AGENDA

January 19, 2016
1:30 p.m. – 3:30pm

Charles Ed McFall Board Room

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

II. Action Item: Approval of Minutes of the November 17, 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: **Melissa McCully, Insure Oklahoma Administrator**

  - **A.** Opioid Use Update: **Mike Herndon, DO, Chief Medical Officer**
  - **B.** Action Item Follow-up: **Mike Herndon, DO Chief Medical Officer**

VII. Legislative Update: **Emily Shipley, Director of Governmental Affairs**

VIII. Oklahoma's 2016 Top Forty Under Forty: **Tywanda Cox, Health Policy Director**

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

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

  - **A.** APA WF #16-11 School Based Language Cleanup Only
  - **B.** APA WF #16-14 Inpatient Behavioral Health Policy Revisions
  - **C.** APA WF #16-21 SPARC Membership Increase and Allowance for Alternate
  - **D.** APA WF #16-22 Purchasing Language Cleanup
  - **E.** APA WF #16-23 I/T/U and FQHC Cleanup
  - **F.** APA WF #16-26 Molecular Pathology Reimbursement Changes
  - **G.** APA WF #16-27 Home Health Face to Face Requirement

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

XII. Future Meetings

March 9, 2017
May 18, 2017
July 20, 2017
September 21, 2017
November 16, 2017

XIII. Adjourn

Agenda

MAC Minutes for November 17, 2016

Welcome and Roll Call

Chairman Crawford called the meeting to order at 1:00 PM. ***Delegates present were*:** Ms. Renee Banks, Ms. Debra Billingsley, Ms. Mark Brinkley, Dr. Steve Crawford, Ms. Wanda Felty, Ms. Terrie Fritz, Mr. Steven Goforth, Mr. Mark Jones, Dr. Ashley Orynich, Ms. Annette Mays, Mr. Victor Clay, Mr. James Patterson, Dr. J. Daniel Post, Ms. Toni Pratt-Reid, Dr. Edd Rhoades, Dr. Jason Rhynes, Mr. Rick Snyder, Mr. Jeff Tallent, Dr. Gail Poyner and Dr. Paul Wright.

Alternates present were: Ms. Sarah Baker, Ms. Leslie Petty, Mr. Brett Cobul, Mr. Traylor Rains-Sims, and providing a quorum.

***Delegates absent without an alternate were*:** Dr. David Cavallaro, Ms. Melissa Gastorf, Dr. Stanley Grogg, and Dr. Kanwal Obhrai

Public Comments

There were no public comments made at this meeting.

Approval of September 15, 2016 Minutes

Chairman Crawford did a call to vote to approve the meeting minutes for September 15, 2016.
It was accepted by Mr. Traylor Rains-Sims and Ms. Toni Pratt-Reid gave the second for the motion. All members voted to approve the minutes.

MAC Member Comments

Dr. Crawford asked if any member of the MAC had any comments. Mr. Brett Cobul introduced himself as a Nursing Facility Operator from southern Oklahoma. He stated he is on the Board for the Oklahoma Association of Healthcare Providers. Mr. Cobul stated he is a part of the Supplemental Payment Workgroup in conjunction with the Health Care Authority. He stated they have been working for some time to develop this program and requested the support of the committee members. Mr. Cobul noted that this is a viable program for sustaining current services and enhancing the services we provide to the elderly and frail Medicaid members of Oklahoma 24 hours a day 7 days a week 365 days a year. The costs are continuing to rise and reimbursement rates are going down. This program is real opportunity to enhance the services we bring through the supplemental pay program. Dr. Crawford expressed his thanks for Mr. Cobul's comments.

Financial Update

Gloria Hudson, Director of General Accounting, reported on the state's Fiscal Year 2017 financial transactions through the month of August. She reported that the state budget variance is a positive $1.5 million dollars. On the expenditure side, we are under budget with the Medicaid Program by 0.9% for $1.9 million state dollars and in administration by 3.9% for $0.4 million state dollars. On the revenue side, we were over budget on Drug Rebates and Collections by 12.7% for $0.7 million state dollars and under budget in Settlements and Overpayments by 29.2% for negative $0.6 million state dollars and in Tobacco Tax Collections and Fees by 9.4% for negative $0.9 million state dollars. With preliminary data in through the month of October it looks like our

agency will continue to remain slightly under budget. Ms. Hudson asked for questions, but there were no questions.

Fiscal Year 2018 Budget Appropriations

Vickie Kersey, Director of Fiscal Planning and Procurement came forward to give an update on the Fiscal 2018 Budget Appropriations. She stated this was submitted as required by law by October 1. The requested funds are in addition to state funds for the base budget of $91 million state dollars and we will begin utilizing these funds on July 1, 2017. The top four items listed on the table Ms. Kersey provided are what we need to maintain the program at the current level. She noted that these items total $111,000 million dollars in state funds. Priority one annualization is representing our largest need. This is created by unfortunately another drop in our FMAP. MS. Kersey stated the FMAP for Oklahoma is dropping from 59.94% to 58.57 %., which is the lowest FMAP we have had since the 1980's and the lowest FMAP the Health Care Authority has seen since it has been an agency. Another component is the Medicare payee premiums plus the deductibles that we pay for our dual populations and the Health Care Authority estimates that will cost an additional $1 million state dollars. Ms. Kersey stated that once again we are facing the uncertainty for the continued funding of the Children's Health Insurance Program (CHIP). We currently receive an enhanced match rate of 94.96%. The current funding by Congress is authorized through September 30 of 2017. Ms. Kersey stated if they do not authorize more funding it will require an additional in $50 million in state funds. Under maintenance of effort we are required to continue coverage of that population, but will receive the regular FMAP rate. Ms. Kersey stated If Congress reauthorizes funding for CHIP we can remove that from our budget request and lower our overall request for state funds. We faced this same situation in 2015 and will be something we continue to monitor. Under priority two, maintenance we are projecting a very conservative 1.6 % growth in utilization increase that requires an additional $17 million in state dollars. Medicare A and B premiums for the last six months of fiscal year '18 is $1 million and our Medicare part B fall backs are $7 million. Due to reductions in our admin budget the last three years we are no longer able to absorb inflationary increases professional service contracts so we are requesting an additional $406,000 state dollars for that. Ms. Kersey stated we are also requesting $312,000 for 11 more FTE to continue ensuring quality performance in reporting and auditing. Priority three is for a Security Governments Director and 4 FTE for our provider enrollment unit. This will allow us to comply with new federal mandates and we are requesting $133,000 for that item. Priority four is a replacement of carry over funds used to fund the current year's budget. With the $23.5 million that we receive from the state when they reconciled the at the FY 2016 general revenue fund we received those funds in September and then we are not having to budget for an extra claims payment cycle in Fiscal Year 2018. That results in a negative amount and lowers the overall state funds that we are requesting. Priority number five is a request for funds to implement care coordination for the ABD population for House Bill 1566. We are continuing to develop our RFP for that project. The $53 million in state funds requested includes $46 million for claims, $1.4 million for independent behavioral health assessments, $2 million for modifications to MMIS, $5,000 for
Software licenses, $3 million for professional service contracts and $671, 000 for new FTE to implement the program. The $2 million requested in state funds in priority number six will allow us to remove insulin, immunosuppressants and Hepatitis C meds from the monthly prescription limits. Priority number seven is a request for $138 million state dollars so we can restore provider rates back to the 2009 level. Overall, our budget request for state dollars involves lots of moving pieces that we will continue to monitor. Ms. Kersey noted the document she provided will change may times between now and when the agency actually beings to receive funds. She then asked for questions, but there were none at this juncture.

SoonerCare Operations Update

Marlene Asmussen, Director of Population Care Management, presented the SoonerCare Operations Update to the committee. She presented information based on data for August of 2016. Patient Centered Medical Home enrollment is at 538,128 which is an increase from the previous month of 6,225. Sooner Care Traditional has a current enrollment of 229,876 which is 1,921 more than the previous month. Insure Oklahoma has a total enrollment of 19,102 of which 4,486 are in the Individual Plan and 14,616 are in the Employee Sponsored Plan which is an increase of 219 from the previous month. In total SoonerCare enrollment is at 821,057 for August which is an increase of 9,787. Ms. Asmussen stated that the two tables of in state providers show 33,803 contracted providers for August which is an increase of 585 additional providers. Our Medical Home Program SoonerCare Choice currently has 2,630 primary care providers serving in that network. Ms. Asmussen stated the per member per month cost of SoonerCare Traditional is $1,408 which is an increase from the month before. The per member per month cost for SoonerCare PCMH is $1,094 also a slight increase. SoonerCare Traditional is at $394 remaining fairly flat from July. The SoonerCare Choice PCMH Low Cost is at $259 which is also slightly higher from the previous month. Ms. Asmussen noted that the per member per month cost for the IO IP Plan is $506 and the ESI is $306 which reflects an increase for both from the previous month. Ms. Asmussen stated that SoonerPlan is fairly flat at $10. There were no questions at this juncture. Ms. Asmussen then introduced Rebekah Gossett who was recently recognized by two separate organizations for her accomplishments and contributions to the field of nursing. Ms. Asmussen noted the Ms. Gossett has been selected as one of the Great 100 Nurses for 2016 and a March of Dimes nurse for 2016. Ms. Gossett is supervisor in the Population Care Management unit as well as the Project Lead for the Infant Mortality Reduction Project and has been with the Health Care Authority since 2008. She has been a nurse for 14 years working both stateside and abroad. Ms. Asmussen then brought for Della Gregg who is the manager over the Health Management Program to give an update on the independent evaluation recently done over this unit. Ms. Gregg stated the Population Care Management Department is comprised of three units under one umbrella. The Case Management unit primarily focuses on episodic and acute types of cases, such as OB or pediatric. The Health Management Program and Chronic Care Unit are focused on the chronic conditions our members face. The Health Management Program was produced due to the 2006 Medicaid Reform Act House Bill 2842 that outlined the development of a disease management program to help the chronically ill. The bill was intended to improve their quality of care and address the costs of caring for those members. In 2008, the Health Management Program was launched to meet those goals. Health coaches who are Registered Nurses serve those SoonerCare Choice members who are diagnosed or at risk for chronic conditions. In 2013, the program transitioned to imbedding to Health Coaches into the Patient Centered Medical Homes with high numbers of those with chronic illnesses. Practice Facilitators are also on hand to provide education for providers on how to deal with these members. Ms. Gregg noted that The Health Care authority utilizes an outside vendor by the name of Telligen for these positions. The Chronic Care unit is made of 6 FTE to case management through telephonic means internally. The members they serve are those not aligned with Patient Centered Medical Home with a Health Coach. The specialty groups they serve include members with Hemophilia, Sickle Cell, Hepatitis C that need additional assistance and bariatric surgery candidates. These members are not limited to SoonerCare Choice members. The objectives of HMP and Chronic care are to address both the physical and behavioral needs of our chronically ill members to improve member self-management skills. Ms. Gregg noted that all of our staff is trained in motivational interviewing. One goal under this is to reduce the amount of inpatient ER utilization and the costs associated with this. On the HMP side the goal is to help improve care and efficiency for the provider under practice facilitation to improve health outcomes. Ms. Gregg stated the recent study of HMP done by The Pacific Health Policy Group focuses on four categories to include satisfaction, quality of care, utilization and cost effectiveness. The latest report we have is through state fiscal year is through 2015. Under all categories for satisfaction the scores range from high to mid-90's. Dr. Crawford then asked how this compares to previous years. She stated it is about the same in this area.

She stated the scores under quality of care participants exceeded comparison the comparison group on 17 disease specific HEDIS measures. Under ER utilization those who were Health Coaching participants decreased by 23%, Those members in a Patient Centered Medical Home with a Practice Facilitator decreased by 8% and Chronic Care members by 21%. Under Inpatient utilization those who were Health Coaching participants decreased by 44%. Rates for members in a Patient Centered Medical Home with a Practice Facilitator decreased by 29% and chronic members by 48%. The Health Management Program net savings is nearly $42 million. This accounts for medical savings related to the members and care, as well as, the administration costs to run the program. The Chronic Care unit net savings is over $2.6 million taking in to account the medical savings plus administration costs in just two years since the program started. Ms. Gregg noted the full reports are available online for review. Dr. Crawford noted that the numbers reflect practice facilitation is an important component and his patients have greatly benefited from this. Dr. Crawford noted the value of expanding this program to include even more practices to improve the health of our state. Ms. Gregg noted that the HEDIS criteria was determined by PHPG and must be claims based and not necessarily controlled factors. There were no more questions or comments regarding this topic.

