom)	3.9%	2.8%
Emergency Dept. visits (mom) 30 days	11.4%	8.9%
Emergency Dept. visits (mom) 60 days	15.2%	12.8%

AT-RISK OBSTETRICAL CASE MANAGEMENT

Members identified for program through outreach letters **(Pat Brown)** and subsequent positive screening by Member Services Department OR through response to health risk assessment

Full assessment by case manager, linkage to resources, routine follow-up with member throughout pregnancy

Assistance in accessing resources and services for newborn, patient education

AT-RISK OB CASE MANAGEMENT OUTCOMES

1,610 members evaluated

72.5 percent are ages 21-34

12 percent under age 21

In satisfaction surveys, 97 percent would recommend the program to a friend

AT-RISK OB CASE MANAGEMENT OUTCOMES

	SFY2010	SFY2013
30-day readmission (mom)	4.7%	1.4%
60-day readmission (mom)	6.4%	1.4%
Emergency Dept. visits (mom) 30 days	16.9%	11%
Emergency Dept. visits (mom) 60 days	23.3%	13.0%

QUESTIONS?

Full evaluation can be found at:

http://www.okhca.org/research.aspx?id=87

Click on “Studies and Evaluations”

- 2016 - Population Care Management Independent Evaluation

Agenda

Presentation, Discussion, and Vote on Proposed Rule Changes

September MAC
Proposed Rule Amendment Summaries

Face to face tribal consultation regarding the following proposed changes were held Tuesday, November 3, 2016, Tuesday, July 5, 2016 and Tuesday, September 6, 2016 in the Board Room of the OHCA.

APA WF# 16-08 and 16-12 were posted for comments from August 15, 2016 through September 15, 2016.

16-08 Screening Procedures and Fitness Plan for Certain Providers and Owners Designated High Risk — Proposed rule revisions outline screening procedures for providers who pose an increased financial risk of fraud, waste or abuse to the SoonerCare program. Rules add information regarding applicants who are seeking new or renewed contract enrollment as being subject to a fingerprint-based criminal background check if they are designated as high risk in accordance with Federal law. Rules also specify types of criminal convictions for which an applicant shall (regarding felonies) or may (regarding misdemeanors) be denied enrollment. Rules also state that there is no right to appeal an OHCA decision denying an application for contract enrollment based on the applicant's criminal history.

Budget Impact: Budget neutral

16-12 Medical Residents' Licensure Requirements and Policy Clean Up — The proposed General Coverage policy revisions adds licensing provisions for medical residents as required by their appropriate regulatory medical licensing board. This policy revision also adds language requiring these individuals contract with the OHCA to perform services within the scope of their licensure. These emergency revisions are necessary to comply with federal regulations that requires all ordering or referring physicians be enrolled as participating providers. Additional revisions remove language specific to non-licensed physicians in a training program and clarify that SoonerCare Choice members are exempt from primary care office visits limits. Since residents receive either a medical license or a specialty license for training, there is no further need for policy addressing non-licensed physicians in a training program.
Budget Impact: Budget neutral

16-15 A&B Obstetrical Reimbursement — Proposed revisions will amend the obstetrical reimbursement policy to revert back to a bundled reimbursement structure.
Budget Impact: Budget neutral

Agenda

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

SUBCHAPTER 3. GENERAL PROVIDER POLICIES

PART 1. GENERAL SCOPE AND ADMINISTRATION

317:30-3-19.2. Denial of application for new or renewed provider enrollment contract based on criminal history

(a) **Definitions.** The following words and terms, when used in this section, shall have the following meaning:

(1) **"Applicant"** means providers, persons with a five percent or more direct or indirect ownership interest therein, as well as providers' officers, directors, and managing employees.

(2) **"Criminal conviction"** means an individual or entity has been convicted of a criminal offense pursuant to 42 U.S.C. § 1320a-7(i).

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

(c) Any applicant shall be denied enrollment if he/she has a felonious criminal conviction and may be denied enrollment for a misdemeanor criminal conviction relating, but not limited, to:

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

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

(3) Aggravated assault;

(4) Kidnapping;

(5) Robbery;

(6) Abandonment, abuse, or negligence of a child;

(7) Human trafficking;

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

(9) Forcible rape and/or sexual assault;

(10) Terrorism;

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

(12) Controlled Substances.

(d)There is no right to appeal any OHCA decision denying an application for contract enrollment based on the applicant's criminal history. However, nothing in this section shall preclude an applicant whose criminal conviction has been overturned on final appeal, and for whom no other appeals are pending or may be brought, from reapplying for enrollment.

Agenda

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 1. PHYSICIANS

317:30-5-2. General coverage by category
(a) **Adults**. Payment for adults is made to physicians for medical and surgical services within the scope of the Oklahoma Health Care Authority's (OHCA) SoonerCare program, provided the services are reasonable and necessary for the diagnosis and treatment of illness or injury, or to improve the functioning of a malformed body member. Coverage of certain services must be based on a determination made by the OHCA's medical consultant in individual circumstances.

(1) Coverage includes the following medically necessary services:

(A) Inpatient hospital visits for all SoonerCare covered stays. All inpatient services are subject to post-payment review by the OHCA, or its designated agent.
(B) Inpatient psychotherapy by a physician.
(C) Inpatient psychological testing by a physician.
(D) One inpatient visit per day, per physician.
(E) Certain surgical procedures performed in a Medicare certified free-standing ambulatory surgery center (ASC) or a Medicare certified hospital that offers outpatient surgical services.
(F) Therapeutic radiology or chemotherapy on an outpatient basis without limitation to the number of treatments per month for members with proven malignancies.
~~(G) Direct physician services on an outpatient basis. A maximum of four visits are allowed per month per member in office or home regardless of the number of physician s providing treatment. Additional visits per month are allowed for those services related to emergency medical conditions and for services in connection with Family Planning. SoonerCare Choice members are exempt from the four visits per month limitation.~~
(G) Physician services on an outpatient basis include:

(i) A maximum of four primary care visits per member per month, with the exception of SoonerCare Choice members. (ii) A maximum of four specialty visits per member per month.
(iii) Additional visits are allowed per month for treatment related to emergency medical conditions and Family Planning services.

