OKLAHOMA HEALTH CARE AUTHORITY
REGULARLY SCHEDULED BOARD MEETING
June 26, 2014 at 1:00 P.M.
Oklahoma Health Care Authority
Charles Ed McFall Boardroom
4345 N. Lincoln Blvd.
Oklahoma City, OK

A G E N D A

Items to be presented by Ed McFall, Chairman

1. Call to Order / Determination of Quorum

2. Action Item – Approval of May 8, 2014 OHCA Board Minutes

3. Discussion Item – Reports to the Board by Board Committees

    a) Audit/Finance Committee – George Miller
    b) Strategic Planning Committee – Ed McFall
    d) Rules Committee – Carol Robison

Item to be presented by Nico Gomez, Chief Executive Officer

4. Discussion Item – Chief Executive Officer's Report

    a) All Stars Introduction – Nico Gomez, Chief Executive Officer
        - May – Leslie Sickler, DP Analyst/Planning Specialist III, Contractor Systems (Lisa Gifford)

    b) Financial Update – Gloria Hudson, Director of General Accounting

    c) Medicaid Director's Update – Garth Splinter, State Medicaid Director

        1.) OHCA Quality Initiatives in Maternal & Child Health – Shelly Patterson

    d) Legislative Update – Carter Kimble, Director of Governmental Relations

Item to be presented by Dr. Sylvia Lopez, Chief Medical Director & Jackie Keyser, Project Manager

5. Discussion Item – Strong Start Update

Item to be presented by Sharon Hsieh, Deputy General Counsel

6. Discussion Item – Public Comment on this meeting's agenda items by attendees who gave 24 hour prior written notice

Item to be presented by Sharon Hsieh, Deputy General Counsel

7. Announcements of Conflicts of Interest Panel Recommendations for All Action Items Regarding This Board Meeting.

Item to be presented by Nancy Nesser, Pharmacy Director

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

    a) Consideration and vote to add **Sovaldi™ (Sofosbuvir), Olysio™ (Simeprevir), Victrelis® (Boceprevir), Incivek® (Telaprevir), Trokendi XR™ (Topiramate ER), Aptiom® (Eslicarbazepine Acetate), Qudexy™ XR (Topiramate ER), and Generic Divalproex ER** to the utilization and scope prior authorization program under OAC 317:30-5-77.2(e).

    b) Consideration and vote to add **Ophthalmic Anti-Inflammatory Medications** to the Product Based Prior Authorization program under OAC 317:30-5-77.3.

DRAFT

Item to be presented by Cindy Roberts, Deputy CEO – Planning, Policy & Integrity Division

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

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

OHCA Initiated Rules:

A. AMENDING Agency rules at OAC 317:30-5-355.1, 317:30-5-356, 317:30-5-357, 317:30-5-361, 317:30-5-664.3, and 317:30-5-664.12 and revoking 317:30-5-664.4 to limit encounters within Federal Qualified Health Centers (FQHC) and Rural Health Clinic Services (RHC) to one encounter per member per day as well as limit encounters to a total of four visits per member per month for adults.
Budget Impact: $218,331 **Total Savings** and $81,372 **State Share**

(Reference APA WF # 14-02)

B. AMENDING Agency rules at OAC 317:30-5-126 to eliminate payment for hospital leave to nursing facilities and ICF/IIDs. Hospital leave is planned or unplanned leave when the patient is admitted to a licensed hospital.
Budget Impact: $1,615,367 **Total Savings** and $608,993 **State Share**

(Reference APA WF # 14-03)

C. AMENDING Agency rules at OAC 317:30-5-56 to reduce/deny payment for preventable readmissions that occur within 30 days from discharge. The current policy reviews readmissions occurring within 15 days of prior acute care admissions or a related condition to determine medical necessity and appropriateness of care. If it is determined either or both admissions may be inappropriate, payment for either or both admissions may be denied.
Budget Impact: $18,783,264 **Total Savings** and $7,000,523 **State Share**

(Reference APA WF # 14-04)

D. AMENDING Agency cost-sharing rules at OAC 317:30-3-5 to permit an increase of copays to the federal maximum.
Budget Impact: $8,294,160 **Total Savings** and $3,091,234 **State Share**

(Reference APA WF # 14-05)

E. AMENDING Agency dental rules at OAC 317:30-5-696, 317:30-5-698, and 317:30-5-699 to eliminate the perinatal dental benefit.
Budget Impact: $3,951,697 **Total Savings** and $1,472,797 **State Share**

(Reference APA WF # 14-06)

F. AMENDING Agency rules at OAC 317:30-5-211.11, 317:30-5-211.12, and 317:30-5-211.16 to require a prior authorization for oxygen after the initial three months. In addition, rules are revised to clarify arterial blood gas analysis (ABG) and pulse oximetry testing and Certificate of Medical Necessity requirements.
Budget Impact: $2,000,000 **Total Savings** and $745,400 **State Share**

(Reference APA WF # 14-07)

G. AMENDING Agency rules at OAC 317:30-3-57, 317:30-3-65.7, and 317:30-5-432.1 to limit the number of payments for glasses for children to two per year. Any additional glasses beyond this limit must be prior authorized and determined to be medically necessary.
Budget Impact: $347,055 **Total Savings** and $129,347 **State Share**

(Reference APA WF # 14-08)

H. AMENDING Agency SoonerCare Choice rules regarding enrollment ineligibility at OAC 317:25-7-13 and 317:25-7-28 to make individuals with other forms of creditable health insurance coverage ineligible for SoonerCare Choice.
Additionally, members who are currently enrolled in SoonerCare Choice who have or gain other forms of creditable insurance will be disenrolled from SoonerCare Choice.
Budget Impact: $3,887,634 **Total Savings** and $1,448,921 **State Share**

(Reference APA WF # 14-09)

DRAFT

DMHSAS Initiated Rules:

I. **Eligibility for Psychosocial Rehabilitation Services –** Outpatient behavioral health rules are amended to add additional eligibility criteria required in order to receive psychosocial rehabilitation (PSR) services. Adult PSR services will be limited to members with a history of psychiatric hospitalization or admissions to crisis centers; have been determined disabled by the Social Security Administration for mental health reasons; are residing in residential care facilities; or are receiving services through a specialty court program. Children's PSR services will be limited to members with a history of psychiatric hospitalization or admissions to crisis centers; have been determined disabled by the Social Security Administration for mental health reasons; have a current Individual Education Plan (IEP) or 504 Plan for emotional disturbance; or have been evaluated by a school psychologist, licensed psychologist, or psychiatrist and determined to be "at risk". Narrowing the eligibility criteria for PSR services comports with the Federal definition of rehabilitative services found in 42 CFR 440.130(d) which defines them as "any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts…for maximum reduction of physical or *mental disability* and restoration of a beneficiary to his best possible functional level." Without the recommended revisions, ODMHSAS is at risk of exhausting its State appropriated dollars required to maintain the State's Medicaid Behavioral Health Program.
Estimated SFY 2015 Budget Impact: Savings to ODMHSAS of $54,322,344 Total; $20,479,524 State

Item to be presented by Cindy Roberts, Chairperson of State Plan Amendment Rate Committee

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

    a) Consideration and vote to convert blood glucose supplies to the competitive bid national rate. These changes have an estimated total dollar (state and federal) savings of $797,964 and $297,401 state savings.

    b) Consideration and vote to reduce payment for co-insurance from 100% to 83.75% of the Medicare fee schedule. These changes have an estimated total dollar (state and federal) savings of $8,229,146 and $3,067,003 state savings.

    c) Consideration and vote to implement a rate reduction in the amount of 7.75% to providers reimbursed on the Medicaid physician fee schedule and other payment methodologies. These changes have an estimated total dollar (state and federal) savings of $149,633,700 and $55,768,480 state savings.

    d) Consideration and vote to amend the state plan to reflect changes to the reimbursement pool amounts for nursing facilities.

Item to be presented by Vickie Kersey, Director, Fiscal Planning and Procurement

11. Action Item – Consideration and Vote of the State Fiscal Year 2015 Budget Work Program.

Item to be presented by Chairman McFall

12. Discussion Item – Proposed Executive Session as Recommended by the Deputy General Counsel of Legal Services and Authorized by the Open Meetings Act, 25 Oklahoma Statutes § 307(B) (1), (4), (7) and (9).

    a) Discussion of Pending Litigation, Investigations and Claims

13. New Business

14. ADJOURNMENT

NEXT BOARD MEETING
August 13, 2014
Strategic Planning Conference
August 14 & 15, 2014
Samis Education Center
1200 Children's Ave.
Oklahoma City, OK

DRAFT

MINUTES OF A REGULARLY SCHEDULED BOARD MEETING
OF THE HEALTH CARE AUTHORITY BOARD
May 8, 2014
Held at Oklahoma Health Care Authority
Oklahoma City, Oklahoma

Manner and Time of Notice of Meeting: A statutorily required public meeting notice was placed on the front door of the Oklahoma Health Care Authority on May 7, 2014, 10:30 a.m. Advance public meeting notice is provided to the Oklahoma Secretary of State. In addition to the posting of the statutory public notice, the agency placed its agenda on its website on May 1, 2014, 2:40 p.m.