Proposed Rule Changes

Dr. Crawford invited Demetria Bennett, Policy Development Coordinator to discuss three proposed rule changes. Demetria noted that all three rules were presented at various Tribal Consultations and they are listed in the agenda. Ms. Bennett stated that rule 16-13 is regarding Pharmacy reimbursement changes. CMS published a new regulation for pharmacy pricing and to comply with this regulation the Health Care Authority is proposing this rule to amend the pricing structure for ITU and non ITU pharmacies. The revisions simply align payments for covered outpatient drugs with actual acquisition costs. They also create new pricing terms for specialty pharmaceutical products. In addition, revisions modify the current dispensing fee to a professional dispensing fee which is as added to the pharmacy claim paid at non ITU pharmacies. The revisions also modify the payment structure for ITU pharmacies and these pharmacies will be reimbursed at the federal OMB counter rate. They will receive one rate per member per facility per day regardless of the number of prescriptions dispensed to the member on that day. The policy is also revised for cleanup and we are removing outdated reference from policy. The proposed revisions are expected to remain budget neutral if not provide a small savings. This rule will be posted for public comment through December 7th and will then presented to the Board on December 8th. Ms. Bennett then asked for comments or questions. Ms. Debar Billingsley, with the Oklahoma Pharmacists Association, stated that they did their own analytics there will actually be a loss of .56 per claim and that is causing concern. They believe the study used outdated pricing and would request another study be done. This specific rule has a provision that allows for pharmacy challenges and two wholesalers. The request is that this be changed to one wholesaler because many pharmacists do not have two wholesalers making this impossible. Ms. Billingsley also noted that another cause for concern is that specialty drugs would have $1,000 threshold and that may result in maintenance drugs being put on a specialty drug list. Jill Ratterman, Health Care Authority Clinical Pharmacists, then came forward to address the concerns. She stated this is a CMS rule that came out and we have to implement by April 1 and are looking implement it by January 1 to allow time to have everything done by the deadline. The cost neutral dispensing fee survey was from 2013 data, but was trended to reflect 2016 values. Ms. Ratterman stated they are looking at doing new survey in 2017, but in order to be in compliance with CMS the data provided is what must be used. In regards, to changing the language to one wholesaler instead she stated we are happy to make this change, but the language is not new and has been in our rules for some time. She stated this change would be done by the time the rule is presented to the Board. She stated the legal department would look into whether this would violate the MAC pricing. Ms. Ratterman addressed the list of medications regarding the $1,000 limit and stated this will be discussed internally. She

stated the Health Care Authority is not trying to be unfair in their pricing, but are trying to be CMS compliant. The goal is to get members to stay in the state and use Oklahoma pharmacies. Dr. Crawford did a call to vote for this rule with modifications. Mr. Traylor Rains-Sims accepted the motion and Ms. Toni Pratt-Reid gave the second. All members were in favor of the rule change with amendments regarding the language being changed from two wholesalers to one. Ms. Bennett then introduced rule 16-16 parts A & B. The proposed policy adds a supplemental payment program for nursing facilities owned and as applicable operated by non-state government owned (NSGO) entities. The policy adds requirements and criteria for supplemental payments to be made to participating NSGOs up to the allowable Medicare upper payment limit (UPL). In addition, proposed revisions define terms related to the program and set forth criteria and eligibility requirements. Rules are also added to outline cost reporting, change in ownership, disbursement of payment, and appeal requirements.
There is no cost to the OHCA as the state share will be financed by the NSGO and will be transferred to the state by way of an intergovernmental transfer for claiming of federal financial participation. These proposed revisions will be posted on our public website through December 7th and will be presented to the December 8th Board. Ms. Bennett then asked for questions. Mr. Rick Snyder, with the Oklahoma Hospital Association, expressed their appreciation for all the work on this rule by the various departments within OHCA. The recommendations would be that the provisions regarding re-entry after suspension and sole discretion of the Health Care Authority be more spelled out in the language. In paragraph J, the language states participant fields and would like this to be changed to participants and applicants fields. Ms. Terrie Fritz, with the National Association of Social Workers, asked if this had been used in other states. Ms. Bennett answered that yes it has. Mr. Brett Cobul stated Indiana has been using this for the last 15 years, as well as, Texas using a similar program. Ms. Annette Mays, with the Home Care and Hospice Association then asked how this works with Nursing Homes. She stated it sounds like it would help facilities in rural areas. Mr. Snyder stated the local governments in the area of these public hospitals are able to put up the state share for additional supplemental Medicaid payments up to the rate that Medicare would have paid for those same services. Mr. Snyder noted that there are many rural Hospitals that operate long term care units. These hospitals come to an agreement with the nursing home for a sort of lease provision for the nursing home. The hospital under this is responsible for the nursing home and there would be care criteria for the program. At least two of these would have to be met to get the full payment and the state would have oversight on this. Tywanda Cox, Chief of Federal and state Policy, came forward to reiterate that we work extensively with workgroups both internal, as well as, external and have been working on this for many years. CMS has been cooperative and the program is linked to criteria and measures must be met. Chairman Crawford then did a call to vote for this rule. Mr. Rick Snyder accepted the motion with Ms. Toni Pratt-Reid giving the second. All were in favor with no dissent. The next rule 16-18 is regarding Telemedicine Consent. The proposed revisions amend language in Chapter 30 to reflect the repeal of 36 O.S. Section 6804, of The Oklahoma Telemedicine Act, which eliminates the informed consent requirement from Oklahoma Statutes.
The budget impact is expected to remain neutral. The Health Care Authority is hoping this change will reduce an administration burden on our providers. Ms. Bennett stated this rule will be posted for public comment through December 1st and will be voted on by the Board on December 8th. Dr. Crawford then did a call to vote for this rule. Dr. Paul Wright accepted the motion and Mr. Traylor Rains-Sims gave the second. There was no dissent regarding this rule. Ms. Bennett stated we are approaching are permanent rule making session. The first round of rules will be posted for public comment December 16 through January 15. Those rules will then be heard at a public hearing to be held on January 17 and then we plan to present those revisions this committee on January 19. Ms. Bennett stated the agency will not have an effective date until September of 2017 for both first and permanent rule making cycles. The second set of rules will be posted for public comments January 18 through February 17. They are set to be presented at a public hearing to be held on February 21 and presented to this committee in March. There were no other comments.

New Business / Election of Officers

Dr. Steven Crawford made a motion for the election of officers for 2017. Dr. Crawford stated he was being nominated for Chair with Mr. Steve Goforth being named as Co-chair. Dr. Crawford asked if there were any other nominations to be considered. There were no other nominations. Dr. Crawford then made a motion to name himself as the Chair and Mr. Goforth the Co-chair. Dr. Paul Wright accepted the motion and Mr. Traylor Rains-Sims gave the second. There were no members opposed. Dr. Paul Wright, with the Oklahoma State Medical Association, then addressed the topic of managed care for our SoonerCare diabetic population as it relates to retinal optic screening. He noted early detection and treatment of retinopathy can help prevent blindness. He stated the between 40% and 45% have some form of this condition and only half of those are aware. The Oklahoma screening rates for this are fairly dismal. Dr. Wright stated two issues are that patients are often A-symptomatic and of little means. Dr. Wright noted that Technology advances allow in office screening and better results. Dr. Wright found that Medicaid does not currently reimburse for this in examining codes related to this. He believes OHCA should review the policy regarding this issue. He made a motion for OHCA to formally investigate this issue and Ms. Toni Pratt-Reid accepted the motion. Dr. Jason Rhynes, Optometrist, stated there is no screening code. Code 922.50 in its current standing will not get you to where you need to be in terms of your HEDIS criteria. Dr. Crawford stated this is something the agency should look into. Chairman Crawford then posed the question as to whether this would improve diabetic screening compliance rates therefore diminish episodes of blindness in diabetic patients. Dr. Mike Herndon, Chief Medical Officer for the Oklahoma Health Care Authority, then came on the phone to state we do want out diabetic members to get the care that is standard. The agency is open to explore this further and see what the appropriate codes are to be used. He noted based on research private payers are mixed on this issue, but the agency is open to further review retinal screening for diabetic members. Dr. Rhynes then stated that three challenges of this are the HEDIS criteria, screening verbalization and eye codes are currently bundled. There were no other comments.

Future Meetings

Dr. Crawford stated the next meeting will be held on January 19, 2017. The new dates for 2017 will be sent out to the delegates as soon as possible.

Adjournment

Dr. Crawford asked for a motion to adjourn. It was provided by Mr. Traylor Rains-sims and seconded by Ms. Terrie Fritz. There was no dissent and the meeting was adjourned.

Agenda

FINANCIAL REPORT

For the Five Months Ended November 30, 2016
Submitted to the CEO & Board

- Revenues for OHCA through November, accounting for receivables, were **$1,654,625,831** or **.9% under** budget.
- Expenditures for OHCA, accounting for encumbrances, were **$1,695,195,449 or 1.1% under** budget.
- The state dollar budget variance through November is a **positive $3,563,335.**
- The budget variance is primarily attributable to the following (in millions):

Expenditures:		
Medicaid Program Variance		5.0
Administration		1.3
Revenues:		
Drug Rebate		.6
Taxes and Fees		(.9)
Overpayments/Settlements		(2.4)
Total FY 17 Variance	**$**	**3.6**

ATTACHMENTS

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

OKLAHOMA HEALTH CARE AUTHORITY
SUMMARY OF REVENUES & EXPENDITURES:
Fund 250: Belle Maxine Hilliard Breast and Cervical Cancer Treatment Revolving Fund
SFY 2017, For the Five Month Period Ending November 30, 2016

REVENUES	FY 17 Revenue	State Share
Tobacco Tax Collections	$ 336,352	$ 336,352
TOTAL REVENUES	**$ 336,352**	**$ 336,352**

EXPENDITURES	FY 17 Total $ YTD	FY 17 State $ YTD	Total State $ Cost
Program Costs			
SoonerCare Choice	$ 4,661	$ 214	
Inpatient Hospital	781,193	35,935	
Outpatient Hospital	1,611,071	74,109	
Inpatient Services-DRG	-	-	
Psychiatrist	-	-	
TFC-OHCA	-	-	
Nursing Facility	-	-	
Physicians	1,760,404	80,979	
Dentists	4,158	191	
Mid-level Practitioner	989	45	
Other Practitioners	34,709	1,597	
Home Health	3,508	161	
Lab & Radiology	99,511	4,578	
Medical Supplies	12,749	586	
Clinic Services	70,107	3,225	
Ambulatory Surgery Center	4,619	212	
Prescription Drugs	1,062,991	48,898	
Transportation	16,053	738	
Miscellaneous Medical	2,296	106	
Total OHCA Program Costs	**$ 5,469,020**	**$ 251,575**	
OSA DMHSAS Rehab	$ 28,029	$ 1,289	
Total Medicaid Program Costs	**$ 5,497,049**	**$ 252,864**	
TOTAL STATE SHARE OF COSTS			**$ 252,864**

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

Agenda

SoonerCare Operations Update

(November 2016 Data)

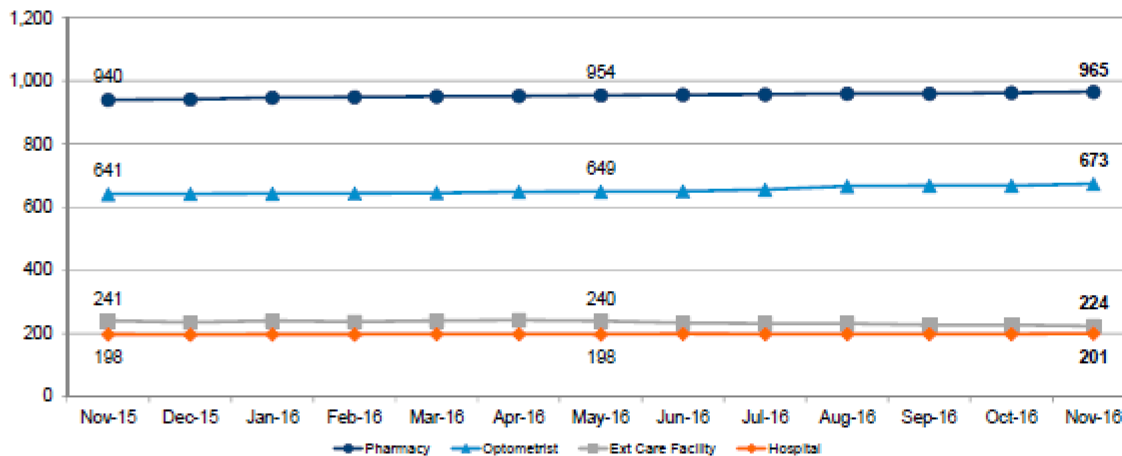
SOONERCARE ENROLLMENT/EXPENDITURES

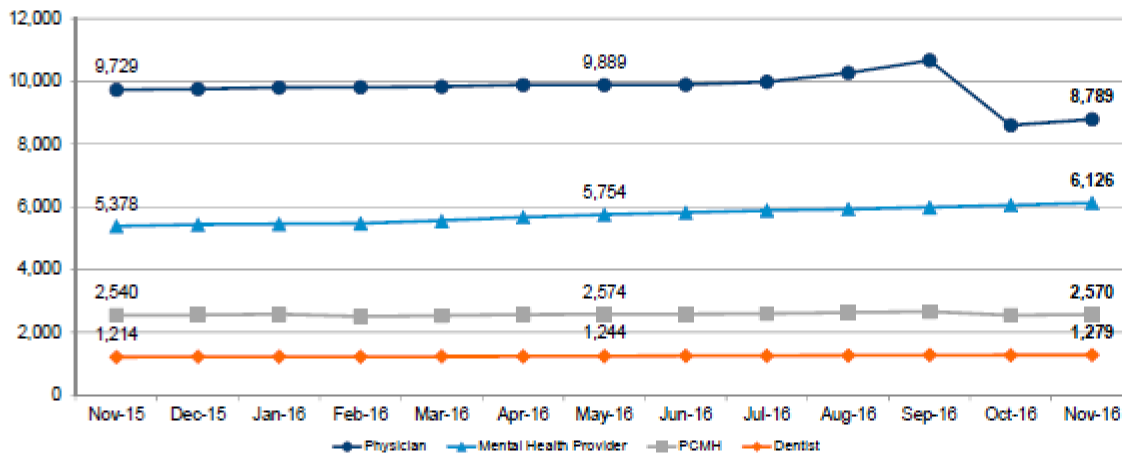
Delivery System	Enrollment November 2016	Children November 2016	Adults November 2016	Enrollment Change	Total Expenditures November	PMPM November 2016	Forecasted Nov 2016 Trend PMPM
SoonerCare Choice Patient-Centered Medical Home	**549,196**	**453,411**	**95,785**	**3,647**	**$176,618,681**		
Lower Cost (Children/Parents; Other)	505,884	439,763	66,121	3,668	$129,417,546	$256	$233
Higher Cost (Aged, Blind or Disabled; TEFRA; BCC)	43,312	13,648	29,664	-21	$47,201,136	$1,090	$1,198
SoonerCare Traditional	**232,631**	**87,303**	**145,328**	**2,574**	**$207,788,939**		
Lower Cost (Children/Parents; Other)	119,800	82,205	37,595	2,547	$52,110,508	$435	$373
Higher Cost (Aged, Blind or Disabled; TEFRA; BCC & HCBS Waiver)	112,831	5,098	107,733	27	$155,678,431	$1,380	$1,192
SoonerPlan	**34,768**	**2,778**	**31,990**	**1,137**	**$261,608**	$8	$8
Insure Oklahoma	**19,891**	**557**	**19,334**	**364**	**$7,231,637**		
Employer-Sponsored Insurance	15,172	361	14,811	323	$4,891,415	$322	$333
Individual Plan	4,719	196	4,523	41	$2,340,222	$496	$416
TOTAL	**836,486**	**544,049**	**292,437**	**7,722**	**$391,900,866**		

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.