(H)Direct physician services in a nursing facility for those members residing in a long-term care facility. A maximum of two nursing facility visits per month are allowed. To receive

payment for a second nursing facility visit in a month denied by Medicare for a Medicare/SoonerCare member, attach the EOMB from Medicare showing denial and mark "carrier denied coverage".
(I) Diagnostic x-ray and laboratory services.
(J) Mammography screening and additional follow-up mammograms as per current guidelines.
(K) Obstetrical care.
(L) Pacemakers and prostheses inserted during the course of a surgical procedure.
(M) Prior authorized examinations for the purpose of determining medical eligibility for programs administered by OHCA. A copy of the authorization, OKDHS form 08MA016E, Authorization for Examination and Billing, must accompany the claim.
(N) If a physician renders direct care to a member on the same day as a dialysis treatment, payment is allowed for a separately identifiable service unrelated to the dialysis.
(O) Family planning includes sterilization procedures for legally competent members 21 years of age and over who voluntarily request such a procedure and execute the federally mandated consent form with his/her physician. A copy of the consent form must be attached to the claim form. Separate payment is allowed for the insertion and/or implantation of contraceptive devices during an office visit. Certain family planning products may be obtained through the Vendor Drug Program. Reversal of sterilization procedures for the purposes of conception is not allowed. Reversal of sterilization procedures are allowed when medically indicated and substantiating documentation is attached to the claim.
(P) Genetic counseling.
(Q) Laboratory testing.
(R) Payment for ultrasounds for pregnant women as specified in OAC 317:30-5-22.
(S) Payment to the attending physician in a teaching medical facility for compensable services when the physician signs as claimant and renders personal and identifiable services to the member in conformity with federal regulations.
(T) Payment to the attending physician for the services of a currently Oklahoma licensed physician in training when the following conditions are met~~.~~;

(i) Attending physician performs chart review and signs off on the billed encounter;
(ii) Attending physician is present in the clinic/or hospital setting and available for consultation; and
(iii) Documentation of written policy and applicable training of physicians in the training program regarding when to seek the consultation of the attending physician.

~~(U) Payment to the attending physician for the outpatient~~

~~services of an unlicensed physician in a training program when the following conditions are met:~~

~~(i) The member must be at least minimally examined by the attending physician or a licensed physician under the supervision of the attending physician;~~

~~(ii) The contact must be documented in the medical record.~~

(U) Payment for services rendered by medical residents in an outpatient academic setting when the following conditions are met:

(i) the resident has obtained a medical license or a special license for training from the appropriate regulatory state medical board; and

(ii) has the appropriate contract on file with the OHCA to render services within the scope of their licensure.

(V) The payment to a physician for medically directing the services of a CRNA or for the direct supervision of the services of an Anesthesiologist Assistant (AA) is limited. The maximum allowable fee for the services of both providers combined is limited to the maximum allowable had the service been performed solely by the anesthesiologist.

(W) Screening and follow up Pap Smears as per current guidelines.

(X) Medically necessary solid organ and bone marrow/stem cell transplantation services for children and adults are covered services based upon the conditions listed in (i)-(iv) of this subparagraph:

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

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

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

(iv) Procedures considered experimental or investigational are not covered.

(Y) Donor search and procurement services are covered for transplants consistent with the methods used by the Medicare program for organ acquisition costs.

(Z) Donor expenses incurred for complications are covered only if they are directly and immediately attributable to the donation procedure. Donor expenses that occur after the 90 day global reimbursement period must be submitted to the OHCA for review.

(AA) Total parenteral nutritional therapy (TPN) for identified diagnoses and when prior authorized.

(BB) Ventilator equipment.

(CC) Home dialysis equipment and supplies.

(DD) Ambulatory services for treatment of members with tuberculosis (TB). This includes, but is not limited to, physician visits, outpatient hospital services, rural health clinic visits and prescriptions. Drugs prescribed for the treatment of TB beyond the prescriptions covered under SoonerCare require prior authorization by the University of Oklahoma College of Pharmacy Help Desk using form "Petition for TB Related Therapy". Ambulatory services to members infected with TB are not limited to the scope of the SoonerCare program, but require prior authorization when the scope is exceeded.

(EE) Smoking and Tobacco Use Cessation Counseling for treatment of members using tobacco.

(i) Smoking and Tobacco Use Cessation Counseling consists of the 5As:

(I) Asking the member to describe their smoking use;

(II) Advising the member to quit;

(III) Assessing the willingness of the member to quit;

(IV) Assisting the member with referrals and plans to quit; and

(V) Arranging for follow-up.

(ii) Up to eight sessions are covered per year per individual.

(iii) Smoking and Tobacco Use Cessation Counseling is a covered service when performed by physicians, physician assistants, advanced registered nurse practitioners, certified nurse midwives, dentists, Oklahoma State Health Department and FQHC nursing staff, and Maternal/Child Health Licensed Clinical Social Workers with a certification as a Tobacco Treatment Specialist Certification (CTTS). It is reimbursed in addition to any other appropriate claims for obstetrical care, PCP care coordination payments, evaluation and management codes, or other appropriate services rendered. It must be a significant, separately identifiable service, unique from any other service provided on the same day.

(iv) Chart documentation must include a separate note that addresses the 5A's and office note signature along with the member specific information addressed in the five steps and the time spent by the practitioner performing the counseling. Anything under three minutes is considered part of a routine visit and not separately billable.

(FF) Immunizations as specified by the Advisory Committee on Immunization Practices (ACIP) guidelines.

(GG) Genetic testing is covered when medically necessary. Genetic testing may be considered medically necessary when the following conditions are met:

(i) The member displays clinical features of a suspected genetic condition or is at direct risk of inheriting the genetic condition in question (e.g., a causative familial

variant has been identified); and

(ii) Clinical studies published in peer-reviewed literature have established strong evidence that the result of the test will positively impact the clinical decision-making or clinical outcome for the member; and

(iii) The testing method is proven to be scientifically valid for the identification of a specific genetically-linked inheritable disease or clinically important molecular marker; and

(iv) A medical geneticist physician or licensed genetic counselor provides documentation that supports the recommendation for testing based on a review of risk factors, clinical scenario, and family history.

(2) General coverage exclusions include the following:

(A) Inpatient admission for diagnostic studies that could be performed on an outpatient basis.

(B) Services or any expense incurred for cosmetic surgery.

(C) Services of two physicians for the same type of service to the same member on the same day, except when supplemental skills are required and different specialties are involved.

(D) Routine eye examinations for the sole purpose of prescribing glasses or visual aids, determination of refractive state, treatment of refractive errors or purchase of lenses, frames or visual aids.