Pursuant to a roll call of the members, a quorum was declared to be present, and Chairman McFall called the meeting to order at 1:00 p.m.

BOARD MEMBERS PRESENT: Chairman McFall, Vice-Chairman Armstrong, Member Miller, Member Bryant, Member Nuttle, Member McVay, Member Robison

OTHERS PRESENT:
David Dude, American Cancer Society
Warren Vieth, Oklahoma Watch
Princiss Rockmore, OHCA
Mark McCullough, OK State House
Judy Goforth Parker, Chickasaw Nation
Jimmy Durant, SSM HealthCare
Will Widman, HP
Marlene Asmussen, OHCA
Mary Brinkley, Leading Age
Sandra Harrison, OHA
Erin Jackson, OHCA
Reggie Mason, OHCA
Nichole Burland, OHCA
Casey Dunham, OHCA
Peggie Littlejohn, FAIS
Juarez McCann, ODMHSAS
Ashley Neel, OMES
Dr. Derby

OTHERS PRESENT:
Debbie Spaeth, Quest MHSA LLC
Carolyn Reconnu, OHCA
Kasie Wren, OHCA
Charlene Kaiser, Amgen
Tywanda Cox, OHCA
Rebecca Moore, OAHCP
Lisa Spain, HP
Becky Ikard, OHCA
Catina Baker, OHCA
Lynne White, OHA
Brittney Stallworth, OHCA
Terry Cothran, OU COP
Jennifer King, OHCA
Stan Ruffner, OHCA
Sherris H Ososanya, OHCA
Julie Cox, OSDH
Brent Wilborn, OKPCA

DISCUSSION AND POSSIBLE VOTE ON APPROVAL OF BOARD MINUTES OF THE REGULARY SCHEDULED BOARD MEETING HELD MARCH 27, 2014.

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

MOTION: Member Nuttle moved for approval of the March 27, 2014 board meeting minutes as published. The motion was seconded by Member McVay.

FOR THE MOTION: Chairman McFall, Member Miller, Member Bryant, Member Robison, Member McVay

ITEM 3 / REPORTS TO THE BOARD BY BOARD COMMITTEES

Audit/Finance Committee
Member Miller stated that the committee did meet and discussed the financial report through the month of March and that things look positive. The agency's positive variance is up an additional $5 million for a total of almost $47 million. We do not feel good about next year's budget overall of the Governor in regards to budget issues. Member Miller state that the agency is facing a loss in the percentage of federal matching that we receive during the next fiscal year which starts October 1st and will need to be made up in some way or we will have to look at cuttings services or programs. The committee is very concerned that the bottom line will be that the Board will have to address provider rates. Because of this potential, there are public notifications that have to be made in a timely manner, in which the process has been started. Member Miller also noted that they reviewed the single state audit report which covered the audit of every state agency that receives federal funds. The committee was given the OHCA state audit report and there were only minor findings and the committee felt good about how the report concluded.

Strategic Planning Committee
Vice-Chairman Armstrong stated that the committee did meet and noted that the agency has some deadlines coming up and hopefully we will get our budget soon as May 22nd is one of our deadlines to have the changes to providers before action can be taken. What we are expecting is less than what we have now, which will result in provider cuts. He applauds staff for all of their efforts to position this organization and the populations that we serve in the forefront of the legislative

discussions. He noted that they discussed the OHCA board retreat and that it will be local this year and we would like to continue to have the opportunity to bring people around the tables to discuss and address new issues.

Legislative Committee
Member Bryant stated that the committee did meet. She said that Mr. Kimble will give a legislative update during the meeting. Member Bryant also noted that Nico discussed the budget and he will give a more detailed report.

ITEM 4 / CHIEF EXECUTIVE OFFICER'S REPORT
Nico Gomez, Chief Executive Officer

Mr. Gomez thanked Mark McCullough for being present at the meeting.

4a. ALL STARS INTRODUCTION
Nico Gomez, Chief Executive Officer

Mr. Gomez introduced the OHCA Employee All-Star for February and March 2014 through his direct reports.

Cindy Roberts presented the February All Star – Rebecca Cochran, Behavioral Health Specialist, Behavioral Health Provider Audits

Becky Pasternik-Ikard presented the March All Star – Sherry Tinsley, Member Services Coordinator III, SoonerCare Operations

4b. FINANCIAL UPDATE
Carrie Evans, Chief Financial Officer

Ms. Evans reported on the financial transactions through the month of March with a positive variance of $46.9 million dollars. We did run over budget with our program expenditures; however we are still significantly under. Drug rebate continues to be considerably over budget and we did collect some additional federal funds this last quarter. Looking ahead for April, we are going to run slightly over budget. However we did receive about $5 million dollars of pharmaceutical restitution money that we were not expecting. Our administration continues to also run under budget so we expect for April to be in the black. For more detailed information, see Item 4b in the board packet.

Mr. Gomez thanked Dr. David Derby for attending the board meeting.

4c. MEDICAID DIRECOR'S UPDATE
Garth Splinter, State Medicaid Director

Dr. Splinter provided an update for March that included a report on the number of enrollees in the Medicaid program and also gave a preliminary report for April numbers. He reported on the dual enrollees, total providers, percentage of capacity and total primary care providers and patient centered medical homes. He discussed the electronic health records (EHR) incentive statistics in detail. For more detailed information, see Item 4c in the board packet.

Member Miller asked how many of the 12,706 new enrollees might be considered 'woodwork', meaning eligible but not enrolled? Dr. Splinter noted that when we reach the new baseline then we will be able to look at the people who are woodwork.

4d. LEGISLATIVE UPDATE
Carter Kimble, Director of Governmental Relations

Mr. Kimble reported there are two bills with major direct impact on OHCA. The first is House Bill 2384 which has language allowing prior authorization by the DUR and OHCA for Hepatitis C medication. The second is House Bill 2906 which requires OHCA to conduct a study of ER diversion models for persons enrolled in Medicaid and explore options for cost containment and deliver alternatives that are consistent with the existing Patient-Centered Medical Home program. For more detailed information, see Item 4d in the board packet.

4e. BUDGET UPDATE
Nico Gomez, Chief Executive

Mr. Gomez stated that we are still unclear of what OHCA's appropriation will be. When session first began, it was clear that the legislature would have less revenue to appropriate to agencies than the previous year. That is an issue to us in this program because we will lose about $50 million dollars in federal matching dollars and we have standard growth and utilization in the program and we project a budget of 4% increase next year. We would need about $90 million dollars over what we were appropriated last year to run the same program July 1 as we are running today. He noted that we are seeing a reduction in the tobacco tax revenue that comes to the agency as part of our budget which we match with federal funds and help pay for the program. The agency started to engage and meet with the providers early on in March and April to prepare and develop a list of potential budget reductions. The list under item 4e is not a recommendation for the board but just an update in preparation for what OHCA is possibly looking at depending on appropriations. Mr. Gomez went through the budget list. He noted that we are trying to move all cash that we can to minimize the depth of provider rate cuts and doesn't believe it is avoidable at this point. He has had very good conversations with the budget negotiators who are clearly

DRAFT

sympathetic and he feels that he has their support to minimize any negative impact to this program. For more detailed information, please see item 4e in the board packet.

Chairman McFall noted that these are very serious situations and that OHCA takes it very seriously and if there are concerns or questions for Mr. Gomez, please take the opportunity to discuss after the board meeting. He also requested that that we single out the long term care facilities on the prior authorizations for controlled substances.

Mr. Gomez stated that we had 9 submissions of projects for Team Day at the capitol today.

ITEM 5 / HEALTH MANAGEMENT PROGRAM UPDATE
Dr. Mike Herndon & Della Gregg

Dr. Herndon and Ms. Gregg reported on the details and statistics of the Health Management Program. For more detailed information, see Item 5 in the board packet.

ITEM 6 / PROPOSED EXECUTIVE SESSION AS RECOMMENDED BY THE DIRECTOR OF LEGAL SERVICES AND AUTHORIZED BY THE OPEN MEETINGS ACT, 25 OKLAHOMA STATUTES §307(B) (1), (4), (7) AND (9).
Nicole Nantois, Chief of Legal Services

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

MOTION:	Vice-Chairman Armstrong moved for approval to go into Executive Session. The motion was seconded by Member McVay.
FOR THE MOTION:	Chairman McFall, Member Bryant, Member Miller, Member Robison, Member Nuttle

10. Discussion Item – Proposed Executive Session as Recommended by the Director of Legal Services and Authorized by the Open Meetings Act, 25 Oklahoma Statutes § 307(B) (1), (4), (7) and (9)

    a) Discussion of Pending Litigation, Investigations and Claims

ITEM 7 / NEW BUSINESS

There was no new business.

ITEM 8 / INFORMAL BOARD FACILITY TOUR

There were no board members able to take a tour.