IN-STATE CONTRACTED PROVIDERS

Total In-State Providers: 32,868 (+264) (In-State Providers counted multiple times due to multiple locations, programs, types, and specialties)





*Decrease in Physician count is due to contract renewal. Decrease during contract renewal period is typical during all renewal periods.

Data Set 2 of 4, 12/23/2016

Agenda

PAIN MANAGEMENT AND OPIOID USE UPDATE

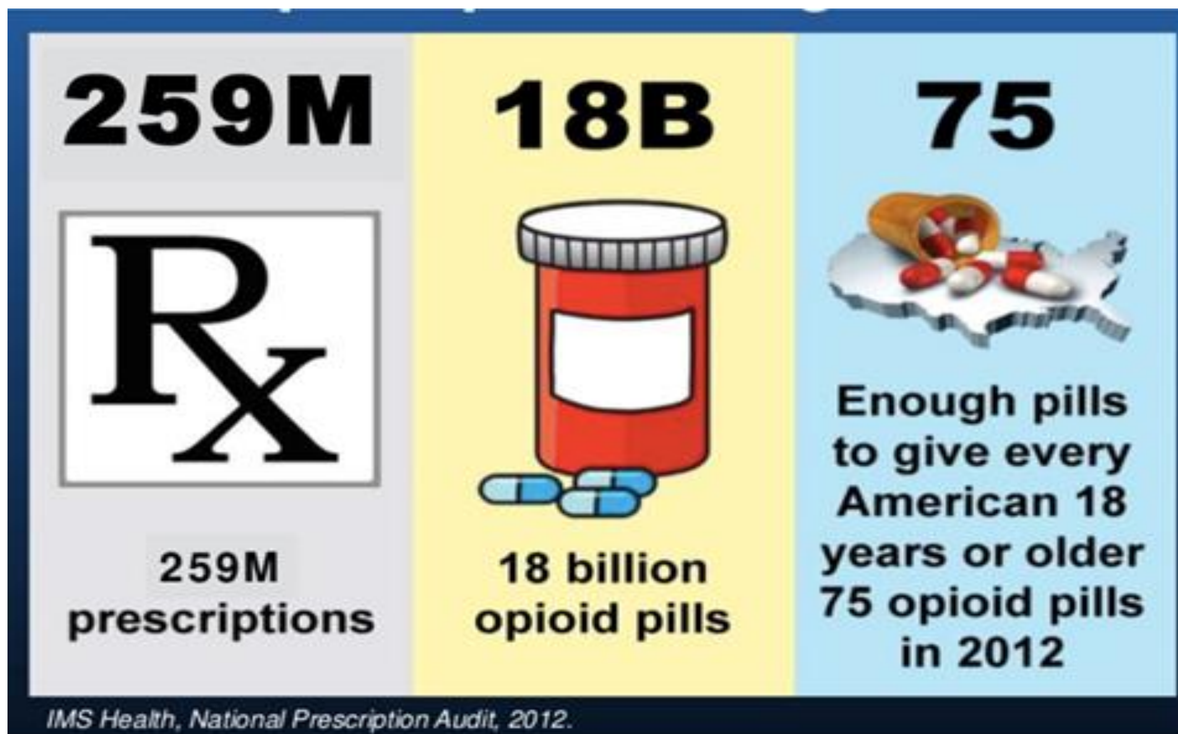
Oklahoma HealthCare Authority 1

ABUSE AND DIVERSION – BY THE NUMBERS

- Prescription drug abuse is a national epidemic
- From 2000 to 2014, nearly half a million people died from drug overdoses
- 78 people die every day in the U.S. from opioid-related overdose.*
- 28,647 opioid and heroin deaths 2014*

*Overdose deaths in the United States hit record numbers in 2014 available at: www.cdc.gov/drugoverdose/epidemic/public.html. Accessed May 3, 2016.
Fact sheet available at: https://www.hhs.gov/sites/default/files/Factsheet-opioids-061516.pdf. Accessed August 10, 2016.

Oklahoma HealthCare Authority 2



PRESCRIPTION DRUG OVERDOSE IN OKLAHOMA

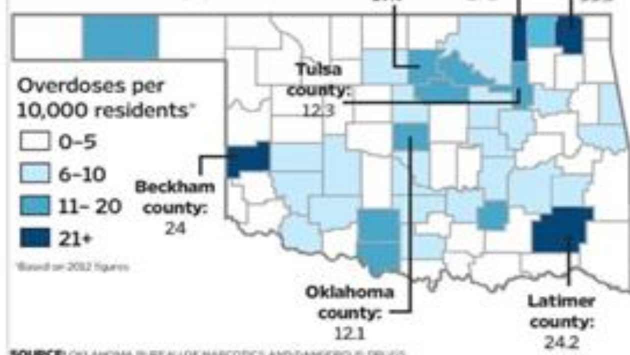
- 15.8 per 100,000 people unintentional poisoning deaths
- 5th leading cause of death in Oklahoma – unintentional injury
  - 2014 State of the State's Health
- 6th highest drug overdose in U.S.

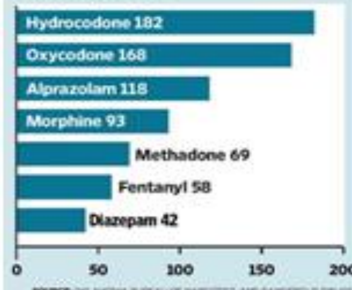
Sources: https://www.ok.gov/health/pub/boh/state/SOSH%202014.pdf
http://www.cdc.gov/vitalsigns/pdf/2014-07-vitalsigns.pdf. Accessed September 2, 2016.

Oklahoma HealthCare Authority 4

"PROFITING FROM PAIN"

From The Oklahoman, Dec. 7, 2014





Source: http://oklahomawatch.org/series/addicted-oklahoma/ and http://oklahomawatch.org/2014/12/07/overdoses-in-oklahoma/. Accessed September 2, 2016.

PAIN MANAGEMENT AND OPIOID USE INITIATIVES

Pain Management Program

- Toolkit
- Practice Facilitation
- Substance Use Disorder Treatment coverage
- Referral Assistance for SUD treatment

State Plan Workgroup Involvement

- Provider Education
- Prescriber Guidelines

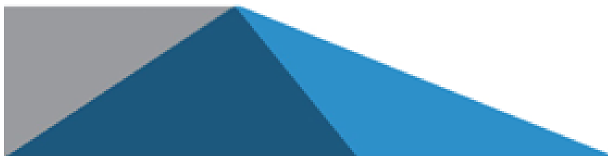
OHCA Pharmacy Activities

- Quantity Limits
- Naloxone
- Lock-in - Patient Restriction Program

6

OHCA INITIATIVES

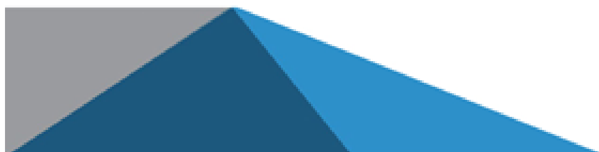
- Management Program Update
- Substance Use Disorder Treatment Coverage
- State Plan Workgroup Involvement
- Collaboration with other state agencies
  - State Plan - Reducing Rx Drug Abuse
    Updated Oklahoma Prescribing Guidelines
  - Increase access to naloxone



7

PAIN MANAGEMENT PROGRAM

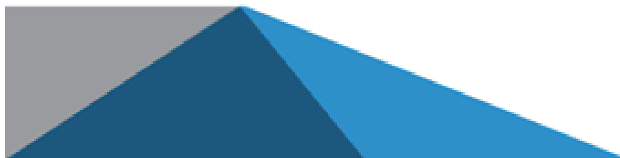
- Provider Toolkit
- Practice Facilitation
- Referral Assistance for Substance Use Disorder (SUD) Treatment
- State Plan – Reducing Prescription Drug Abuse in Oklahoma
- Pain Management Toolkit available at: http://www.okhca.org/providers.aspx?id=18411



8

PHARMACY INITIATIVES
UTILIZATION CONTROL TOOLS - OPIOIDS

- Quantity limits
  - No more than 4 per day – Jan 2015
- Early refill limit
  - 90 % of the medication must be used before refill
- Cumulative early refill limits
- Tiered structure for receiving long-acting opioid
- Duplication edits for short-acting and long-acting opioids
- DUR - concomitant use of opioid and benzodiazepines
- Methadone restrictions – January 2017



Oklahoma HealthCare Authority

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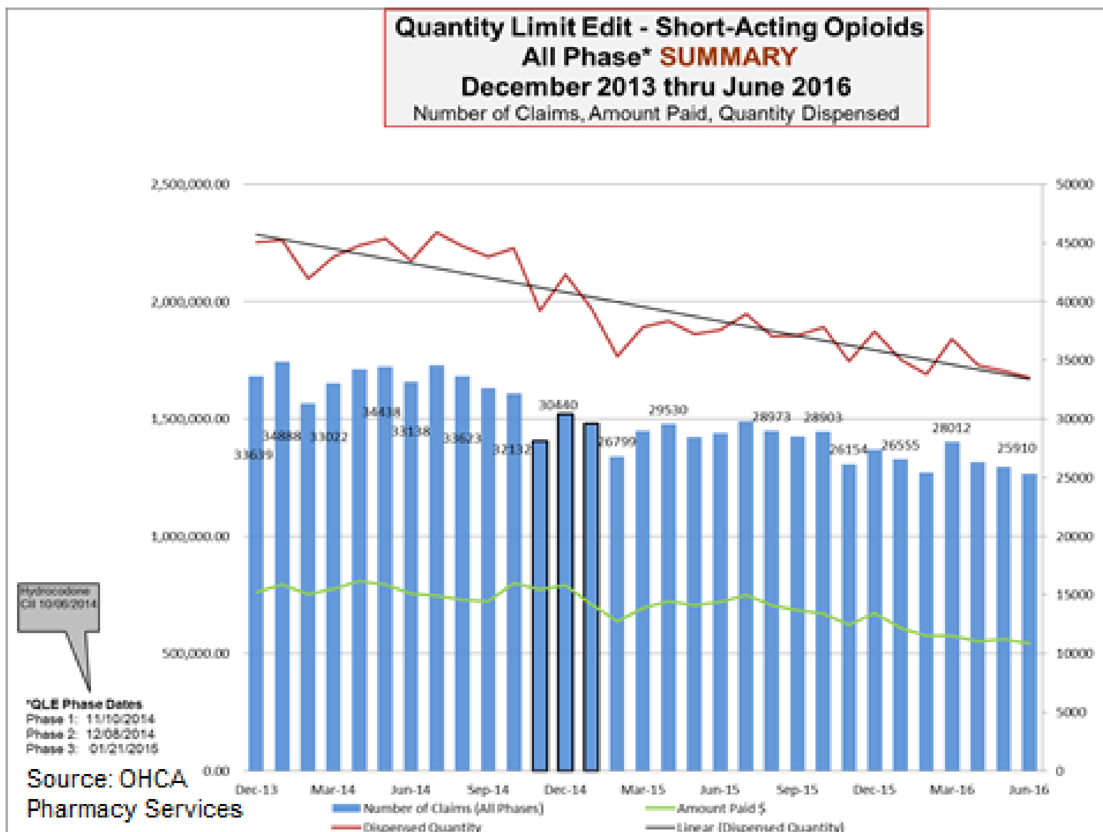
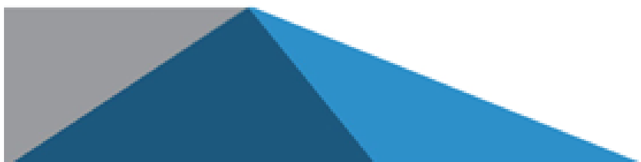


NALOXONE

Oklahoma HealthCare Authority 11

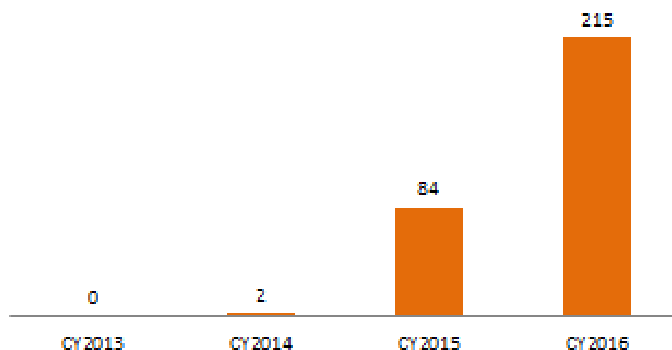
NALOXONE (CONT.)