(E) Pre-operative care within 24 hours of the day of admission for surgery and routine post-operative care as defined under the global surgery guidelines promulgated by Current Procedural Terminology (CPT) and the Centers for Medicare and Medicaid Services (CMS).

(F) Payment to the same physician for both an outpatient visit and admission to hospital on the same date.

(G) Sterilization of members who are under 21 years of age, mentally incompetent, or institutionalized or reversal of sterilization procedures for the purposes of conception.

(H) Non-therapeutic hysterectomies.

(I) Medical services considered experimental or investigational.

(J) Payment for more than four outpatient visits per ~~month~~member (home or office) per ~~member~~month, except ~~those~~ visits in connection with family planning~~ or~~, services related to emergency medical conditions~~.~~,or primary care services provided to SoonerCare Choice members.

(K) Payment for more than two nursing facility visits per month.

(L) More than one inpatient visit per day per physician.

(M) Physician services which are administrative in nature and not a direct service to the member including such items as quality assurance, utilization review, treatment staffing,

tumor board review or multidisciplinary opinion, dictation, and similar functions.

(N) Charges for completion of insurance forms, abstracts, narrative reports or telephone calls.

(O) Payment for the services of social workers, licensed family counselors, registered nurses or other ancillary staff, except as specifically set out in OHCA rules.

(P) Induced abortions, except when certified in writing by a physician that the abortion was necessary due to a physical disorder, injury or illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would place the woman in danger of death unless an abortion is performed, or that the pregnancy is the result of an act of rape or incest. (Refer to OAC 317:30-5-6 or 317:30-5-50.)

(Q) Speech and Hearing services.

(R) Mileage.

(S) A routine hospital visit on the date of discharge unless the member expired.

(T) Direct payment to perfusionist as this is considered part of the hospital reimbursement.

(U) Inpatient chemical dependency treatment.

(V) Fertility treatment.

(W) Payment for removal of benign skin lesions.

(X) Sleep studies.

(b) **Children**. Payment is made to physicians for medical and surgical services for members under the age of 21 within the scope of the Authority's SoonerCare program, provided the services are medically necessary for the diagnosis and treatment of illness or injury, or to improve the functioning of a malformed body member. Medical and surgical services for children are comparable to those listed for adults. For services rendered to a minor child, the child's parent or court-appointed legal guardian must provide written authorization prior to the service being rendered, unless there is an explicit state or federal exception to this requirement. In addition to those services listed for adults, the following services are covered for children.

(1) **Pre-authorization of inpatient psychiatric services**. All inpatient psychiatric services for members under 21 years of age must be prior authorized by an agency designated by the Oklahoma Health Care Authority. All psychiatric services are prior authorized for an approved length of stay. Non-authorized inpatient psychiatric services are not SoonerCare compensable.

(A) All residential and acute psychiatric services are authorized based on the medical necessity criteria as described in OAC 317:30-5-95.25,317:30-5-95.27 and 317:30-5-95.29.

(B) Out of state placements are not authorized unless it is determined that the needed medical services are more readily available in another state or it is a general practice for

members in a particular border locality to use resources in another state. If a medical emergency occurs while a member is out of the State, treatment for medical services is covered as if provided within the State. A prime consideration for placements is proximity to the family or guardian in order to involve the family or guardian in discharge and reintegration planning.

(2) **General acute care inpatient service limitations.** All general acute care inpatient hospital services for members under the age of 21 are not limited. All inpatient care must be medically necessary.

(3) **Procedures for requesting extensions for inpatient services.** The physician and/or facility must provide necessary justification to enable OHCA, or its designated agent, to make a determination of medical necessity and appropriateness of treatment options. Extension requests for psychiatric admissions must be submitted to the OHCA or its designated agent. Extension requests must contain the appropriate documentation validating the need for continued treatment in accordance with the medical necessity criteria described in OAC 317:30-5-95.26, 317:30-5-95.28 and 317:30-5-95.30. Requests must be made prior to the expiration of the approved inpatient stay. All decisions of OHCA or its designated agent are final.

(4) **Utilization control requirements for psychiatric beds.** Utilization control requirements for inpatient psychiatric services for members under 21 years of age apply to all hospitals and residential psychiatric treatment facilities.

(5) **Early and periodic screening diagnosis and treatment program.** Payment is made to eligible providers for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) of members under age 21. These services include medical, dental, vision, hearing and other necessary health care. Refer to OAC 317:30-3-65.2 through 317:30-3-65.11 for specific guidelines.

(6) **Child abuse/neglect findings.** Instances of child abuse and/or neglect discovered through screenings and regular exams are to be reported in accordance with State Law. Section 7103 of Title 10 of the Oklahoma Statutes mandates reporting suspected abuse or neglect to the Oklahoma Department of Human Services. Section 7104 of Title 10 of the Oklahoma Statutes further requires reporting of criminally injurious conduct to the nearest law enforcement agency.

(7) **General exclusions.** The following are excluded from coverage for members under the age of 21:

(A) Inpatient admission for diagnostic studies that could be performed on an outpatient basis.

(B) Services or any expense incurred for cosmetic surgery unless the physician certifies the procedure emotionally necessary.

(C) Services of two physicians for the same type of service to the same member on the same day, except when supplemental skills are required and different specialties are involved.
(D) Pre-operative care within 24 hours of the day of admission for surgery and routine post-operative care as defined under the global surgery guidelines promulgated by Current Procedural Terminology (CPT) and the Centers for Medicare and Medicaid Services (CMS).
(E) Payment to the same physician for both an outpatient visit and admission to hospital on the same date.
(F) Sterilization of members who are under 21 years of age, mentally incompetent, or institutionalized or reversal of sterilization procedures for the purposes of conception.
(G) Non-therapeutic hysterectomies.
(H) Medical Services considered experimental or investigational.
(I) More than one inpatient visit per day per physician.
(J) Induced abortions, except when certified in writing by a physician that the abortion was necessary due to a physical disorder, injury or illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would place the woman in danger of death unless an abortion is performed, or that the pregnancy is the result of an act of rape or incest. (Refer to OAC 317:30-5-6 or 317:30-5-50.)
(K) Physician services which are administrative in nature and not a direct service to the member including such items as quality assurance, utilization review, treatment staffing, tumor board review or multidisciplinary opinion, dictation, and similar functions.
(L) Payment for the services of social workers, licensed family counselors, registered nurses or other ancillary staff, except as specifically set out in OHCA rules.
(M) Direct payment to perfusionist as this is considered part of the hospital reimbursement.
(N) Charges for completion of insurance forms, abstracts, narrative reports or telephone calls.
(O) Mileage.
(P) A routine hospital visit on date of discharge unless the member expired.