ITEM 9 / ADJOURNMENT

MOTION:	Member Nuttle moved for adjournment. The motion was seconded by Vice-Chairman Armstrong.
FOR THE MOTION:	Chairman McFall, Member Miller, Member McVay, Member Robison, Member Bryant

Meeting adjourned at 2:36 p.m., 5/8/2014

NEXT BOARD MEETING
June 26, 2014
Oklahoma Health Care Authority
Charles Ed McFall Boardroom
4345 N. Lincoln Blvd.
OKC, OK

Lindsey Bateman
Board Secretary

Minutes Approved: _____

Initials: _____

DRAFT

FINANCIAL REPORT

For the Ten Months Ended April 30, 2014
Submitted to the CEO & Board

- Revenues for OHCA through April, accounting for receivables, were **$3,370,255,758** or **(.2%) under** budget.
- Expenditures for OHCA, accounting for encumbrances, were **$3,329,289,842 or 1.3% under** budget.
- The state dollar budget variance through April is **$35,050,357 positive.**
- The budget variance is primarily attributable to the following (in millions):

Expenditures:		
Medicaid Program Variance		16.9
Administration		5.1
Revenues:		
Unanticipated Revenue		15.7
Drug Rebate		3.7
Taxes and Fees		(8.3)
Overpayments/Settlements		2.0
Total FY 14 Variance	**$**	**35.1**

ATTACHMENTS

OKLAHOMA HEALTH CARE AUTHORITY
Summary of Revenues & Expenditures: OHCA
Fiscal Year 2014, For the Ten Months Ended April 30, 2014

REVENUES	FY14 Budget YTD	FY14 Actual YTD	Variance	% Over/ (Under)
State Appropriations	$ 800,001,936	$ 796,113,013	$ (3,888,923)	(0.5)%
Federal Funds	1,754,346,716	1,723,288,928	(31,057,789)	(1.8)%
Tobacco Tax Collections	46,552,907	42,115,558	(4,437,349)	(9.5)%
Quality of Care Collections	67,255,042	67,255,042	-	0.0%
Prior Year Carryover	41,811,007	41,811,007	-	0.0%
Unanticipated Revenue	-	15,683,810	15,683,810	100.0%
Federal Deferral - Interest	193,149	193,149	-	0.0%
Drug Rebates	175,145,681	185,805,803	10,660,122	6.1%
Medical Refunds	40,466,053	46,080,171	5,614,118	13.9%
SHOPP	439,111,504	439,111,504	-	0.0%
Other Revenues	12,618,187	12,797,774	179,586	1.4%
TOTAL REVENUES	**$ 3,377,502,183**	**$ 3,370,255,758**	**$ (7,246,425)**	**(0.2)%**

EXPENDITURES	FY14 Budget YTD	FY14 Actual YTD	Variance	% (Over)/ Under
ADMINISTRATION - OPERATING	**$ 50,447,773**	**$ 42,249,789**	**$ 8,197,984**	**16.3%**
ADMINISTRATION - CONTRACTS	**$ 102,313,334**	**$ 96,492,463**	**$ 5,820,871**	**5.7%**
MEDICAID PROGRAMS				
Managed Care:				
SoonerCare Choice	31,316,849	30,685,506	631,343	2.0%
Acute Fee for Service Payments:				
Hospital Services	791,590,492	779,233,666	12,356,826	1.6%
Behavioral Health	18,812,880	17,642,953	1,169,928	6.2%
Physicians	432,762,871	426,260,505	6,502,366	1.5%
Dentists	125,867,735	121,396,763	4,470,972	3.6%
Other Practitioners	38,799,724	36,226,700	2,573,024	6.6%
Home Health Care	18,695,775	17,400,412	1,295,363	6.9%
Lab & Radiology	56,868,473	52,963,800	3,904,674	6.9%
Medical Supplies	43,228,773	39,327,280	3,901,492	9.0%
Ambulatory/Clinics	99,261,350	94,773,690	4,487,660	4.5%
Prescription Drugs	358,838,795	378,173,387	(19,334,592)	(5.4)%
OHCA TFC	1,461,472	1,709,688	(248,216)	0.0%
Other Payments:				
Nursing Facilities	489,955,458	482,485,819	7,469,640	1.5%
ICF-MR Private	50,582,109	49,643,360	938,749	1.9%
Medicare Buy-In	113,341,306	113,625,726	(284,420)	(0.3)%
Transportation	52,610,935	54,362,213	(1,751,278)	(3.3)%
MFP-OHCA	1,373,434	828,077	545,357	0.0%
EHR-Incentive Payments	22,894,985	22,894,985	-	0.0%
Part D Phase-In Contribution	63,812,397	64,252,741	(440,343)	(0.7)%
SHOPP payments	406,660,322	406,660,322	-	0.0%
Total OHCA Medical Programs	**3,218,736,136**	**3,190,547,591**	**28,188,545**	**0.9%**
OHCA Non-Title XIX Medical Payments	89,382	-	89,382	0.0%
TOTAL OHCA	**$ 3,371,586,625**	**$ 3,329,289,842**	**$ 42,296,783**	**1.3%**
REVENUES OVER/(UNDER) EXPENDITURES	**$ 5,915,558**	**$ 40,965,915**	**$ 35,050,357**	

OKLAHOMA HEALTH CARE AUTHORITY
Total Medicaid Program Expenditures
by Source of State Funds
Fiscal Year 2014, For the Ten Months Ended April 30, 2014

Category of Service	Total	Health Care Authority	Quality of Care Fund	HEEIA	Medicaid Program Fund	BCC Revolving Fund	Other State Agencies
SoonerCare Choice	$ 30,955,878	$ 30,671,387	$ -	$ 270,372	$ -	$ 14,119	$ -
Inpatient Acute Care	637,733,031	499,497,782	405,572	7,399,484	42,284,749	1,674,086	86,471,358
Outpatient Acute Care	243,325,999	231,689,505	34,670	7,954,522	-	3,647,302	-
Behavioral Health - Inpatient	21,602,135	10,450,186	-	439,307	-		10,712,642
Behavioral Health - Psychiatrist	7,192,766	7,192,766	-	-	-	-	-
Behavioral Health - Outpatient	21,761,700	-	-	-	-	-	21,761,700
Behavioral Health Facility- Rehab	243,010,864	-	-	-	-	71,465	242,939,399
Behavioral Health - Case Management	8,553,895	-	-	-	-	-	8,553,895
Behavioral Health - PRTF	79,013,183	-	-	-	-	-	79,013,183
Residential Behavioral Management	17,317,614	-	-	-	-	-	17,317,614
Targeted Case Management	55,055,523	-	-	-	-	-	55,055,523
Therapeutic Foster Care	1,709,688	1,709,688	-	-	-	-	-
Physicians	474,430,560	364,322,163	48,417	10,200,263	56,584,749	5,305,176	37,969,792
Dentists	121,457,480	115,562,976	-	60,716	5,810,214	23,574	-
Mid Level Practitioners	3,042,134	2,985,045	-	53,664	-	3,425	-
Other Practitioners	33,443,511	31,994,579	371,970	205,282	863,172	8,509	-
Home Health Care	17,400,601	17,376,912	-	189	-	23,500	-
Lab & Radiology	55,593,550	52,407,753	-	2,629,750	-	556,047	-
Medical Supplies	39,802,135	37,029,976	2,259,614	474,855	-	37,690	-
Clinic Services	97,736,793	86,391,208	-	978,623	-	202,974	10,163,989
Ambulatory Surgery Centers	8,525,919	8,164,604	-	346,411	-	14,904	-
Personal Care Services	11,236,310	-	-	-	-	-	11,236,310
Nursing Facilities	482,485,819	271,010,881	177,431,689	-	34,034,926	8,323	-
Transportation	54,161,802	49,248,113	2,195,694	-	2,670,733	47,261	-
GME/IME/DME	91,050,944	-	-	-	-	-	91,050,944
ICF/MR Private	49,643,360	39,784,927	9,145,832	-	712,601	-	-
ICF/MR Public	32,530,538	-	-	-	-	-	32,530,538
CMS Payments	177,878,466	177,277,670	600,797	-	-	-	
Prescription Drugs	392,225,332	337,419,530	-	14,051,945	39,364,206	1,389,651	-
Miscellaneous Medical Payments	200,490	192,905	-	79	-	7,506	-
Home and Community Based Waiver	144,925,264	-	-	-	-	-	144,925,264
Homeward Bound Waiver	75,955,577	-	-	-	-	-	75,955,577
Money Follows the Person	8,579,360	828,077	-	-	-	-	7,751,284
In-Home Support Waiver	20,134,595	-	-	-	-	-	20,134,595
ADvantage Waiver	154,883,044	-	-	-	-	-	154,883,044
Family Planning/Family Planning Waiver	9,816,685	-	-	-	-	-	9,816,685
Premium Assistance*	37,808,149	-	-	37,808,149		-	-
EHR Incentive Payments	22,894,985	22,894,985	-	-	-	-	-
SHOPP Payments**	406,660,323	406,660,323	-	-	-	-	-
Total Medicaid Expenditures	**$ 4,391,736,001**	**$2,802,763,938**	**$ 192,494,256**	**$ 82,873,610**	**$ 182,325,349**	**$ 13,035,513**	**$1,118,243,336**

* Includes $37,517,602.19 paid out of Fund 245 and **$182,116,227.02 paid out of Fund 205