- 2014 Okla. legislation passed that allows naloxone to be purchased at pharmacies
  - Collaborative practice agreement
- Oklahoma Department of Mental Health and Substance Abuse Services (ODMHASAS) is working to expand use of naloxone throughout the state
- Opioid Education Naloxone Distribution
  - OHCA partnership HSI CHIP grant



Oklahoma HealthCare Authority 12

OHCA NALOXONE CLAIMS
CY 2013 – CY 2016



Source: OHCA Pharmacy Services. Data valid as of October 31, 2016.

PHARMACY LOCK-IN
Patient review and restriction program

PHARMACY LOCK-IN PROGRAM

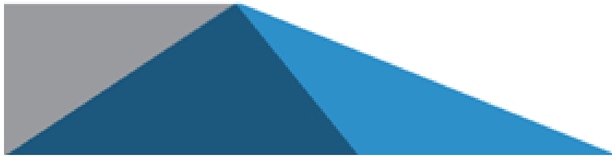
SoonerCare Pharmacy-administered program

"Locks" a member into one pharmacy AND one prescriber

- Pharmacy claims will deny if not from designated providers
- Various medications monitored

Referral by health care providers

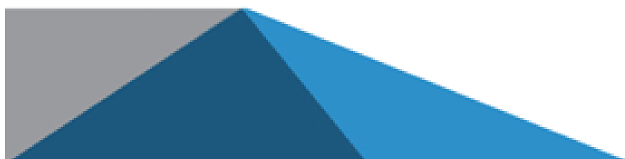
- Anonymous
- FAX/Call SoonerCare Pharmacy Helpdesk



Oklahoma Health Care Authority 15

PHARMACY INITIATIVES - 2017

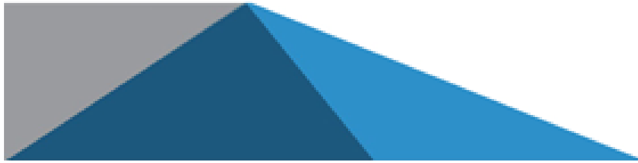
- Preventive measures to intervene
  - Pre-lock in
- BH outreach *current* in lock-in members
- Enhance communication
  - Prescribers – flyers, letters, electronic
  - Members – text, social media
- Morphine Milligram Equivalent (MME)
- Mortality Data Review for intervention(s)



Oklahoma Health Care Authority 16

SUMMARY – QUESTIONS/COMMENTS

- Continued provider education and outreach
- Participation in local and national work groups
- Internal monitoring of activities
- Continued vigilance and process improvement



Oklahoma HealthCare Authority 17

Agenda

OHCA MEDICAL ADVISORY COMMITTEE MEETING

LEGISLATIVE UPDATE, JANUARY 19, 2017

FINAL REPORT ON HOUSE BILL 2962

Passed during the 2nd regular session of the 55th Legislature, House Bill 2962 (HB 2962), authored by Representative Jason Nelson and Senator AJ Griffin, directs the Oklahoma Health Care Authority (OHCA) and partnering state agencies Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS), Oklahoma State Department of Education (OSDE), and the Oklahoma State Department of Health (OSDH) to study and prepare a report concentrating on the use of applied behavior analysis therapy treatment for children with ASD within the state's Medicaid program. In the last six months, the interagency workgroup has developed a comprehensive report examining the current landscape of treatment options available to ASD children through state services, the medical evidence behind ABA treatment, services offered by other states and the fiscal impact to Oklahoma if ABA treatment is included as a covered Medicaid benefit. This report was submitted to the Governor and the Oklahoma State Legislature at the end of December, 2016.

56th LEGISLATURE

Following the November 2016 general election, the Senate and House will have several new members. The 56th Legislature will include 42 Republicans and 6 Democrats in the Senate, and the House has 75 Republicans and 26 Democrats.

The 56th Legislature will have new leaders for the Senate and House. President Pro Tempore Mike Schulz (R-Altus) and Speaker Charles McCall (R-Atoka) were both elected by their colleagues to lead their respective chambers.

Leadership positions announced in the Senate include Senator Greg Treat (R-Oklahoma City) as Senate Majority Floor Leader and Senator Kim David (R-Porter) as Senate Appropriations Chairwoman. House leadership positions named are Representative Harold Wright (R-Weatherford) as Speaker Pro Tempore and Representative Jon Echols (R-OKC) as House Majority Floor Leader. Representative Leslie Osborn (R-Mustang) will serve as House Appropriations & Budget Chairwoman.

UPCOMING DEADLINES FOR THE 2017 LEGISLATIVE SESSION

Thursday, January 19, 2017: Deadline for introduction of bills and joint resolutions.

Monday, February 6, 2017: 1st Session of the 56th Oklahoma Legislature.

Friday, May 26, 2017: Sine Die adjournment

January MAC

Proposed Rule Amendment Summaries

Face to face tribal consultation regarding the following proposed changes were held Tuesday, September 6, 2016 and Tuesday, November 1, 2016 in the Board Room of the OHCA.

The following rules were posted for comment on December 16, 2016 through January 15, 2017.

16-11 School Based Language Cleanup Only — The proposed School Based Services policy is revised to correct the number of units authorized for personal care services. In addition, rules are updated to reflect that claims must be received within six months from the date of service.
Budget Impact: Budget Neutral

16-14 Inpatient Behavioral Health Policy Revisions — The proposed Inpatient Behavioral Health revisions amend existing language to accurately reflect the total number of core active treatment hours for individuals in a Community Based Transitional (CBT) setting. In addition, revisions clarify active treatment requirements for process group therapy if a child is admitted to the facility on a day other than the beginning of a treatment week. Revisions also update medical necessity criteria for continued stay in an acute psychiatric setting for children, to include requirements for 24 hour nursing/medical supervision. This change will help ensure appropriate level of care is being provided. Rules are also revised to update the time between treatment plan reviews. Revisions clarify that time between treatment plan reviews are at a minimum every five to nine calendar days when in acute care, 14 calendar days when in a regular PRTF, 21 calendar days in the OHCA approved longer term treatment programs or specialty PRTFs and 30 calendar days in CBT treatment programs. The extension of treatment plan reviews will allow inpatient providers additional time to determine response to treatment as well as ease the administrative burden without compromising quality of care. Further, rules are added to clarify that payment for Health Home transitioning services provided under arrangement with an inpatient provider will be directly reimbursed to the Health home outside of the inpatient facility's per diem or DRG rate.
Budget Impact: The rule change to add health home transitioning services has a projected total savings of $937,128 with a state share savings of $132,008 attributable to the Oklahoma Department of Mental Health and Substance Abuse Services.

16-21 SPARC Membership Increase and Allowance for Alternate — The proposed revisions to the State Plan Amendment Rate Committee (SPARC) policy increase the SPARC officials from five persons to seven persons and allows for appointed alternates. The changes to the membership enhances our coordinated efforts with sister agencies.
Budget Impact: Budget neutral

16-22 Purchasing Language Cleanup — The proposed revisions amend language to replace outdated references to the Oklahoma Department of Central Services with the Office of Management and Enterprise Services. The Oklahoma Department of Central Services was consolidated under the Office of Management and Enterprise Services in 2011. Additional revisions replace specific references to OAC Title 580 with OAC Title 260. Revisions also clarify that supply and non-professional services acquisitions over $5,000 must be approved by the Chief Executive Officer, Executive Staff, or designee.
Budget Impact: Budget neutral

16-23 I/T/U and FQHC cleanup – Proposed Indian Health Services, Tribal Program and Urban Indian Clinics (I/T/U) and Federally Qualified Health Centers (FQHC) policy is amended to remove the minimum 45-50 minute time requirement for outpatient behavioral health encounters. Rules are also added to indicate that behavioral health services must be billed on an appropriate claim form using appropriate Current Procedural Code (CPT) and guidelines. The time indicated on the claim form must be the time actually spent with the member. In addition, rules add appropriate billing for pharmacy outpatient encounters. Rules are added to indicate that prescriptions are reimbursed pursuant to pharmacy reimbursement exceptions. Further, revisions add requirements for I/T/U providers who render home health services. Revisions also include changes to policy references. In addition, rules are revised to replace the term telemedicine with telehealth to be more inclusive of an array of telehealth technologies that could potentially be used to deliver healthcare services to SoonerCare members.
Budget Impact: **Services provided to the Native American population are 100% federally funded therefore, no impact on state revenue is expected.**

16-26 Molecular Pathology Reimbursement Changes — The proposed General Coverage policy clarifies medical necessity criteria for molecular pathology services and which provider types can order testing. Additionally, proposed Laboratory Services policy clarifies reimbursement requirements for molecular pathology tests that examine multiple genes in a single test panel. Providers must utilize a one code for one test approach to billing molecular pathology tests. If an appropriate code is not available, providers are permitted to bill one unit of an unlisted molecular pathology procedure code.
Budget Impact: A one year proposed budget savings is estimated at $50,000 total dollars; State share $20,715; Federal Share $29,285.

16-27 Home Health Face to Face Requirement — The proposed Home Health revisions add language in accordance with Federal regulation that directs Home Health providers to conduct and document a face to face encounter with a member to validate the need services. Providers must document a face to face visit with the member and the visit must relate to the member's need for home health services.
Budget Impact: Budget neutral

Agenda

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 103. QUALIFIED SCHOOLS AS PROVIDERS OF HEALTH RELATED SERVICES

317:30-5-1027. Billing(a) Each service has a specified unit of service (unit) for billing purposes which represents the actual time spent providing a direct service. Direct service must be face-to face with the child. There is no reimbursement for time reviewing/completing paperwork and/or documentation related to the service or for staff travel to/from the site of service, unless otherwise specified.

(1) Most units of service are time-based, meaning that the service must be of a minimum duration in order to be billed. A unit of service that is time-based is continuous minutes; the time cannot be aggregated throughout the day.
(2) There are no minimum time requirements for evaluation services, for which the unit of service is generally a completed evaluation. The only exception is the Psychological Evaluation, which is billed in hourly increments.

(b) The following units of service are billed on the appropriate claim form:
(1) Service: Child Health Screening; Unit: Completed comprehensive screening.
(2) Service: Interperiodic Child Health Screening; Unit: Completed interperiodic screening.
(3) Service: Child Health Encounter; Unit: per encounter; limited to 3 encounters per day.
(4) Service: Individual Treatment Encounter; Unit: 15 minutes, unless otherwise specified.
(A) Hearing and Vision Services.
(B) Speech Language Therapy; Unit: per session, limited to one per day.
(C) Physical Therapy.
(D) Occupational Therapy.
(E) Nursing Services; Unit: up to 15 minutes; maximum 32 units per day.
(F) Psychotherapy Services; maximum 8 units per day.
(G) Assistive Technology.
(H) Therapeutic Behavioral Services.
(5) Service: Group Treatment Encounter; no more than 5 members per group, Unit: 15 minutes, unless otherwise specified. A daily log/list must be maintained and must identify the SoonerCare participants for each group therapy session.
(A) Hearing and Vision Services.
(B) Speech Language Therapy; Unit: per session, limited to one per day.
(C) Physical Therapy.
(D) Occupational Therapy.
(E) Psychotherapy Services; maximum 8 units per day.
(6) Service: Administration only, Immunization; Unit: one administration.
(7) Service: Hearing Evaluation; Unit: Completed Evaluation.
(8) Service: Hearing Aid Evaluation; Unit: Completed Evaluation.
(9) Service: Audiometric Test (Impedance); Unit: Completed Test (Both Ears).
(10) Service: Tympanometry and acoustic reflexes.
(11) Service: Ear Impression Mold; Unit: 2 molds (one per ear).
(12) Service: Vision Screening; Unit: one examination, by state licensed O.D., M.D., or D.O.
(13) Service: Speech Language Evaluation; Unit: one evaluation.
(14) Service: Physical Therapy Evaluation; Unit: one evaluation.
(15) Service: Occupational Therapy Evaluation; Unit: one evaluation.

(16) Service: Psychological Evaluation and Testing; Unit: one hour.
(17) Service: Personal Care Services; Unit: 10 minutes, 32 units ~~yearly~~daily.
(18) Service: Nursing Assessment/Evaluation (Acute episodic care); Unit: one assessment/evaluation, 18 yearly.
(19) Service: Psychological Evaluation and Testing; Unit: per hour of psychologist time, 8 hours yearly.