(c) **Individuals eligible for Part B of Medicare.** Payment is made utilizing the OHCA allowable for comparable services. Claims filed with Medicare Part B should automatically cross over to OHCA. The explanation of Medicare Benefits (EOMB) reflects a message that the claim was referred to SoonerCare. If such a message is not present, a claim for coinsurance and deductible must be filed with the OHCA within 90 days of the date of Medicare payment and within one year of the date of service in order to be considered timely filed.

(1) In certain circumstances, some claims do not automatically

"cross over". Providers must file a claim for coinsurance and/or deductible to SoonerCare within 90 days of the Medicare payment and within one year from the date of service.
(2) If payment was denied by Medicare Part B and the service is a SoonerCare covered service, mark the claim "denied by Medicare" and attach the Medicare EOMB showing the reason for the denial.

Agenda

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 1. PHYSICIANS

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

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

(1) Coverage includes the following medically necessary services:

(A) Inpatient hospital visits for all SoonerCare covered stays. All inpatient services are subject to post-payment review by the OHCA, or its designated agent.
(B) Inpatient psychotherapy by a physician.
(C) Inpatient psychological testing by a physician.
(D) One inpatient visit per day, per physician.
(E) Certain surgical procedures performed in a Medicare certified free-standing ambulatory surgery center (ASC) or a Medicare certified hospital that offers outpatient surgical services.
(F) Therapeutic radiology or chemotherapy on an outpatient basis without limitation to the number of treatments per month for members with proven malignancies.
(G) Direct physician services on an outpatient basis. A maximum of four visits are allowed per month per member in office or home regardless of the number of physicians providing treatment. Additional visits per month are allowed for those services related to emergency medical conditions and for services in connection with Family Planning. SoonerCare Choice members are exempt from the four visits per month limitation.
(H) Direct physician services in a nursing facility for those members residing in a long-term care facility. A maximum of two nursing facility visits per month are allowed. To receive

payment for a second nursing facility visit in a month denied by Medicare for a Medicare/SoonerCare member, attach the EOMB from Medicare showing denial and mark "carrier denied coverage".

(I) Diagnostic x-ray and laboratory services.

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

(K) Obstetrical care.

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

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

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

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

(P) Genetic counseling.

(Q) Laboratory testing.

(R) Payment for ultrasounds for pregnant women as specified in OAC 317:30-5-22.

(S) Payment to the attending physician in a teaching medical facility for compensable services when the physician signs as claimant and renders personal and identifiable services to the member in conformity with federal regulations.

(T) Payment to the attending physician for the services of a currently Oklahoma licensed physician in training when the following conditions are met.

(i) Attending physician performs chart review and signs off on the billed encounter;

(ii) Attending physician is present in the clinic/or hospital setting and available for consultation;

(iii) Documentation of written policy and applicable training of physicians in the training program regarding when to seek the consultation of the attending physician.

(U) Payment to the attending physician for the outpatient

services of an unlicensed physician in a training program when the following conditions are met:

(i) The member must be at least minimally examined by the attending physician or a licensed physician under the supervision of the attending physician;

(ii) The contact must be documented in the medical record.

(V) The payment to a physician for medically directing the services of a CRNA or for the direct supervision of the services of an Anesthesiologist Assistant (AA) is limited. The maximum allowable fee for the services of both providers combined is limited to the maximum allowable had the service been performed solely by the anesthesiologist.

(W) Screening and follow up Pap Smears as per current guidelines.

(X) Medically necessary solid organ and bone marrow/stem cell transplantation services for children and adults are covered services based upon the conditions listed in (i)-(iv) of this subparagraph:

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

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

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

(iv) Procedures considered experimental or investigational are not covered.

(Y) Donor search and procurement services are covered for transplants consistent with the methods used by the Medicare program for organ acquisition costs.

(Z) Donor expenses incurred for complications are covered only if they are directly and immediately attributable to the donation procedure. Donor expenses that occur after the 90 day global reimbursement period must be submitted to the OHCA for review.

(AA) Total parenteral nutritional therapy (TPN) for identified diagnoses and when prior authorized.

(BB) Ventilator equipment.

(CC) Home dialysis equipment and supplies.

(DD) Ambulatory services for treatment of members with tuberculosis (TB). This includes, but is not limited to, physician visits, outpatient hospital services, rural health clinic visits and prescriptions. Drugs prescribed for the treatment of TB beyond the prescriptions covered under SoonerCare require prior authorization by the University of Oklahoma College of Pharmacy Help Desk using form "Petition for TB Related Therapy". Ambulatory services to members infected

with TB are not limited to the scope of the SoonerCare program, but require prior authorization when the scope is exceeded.

(EE) Smoking and Tobacco Use Cessation Counseling for treatment of members using tobacco.

(i) Smoking and Tobacco Use Cessation Counseling consists of the 5As:

(I) Asking the member to describe their smoking use;

(II) Advising the member to quit;

(III) Assessing the willingness of the member to quit;

(IV) Assisting the member with referrals and plans to quit; and

(V) Arranging for follow-up.

(ii) Up to eight sessions are covered per year per individual.

(iii) Smoking and Tobacco Use Cessation Counseling is a covered service when performed by physicians, physician assistants, advanced registered nurse practitioners, certified nurse midwives, dentists, Oklahoma State Health Department and FQHC nursing staff, and Maternal/Child Health Licensed Clinical Social Workers with a certification as a Tobacco Treatment Specialist Certification (CTTS). It is reimbursed in addition to any other appropriate ~~claims~~global payments for obstetrical care, PCP care coordination payments, evaluation and management codes, or other appropriate services rendered. It must be a significant, separately identifiable service, unique from any other service provided on the same day.

(iv) Chart documentation must include a separate note that addresses the 5A's and office note signature along with the member specific information addressed in the five steps and the time spent by the practitioner performing the counseling. Anything under three minutes is considered part of a routine visit and not separately billable.

(FF) Immunizations as specified by the Advisory Committee on Immunization Practices (ACIP) guidelines.