OKLAHOMA HEALTH CARE AUTHORITY

Summary of Revenues & Expenditures:
Other State Agencies
Fiscal Year 2014, For the Ten Months Ended April 30, 2014

		FY14 Actual YTD
REVENUE		
Revenues from Other State Agencies	$	467,424,216
Federal Funds		719,881,733
TOTAL REVENUES	**$**	**1,187,305,949**
EXPENDITURES		**Actual YTD**
Department of Human Services		
Home and Community Based Waiver	$	144,925,264
Money Follows the Person		7,751,284
Homeward Bound Waiver		75,955,577
In-Home Support Waivers		20,134,595
ADvantage Waiver		154,883,044
ICF/MR Public		32,530,538
Personal Care		11,236,310
Residential Behavioral Management		12,691,272
Targeted Case Management		40,438,583
Total Department of Human Services		**500,546,467**
State Employees Physician Payment		
Physician Payments		37,969,792
Total State Employees Physician Payment		**37,969,792**
Education Payments		
Graduate Medical Education		44,367,799
Graduate Medical Education - PMTC		3,412,990
Indirect Medical Education		31,088,706
Direct Medical Education		12,181,449
Total Education Payments		**91,050,944**
Office of Juvenile Affairs		
Targeted Case Management		2,500,376
Residential Behavioral Management		4,626,342
Total Office of Juvenile Affairs		**7,126,718**
Department of Mental Health		
Case Management		8,553,895
Inpatient Psych FS		10,712,642
Outpatient		21,761,700
PRTF		79,013,183
Rehab		242,939,399
Total Department of Mental Health		**362,980,819**
State Department of Health		
Children's First		1,826,318
Sooner Start		1,956,772
Early Intervention		5,167,802
EPSDT Clinic		1,798,935
Family Planning		(150,382)
Family Planning Waiver		9,934,789
Maternity Clinic		54,591
Total Department of Health		**20,588,826**
County Health Departments		
EPSDT Clinic		673,545
Family Planning Waiver		32,277
Total County Health Departments		**705,822**
State Department of Education		**99,970**
Public Schools		**5,022,475**
Medicare DRG Limit		**77,702,312**
Native American Tribal Agreements		**5,680,146**
Department of Corrections		**2,028,503**
JD McCarty		**6,740,543**
Total OSA Medicaid Programs	**$**	**1,118,243,336**
OSA Non-Medicaid Programs	**$**	**64,660,766**
Accounts Receivable from OSA	**$**	**(4,401,847)**

OKLAHOMA HEALTH CARE AUTHORITY

SUMMARY OF REVENUES & EXPENDITURES:

Fund 205: Supplemental Hospital Offset Payment Program Fund

Fiscal Year 2014, For the Ten Months Ended April 30, 2014

REVENUES		FY 14 Revenue
SHOPP Assessment Fee	$	178,616,889
Federal Draws		260,325,604
Interest		148,131
Penalties		20,881
State Appropriations		(22,700,000)
TOTAL REVENUES	$	416,411,504

EXPENDITURES	Quarter	Quarter	Thru Fund 340 Quarter	Quarter		FY 14 Expenditures
Program Costs:	7/1/13 - 9/30/13	10/1/13 - 12/31/13	1/1/14 - 3/31/14	4/1/14 - 6/30/14		
Hospital - Inpatient Care	76,710,371	86,962,208	87,919,865	93,110,378	$	344,702,822
Hospital -Outpatient Care	2,748,407	2,899,948	14,433,147	15,081,373	$	35,162,875
Psychiatric Facilities-Inpatient	5,785,055	6,483,431	6,540,191	6,928,169	$	25,736,846
Rehabilitation Facilities-Inpatient	248,410	278,398	257,838	273,133	$	1,057,779
Total OHCA Program Costs	85,492,242	96,623,985	109,151,041	115,393,054	$	406,660,322
Total Expenditures					$	406,660,322
CASH BALANCE					$	9,751,182

OKLAHOMA HEALTH CARE AUTHORITY
SUMMARY OF REVENUES & EXPENDITURES:
Fund 230: Nursing Facility Quality of Care Fund
Fiscal Year 2014, For the Ten Months Ended April 30, 2014

REVENUES	Total Revenue	State Share
Quality of Care Assessment	**$ 64,573,758**	**$ 64,573,758**
Interest Earned	**33,842**	**33,842**
TOTAL REVENUES	**$ 64,607,600**	**$ 64,607,600**

EXPENDITURES	FY 14 Total $ YTD	FY 14 State $ YTD	Total State $ Cost
Program Costs			
NF Rate Adjustment	$ 174,379,581	$ 62,776,649	
Eyeglasses and Dentures	236,329	85,078	
Personal Allowance Increase	2,815,780	1,013,681	
Coverage for DME and supplies	2,259,613	813,461	
Coverage of QMB's	860,630	309,827	
Part D Phase-In	600,797	600,797	
ICF/MR Rate Adjustment	4,587,947	1,651,661	
Acute/MR Adjustments	4,557,885	1,640,839	
NET - Soonerride	2,195,694	790,450	
Total Program Costs	**$ 192,494,255**	**$ 69,682,442**	**$ 69,682,442**
Administration			
OHCA Administration Costs	$ 392,910	$ 196,455	
PHBV - QOC Exp	-	-	
OSDH-NF Inspectors	800,000	800,000	
Mike Fine, CPA	9,500	4,750	
Total Administration Costs	**$ 1,202,410**	**$ 1,001,205**	**$ 1,001,205**
Total Quality of Care Fee Costs	**$ 193,696,665**	**$ 70,683,647**	
TOTAL STATE SHARE OF COSTS			**$ 70,683,647**

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

OKLAHOMA HEALTH CARE AUTHORITY

SUMMARY OF REVENUES & EXPENDITURES:

Fund 245: Health Employee and Economy Improvement Act Revolving Fund

Fiscal Year 2014, For the Ten Months Ended April 30, 2014

REVENUES	FY 13 Carryover	FY 14 Revenue	Total Revenue
Prior Year Balance	$ 10,427,850	$ -	$ 3,665,468
State Appropriations	-	-	(3,000,000)
Tobacco Tax Collections	-	34,639,050	34,639,050
Interest Income	-	180,936	180,936
Federal Draws	375,153	25,548,224	25,548,224
All Kids Act	(6,777,250)	206,106.38	206,106
TOTAL REVENUES	**$ 4,025,753**	**$ 60,574,317**	**$ 61,033,678**

EXPENDITURES		FY 13 Expenditures	FY 14 Expenditures	Total $ YTD
Program Costs:				
	Employer Sponsored Insurance		$ 37,025,853	$ 37,025,853
	College Students		290,547	290,547
	All Kids Act		491,750	491,750
Individual Plan				
	SoonerCare Choice		$ 259,785	$ 93,523
	Inpatient Hospital		7,385,424	2,658,753
	Outpatient Hospital		7,838,529	2,821,871
	BH - Inpatient Services-DRG		423,698	152,531
	BH -Psychiatrist		-	-
	Physicians		10,119,706	3,643,094
	Dentists		42,920	15,451
	Mid Level Practitioner		52,904	19,045
	Other Practitioners		198,625	71,505
	Home Health		189	68
	Lab and Radiology		2,602,403	936,865
	Medical Supplies		470,676	169,444
	Clinic Services		960,387	345,739
	Ambulatory Surgery Center		345,553	124,399
	Prescription Drugs		13,890,051	5,000,418
	Miscellaneous Medical		79	79
	Premiums Collected		-	(1,078,386)
Total Individual Plan			**$ 44,590,930**	**$ 14,974,399**
	College Students-Service Costs		**$ 393,764**	**$ 141,755**
	All Kids Act- Service Costs		**$ 80,768**	**$ 29,076**
Total OHCA Program Costs			**$ 82,873,611**	**$ 52,953,380**
Administrative Costs				
	Salaries	$ 7,360	$ 899,468	$ 906,828
	Operating Costs	85,634	618,116	703,751
	Health Dept-Postponing	-	-	-
	Contract - HP	267,291	906,478	1,173,769
Total Administrative Costs		**$ 360,286**	**$ 2,424,062**	**$ 2,784,347**
Total Expenditures				**$ 55,737,727**
NET CASH BALANCE		**$ 3,665,468**		**$ 5,295,951**

OKLAHOMA HEALTH CARE AUTHORITY
SUMMARY OF REVENUES & EXPENDITURES:
Fund 250: Belle Maxine Hilliard Breast and Cervical Cancer Treatment Revolving Fund
Fiscal Year 2014, For the Ten Months Ended April 30, 2014

REVENUES	FY 14 Revenue	State Share
Tobacco Tax Collections	$ 691,231	$ 691,231
TOTAL REVENUES	**$ 691,231**	**$ 691,231**

EXPENDITURES	FY 14 Total $ YTD	FY 14 State $ YTD	Total State $ Cost
Program Costs			
SoonerCare Choice	$ 14,119	$ 3,558	
Inpatient Hospital	1,674,086	421,870	
Outpatient Hospital	3,647,302	919,120	
Inpatient Services-DRG	-	-	
Psychiatrist	-	-	
TFC-OHCA	-	-	
Nursing Facility	8,323	2,097	
Physicians	5,305,176	1,336,904	
Dentists	23,574	5,941	
Mid-level Practitioner	3,425	863	
Other Practitioners	8,509	2,144	
Home Health	23,500	5,922	
Lab & Radiology	556,047	140,124	
Medical Supplies	37,690	9,498	
Clinic Services	202,974	51,149	
Ambulatory Surgery Center	14,904	3,756	
Prescription Drugs	1,389,651	350,192	
Transportation	47,261	11,910	
Miscellaneous Medical	7,506	1,892	
Total OHCA Program Costs	$ 12,964,048	$ 3,266,940	
OSA DMHSAS Rehab	$ 71,465	$ 18,009	
Total Medicaid Program Costs	$ 13,035,513	$ 3,284,949	
TOTAL STATE SHARE OF COSTS			**$ 3,284,949**

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.