PART 104. SCHOOL-BASED CASE MANAGEMENT SERVICES

317:30-5-1033. Billing

Claims should not be submitted until SoonerCare eligibility of the individual has been determined. However, a claim must be received by OHCA within ~~12~~six (6) months of the date of service. If the eligibility of the individual has not been determined after ~~10~~four (4) months from the date of service, a claim should be submitted in order to assure that the claim is filed and reimbursement can be made should the individual be determined eligible at a later date.

Agenda

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 6. INPATIENT PSYCHIATRIC HOSPITALS

317:30-5-95.26. Medical necessity criteria for continued stay - acute psychiatric admission for children

For continued stay acute psychiatric admissions for children must meet all of the conditions set forth in (1) to ~~(4)~~(5) of this subsection.

(1) A primary diagnosis from the most recent edition of "The Diagnostic and Statistical Manual of Mental Disorders" (DSM) with the exception of V-Codes, adjustment disorders, and substance abuse related disorders, accompanied by a detailed description of the symptoms supporting the diagnosis. In lieu of a qualifying diagnosis, children 18-20 years of age may have a diagnosis of any personality disorder. Adjustment or substance related disorders may be a secondary diagnosis.
(2) Patient continues to manifest a severity of illness that requires an acute level of care as defined in the admission criteria and which could not be provided in a less restrictive setting.
(A) Documentation of regression is measured in behavioral terms.
(B) If condition is unchanged, evidence of re-evaluation of treatment objectives and therapeutic interventions.

(3) Conditions are directly attributable to a mental disorder as the primary need for professional attention (this does not include placement issues, criminal behavior, status offenses).

(4) Documented efforts of working with the child's family, legal guardians and/or custodians and other human service agencies toward a tentative discharge date.

(5) Requires secure 24-hour nursing/medical supervision as evidenced by:

(A) Stabilization of acute psychiatric symptoms;

(B) Need for extensive treatment under the direction of a physician; and

(C) Physiological evidence or expectation of withdrawal symptoms which require 24-hour medical supervision.

317:30-5-95.33. Individual plan of care for children

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

(1) **"Licensed Behavioral Health Professional (LBHP)"** means licensed psychologists, licensed clinical social workers (LCSW), licensed marital and family therapists (LMFT), licensed professional counselors (LPC), licensed behavioral practitioners (LBP), licensed alcohol and drug counselors (LADC), and advanced practice nurses (APN).

(2) **"Licensure Candidate"** means practitioners actively and regularly receiving board approved supervision, and extended supervision by a fully licensed clinician if board's supervision requirement is met but the individual is not yet licensed, to become licensed by one of the following licensing boards:

(A) Psychology,

(B) Social Work (clinical specialty only),

(C) Professional Counselor,

(D) Marriage and Family Therapist,

(E) Behavioral Practitioner, or

(F) Alcohol and Drug Counselor.

(3) **"Individual plan of Care (IPC)"** means a written plan developed for each member within four calendar days of any admission to an acute psychiatric facility or a PRTF and is the document that directs the care and treatment of that member. In Community Based Transitional RTC, the IPC must be completed within 7 days. The individual plan of care must be recovery focused, trauma informed, and specific to culture, age and gender and includes:

(A) A primary diagnosis from the most recent edition of "The Diagnostic and Statistical Manual of Mental Disorders" (DSM) with the exception of V-Codes, adjustment disorders, and substance abuse related disorders, accompanied by a detailed description of the symptoms supporting the diagnosis. Children 18-20 years of age may have a diagnosis of any personality disorder. Adjustment or substance related disorders may be a secondary diagnosis.

(B) the current functional level of the individual;

(C) treatment goals and measurable time limited objectives;
(D) any orders for psychotropic medications, treatments, restorative and rehabilitative services, activities, therapies, social services, diet and special procedures recommended for the health and safety of the member;
(E) plans for continuing care, including review and modification to the plan of care; and
(F) plan for discharge, all of which is developed to improve the child's condition to the extent that the inpatient care is no longer necessary.

(b) The individual plan of care:
(1) must be based on a diagnostic evaluation that includes examination of the medical, psychological, social, behavioral and developmental aspects of the individual member and reflects the need for inpatient psychiatric care;
(2) must be developed by a team of professionals as specified in OAC 317:30-5-95.35 in collaboration with the member, and his/her parents for members under the age of 18, legal guardians, or others in whose care he/she will be released after discharge;
(3) must establish treatment goals that are general outcome statements and reflective of informed choices of the member served. Additionally, the treatment goal must be appropriate to the member's age, culture, strengths, needs, abilities, preferences and limitations;
(4) must establish measurable and time limited treatment objectives that reflect the expectations of the member served and parent/legal guardian (when applicable) as well as being age, developmentally and culturally appropriate. When modifications are being made to accommodate age, developmental level or a cultural issue, the documentation must be reflected on the individual plan of care. The treatment objectives must be achievable and understandable to the member and the parent/guardian (when applicable). The treatment objectives also must be appropriate to the treatment setting and list the frequency of the service;
(5) must prescribe an integrated program of therapies, activities and experiences designed to meet the objectives;
(6) must include specific discharge and after care plans that are appropriate to the member's needs and effective on the day of discharge. At the time of discharge, after care plans will include referral to medication management, out-patient behavioral health counseling and case management to include the specific appointment date(s), names and addresses of service provider(s) and related community services to ensure continuity of care and reintegration for the member into their family, school, and community;
~~(7) must be reviewed every five to nine calendar days when in acute care and a regular PRTF, every 11 to 16 calendar days in the OHCA approved longer term treatment programs or specialty PRTF and every 30 days in Community Based Transitional treatment programs by the team specified to determine that services are being appropriately provided and to recommend changes in the individual~~

~~plan of care as indicated by the member's overall adjustment, progress, symptoms, behavior, and response to treatment;~~

(7) must be reviewed at a minimum every five (5) to nine (9) calendar days when in acute care, every fourteen (14) calendar days when in a regular PRTF, every twenty (21) calendar days when in an OHCA approved longer term treatment program or specialty PRTFs, and every thirty (30) calendar days in Community Based Transitional treatment programs by the team specified to determine that services are being appropriately provided and to recommend changes in the individual plan of care as indicated by the member's overall adjustment, progress, symptoms, behavior, and response to treatment;

(8) development and review must satisfy the utilization control requirements for physician re-certification and establishment of periodic reviews of the individual plan of care; and,

(9) each individual plan of care and plan of care review must be clearly identified as such and be signed and dated individually by the physician, LBHP or licensure candidate, member, parent/guardian (for members under the age of 18), registered nurse, and other required team members. All plans of care and plan of care reviews must be signed by the member upon completion, except when a member is too physically ill or the member's acuity level precludes him/her from signing. If the member is too physically ill or the member's acuity level precludes him/her from signing the plan of care and/or the plan of care review at the time of completion, the member must sign the plan when his/her condition improves but before discharge. The documentation should indicate the reason the member was unable to sign and when the next review will occur to obtain the signature. Individual plans of care and individual plan of care reviews are not valid until completed and appropriately signed and dated. All requirements for the individual plan of care or individual plan of care reviews must be met or a partial per diem recoupment will be merited. If the member's parent/guardian is unable to sign the IPC or IPC review on the date it is completed, then within 72 hours the provider must in good faith and with due diligence attempt to telephonically notify the parent/guardian of the document's completion and review it with them. Documentation of reasonable efforts to make contact with the member's parent/guardian must be included in the clinical file. In those instances where it is necessary to mail or fax an IPC or IPC review to a parent or OKDHS/OJA worker for review, the parent and/or OKDHS/OJA worker may fax back their signature. The provider must obtain the original signature for the clinical file within 30 days. Stamped or photocopied signatures are not allowed for any parent or member of the treatment team.

317:30-5-95.34. Active treatment for children

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

(1) **"Discharge/Transition Planning"** means a patient-centered, interdisciplinary process that begins with an initial assessment of the patient's potential needs at the time of admission and continues throughout the patient's stay. Active collaboration with the patient, family and all involved outpatient practitioners and agencies should be ongoing throughout treatment so that effective connections remain intact. Needed services may consist of the wraparound process through Systems of Care, counseling, case management and other supports in their community. The linkages with these supports should be made prior to discharge to allow for a smooth transition.

(2) **"Expressive group therapy"** means art, music, dance, movement, poetry, drama, psychodrama, structured therapeutic physical activities, experiential (ROPES), recreational, or occupational therapies that encourage the member to express themselves emotionally and psychologically.

(3) **"Family therapy"** means interaction between an LBHP or licensure candidate, member and family member(s) to facilitate emotional, psychological or behavioral changes and promote successful communication and understanding.

(4) **"Group rehabilitative treatment"** means behavioral health remedial services, as specified in the individual care plan which are necessary for the treatment of the existing primary behavioral health disorders and/or any secondary alcohol and other drug (AOD) disorders in order to increase the skills necessary to perform activities of daily living.

(5) **"Individual rehabilitative treatment"** means a face to face, one on one interaction which is performed to assist members who are experiencing significant functional impairment due to the existing primary behavioral health disorder and/or any secondary AOD disorder in order to increase the skills necessary to perform activities of daily living.

(6) **"Individual therapy"** means a method of treating existing primary behavioral health disorders and/or any secondary AOD disorders using face to face, one on one interaction between an LBHP or licensure candidate and a member to promote emotional or psychological change to alleviate disorders.

(7) **"Process group therapy"** means a method of treating existing primary behavioral health disorders and/or secondary AOD disorders using the interaction between an LBHP or licensure candidate as defined in OAC 317:30-5-240.3, and two or more members to promote positive emotional and/or behavioral change.

(b) Inpatient psychiatric programs must provide "Active Treatment". Active Treatment involves the member and their family or guardian from the time of an admission throughout the treatment and discharge process. Families and/or guardians must be notified of the dates and times of treatment team meetings and be welcomed to attend. Family members must attend family therapy weekly for continued SoonerCare reimbursement. Reasons for exceptions to this requirement must be well documented in the member's treatment plan. For individuals in the age range of 18 up to 21, it is understood that family members and guardians will not always be involved in the member's treatment.

Active Treatment also includes an ongoing program of assessment, diagnosis, intervention, evaluation of care and treatment, and planning for discharge and aftercare under the direction of a physician. Evidence based practices such as trauma informed methodology should be utilized to minimize the use of seclusion and restraint.

(c) For individuals age 18 up to 21, the Active Treatment program must be appropriate to the needs of the member and be directed toward restoring and maintaining optimal levels of physical and psychiatric-social functioning. The services and individual plan of care must be recovery focused, trauma informed, specific to culture, age and gender, and provided face-to-face. Services, including type and frequency, will be specified in the Individual Plan of Care.

(d) For individuals under age 18, the components of Active Treatment consist of face-to-face integrated therapies that are provided on a regular basis and will remain consistent with the member's ongoing need for care. The services and individual plan of care must be recovery focused, trauma informed, and specific to culture, age, and gender. Individuals in acute care must receive seventeen (17) hours of documented active treatment services each week, with seven (7) of those hours being dedicated to core services as described in (1) below. Individuals in PRTFs must receive fourteen (14) hours of documented active treatment services each week, with four and a half (4.5) of those hours being dedicated to core services as described in (1) below. Individuals in Community Based Transitional (CBT) must receive ten (10) hours of documented active treatment services each week, with ~~4~~four and a half (4.5) of those hours being dedicated to core services as described in (1) below. The remainder of the active treatment services may include any or all of the elective services listed in (2) below or additional hours of any of the core services. Sixty minutes is the expectation to equal one hour of treatment. When appropriate to meet the needs of the child, the 60 minute timeframe may be split into sessions of no less than 15 minutes each on the condition that the Active Treatment requirements are fully met by the end of the treatment week. The following components meet the minimum standards required for Active Treatment, although an individual child's needs for treatment may exceed this minimum standard:

(1) **Core Services.**

(A) **Individual treatment provided by the physician.** Individual treatment provided by the physician is required three times per week for acute care and one time a week in Residential Treatment Facilities. Individual treatment provided by the physician will never exceed ten calendar days between sessions in PRTFs, never exceed seven calendar days in a specialty PRTF and never exceed 30 calendar days in CBTs. Individual treatment provided by the physician may consist of therapy or medication management intervention for acute and residential programs.

(B) **Individual therapy.** LBHPs or licensure candidates performing this service must use and document an approach to treatment such as cognitive behavioral treatment, narrative therapy, solution focused brief therapy or another widely accepted theoretical framework for treatment. Ongoing

assessment of the member's status and response to treatment as well as psycho-educational intervention are appropriate components of individual therapy. Individual therapy must be provided in a confidential setting. The therapy must be goal directed utilizing techniques appropriate to the individual member's plan of care and the member's developmental and cognitive abilities. Individual therapy must be provided two hours per week in acute care and one hour per week in residential treatment by an LBHP or licensure candidate as described in OAC 317:30-5-240.3. One hour of family therapy may be substituted for one hour of individual therapy at the treatment team's discretion.

(C) **Family therapy.** The focus of family therapy must be directly related to the goals and objectives on the individual member's plan of care. Family therapy must be provided one hour per week for acute care and residential. One hour of individual therapy addressing relevant family issues may be substituted for a family session in an instance in which the family is unable to attend a scheduled session by an LBHP or licensure candidate as described in OAC 317:30-5-240.3.