(GG) Genetic testing is covered when medically necessary. Genetic testing may be considered medically necessary when the following conditions are met:

(i) The member displays clinical features of a suspected genetic condition or is at direct risk of inheriting the genetic condition in question (e.g., a causative familial variant has been identified); and

(ii) Clinical studies published in peer-reviewed literature have established strong evidence that the result of the test will positively impact the clinical decision-making or clinical outcome for the member; and

(iii) The testing method is proven to be scientifically valid for the identification of a specific genetically-linked inheritable disease or clinically important molecular

marker; and

(iv) A medical geneticist physician or licensed genetic counselor provides documentation that supports the recommendation for testing based on a review of risk factors, clinical scenario, and family history.

(2) General coverage exclusions include the following:

(A) Inpatient admission for diagnostic studies that could be performed on an outpatient basis.

(B) Services or any expense incurred for cosmetic surgery.

(C) Services of two physicians for the same type of service to the same member on the same day, except when supplemental skills are required and different specialties are involved.

(D) Routine eye examinations for the sole purpose of prescribing glasses or visual aids, determination of refractive state, treatment of refractive errors or purchase of lenses, frames or visual aids.

(E) Pre-operative care within 24 hours of the day of admission for surgery and routine post-operative care as defined under the global surgery guidelines promulgated by Current Procedural Terminology (CPT) and the Centers for Medicare and Medicaid Services (CMS).

(F) Payment to the same physician for both an outpatient visit and admission to hospital on the same date.

(G) Sterilization of members who are under 21 years of age, mentally incompetent, or institutionalized or reversal of sterilization procedures for the purposes of conception.

(H) Non-therapeutic hysterectomies.

(I) Medical services considered experimental or investigational.

(J) Payment for more than four outpatient visits per month (home or office) per member, except those visits in connection with family planning or related to emergency medical conditions.

(K) Payment for more than two nursing facility visits per month.

(L) More than one inpatient visit per day per physician.

(M) Physician services which are administrative in nature and not a direct service to the member including such items as quality assurance, utilization review, treatment staffing, tumor board review or multidisciplinary opinion, dictation, and similar functions.

(N) Charges for completion of insurance forms, abstracts, narrative reports or telephone calls.

(O) Payment for the services of social workers, licensed family counselors, registered nurses or other ancillary staff, except as specifically set out in OHCA rules.

(P) Induced abortions, except when certified in writing by a physician that the abortion was necessary due to a physical disorder, injury or illness, including a life-endangering

physical condition caused by or arising from the pregnancy itself, that would place the woman in danger of death unless an abortion is performed, or that the pregnancy is the result of an act of rape or incest. (Refer to OAC 317:30-5-6 or 317:30-5-50.)

(Q) Speech and Hearing services.

(R) Mileage.

(S) A routine hospital visit on the date of discharge unless the member expired.

(T) Direct payment to perfusionist as this is considered part of the hospital reimbursement.

(U) Inpatient chemical dependency treatment.

(V) Fertility treatment.

(W) Payment for removal of benign skin lesions.

(X) Sleep studies.

(b) **Children**. Payment is made to physicians for medical and surgical services for members under the age of 21 within the scope of the Authority's SoonerCare program, provided the services are medically necessary for the diagnosis and treatment of illness or injury, or to improve the functioning of a malformed body member. Medical and surgical services for children are comparable to those listed for adults. For services rendered to a minor child, the child's parent or court-appointed legal guardian must provide written authorization prior to the service being rendered, unless there is an explicit state or federal exception to this requirement. In addition to those services listed for adults, the following services are covered for children.

(1) **Pre-authorization of inpatient psychiatric services**. All inpatient psychiatric services for members under 21 years of age must be prior authorized by an agency designated by the Oklahoma Health Care Authority. All psychiatric services are prior authorized for an approved length of stay. Non-authorized inpatient psychiatric services are not SoonerCare compensable.

(A) All residential and acute psychiatric services are authorized based on the medical necessity criteria as described in OAC 317:30-5-95.25,317:30-5-95.27 and 317:30-5-95.29.

(B) Out of state placements are not authorized unless it is determined that the needed medical services are more readily available in another state or it is a general practice for members in a particular border locality to use resources in another state. If a medical emergency occurs while a member is out of the State, treatment for medical services is covered as if provided within the State. A prime consideration for placements is proximity to the family or guardian in order to involve the family or guardian in discharge and reintegration planning.

(2) **General acute care inpatient service limitations**. All general acute care inpatient hospital services for members under the age of 21 are not limited. All inpatient care must be medically

necessary.
(3) **Procedures for requesting extensions for inpatient services.** The physician and/or facility must provide necessary justification to enable OHCA, or its designated agent, to make a determination of medical necessity and appropriateness of treatment options. Extension requests for psychiatric admissions must be submitted to the OHCA or its designated agent. Extension requests must contain the appropriate documentation validating the need for continued treatment in accordance with the medical necessity criteria described in OAC 317:30-5-95.26, 317:30-5-95.28 and 317:30-5-95.30. Requests must be made prior to the expiration of the approved inpatient stay. All decisions of OHCA or its designated agent are final.
(4) **Utilization control requirements for psychiatric beds.** Utilization control requirements for inpatient psychiatric services for members under 21 years of age apply to all hospitals and residential psychiatric treatment facilities.
(5) **Early and periodic screening diagnosis and treatment program.** Payment is made to eligible providers for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) of members under age 21. These services include medical, dental, vision, hearing and other necessary health care. Refer to OAC 317:30-3-65.2 through 317:30-3-65.11 for specific guidelines.
(6) **Child abuse/neglect findings.** Instances of child abuse and/or neglect discovered through screenings and regular exams are to be reported in accordance with State Law. Section 7103 of Title 10 of the Oklahoma Statutes mandates reporting suspected abuse or neglect to the Oklahoma Department of Human Services. Section 7104 of Title 10 of the Oklahoma Statutes further requires reporting of criminally injurious conduct to the nearest law enforcement agency.
(7) **General exclusions.** The following are excluded from coverage for members under the age of 21:

(A) Inpatient admission for diagnostic studies that could be performed on an outpatient basis.

(B) Services or any expense incurred for cosmetic surgery unless the physician certifies the procedure emotionally necessary.

(C) Services of two physicians for the same type of service to the same member on the same day, except when supplemental skills are required and different specialties are involved.

(D) Pre-operative care within 24 hours of the day of admission for surgery and routine post-operative care as defined under the global surgery guidelines promulgated by Current Procedural Terminology (CPT) and the Centers for Medicare and Medicaid Services (CMS).

(E) Payment to the same physician for both an outpatient visit and admission to hospital on the same date.