SoonerCare Programs

April 2014 Data for June 2014 Board Meeting

SOONERCARE ENROLLMENT/EXPENDITURES

Delivery System			Monthly Enrollment Average SFY2013	Enrollment April 2014	Total Expenditures April 2014	Average Dollars Per Member Per Month April 2014
SoonerCare Choice Patient-Centered Medical Home			513,315	**565,329**	**$185,870,951**	
	Lower Cost	*(Children/Parents; Other)*		518,292	$144,031,382	$278
	Higher Cost	*(Aged, Blind or Disabled; TEFRA; BCC)*		47,037	$41,839,569	$890
SoonerCare Traditional			217,231	**197,795**	**$222,749,740**	
	Lower Cost	*(Children/Parents; Other)*		88,978	$47,613,261	$535
	Higher Cost	*(Aged, Blind or Disabled; TEFRA; BCC & HCBS Waiver)*		108,174	$175,136,480	$1,619
SoonerPlan*			48,346	**45,282**	**$766,425**	$17
Insure Oklahoma			30,202	**19,106**	**$7,121,533**	
	Employer-Sponsored Insurance		16,644	14,154	$4,148,436	$293
	*Individual Plan**		13,559	4,952	$2,973,097	$600
TOTAL			**809,094**	**827,512**	**$416,508,650**	

The enrollment totals above include all members enrolled during the report month; therefore, some members may not have expenditure data.
Custody expenditures are excluded. Non-member specific expenditures of $161,249,978 are excluded.

*In January 2014, SoonerPlan's qualifying income guidelines decreased from 185% to 133% of FPL and Insure Oklahoma IP's qualifying income guidelines decreased from 200% to 100% of FPL.

Net Enrollee Count Change from Previous Month Total**	(22,908)

**The decrease in Net Enrollees was mostly due to the requirement to maintain coverage through March 2014.

New Enrollees	18,047

Members that have not been enrolled in the past 6 months.

Dual Enrollees & Long-Term Care Members (subset of data above)

Medicare and SoonerCare		Monthly Average SFY2013	Enrolled April 2014
Dual Enrollees		**108,514**	**109,819**
	Child	*201*	179
	Adult	*108,313*	109,640

		Monthly Average SFY2013	Enrolled April 2014	FACILITY PER MEMBER PER MONTH
Long-Term Care Members		**15,674**	**15,276**	**$4,210**
	Child	64	61	
	Adult	15,610	15,215	

Child is defined as an individual under the age of 21.

SOONERCARE CONTRACTED PROVIDER INFORMATION

Provider Counts		Monthly Average SFY2013	Enrolled April 2014
Total Providers		**36,948**	**38,790**
	In-State	28,587	29,532
	Out-of-State	8,362	9,258

Provider Network includes providers who are contracted to provide health care services by locations, programs, types, and specialties. Providers are being counted multiple times if they have multiple locations, programs, types, and specialties.

Program	% of Capacity Used
SoonerCare Choice	45%
SoonerCare Choice I/T/U	19%
Insure Oklahoma IP	1%

Select Provider Type Counts	*In-State*		*Totals*	
	Monthly Average SFY2013	*Enrolled April 2014**	Monthly Average SFY2013	Enrolled April 2014
Physician	*7,859*	*8,570*	*12,432*	14,037
Pharmacy	*901*	*952*	*1,208*	1,289
Mental Health Provider**	*5,811*	*5,217*	*5,880*	5,257
Dentist**	*1,205*	*1,017*	*1,380*	1,148
Hospital**	*194*	*184*	*923*	775
Optometrist	*578*	*576*	*612*	607
Extended Care Facility	*362*	*355*	362	355

Above counts are for specific provider types and are not all-inclusive.

Total Primary Care Providers***	*4,997*	*5,519*	6,541	7,120
Patient-Centered Medical Home	*1,935*	*2,134*	1,985	2,225

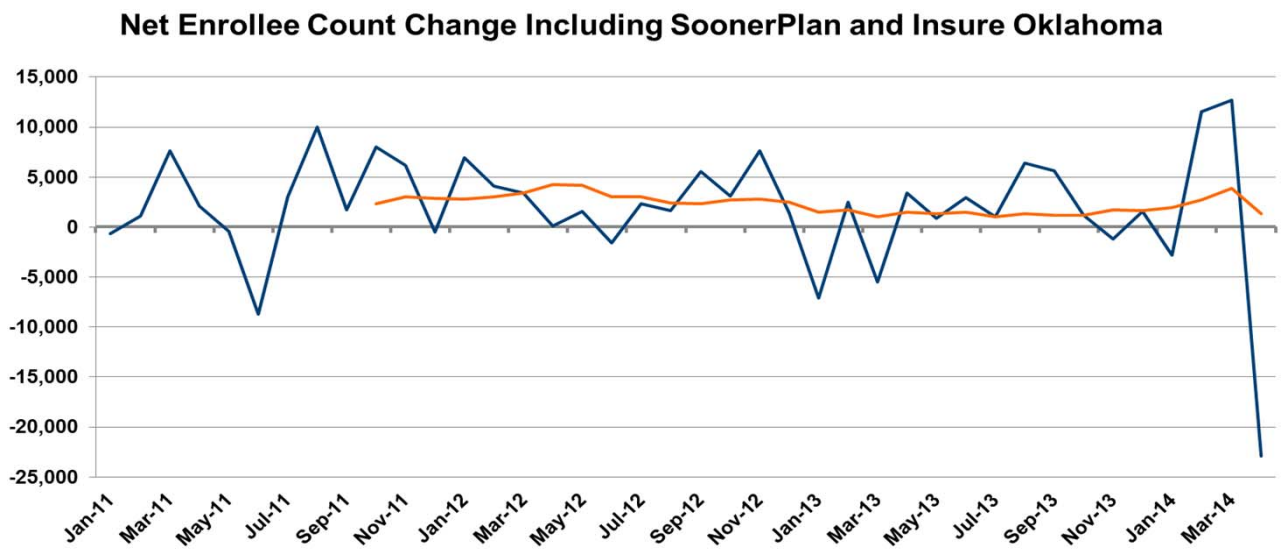
Including Physicians, Physician Assistants and Advance Nurse Practitioners.

*Items shaded above represent a 10% or more increase (green) or decrease (red) from the previous fiscal year's average.

**Decrease in current month's count is due to contract renewal period which is typical during all renewal periods. Hospitals renewal started in March 2013, renewals for Mental Health Providers started in June 2013 and Dentist renewals started in October 2013.

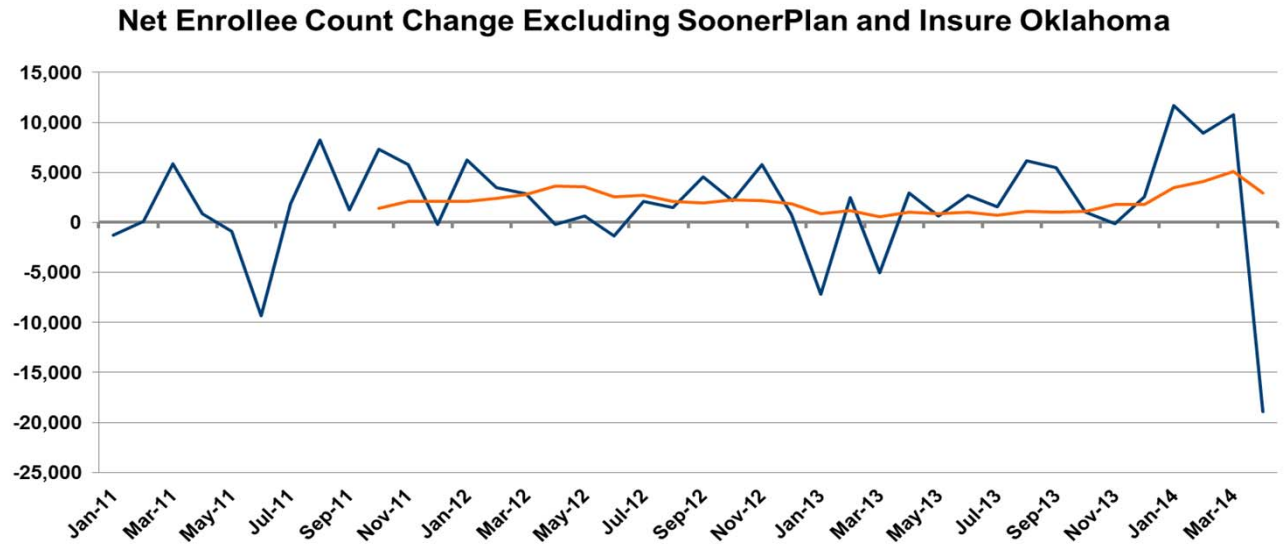
SoonerCare Programs

SOONERCARE NET ENROLLEE COUNT CHANGE FROM MONTH TO MONTH (Including SoonerPlan & Insure Oklahoma)



Net Enrollee Count Change includes SoonerPlan and Insure Oklahoma. Trendline is 10 month rolling average. In January 2014, SoonerPlan's qualifying income guidelines decreased from 185% to 133% of federal poverty level (FPL) and Insure Oklahoma IP's qualifying income guidelines decreased from 200% to 100% of FPL. The large decrease in April 2014 was due to some members with eligibility redeterminations between January and March 2014 having their enrollment extended until the end of March.