(D) **Process group therapy.** The focus of process group therapy must be directly related to goals and objectives on the individual member's plan of care. The individual member's behavior and the focus of the group must be included in each member's medical record. This service does not include social skills development or daily living skills activities and must take place in an appropriate confidential setting, limited to the therapist, appropriate hospital staff, and group members. Group therapy must be provided three hours per week in acute care and two hours per week in residential treatment by an LBHP or licensure candidate as defined in OAC 317:30-5-240.3. In lieu of one hour of process group therapy, one hour of expressive group therapy provided by an LBHP, licensure candidate, or Licensed Therapeutic Recreation Specialist may be substituted.

(E) **Transition/Discharge Planning.** Transition/discharge planning must be provided one hour per week in acute care and thirty minutes per week in residential and CBT. Transition/Discharge planning can be provided by any level of inpatient staff.

(2) **Elective services.**

(A) **Expressive group therapy.** Through active expression, inner-strengths are discovered that can help the member deal with past experiences and cope with present life situations in more beneficial ways. The focus of the group must be directly related to goals and objectives on the individual member's plan of care. Documentation must include how the member is processing emotions/feelings. Expressive therapy must be a planned therapeutic activity, facilitated by staff with a relevant Bachelor's degree and/or staff with relevant training, experience, or certification to facilitate the therapy.

(B) **Group rehabilitative treatment.** Examples of educational and supportive services, which may be covered under the definition of group rehabilitative treatment services, are basic living skills, social skills (re)development, interdependent living, self-care, lifestyle changes and recovery principles. Each service provided under group rehabilitative treatment services must have goals and objectives, directly related to the individual plan of care.

(C) **Individual rehabilitative treatment.** Services will be for the reduction of psychiatric and behavioral impairment and the restoration of functioning consistent with the requirements of independent living and enhanced self-sufficiency. This service includes educational and supportive services regarding independent living, self-care, social skills (re)development, lifestyle changes and recovery principles and practices. Each individual rehabilitative treatment service provided must have goals and objectives directly related to the individualized plan of care and the member's diagnosis.

(D) **Recreation therapy.** Services will be provided to reduce psychiatric and behavioral impairment as well as to restore, remediate and rehabilitate an individual's level of functioning and independence in life activities. Services will also be provided in such a way as to promote health and wellness as well as reduce or eliminate the activity limitations and restrictions to participation in life situations caused by an illness or disabling condition. Recreational therapy can be provided in an individual or group setting. If the only activities prescribed for the individual are primarily diversional in nature, (i.e. to provide some social or recreational outlet for the individual), it will not be regarded as active treatment. If provided, recreational therapy must be a planned therapeutic activity, facilitated by a Licensed Therapeutic Recreation Specialist.

(E) **Occupational therapy.** Services will be provided to address developmental and/or functional needs related to the performance of self-help skills, adaptive behavioral, and/or sensory, motor and postural development. Services include therapeutic goal-directing activities and/or exercises used to improve mobility and activities of daily living (ADL) functions when such functions have been impaired due to illness or injury. Services must be provided by an occupational therapist appropriately licensed in the state in which they practice.

(F) **Wellness resource skills development.** Services include providing direction and coordinating support activities that promote good physical health. The focus of these activities should include areas such as nutrition, exercise, support with averting or managing physical health concerns like heart disease, diabetes, and cholesterol, and support regarding the effects of medications have on physical health. Services can include support groups, exercise groups, and individual physical wellness plan development, implementation assistance and support.

(3) **Modifications to active treatment.** When a member is too physically ill or their acuity level precludes them from active behavioral health treatment, documentation must demonstrate that alternative clinically appropriate services were provided.

(e) The expectation is that active treatment will occur regularly throughout the treatment week. A treatment week in Acute is based on the number of days of acute service, beginning the day of admission (day 1). Required active treatment components will be based upon the length of stay as described below. A treatment week in RTC, PRTF and CBT is considered to be a calendar week (i.e. Sunday through Saturday). When a child is admitted to RTC, PRTF or CBT level of care on a day other than Sunday, or discharges on a day other than Saturday, the week will be considered a partial week and services will be required as described below. Active treatment components may include assessments/evaluations to serve as the initial individual or family session if completed by an LBHP or licensure candidate. Start and stop time must be documented. Active treatment begins the day of admission. Days noted are calendar days.

(1) **Individual treatment provided by the physician.**

(A) In acute, by day two, 1 visit is required. By day 4, 2 visits are required. By day 7, 3 visits are required.

(B) In RTC, PRTF or CBT, one visit during admission week is required. In RTCs, 1 visit during the admission week is required, then once a week thereafter. In PRTFs, one visit during the admission week is required, then once a week thereafter. In CBT, 1 visit is required within 7 days of admission. Individual treatment provided by the physician will never exceed 10 days between sessions in PRTFs, never exceed 7 days in a specialty PRTF and never exceed 30 days in CBTs. The completion of a psychiatric evaluation or a combined psychiatric evaluation and a History and Physical (H&P) evaluation may count as the first visit by the physician if the evaluation was personally rendered by the psychiatrist. If the member is admitted on the last day of the admission week, then the member must be seen by a physician within 24 hours of admission time.

(2) **Individual therapy.**

(A) In acute, by day 3, 30 minutes of treatment are required. By day 5, 1 hour of treatment is required. Beginning on day 7, 2 hours of treatment are required each week. This does not include admission assessments/evaluations or Psychosocial Evaluations unless personally (face to face) rendered by the LBHP or licensure candidate.

(B) In residential treatment (including PRTF and CBT), by day 6, 30 minutes of treatment must be documented. Beginning on day 7, 1 hour of treatment is required each week. The treatment week is defined as Sunday through Saturday. Individual therapy may not exceed a total of 10 days between sessions. This does not include admission assessment/ evaluation or Psychosocial Evaluations unless personally (face to face) rendered by the LBHP or licensure candidate.

(3) **Family therapy.**

(A) In acute, by day 6, 30 minutes of treatment must be documented. Beginning on day 7, 1 hour of treatment is required each week. This does not include admission assessments/evaluation or Psychosocial Evaluations unless personally (face to face) rendered by the LBHP or licensure candidate and the assessments/evaluation or Psychosocial Evaluation has not been used to substitute the initial individual therapy requirement.

(B) In residential treatment (including PRTF and CBT), by day 6, 30 minutes of treatment must be documented. Beginning on day 7, 1 hour of treatment is required each week. This does not include admissions assessment/evaluation or Psychosocial Evaluations unless personally (face to face) rendered by the LBHP or licensure candidate and the assessment/evaluation or Psychosocial Evaluation has not been used to substitute the initial individual therapy requirement. Family therapy provided by the LBHP or licensure candidate should not exceed 10 days in between sessions.

(4) Process group therapy.

(A) In acute, by day 3, 1 hour of treatment is required. By day 5, 2 hours of treatment are required. Beginning on day 7, 3 hours of treatment are required each week.

(B) In residential treatment (including PRTF and CBT), by day 5, 1 hour of treatment is required. Beginning on day 7, 2 hours of treatment are required each week.

(f) When an individual is determined to be too ill to participate in treatment, as determined by medical/nursing staff (RN/LPN), documentation must be in the record clearly indicating the reason, limitations, and timeframe for those services to be excused without penalty.

317:30-5-96.3. Methods of payment

(a) **Reimbursement.** Covered inpatient psychiatric and/or substance abuse services will be reimbursed using one of the following methodologies:

(1) Diagnosis Related Group (DRG);

(2) cost based; or

(3) a predetermined per diem payment.

(b) **Acute Level of Care.**

(1) Psychiatric units within general medical surgical hospitals and Critical Access hospitals. Payment will be made utilizing a DRG methodology. [See OAC 317:30-5-41(b)]. Psychiatric professional (physicians and psychologists) services provided in conjunction with the inpatient stay are separately payable from the DRG paid to the hospital;

(2) Freestanding Psychiatric Hospitals. A predetermined statewide per diem payment will be made for all facility services provided during the inpatient stay. Psychiatric professional (physicians and psychologists) services provided in conjunction with the inpatient stay are separately payable from the per diem paid to the hospital. Rates vary for public and private providers.

(c) **Residential Level of Care**

(1) **Instate Services.**

(A) Psychiatric Hospitals or Inpatient Psychiatric Programs. A pre-determined all-inclusive per diem payment will be made for routine, ancillary and professional services. Public facilities will be reimbursed using either the statewide or facility specific interim rates and settled to total allowable costs as determined by analyses of the cost reports (Form CMS 2552) filed with the OHCA.

(B) Psychiatric Residential Treatment Facilities. A pre-determined per diem payment will be made to private PRTFs with 16 beds or less for routine services. All other services are separately billable. A predetermined all-inclusive per diem payment will be made for routine, ancillary and professional services to private facilities with more than 16 beds. Public facilities will be reimbursed using either the statewide or facility specific interim rates and settled to total allowable costs as determined by analyses of the cost reports (Form 2552) filed with the OHCA.

(2) **Out-of-state services.**

(A) Border and "border status" placements. Facilities are reimbursed in the same manner as in-state hospitals or PRTFs.

(B) Out-of-state placements. In the event comparable services cannot be purchased from an Oklahoma facility and the current payment levels are insufficient to obtain access for the member, the OHCA may negotiate a predetermined, all-inclusive per diem rate for specialty programs/units. An incremental payment adjustment may be made for 1:1 staffing (if clinically appropriate and prior authorized). Payment may be up to, but no greater, than usual and customary charges. The 1:1 staffing adjustment is limited to 60 days annually.

(d) **Health Home Transitioning Services.** Health Home services for the provision of comprehensive transitional care to existing members are considered to be inpatient psychiatric services, when services exceed and do not duplicate ordinary inpatient discharge planning during the last 30 days of a covered acute or residential stay. Payment for Health Home transitioning services provided under arrangement with the inpatient provider will be directly reimbursed to the Health Home outside of the facility's per diem or DRG rate.

Agenda

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 1. ADMINISTRATIVE OPERATIONS

SUBCHAPTER 3. FORMAL AND INFORMAL PROCEDURES

317:1-3-4. State Plan Amendment and Rate Committee

(a) **Definitions.** Unless the context clearly indicates otherwise, the following words and terms when used in this section are defined as follows:

(1) **Public Process** means a process as defined by federal law under ~~42.U.S.C § 1396a(A)(13)(A)~~42 U.S.C. § 1396(a)(13)A.
(2) **State Plan Amendment** means the document described in the Federal Regulations at 42 C.F.R. § 430.10.
(3) **State Plan Amendment and Rate Committee (SPARC)** means a committee comprised of administrative and executive level staff designated by the Chief Executive Officer for the Oklahoma Health Care Authority. The SPARC ~~facilities~~facilitates the rate setting process by conducting public hearings at which the public, vendors, and OHCA staff are afforded the opportunity to provide testimony and documented evidence in support of rate recommendations. The SPARC only operates to make recommendations for changes to rates that necessitate a State Plan Amendment and/or Waiver Amendment. Rates that do not necessitate a State Plan Amendment and/or Waiver Amendment do not require a hearing.
(4) **Rate Change** means a change that affects the numerical value of payment from the Medicaid agency to the provider including the application of pre-existing factors that increase or decrease a rate. A ~~Rate Change~~rate change is not a method change. Rates found in contracts are excluded from the definition of rate change because they are set consensually in a contract. A method or methodology change, as defined below, is not a rate change.
(5) **Method Change or Methodology Change** means a change to how the rate is calculated, not the end result of the rate. In Medicaid rate setting the application of pre-existing factors many times, results in rate changes. The application of pre-existing factors, even if it results in a different rate is not a method change. A method change occurs when OHCA adds, subtracts or alters the factors used to construct the rate.

(b) **Meeting of the State Plan Amendment and Rate Committee (SPARC).** In certain instances the SPARC meets to hold public hearings regarding rates set by the Oklahoma Health Care Authority. Under certain provisions of federal law, the agency is required to hold a public hearing to gather public comment regarding proposed method changes or methodology changes regarding the rates it pays its medical providers.
(1) The SPARC only meets when a method change or methodology change occurs in a rate paid from OHCA to a medical provider.
(2) The SPARC does not meet to establish any contractually set rate to a contractor or a contractually bid rate nor does the SPARC meet to hear rate changes.

(c) **SPARC public hearing process.**
(1) The ~~five~~seven person panel conducts an open meeting under the Oklahoma Open Meetings Act.
(2) The proceedings are recorded.
(3) The panel hears agency presentations of proposals for method changes or methodology changes and considers comments of any member of the public who desires to comment upon the rate. The Chairperson controls both the agency presentation of proposals and the presentation of comments on the proposed method change.
(4) The panel votes to approve or disapprove the proposed method change in the open meeting, but may adjourn the meeting to gather

further information, if necessary. The panel also may adjourn for legal advice during the proceeding. The OHCA board will vote to approve or disapprove the rate methodology upon approval by the SPARC.

(d) **Composition of the SPARC.** The Chief Executive ~~Office~~Officer appoints ~~OHCA~~ officials to serve on the SPARC. Officials may consist of OHCA employees and other state agency employees whose agencies assist in the administration of the Medicaid State Plan and/or Waiver programs. A regular alternate for each official may be approved. In such cases an official is unable to attend a committee meeting, he or she must notify the regular alternate and OHCA Chairperson.