(F) Sterilization of members who are under 21 years of age, mentally incompetent, or institutionalized or reversal of sterilization procedures for the purposes of conception.
(G) Non-therapeutic hysterectomies.
(H) Medical Services considered experimental or investigational.
(I) More than one inpatient visit per day per physician.
(J) Induced abortions, except when certified in writing by a physician that the abortion was necessary due to a physical disorder, injury or illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would place the woman in danger of death unless an abortion is performed, or that the pregnancy is the result of an act of rape or incest. (Refer to OAC 317:30-5-6 or 317:30-5-50.)
(K) Physician services which are administrative in nature and not a direct service to the member including such items as quality assurance, utilization review, treatment staffing, tumor board review or multidisciplinary opinion, dictation, and similar functions.
(L) Payment for the services of social workers, licensed family counselors, registered nurses or other ancillary staff, except as specifically set out in OHCA rules.
(M) Direct payment to perfusionist as this is considered part of the hospital reimbursement.
(N) Charges for completion of insurance forms, abstracts, narrative reports or telephone calls.
(O) Mileage.
(P) A routine hospital visit on date of discharge unless the member expired.

(c) **Individuals eligible for Part B of Medicare.** Payment is made utilizing the OHCA allowable for comparable services. Claims filed with Medicare Part B should automatically cross over to OHCA. The explanation of Medicare Benefits (EOMB) reflects a message that the claim was referred to SoonerCare. If such a message is not present, a claim for coinsurance and deductible must be filed with the OHCA within 90 days of the date of Medicare payment and within one year of the date of service in order to be considered timely filed.
(1) In certain circumstances, some claims do not automatically "cross over". Providers must file a claim for coinsurance and/or deductible to SoonerCare within 90 days of the Medicare payment and within one year from the date of service.
(2) If payment was denied by Medicare Part B and the service is a SoonerCare covered service, mark the claim "denied by Medicare" and attach the Medicare EOMB showing the reason for the denial.

317:30-5-22. Obstetrical care

~~(a) Providers of obstetrical services must bill each antepartum visit separately, utilizing the appropriate evaluation and management~~

~~service code. The OHCA does not recognize the codes for "global obstetrical care" which bundle these services under a single procedure code. Delivery only and postpartum care services are also billed separately by the rendering provider.~~
~~(b) The following routine obstetrical services are covered as detailed below:~~

(a) Obstetrical (OB) care is billed using the appropriate CPT codes for Maternity Care and Delivery. The date of delivery is used as the date of service for charges for total obstetrical care. Inclusive dates of care should be indicated on the claim form as part of the description. Payment for total obstetrical care includes all routine care, and any ultrasounds performed by the attending physician provided during the maternity cycle unless otherwise specified in this Section. For payment of total OB care, a physician must have provided care for more than one trimester. To bill for prenatal care only, the claim is filed after the member leaves the provider's care. Payment for routine or minor medical problems will not be made separately to the OB physician outside of the ante partum visits. The ante partum care during the prenatal care period includes all care by the OB attending physician except major illness distinctly unrelated to the pregnancy.

(b)Procedures paid separately from total obstetrical care are listed in (1) - (8) of this subsection.

(1) The completion of an American College of Obstetricians and Gynecologist (ACOG) assessment form or form covering same elements as ACOG and the most recent version of the Oklahoma Health Care Authority's Prenatal Psychosocial Assessment are reimbursable when both documents are included in the prenatal record. SoonerCare allows one assessment per provider and no more than two per pregnancy.

(2) Medically necessary real time antepartum diagnostic ultrasounds will be paid in addition to antepartum care, delivery and postpartum obstetrical care under defined circumstances. To be eligible for payment, all ultrasound reports must meet the guideline standards published by the American Institute of Ultrasound Medicine (AIUM).

(A) One abdominal or vaginal ultrasound will be covered in the first trimester of pregnancy. The ultrasound must be performed by a Board Eligible/Board Certified Obstetrician-Gynecologist (OB-GYN), Radiologist, or a Board Eligible/Board Certified Maternal-Fetal Medicine specialist. In addition, this ultrasound may be performed by a Nurse Midwife, Family Practice Physician or Advance Practice Nurse Practitioner in Obstetrics with a certification in obstetrical ultrasonography.

(B) One ultrasound after the first trimester will be covered. This ultrasound must be performed by a Board Eligible/Board Certified Obstetrician-Gynecologist (OB-GYN), Radiologist, or a Board Eligible/Board Certified Maternal-Fetal Medicine specialist. In addition, this ultrasound may be performed by a

Nurse Midwife, Family Practice Physician or Advance Practice Nurse Practitioner in Obstetrics with certification in obstetrical ultrasonography.

(C) One additional detailed ultrasound is allowed by a Board Eligible/Board Certified Maternal Fetal Specialist or general obstetrician with documented specialty training in performing detailed ultrasounds. This additional ultrasound is allowed to identify or confirm a suspected fetal/maternal anomaly. This additional ultrasound does not require prior authorization. Any subsequent ultrasounds will require prior authorization.

(3) Standby attendance at Cesarean Section (C-Section), for the purpose of attending the baby, is compensable when billed by a physician or qualified health care provider not participating in the delivery.

(4) Anesthesia administered by the attending physician is a compensable service and may be billed separately from the delivery.

(5) Amniocentesis is not included in routine obstetrical care and is billed separately. Payment may be made for an evaluation and management service and a medically indicated amniocentesis on the same date of service. This is an exception to general information regarding surgery found at OAC 317:30-5-8.

(6) Additional payment is not made for the delivery of multiple gestations. If one fetus is delivered vaginally and additional fetus(es)are delivered by C-section by the same physician, the higher level procedure is paid. If one fetus is delivered vaginally and additional fetus(es)are delivered by C-Section, by different physicians, each should bill the appropriate procedure codes without a modifier. Payment is not made to the same physician for both standby and assistant at C-Section.

(7) Reimbursement is allowed for nutritional counseling in a group setting for members with gestational diabetes. Refer to OAC 317:30-5-1076(5).

(c) Assistant surgeons are paid for C-Sections which include only in-hospital post-operative care. Family practitioners who provide prenatal care and assist at C-Section ~~may~~ bill separately for the ~~antenatal~~prenatal and the six weeks postpartum office ~~visits~~visit.

(d) Procedures listed in (1) - (5) of this subsection are not ~~separately reimbursable~~ paid or not covered separately from total obstetrical care.