SOONERCARE NET ENROLLEE COUNT CHANGE FROM MONTH TO MONTH (Excluding SoonerPlan & Insure Oklahoma)



Net Enrollee Count Change excludes SoonerPlan and Insure Oklahoma. Trendline is 10 month rolling average. The large decrease in April 2014 was due to some members with eligibility redeterminations between January and March 2014 having their enrollment extended until the end of March.

Oklahoma Health Care Authority

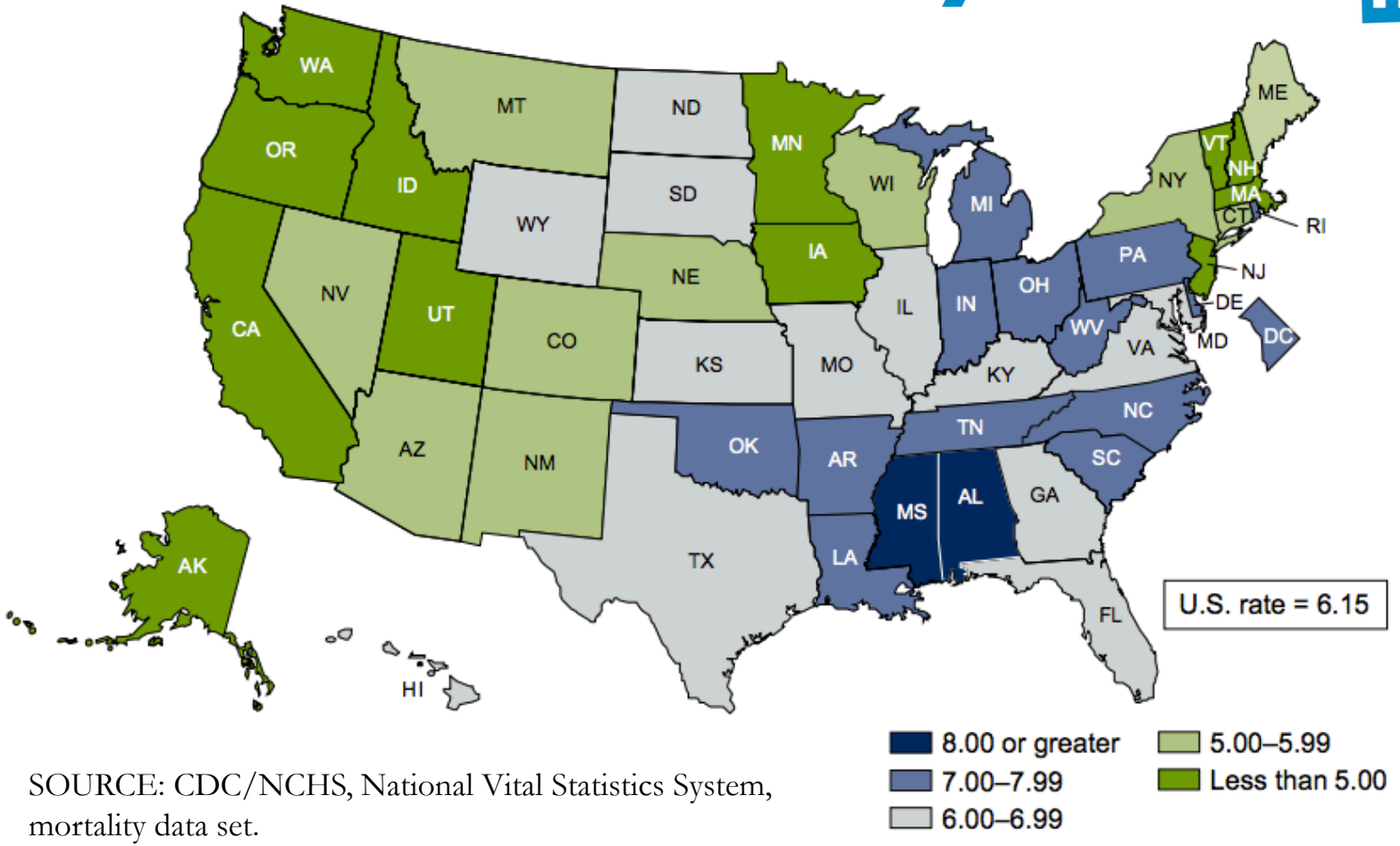
OHCA QUALITY EFFORTS IN MATERNAL & INFANT HEALTH

June 2014

Shelly Patterson, MPH

US Infant Mortality 2010

Oklahoma HealthCare Authority

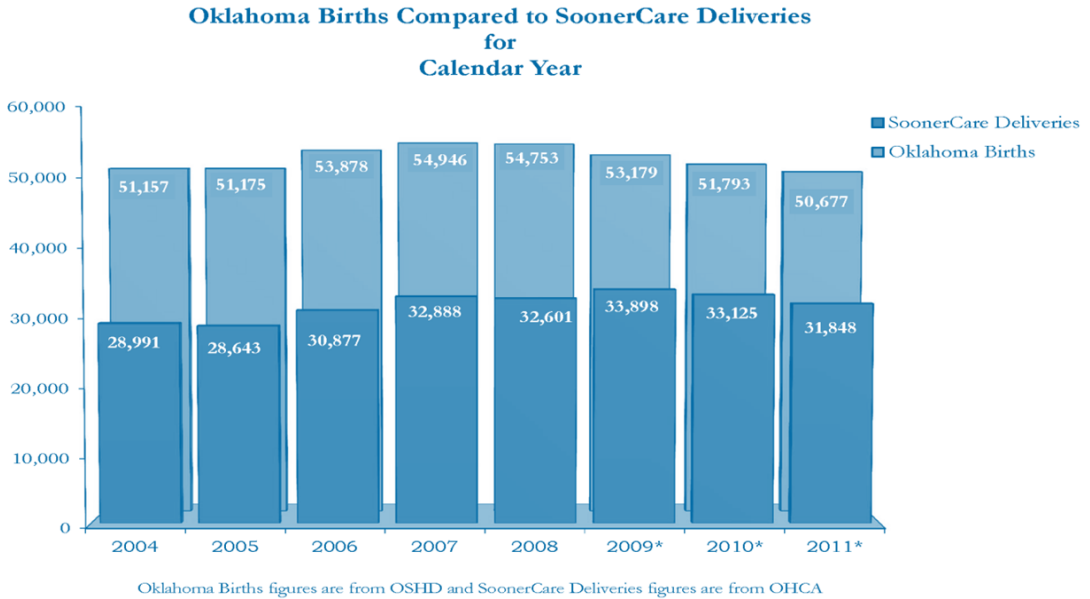


SOURCE: CDC/NCHS, National Vital Statistics System, mortality data set.

SoonerCare & Pregnancy

2012

- 51,859 Total OK Births
- 32,517 Deliveries Covered by SoonerCare



Oklahoma Births figures are from OSHD and SoonerCare Deliveries figures are from OHCA

* 2009, 2010, and 2011 Oklahoma Births data are preliminary figures.