Agenda

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY

CHAPTER 10. PURCHASING

317:10-1-1. Purpose

(a) The purpose of this Chapter is to describe the rules governing the contracting and purchasing requirements of the Oklahoma Health Care Authority (OHCA). The Contracts and Purchasing Divisions are internal divisions of the OHCA. These divisions provide the mechanism for the acquisition of goods, equipment, non-professional and professional services for the operation of the OHCA. These rules are superseded by the ~~Oklahoma Department of Central Services (DCS)~~Office of Management and Enterprise Services (OMES) Purchasing rules~~(OAC 580:16)~~(OAC 260:115) whenever ~~DCS~~OMES has final authority on an acquisition.

(b) Different rules apply depending on which of the above three entities is making the acquisition and whether the purchase is for professional services or non-professional services and products. When an acquisition is made by ~~DCS~~OMES, the ~~DCS~~OMES Purchasing rules at ~~OAC 580:16~~OAC 260:115 apply. When an acquisition is made by OHCA, these rules must be read in conjunction with the ~~DCS~~OMES rules.

317:10-1-3. General contracting and purchasing provisions

(a) All acquisitions made by the Oklahoma Health Care Authority shall be in accordance with the Oklahoma Central Purchasing Act, 74 Okla. Stat. §§ 85.1 et seq., other applicable statutory provisions, ~~Oklahoma Department of Central Services~~Office of Management and Enterprise Services Central Purchasing Rules and the Authority's approved internal purchasing procedures.

(b) When these rules are silent on a relevant issue related to an acquisition made by the Authority, the appropriate ~~DCS~~OMES rule applies, except that where "State Purchasing Director" is specified, this means "the Authority ~~CPO~~Certified Procurement Officer making the acquisition and/or the CEO". Where "Purchasing Division" is specified, this means "the Authority".

317:10-1-4. Vendor registration

Any vendor wishing to do business with the Authority should register on the vendor bidder list maintained by the Central

Purchasing Division of the ~~Oklahoma Department of Central Services~~Office of Management and Enterprise Services. The Authority may also send solicitations by request to vendors that are not on the vendor bidder list.

317:10-1-12. Protest of award

(a) Protests of awards made by the Authority under 74 Okla. Stat. § 85.5T are addressed at OAC 317:2-1-1 et seq.
(b) Bidders who wish to protest any other award shall follow the process outlined in the ~~Oklahoma Department of Central Services~~Office of Management and Enterprise Services rules at ~~OAC 580:16-3-21~~OAC 260:115-3-19.

317:10-1-16. Delegation of authority

The authority to procure needed products and services for the Authority has been delegated to the Authority from the ~~Oklahoma Department of Central Services~~Office of Management and Enterprise Services, Central Purchasing Division. The Authority Board delegates authority for expenditure of funds to the CEO and other Authority officers and personnel according to the dollar limits and types of products stated in (1), (2) and (3) of this Section. Within this authority, the CEO may delegate in writing to other specific individuals the responsibility for the performance of the procurement duties.

(1) **Supply and non-professional services acquisitions.** Each division director or supervisor may initiate any supply or non-professional services acquisition which is within his or her authorized division budget and approved by the ~~CEO, associate director~~CEO or designee. Any single acquisition of this kind over $5,000 up to $500,000 must be approved by the ~~CEO or a designated associate director~~CEO, Executive Staff or designee. Any single acquisition of this kind over $500,000 must be approved by the Authority Board. A contract amendment that would increase the total original contract acquisition cost to an amount that equals or exceeds $500,000 for a supply or non-professional services contract must be prior approved by the ~~OHCA~~Authority Board. Any amendment to a contract that would result in a 10 percent or greater increase in the total acquisition cost originally approved by the OHCA Board must be submitted to the OHCA Board for prior approval.

(2) **Professional service contracts.** Acquisitions of professional services must be approved by the CEO or designee. All professional service contracts over $125,000 must be approved by the Authority Board. A contract amendment that would increase the total original contract acquisition cost to an amount that equals or exceeds $125,000 for a professional service contract must be prior approved by the ~~OHCA~~Authority Board. Any amendment to a contract that would result in a 25 percent or greater increase or a $250,000 or greater increase in the total acquisition cost originally approved by the ~~OHCA~~Authority Board must be submitted to the ~~OHCA~~Authority Board for prior approval. Board approval is

not required if the increase in total contract acquisition cost results from the exercise of a price increase methodology, option for additional work, or option to renew that was contained in the previously approved contract.

(3) **Interagency/intergovernmental agreements.** All agreements with another state agency or public agency must be approved by the CEO or designee, but are exempt from the Authority Board approval.

Agenda

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 75. FEDERALLY QUALIFIED HEALTH CENTERS

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

(a) For the provision of behavioral health related case management services and psychosocial rehabilitation services, Health Centers must contract as an outpatient behavioral health agency and meet the requirements found at OAC ~~317:30-5-240 through 317:30-5-249.~~317:30-5-241.3 and 317:30-5-241.6.

(b) Health Centers which provide substance ~~abuse~~use treatment services must also be certified by the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS).

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

(a) Medically necessary behavioral health services that are primary, preventive, and therapeutic and that would be covered if provided in another setting may be provided by Health Centers. Services provided by a Health Center (refer to OAC ~~317:30-5-240.3~~317:30-5-241 for a description of services) must meet the same requirements as services provided by other behavioral health providers. Rendering providers must be eligible to individually enroll or meet the requirements as an agency/organization provider specified in OAC 317:30-5-240.2 and 317:30-5-280. Behavioral Health Services include:

(1) Assessment/Evaluation;
(2) Crisis Intervention Services;
(3) Individual/Interactive Psychotherapy;
(4) Group Psychotherapy;
(5) Family Psychotherapy;
(6) Psychological Testing; and
(7) Case Management (as an integral component of services 1-6 above).

(b) Medically necessary behavioral health professional therapy services are covered when provided in accordance with a documented individualized treatment plan, developed to treat the identified behavioral health disorder(s). ~~A minimum of a 45 to 50 minute~~A one-

on-one standard clinical session must be completed by ~~an~~a health care professional authorized in the approved FQHC State Plan pages in order to bill the PPS encounter rate for the session. Services rendered by providers not authorized under the approved FQHC state plan pages to bill the PPS encounter rate will be reimbursed pursuant to the SoonerCare fee-for-service fee schedule and must comply with rules found at OAC 317:30-5-280 through 317:30-5-283. Behavioral health services must be billed on an appropriate claim form using appropriate Current Procedural Terminology (CPT) procedure code and guidelines. The time indicated on the claim form must be the time actually spent with the member.
(c) Centers are reimbursed the PPS rate for services when rendered by approved health care professionals, as authorized under FQHC state plan pages, if the Health Center receives funding pursuant to Section 330 or is otherwise funded under Public Law to provide primary health care services at locations off-site (not including satellite or mobile locations) to Health Center patients on a temporary or intermittent basis, unless otherwise limited by Federal law.
(d) Health Centers that operate day treatment programs in school settings must meet the requirements found at OAC 317:30-5-240.2(b)(7).
(e) In order to support the member's access to behavioral health services, these services may take place in settings away from the Health Center. Off-site behavioral health services must take place in a confidential setting.

317:30-5-664.1. Provision of other health services outside of the Health Center core services
(a) If the Center chooses to provide other SoonerCare State Plan covered health services which are not included in the Health Center core service definition in OAC 317:30-5-661.1, the practitioners of those services are subject to the same program coverage limitations, enrollment and billing procedures described by the OHCA, and these services (e.g., home health services) are not included in the PPS settlement methodology in OAC 317:30-5-664.12.
(b) Other health services include, but are not limited to:
(1) dental services (refer to OAC 317:30-5-696) except for primary preventive dental services;
(2) eyeglasses ~~(refer to OAC 317:30-5-450);~~ (OAC 317:30-5-430 and OAC 317:30-5-450);
(3) clinical lab tests performed in the Center lab (other than the specific laboratory tests set out for Health Centers' certification and covered as Health Center services);
(4) technical component of diagnostic tests such as x-rays and EKGs (interpretation of the test provided by the Center physician is included as physician professional services);
(5) durable medical equipment (refer to OAC 317:30-5-210);
(6) emergency ambulance transportation (refer to OAC 317:30-5-335);
(7) prescribed drugs (refer to OAC 317:30-5-70);

(8) prosthetic devices (other than dental) which replace all or part of an internal body organ (including colostomy bags) and supplies directly related to colostomy care and the replacement of such devices;
(9) specialized laboratory services furnished away from the clinic;
(10) Psychosocial Rehabilitation Services ~~[refer to OAC 317:30-5-241(a)(7)]~~[refer to OAC 317:30-5-241.3]; and
(11) behavioral health related case management services ~~(refer to OAC 317:30-5-240 through 317:30-5-249).~~(refer to OAC 317:30-5-241.6).

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

317:30-5-1087. Terms and definitions

The following words and terms, when used in this Part, have the following meaning, unless the context clearly indicates otherwise:
(1) **"American Indian/Alaska Native (AI/AN)"** means an individual of Native American descent who has or is eligible for a Certificate of Degree of Indian Blood (CDIB) card.
(2) **"Behavioral Health services"** means professional medical services for the treatment of a mental health and/or ~~addiction disorder(s).~~substance use disorder.
(3) **"CFR"** means the Code of Federal Regulations.
(4) **"CMS"** means the Centers for Medicare and Medicaid Services.
(5) **"Encounter"** means a face to face contact between a health care professional and an IHS eligible SoonerCare member for the provision of medically necessary Title XIX or Title XXI covered services through an IHS or Tribal 638 facility or an urban Indian clinic within a 24-hour period ending at midnight, as documented in the patient's record.
(6) **"Licensed Behavioral Health Professional (LBHP)"** means a licensed psychologist, licensed clinical social worker(LCSW), licensed marital and family therapist (LMFT), licensed professional counselor (LPC), licensed behavioral practitioner (LBP) or licensed alcohol and drug counselor (LADC).
(7) **"OHCA"** means the Oklahoma Health Care Authority.
(8) **"OMB rate"** means the Medicaid reimbursement rate negotiated between CMS and IHS. Inpatient and outpatient Medicaid reimbursement rates for ~~I/T/US~~I/T/Us are published annually in the Federal Register or Federal Register Notices. The outpatient rate is also known as the I/T/U encounter rate. The encounter rate is available only to I/T/U facilities that appear on the IHS maintained listing of IHS-operated and Indian health care facilities operating under a 638 agreement. It is the sole responsibility of the facility to petition IHS for placement on this list.
(9) **"Physician"** means a doctor of medicine or osteopathy legally authorized to practice medicine and surgery or who is a licensed physician employed by the Federal Government in an IHS facility or who provides services in a 638 Tribal Facility.

(10) **"State Administering Agency (SAA)"** is the Oklahoma Health Care Authority.
(11) **"638 Tribal Facility"** is a facility that is operated by a tribe or tribal organization and funded by Title I or Title III of the Indian Self Determination and Education Assistance Act (Public Law 93-638).

317:30-5-1090. Provision of other health services outside of the I/T/U encounter

(a) Medically necessary SoonerCare covered services that are not included in the I/T/U outpatient encounter rate may be billed outside the encounter rate within the scope of the SoonerCare fee-for-service contract. The services will be reimbursed at the fee-for-service rate, and will be subject to any limitations, restrictions or prior authorization requirements. Examples of these services include but are not limited to:

~~(1) pharmaceuticals/drugs;~~
~~(2)~~ (1) durable medical equipment;
~~(3)~~ (2) glasses;
~~(4)~~ (3) ambulance;
~~(5)~~ (4) home health~~;~~ [refer to OAC 317:30-5-546];
~~(6)~~ (5) inpatient practitioner services;
~~(7)~~ (6) non-emergency transportation [refer to OAC 317:35-3-2];
~~(8)~~ (7) behavioral health case management ~~[refer to OAC 317:30-5-240 through 317:30-5-249];~~ [refer to OAC 317:30-5-241.6];
~~(9)~~ (8) psychosocial rehabilitative services ~~[refer to OAC 317:30-5-240 through 317:30-5-249];~~ [refer to OAC 317:30-5-241.3]; and
~~(10)~~ (9) psychiatric residential treatment facility services ~~[refer to OAC 317:30-5-96.3].~~ [refer to OAC 317:30-5, Part 6, Inpatient Psychiatric Hospitals].

(b) If the I/T/U facility chooses to provide other SoonerCare State Plan covered health services which are not included in the I/T/U encounter definition, those service providers must be contracted with OHCA and bill for those services under their assigned provider number consistent with program coverage limitations and billing procedures described by the OHCA.

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

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

(1) Mental Health and/or Substance Use Assessment/Evaluation and Testing;
(2) ~~Alcohol and/or Substance Abuse Services Assessment and Treatment~~ Service Plan Development;
(3) Crisis Intervention Services;
(4) Medication Training and Support;
(5) Individual/~~interactive~~ Interactive Psychotherapy;
(6) Group Psychotherapy; and

(7) Family Psychotherapy.

(b) Behavioral health professional therapy services are covered when provided in accordance with a documented individualized treatment plan, developed to treat the identified mental health and/or substance ~~abuse~~use disorder(s).~~ A minimum of a 45 to 50 minute standard clinical session must be completed by an I/T/U in order to bill an encounter for the session. Treatment must be documented in accordance with OAC 317:30-5-248.~~ Behavioral health services must be billed on an appropriate claim form using appropriate Current Procedural Terminology (CPT) procedure code and guidelines. The time indicated on the claim form must be the time actually spent with the member.