(1) Non stress test, unless the pregnancy is determined medically high risk. See OAC 317:30-5-22.1.

(2) Standby at C-Section is not compensable when billed by a physician participating in delivery.

(3) Payment is not made for an assistant surgeon for obstetrical procedures that include prenatal or postpartum care.

~~(3)~~(4) An additional allowance is not made for induction of labor, double set-up examinations, fetal stress tests, or pudendal anesthetic. Providers must not bill separately for these

procedures.

~~(4)~~(5) Fetal scalp blood sampling is considered part of ~~DRG reimbursement~~the total OB care.

(e) Obstetrical coverage for children is the same as for adults. Additional procedures may be covered under EPSDT provisions if determined to be medically necessary.

(1) Services deemed medically necessary and allowable under federal Medicaid regulations are covered by the EPSDT/OHCA Child Health Program even though those services may not be part of the Oklahoma Health Care Authority SoonerCare program. Such services must be prior authorized.

(2) Federal Medicaid regulations also require the State to make the determination as to whether the service is medically necessary and do not require the provision of any items or services that the State determines are not safe and effective or which are considered experimental.

PART 19. CERTIFIED NURSE MIDWIVES

317:30-5-226. Coverage by category

(a) **Adults and children ~~21~~19 and under.** Payment is made for certified nurse midwife services within the scope of practice as defined by state law including obstetrical care such as antepartum care, delivery, postpartum care, and care of the normal newborn during the first 28 days of life. ~~Obstetrical care should be billed using the appropriate evaluation and management codes for antepartum care, as well as the appropriate delivery only and postpartum care services when rendered. Ultrasounds and other procedures for obstetrical care are paid in accordance with OAC 317:30-5-22(b).~~

(1) Obstetrical care should be billed using the appropriate CPT codes for Maternity Care and Delivery. The date of delivery should be used as the date of service for charges for total obstetrical care. Inclusive dates of care should be indicated on the claim form as part of the description. The date the patient was first seen must be on the claim form. Payment for total obstetrical care includes all routine care. Ultrasounds and other procedures reimbursed separately from total obstetrical care are paid in accordance with provisions found at OAC 317:30-5-22(b).

(2) For payment of total OB care, the provider must have provided care for more than one trimester. To bill for prenatal care only, the claim is filed after the member leaves the provider's care. Payment for routine or minor medical problems will not be made separately to the OB provider outside of antepartum visits. The antepartum care during the prenatal care period includes all care by the OB provider except major illness distinctly unrelated to the pregnancy.

(b) **Newborn.** Payment to nurse midwives for services to newborn is the same as for adults and children under ~~21~~19. A newborn is an infant during the first 28 days following birth.

(1) Providers must use OKDHS Form FSS-NB-1, or the eNB1 application on the Secure Website to notify the county DHS office of the child's birth. A claim may then be filed for charges for the baby under the case number and the baby's name and assigned person code.
(2) Charges billed on the mother's person code for services rendered to the child will be denied.

(c) **Individuals eligible for Part B of Medicare.** Payment is made utilizing the Medicaid allowable for comparable services.

317:30-5-229. Reimbursement

In accordance with the Omnibus Budget Reconciliation Act of 1993, effective October 1, 1993, certified nurse midwife services include maternity services, as well as services outside the maternity cycle within the scope of their practice under state law.

(1) Medical verification of pregnancy is required. A written statement from the physician or certified nurse midwife verifying the applicant is pregnant and the expected date of delivery is acceptable. Pregnancy may also be verified by submission of a copy of a laboratory report indicating the individual is pregnant.
(2) Newborn charges billed on the mother's person code will be denied.
(3) Providers must use OKDHS Form FSS-NB-1 to notify the county DHS office of the child's birth.
(4) ~~Obstetrical care should be billed using the appropriate evaluation and management codes for antepartum care, as well as the appropriate delivery only and postpartum care services when rendered.~~ Obstetrical care should be billed using the appropriate CPT codes for Maternity Care and Delivery. The date of delivery should be used as the date of service for charges for total obstetrical care. Inclusive dates of care should be indicated on the claim form as part of the description. The date the patient was first seen must be on the claim form. Payment for total obstetrical care includes all routine care performed by the attending provider. For payment of total OB care, the provider must have provided care for more than one trimester. To bill for prenatal care only, the claim is filed after the member leaves the provider's care. Payment for routine or minor medical problems will not be made separately to the OB provider outside of antepartum visits. The antepartum care during the prenatal care period includes all care by the OB provider except major illness distinctly unrelated to the pregnancy.

PART 35. RURAL HEALTH CLINICS

317:30-5-356. Coverage for adults

Payment is made to rural health clinics for adult services as set forth in this Section.

(1) **RHC services.** Payment is made for one encounter per member per

day. Payment is also limited to four visits per member per month. Refer to OAC 317:30-1, General Provisions, and OAC 317:30-3-65.2 for exceptions to the four visit limit for children under the Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT). Additional preventive service exceptions include:

(A) **Obstetrical care.** A Rural Health Clinic should have a written contract with its physician, nurse midwife, advanced practice nurse, or physician assistant that specifically identifies how obstetrical care will be billed to SoonerCare, in order to avoid duplicative billing situations. The agreement should also specifically identify the physician's compensation for rural health and non-rural health clinic (other ambulatory) services.

(i) If the clinic compensates the physician, nurse midwife or advanced practice nurse to provide obstetrical care, then the clinic must bill the SoonerCare program for each prenatal visit using the appropriate CPT evaluation and management codes.

(ii) ~~If the clinic does not compensate its practitioners to provide obstetrical care, then the independent practitioner must bill the SoonerCare program for each prenatal visit using the appropriate CPT code described in the SoonerCare provider specific rules for physicians, certified nurse midwives, physician assistants, and advanced practice nurses (refer to OAC 317:30-5-22).~~ If the clinic does not compensate its practitioners to provide obstetrical care, then the independent practitioner must bill the OHCA for prenatal care according to the global method described in the SoonerCare provider specific rules for physicians, certified nurse midwives, physician assistants, and advanced practice nurses (refer to OAC 317:30-5-22).

(iii) Under both billing methods, payment for prenatal care includes all routine or minor medical problems. No additional payment is made to the prenatal provider except in the case of a major illness distinctly unrelated to pregnancy.

(B) **Family planning services.** Family planning services are available only to members with reproductive capability. Family planning visits do not count as one of the four RHC visits per month.