Improving Birth Outcomes

Oklahoma HealthCare Authority

National Focus

- HRSA Collaborative Improvement & Innovation Network to Reduce Infant Mortality (COIIN)
- CMS Initiatives
  - Expert Panel on Improving Infant Health Outcomes in Medicaid/CHIP
  - Strong Start for Mothers and Newborns
  - Text for Baby Partnership

Improving Birth Outcomes

State Focus

- OHCA-OSDH Perinatal Advisory Taskforce (2005-2014)
- Oklahoma Perinatal Quality Collaborative (Initiated Spring 2014)
- OSDH Preparing for a Lifetime

OHCA Initiatives

- OHCA C-section Reduction
- Strong Start
- OHCA Fetal/Infant Mortality Reduction
- Interconception Care for Adolescent Mothers
- SoonerQuit
- Baby Friendly Hospitals
- Text for Baby

OHCA Cesarean Section Reduction Quality Initiative

Oklahoma HealthCare Authority

Reduce rate of C-section with no medical indication among SoonerCare members

- **Established January 2011**
- **Rate reports to providers and hospitals**
- **Medical review**
- **Reduced payment for deliveries with no medical indication**

OHCA C-section Reduction

Oklahoma HealthCare Authority

Cesarean Section Rates Among SoonerCare Providers

SoonerCare Rates	SFY 2009	SFY 2011	SFY 2012	SFY 2013
Total C-Section Rate	32.16%	33.1%	30.9%	31.3%
Primary C-Section Rate	20.3%	19.5%	16.6%	16.9%

Strong Start

Oklahoma HealthCare Authority

CMS grant

- **Group prenatal care**
  - **Reduce rate of preterm birth**
  - **Improve health outcomes for pregnant women and newborns**
  - **Decrease associated costs during pregnancy and first year of life of newborn**

Fetal & Infant Mortality Reduction Initiative (FIMR)

Oklahoma HealthCare Authority

Ten counties with highest infant mortality rates

- **Care Management**
  - **For mother during pregnancy and postpartum**
  - **For newborn's first year**

Interconception Care (ICC)

Oklahoma HealthCare Authority

Extension of FIMR

- Mothers 18 years and less in FIMR counties
  - Health needs related to adolescent pregnancy
  - Promote postpartum care
  - Promote preventive care for mother for one year following birth

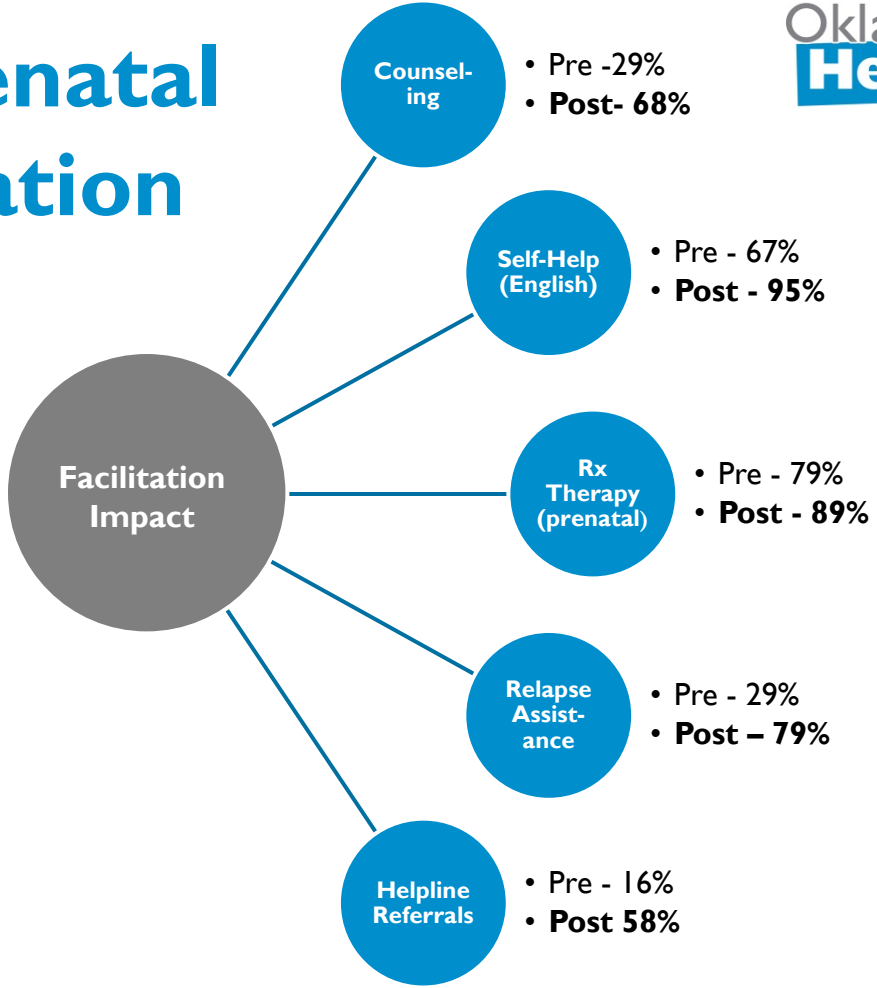
SoonerQuit

Oklahoma HealthCare Authority

OHCA Tobacco Cessation Initiatives

- OK Tobacco Helpline Agreement
- SoonerQuit for Women Media
- SoonerQuit Prenatal/Provider Engagement
- Internal Linkages & Process Improvement
  - Internal Fax Referral System
  - Pharmacy Bag Promotion
  - Provider/Member Education

SoonerQuit Prenatal Practice Facilitation Impact

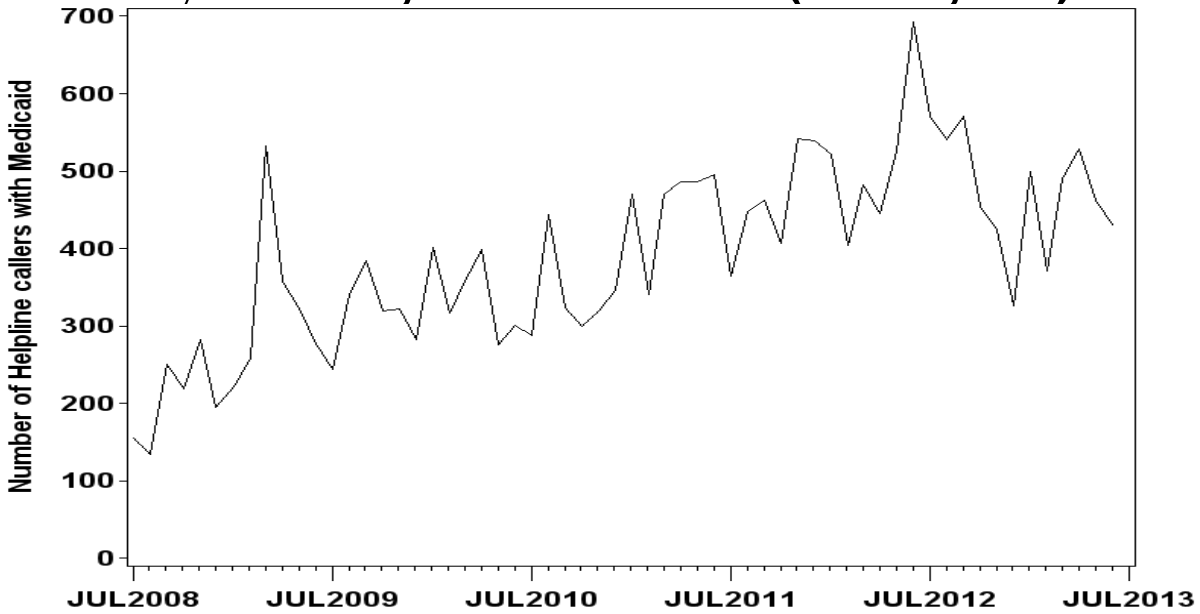


Source- PHPG, SoonerQuit Prenatal Tobacco Cessation Evaluation Report, March 2013

SoonerCare Members & OK Tobacco Helpline Use

Oklahoma HealthCare Authority

Number of Helpline callers with SoonerCare, by month, FY2009-2013 (n=23,430)



Source- Oklahoma Tobacco Research Center, December 2013

Smoking Rates among Adults Cove by SoonerCare

Oklahoma HealthCare Authority

Question: Do you now smoke cigarettes or use tobacco every day, some days, or not at all?

Adult CAHPS® Survey - Percent of Smokers	
OHCA SFY2008	47.8%
OHCA SFY2010	45.5%
OHCA SFY2012	44.4%
OHCA SFY2013	43.0%

Percentages indicate members that answered 'every day' or 'some days'

Source- Adult Medical Health Care Services (CAHPS) Survey www.okhca.org/studies

Becoming Baby Friendly in Oklahoma

Oklahoma HealthCare Authority

- Collaboration with OK State Department of Health to increase breastfeeding initiation and duration
- Increase the number of "Baby-Friendly" hospitals in Oklahoma
- Ten hospitals annually to implement American Academy of Pediatrics endorsed *Ten Steps to Successful Breastfeeding* to achieve Baby-Friendly designation

Text4baby

- Collaboration with National Healthy Mothers Healthy Babies Coalition
- Free mobile health information service for pregnant women and new parents
- Text Baby or Bebe to 511411
- Receive 3 messages per week timed to due date or baby's 1st birthday

Text4baby

Oklahoma HealthCare Authority

Three year pilot awarded by CMS

- **Implement a customized version of Text4Baby**
- **Increase enrollment of pregnant SoonerCare members in Text4baby (20-25% of pregnant SC members)**
  - **Integration into related programs**
  - **Media promotion, partner events**
  - **Governor Fallin PSA**

Text4baby

Oklahoma HealthCare Authority

Questions?