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

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

(e) For the provision of behavioral health related case management services, I/T/U providers must meet the requirements found at OAC ~~317:30-5-240 through 317:30-5-249,~~317:30-5-241.6, and be contracted as such. The provision of these services is considered to be outside of the I/T/U encounter. Contracted behavioral health case management providers are responsible for obtaining all necessary prior authorizations, if needed, and will be paid at the current fee-for-service rate.

(f) For the provision of psychosocial rehabilitation services, I/T/U facilities meet the requirements found at OAC ~~317:30-5-240 through 317:30-5-249,~~317:30-5-241.3, and must contract as an outpatient behavioral health agency. The provision of these services is considered to be outside of the I/T/U encounter. Contracted psychosocial rehabilitation service providers are responsible for obtaining all necessary prior authorizations, if needed, and will be paid at the current fee-for-service rate.

317:30-5-1098. I/T/U outpatient encounters

(a) I/T/U outpatient encounters that are billed to the OHCA must meet the definition in this Section and are limited to services covered by the OHCA. These services include health services included in the State Plan under Title XIX or Title XXI of the Social Security Act.

~~(b) The following words and terms have the following meaning unless the context clearly indicates otherwise:~~

(1) An I/T/U encounter means a face to face or ~~telemedicine~~telehealth contact between a health care professional

and an IHS eligible SoonerCare member for the provision of medically necessary Title XIX or Title XXI covered services through an IHS or Tribal 638 facility or an urban Indian clinic within a 24-hour period ending at midnight, as documented in the patient's record.

(2) An I/T/U outpatient encounter means outpatient services that may be covered when furnished to a patient by a contracted SoonerCare provider employed by the I/T/U facility and rendered at the I/T/U facility or other location, including the patient's place of residence.

~~(c)~~(b) The following services may be considered reimbursable encounters subject to the limitations of the Oklahoma State Plan and include any related medical supplies provided during the course of the encounter:

(1) Medical;
(2) Diagnostic;
(3) Behavioral Health services [refer to OAC 317:30-5-1094];
(4) Dental, Medical and Mental Health Screenings;
(5) Vision;
(6) Physical Therapy;
(7) Occupational Therapy;
(8) Podiatry;
(9) Speech;
(10) Hearing;
(11) Visiting Nurse Service [refer to OAC 317:30-5-1093];
(12) Smoking and Tobacco Use Cessation Counseling;
(13) Other Title XIX or XXI services as allowed under OHCA's SoonerCare State Plan and OHCA Administrative Rules;
(14) Drugs or medication treatments provided during a clinic visit are part of the encounter rate. For example, a member has come into the clinic with high blood pressure and is treated at the clinic with a hypertensive drug or drug sample. Drug samples are included in the encounter rate. ~~Prescriptions are not included in the encounter rate and must be billed through the pharmacy program by a qualified enrolled pharmacy;~~ Prescription drugs are reimbursed pursuant to OAC 317:30-5-78(b)(4)(B).
(15) Encounters with a registered professional nurse or a licensed practical nurse and related medical supplies (other than drugs and biologicals) furnished on a part-time or intermittent basis to home-bound members; and
(16) I/T/U Multiple Outpatient Encounters.
(A) OHCA will cover one medically necessary outpatient medical encounter per member per day unless if due to an emergency, the same member returns on the same day for a second visit with a different diagnosis. Then, a second encounter is allowed.
(B) OHCA will cover one dental encounter per member per day regardless of how many procedures are done or how many providers are seen unless if due to an emergency, the same member returns on the same day for a second visit and has a different diagnosis. Then, a second encounter is allowed.
(C) OHCA will cover one behavioral health professional outpatient encounter per member per day unless if due to an

emergency, the same member returns on the same day for a second visit and has a different diagnosis. Then, a second encounter is allowed.

(D) Each service must have distinctly different diagnoses in order to meet the criteria for multiple I/T/U outpatient encounters.

~~(d)~~ (c) More than one outpatient visit with a medical professional within a 24-hour period for distinctly different diagnoses may be reported as two encounters. This does not imply that if a member is seen at a single office visit with multiple problems that multiple encounters can be billed. For example, a member comes to the clinic in the morning for an immunization, and in the afternoon, the member falls and breaks an arm. This would be considered multiple medical encounters and can be billed as two encounters. However, a member who comes to the I/T/U facility for a diabetic wellness screening and is then referred to a podiatrist within the clinic for diabetes-related follow-up on the same date of service would not be considered a distinctly different diagnosis and can only be billed as a single encounter.

~~(e)~~ (d) The following services may be considered as separate or multiple encounters when two or more services are provided on the same date of service with distinctly different diagnoses:

(1) Medical Services;

(2) Dental Services

(3) Mental Health and addiction services with similar diagnoses can only be billed as one encounter. In addition, if the member is also seen for a medical office visit with a mental health or addiction diagnosis, then it is considered a single encounter;

(4) Physical or occupational therapy (PT/OT). If this service is also performed on the same date of service as the medical encounter that determined the need for PT/OT (initial referral), then it is considered a single encounter;

(5) Administration of immunizations. If no other medical office visit occurs on the same date of services; and

(6) Tobacco cessation limited to state plan services. If no other medical or addiction encounter occurs on the same date of service.

~~(f)~~ (e) I/T/U outpatient encounters for IHS eligible SoonerCare members whether medical, dental, or behavioral health, are not subject to prior authorization. Other State Plan covered services that the I/T/U facility chooses to provide but which are not part of the I/T/U encounter are subject to all applicable SoonerCare regulations which govern the provision and coverage for that service.

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) 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, or

(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 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 license.

(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 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~~and other molecular pathology services are covered when medically necessary. Genetic testing may be considered medically necessary when the following conditions are met:

(i) The member displays clinical features of a suspected genetic condition ~~or~~, is at direct risk of inheriting the genetic condition in question (e.g., a causative familial variant has been identified)~~; and~~ or has been diagnosed with a condition where identification of specific genetic changes will impact treatment or management; and

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

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

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

(2) General coverage exclusions include the following:

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

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

(C) Services of two 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 member (home or office) per month, except visits in connection with family planning, services related to emergency medical conditions, or primary care services provided to SoonerCare Choice members.
(K) Payment for more than two 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.

317:30-5-20. Laboratory services

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

(1) **Compensable services.** Providers may be reimbursed for compensable clinical diagnostic laboratory services only when they personally perform or supervise the performance of the test. If a provider refers specimen to a certified laboratory or a hospital laboratory serving outpatients, the certified laboratory or the hospital must bill for performing the test.
(A) Reimbursement for lab services is made in accordance with the Clinical Laboratory Improvement Amendment of 1988 (CLIA). These regulations provide that payment may be made only for services furnished by a laboratory that meets CLIA conditions, including those furnished in physicians' offices. Eligible providers must be certified under the CLIA program and have obtained a CLIA ID number from CMS and have a current contract on file with the OHCA.
(B) Only medically necessary laboratory services are compensable.

(2) **Non-compensable laboratory services.**
(A) Separate payment is not made for blood specimens obtained by venipuncture or urine specimens collected by a laboratory. These services are considered part of the laboratory analysis.
(B) Claims for inpatient full service laboratory procedures are not covered since this is considered a part of the hospital rate.
(C) Billing multiple units of nucleic acid detection for individual infectious organisms when testing for more than one infectious organism in a specimen is not permissible. Instead, OHCA considers it appropriate to bill a single unit of a procedure code indicated for multiple organism testing.

~~(D) Laboratory services must be medically indicated to be compensable.~~
(D) Billing multiple Current Procedural Terminology (CPT) codes or units for molecular pathology tests that examine multiple genes or incorporate multiple types of genetic analysis in a single run or report is not permissible. Instead, OHCA considers it appropriate to bill a single CPT code for such test. If an appropriate code does not exist, then one unit for an unlisted molecular pathology procedure may be billed.
(3) **Covered services by a pathologist.**
(A) A pathologist may be paid for the interpretation of inpatient surgical pathology specimen when the appropriate CPT procedure code and modifier is used.
(B) Full service or interpretation of surgical pathology for outpatient surgery performed in an outpatient hospital or Ambulatory Surgery Center setting.
(4) **Non-compensable services by a pathologist.** The following are non-compensable pathologist services:
(A) Experimental or investigational procedures.
(B) Interpretation of clinical laboratory procedures.

Agenda

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 3. HOSPITALS

317:30-5-42.16. Related services
(a) **Ambulance.** Ambulance services furnished by the facility are covered separately if otherwise compensable under the Authority's Medical Programs.
(b) **Home health care.** Hospital based home health providers must be Medicare certified and have a current Home Health Agency contract with the OHCA. For home health services, a qualified provider must conduct and document a face-to-face encounter with the member in accordance with provisions of 42 CFR 440.70.
(1) Payment is made for home health services provided in a member's residence to all categorically needy individuals.
(2) Payment is made for a maximum of 36 visits per year for eligible members 21 years of age or older. Payment for any combination of skilled and home health aide visits can not exceed 36 visits per year.
(3) Payment is made for standard medical supplies.
(4) Payment is made on a rental or purchase basis for equipment and appliances suitable for use in the home.
(5) Non-covered items include sales tax, enteral therapy and nutritional supplies, and electro-spinal orthosis systems (ESO).
(6) Payment may be made to home health agencies for prosthetic devices.

(A) Coverage of oxygen includes rental of liquid oxygen systems, gaseous oxygen systems and oxygen concentrators when prior authorized. Purchase of oxygen systems may be made where unusual circumstances exist and purchase is considered most appropriate.
(B) Payment is made for permanent indwelling catheters, drain bags, insert trays and irrigation trays. Male external catheters are also covered.
(C) Sterile tracheotomy trays are covered.
(D)~~Payment~~ Payment is made for colostomy and urostomy bags and accessories.
(E) Payment is made for hyperalimentation, including supplements, supplies and equipment rental on behalf of persons having permanently inoperative internal body organ dysfunction. Information regarding the member's medical condition that necessitates the hyperalimentation and the expected length of treatment, should be attached when requesting prior authorization.
(F) Payment is made for ventilator equipment and supplies when prior authorized.
(G) Payment for medical supplies, oxygen, and equipment is made when using appropriate HCPCS codes which are included in the HCPCS Level II Coding Manual.

(c) **Hospice Services.** Hospice is defined as palliative and/or comfort care provided to the member family when a physician certifies that the member has a terminal illness and has a life expectancy of six months or less. A hospice program offers palliative and supportive care to meet the special needs arising out of the physical, emotional and spiritual stresses which are experienced during the final stages of illness and death. Hospice services must be related to the palliation and management of the member's illness, symptom control, or to enable the individual to maintain activities of daily living and basic functional skills.

(1) Payment is made for home based hospice services for terminally ill individuals under the age of 21 with a life expectancy of six months or less when the member and/or family has elected hospice benefits. Hospice services are available to eligible members without forgoing any other service to which the member is entitled under SoonerCare for curative treatment of the terminal illness. Once the member has elected hospice care, the hospice medical team assumes responsibility for the member's medical care for the terminal illness in the home environment. Hospice providers are not responsible for curative treatments for members that elect such services while on hospice. Hospice care includes nursing care, physician services, medical equipment and supplies, drugs for symptom control and pain relief, home health aide and personal care, physical, occupational and/or speech therapy, medical social services, dietary counseling and grief and bereavement counseling to the member and/or family.
(2) Hospice care is available for two initial 90-day periods and an unlimited number of subsequent 60-day periods during the remainder of the member's lifetime. Beginning January 1, 2011, a

hospice physician or nurse practitioner must have a face to face encounter with the member to determine if the member's terminal illness necessitates continuing hospice care services. The encounter must take place prior to the 180th day recertification and each subsequent recertification thereafter; and attests that such visit took place. The member and/or the family may voluntarily terminate hospice services.

(3) Hospice services must be reasonable and necessary for the palliation or management of a terminal illness or related conditions. A certification that the member is terminally ill must be completed by the member's attending physician or the Medical Director of an Interdisciplinary Group. Nurse practitioners serving as the attending physician may not certify the terminal illness; however, effective January 1, 2011, nurse practitioners may re-certify the terminal illness.

(4) Services must be prior authorized. A written plan of care must be established before services are provided. The plan of care should be submitted with the prior authorization request.

PART 61. HOME HEALTH AGENCIES

317:30-5-546. Coverage by category

Payment is made for home health services as set forth in this ~~Section.~~<u>section when a face to face encounter has occurred in accordance with provisions of 42 CFR 440.70.</u>

(1) **Adults.** Payment is made for home health services provided in the ~~patient's~~<u>member's</u> residence to all categorically needy individuals. Coverage for adults is as follows.

(A) **Covered items.**

(i) Part-time or intermittent nursing services;

(ii) Home health aide services;

(iii) Standard medical supplies;

(iv) Durable medical equipment (DME) and appliances; and

(v) Items classified as prosthetic devices.

(B) **Non-covered items.** The following are not covered:

(i) Sales tax;

(ii) Enteral therapy and nutritional supplies;

(iii) Electro-spinal orthosis system (ESO); and

(iv) Physical therapy, occupational therapy, speech pathology, or audiological services.

(2) **Children.** Home Health Services are covered for persons under age 21.

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