(2) **Other ambulatory services.** Services defined as "other ambulatory" services are not considered a part of a RHC visit and are therefore billable to the SoonerCare program by the RHC or provider of service on the appropriate claim forms. Other ambulatory services are subject to the same scope of coverage as other SoonerCare services billed to the program, i.e., limited adult services and some services for under 21 subject to same prior authorization process. Refer to OAC 317:30-1, General Provisions, and OAC 317:30-3-57, 317:30-5-59, and 317:30-3-60 for

general coverage and exclusions under the SoonerCare program. Some specific limitations are applicable to other ambulatory services as set forth in specific provider rules and excerpted as follows: Coverage under optometrists for adults is limited to treatment of eye disease not related to refractive errors. There is no coverage for eye exams for the purpose of prescribing eyeglasses, contact lenses or other visual aids. (See OAC 317:30-5-431.)

PART 75. FEDERALLY QUALIFIED HEALTH CENTERS

317:30-5-664.8. Obstetrical care provided by Health Centers

(a) **Billing written agreement.** In order to avoid duplicative billing situations, a Health Center must have a written agreement with its physician, certified nurse midwife, advanced practice nurse, or physician assistant that specifically identifies how obstetrical care will be billed. The agreement must specifically identify the service provider's compensation for Health Center core services and other health services that may be provided by the Center.

(b) **Prenatal or postpartum services.**

(1) If the Health Center compensates the physician, certified nurse midwife or advanced practice nurse for the provision of obstetrical care, then the Health Center bills the OHCA for each prenatal and postpartum visit separately using the appropriate CPT evaluation and management code(s) as provided in the Health Center billing manual.

(2) ~~If the clinic does not compensate its practitioners to provide obstetrical care, then the independent practitioner must bill the SoonerCare program for each prenatal visit using the appropriate CPT code described in the SoonerCare provider specific rules for physicians, certified nurse midwives, physician assistants, and advanced practice nurses (refer to OAC 317:30-5-22).~~If the clinic does not compensate the provider for the provision of obstetrical care, then the provider must bill the OHCA for prenatal care according to the global method described in the SoonerCare Traditional provider specific rules for physicians, certified nurse midwives, physician assistants, and advanced practice nurses (refer to OAC 317:30-5-22).

(3) Under both billing methods, payment for prenatal care includes all routine or minor medical problems. No additional payment is made to the prenatal provider except in the case of a major illness distinctly unrelated to pregnancy.

(c) **Delivery services**. Delivery services are billed using the appropriate CPT codes for delivery. If the clinic does not compensate the provider for the provision of obstetrical care, then the provider must be individually enrolled and bill for those services using his or her assigned provider number. The costs associated with the delivery must be excluded from the cost settlement/encounter rate setting process (see OAC 317:300-5-664.11).

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

SUBCHAPTER 5. ELIGIBILITY AND COUNTABLE INCOME

PART 1. DETERMINATION OF QUALIFYING CATEGORICAL RELATIONSHIPS

317:35-5-2. Categorically related programs
(a) In order to be eligible for SoonerCare, an individual must first meet the description of a member eligibility group. For individuals related to the aged, blind, or disabled groups, categorical relationship is established using the same definitions of age, disability and blindness as used by the Social Security Administration (SSA) in determining eligibility for Supplemental Security Income (SSI) or SSA benefits. If the individual is a SSA/SSI recipient in current payment status (including presumptive eligibility), a TANF recipient, an adoption assistance or kinship guardianship assistance recipient, or is under age 19, categorical relationship is automatically established. Categorical relationship to the pregnancy group is established when the determination is made by medical evidence that the individual is or has been pregnant. Effective January 1, 2014, verification of pregnancy is only required if the individual's declaration that she is pregnant is not reasonably compatible with other information available to the agency. Pregnancy-related services include all medical services provided within the scope of the program during the prenatal, delivery and postpartum periods for women in this pregnancy group; see Subchapter 22 of this Chapter for services for unborn children covered under Title XXI. For an individual age 19 or over to be related to the parent and caretaker relative group, the individual must have a minor dependent child. For an individual to be related to the former foster care children group, the individual must not be eligible for the Title XIX pregnancy or parent or caretaker relative groups, must be aged 19-26, and must have been receiving SoonerCare as a foster care child when he/she aged out of foster care in Oklahoma. There is no income or resource test for the former foster care children group. Categorical relationship to Refugee services is established in accordance with OAC 317:35-5-25. Categorical relationship for the Breast and Cervical Cancer Treatment program is established in accordance with OAC 317:35-21. Categorical relationship for the SoonerPlan Family Planning Program is established in accordance with OAC 317:35-5-8. Categorical relationship for pregnancy related benefits covered under Title XXI is established in accordance with OAC 317:35-22. ~~Benefits for pregnancies covered under Title XXI medical services are provided within the limited scope of this particular program for antenatal care and delivery only. Each service must be billed using the appropriate CPT codes. To be eligible for SoonerCare benefits, an individual must be related to one of the~~

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

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

(b) The Authority may provide SoonerCare to reasonable categories of individuals under age 21.
(1) Individuals eligible for SoonerCare benefits include individuals between the ages of 19 and 21:
(A) for whom a public agency is assuming full or partial financial responsibility who are in custody as reported by the Oklahoma Department of Human Services (OKDHS) and in foster homes, private institutions or public facilities; or
(B) in adoptions subsidized in full or in part by a public agency; or
(C) individuals under age 21 receiving active treatment as inpatients in public psychiatric facilities or programs if inpatient psychiatric services for individuals under age 21 are provided under the State Plan and the individuals are supported in full or in part by a public agency; or
(2) Individuals eligible for SoonerCare benefits include individuals between the ages of 18 and 21 if they are in custody as reported by OKDHS on their 18th birthday and living in an out of home placement.

SUBCHAPTER 22. PREGNANCY RELATED BENEFITS COVERED UNDER TITLE XXI

317:35-22-2. Scope of coverage for Title XXI Pregnancy

(a) ~~Pregnancy related services provided are for antepartum and delivery only.~~Pregnancy related services provided are prenatal, delivery, postnatal care when included in the global delivery fee, and other related services that are medically necessary to optimize pregnancy outcomes within the defined program benefits.

(b) ~~Only two additional visits per month to other medical consultants, such as a dietitian or licensed genetic counselor for~~

~~related services to evaluate and/or treat conditions that may adversely impact the fetus are covered.~~Only two visits per month for other related services to evaluate and/or treat conditions that may adversely impact the pregnancy are covered.