Shelly Patterson, MPH
Director, Health Promotion & Community Relations
Oklahoma Health Care Authority
4345 N. Lincoln Blvd.
Oklahoma City, OK 73105
405-522-7332
Shelly.Patterson@okhca.org

OHCA

Quality Efforts in Maternal and Child Health

Garth L. Splinter, MD, MBA and Shelly Patterson, MPH

The Oklahoma Health Care Authority (OHCA), administrator for SoonerCare (Oklahoma's Medicaid), has a deep commitment to improving the health of infants and children. Individuals age 18 and younger are the largest number of enrollees in the SoonerCare program, at approximately 63 percent (state fiscal year 2014 total child enrollment as of April was 574,606). These SoonerCare enrollees are eligible to receive an array of treatment and physician services, including dental, behavioral health, prescription drugs and other child health services. SoonerCare also offers maternity benefits to increase the chances that our youngest Oklahomans get a healthy start in life. In fact, SoonerCare covers 64 percent of pregnant women in the state.

However, OHCA does much more than provide health coverage to eligible pregnant women and children. The OHCA has initiated and/or collaborated on a number of health and community programs for the benefit of children.

In 2011, the **OHCA Cesarean Section (C-section) Quality Initiative** began with the goal of reducing the rates of C-sections that had no medical indication among our SoonerCare members. The medical literature reports that as many as 5-30 percent of C-sections lack medical indication. Based on our data from 2008-2009, approximately 12 percent of SoonerCare members had a primary Cesarean section without documentation of medical necessity.

Beginning in January 2011 and continuing over the subsequent 8 months, every contracted OHCA in-state provider and hospital that performed a minimum of two SoonerCare deliveries per month received a letter with their primary C-section rate and total C-section rate every month. This presented an opportunity for providers to review their processes and make changes internally before medical chart review began in September 2011. Medical chart review was and continues to be conducted for those physicians who had a primary C-section rate of 18 percent or greater. Rates have been reported quarterly since August 2011 and are posted on our public website under the Cesarean Section tab. The results of primary and total C-section rates over the last several years for the SoonerCare members are listed below.

C-SECTION RATES AMONG SOONERCARE PROVIDERS

SoonerCare Rates	SFY 2009	SFY 2011	SFY 2012	SFY 2013
Total C-Section Rate	32.16%	33.1%	30.9%	31.3%
Primary C-Section Rate	20.3%	19.5%	16.6%	16.9%

Through the OHCA C-section Quality Initiative, providers who have performed a primary C-section without a medical indication have their billed charges adjusted to the vaginal delivery rate; hospitals are reimbursed at the complicated vaginal delivery rate. The model has performed so well in reducing Oklahoma's C-Section rates that private payers are starting to follow suit. Many states address the growing trend of early elective delivery by denial of payment for delivery.

Since the initiation of this program, the OHCA has utilized an independent vendor to evaluate the program. That vendor has been able to validate that the primary C-section rate significantly decreased for the Central, Northwest, Southeast and Tulsa regions. The decrease in the primary C-section rate of medically-unnecessary C-sections was significant for the American Indian population which decreased from 2 percent to 1.14 percent. The cost savings to the taxpayers for this period was $1.2 million over the two year study period for those records which were reviewed.

OHCA's Population Care Management (PCM) department initiated the **Fetal Infant Mortality Reduction (FIMR)** program in March 2011, a collaboration with OHCA Child Health and Behavioral Health units and Oklahoma State Department of Health (OSDH) Maternal Child Health. Telephonic intervention focuses on all pregnant women with SoonerCare eligibility residing in the top 10 Oklahoma counties where infant mortality is highest. Topics include tobacco cessation, breastfeeding, depression screening and other pregnancy-related health matters, with continued educational outreach with the member through her infant's first year of life.

The Interconception Care (ICC) Initiative extends case management services for adolescent mothers (age 18 and under) participating in the OHCA FIMR project. This initiative focuses on the special health needs of the adolescent mother and covers postpartum care, family planning, preventive and other important health services for one year following delivery. OHCA staff report this project is well-received by our members; the program is currently being evaluated by an independent body.

SoonerQuit Prenatal and SoonerQuit for Women are two of OHCA's most well-known and successful partnerships with the Oklahoma Tobacco Settlement Endowment Trust (TSET).

- SoonerQuit Prenatal - Tobacco use during pregnancy is one of the greatest predictors of poor outcomes. This program educates SoonerCare obstetric providers on best practices for tobacco cessation for their prenatal and postpartum patients. This is a systems level change that could potentially improve the birth outcomes in the state. There is a new initiative to extend practice facilitation to PCPs.
- SoonerQuit for Women - Encourages women of child-bearing age to talk to their doctor about smoking cessation. Tobacco cessation among this population is a critical factor in positively impacting the health of families across the life span. The SoonerQuit for Women media campaign includes television commercials, billboards and bus ads.

Several collaborations with the Oklahoma State Department of Health (OSDH) aim to improve the health status of children, including **Becoming Baby-Friendly in Oklahoma** (BBFOK) and the **Preparing for a Lifetime** infant mortality reduction effort (http://iio.health.ok.gov). The first provides support to Oklahoma birthing hospitals in the promotion of system-level changes that increase lactation rates prior to hospital discharge and extend the longevity of breastfeeding postpartum; the latter is a statewide public education initiative focused on priority areas identified through data. The overarching goal is to improve the health status of mothers and infants (e.g. preconception/interconception health, prematurity, tobacco, postpartum depression and safe sleep). In addition, a newly-created OHCA/OSDH **Immunization workgroup** has begun to tackle low childhood vaccination rates in Oklahoma in select counties. The initiative aims to increase the number of children age 19 to 35 months receiving the complete 15-shot immunization series (4:3:1:3:3:1).

In regard to national maternal and child health programming, OHCA is involved in several different projects, most notably **Strong Start for Mothers and Newborns** and **Text4Baby.**

Strong Start is an initiative to reduce the rate of preterm births, improve the health outcomes of pregnant women and newborns, and decrease the anticipated total cost of medical care during pregnancy and delivery. OHCA's Strong Start

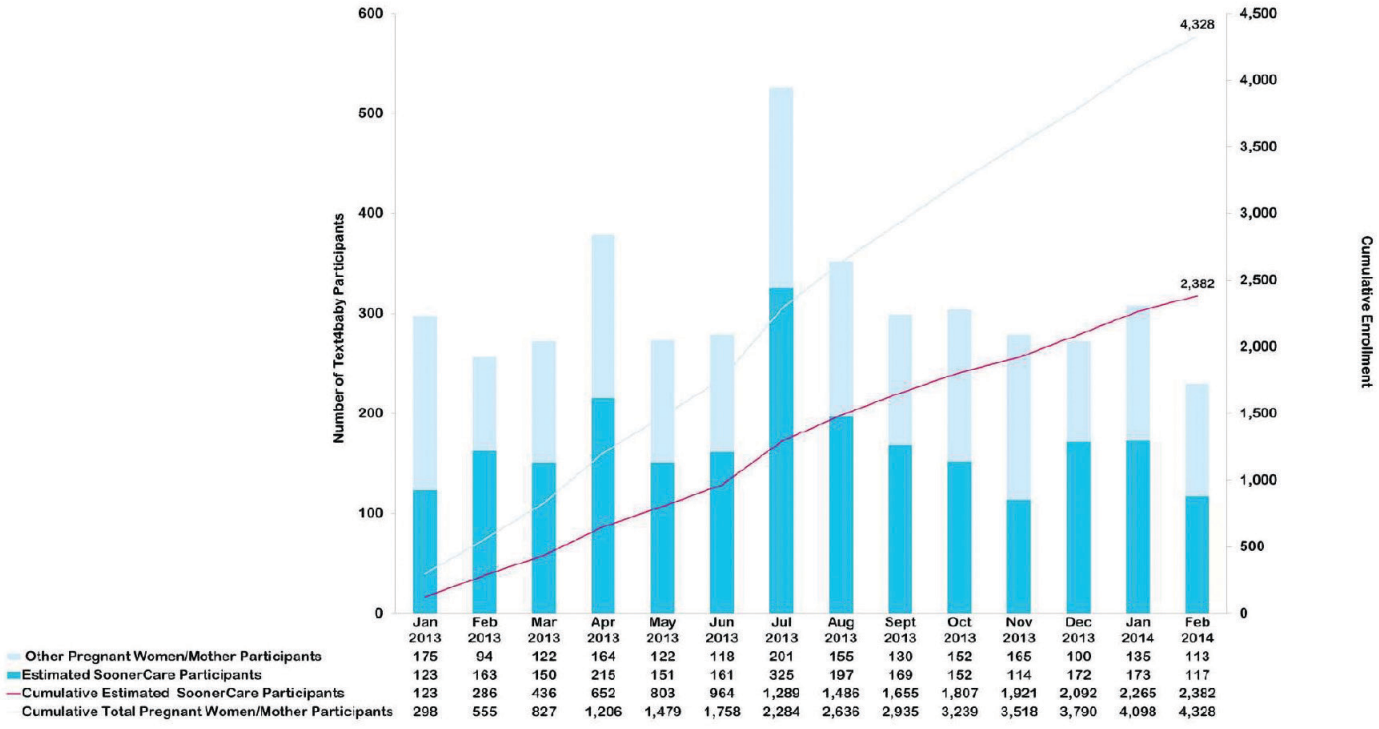
INCREASE IN CALLS TO THE OKLAHOMA TOBACCO HELPLINE BY PREGNANT WOMEN

	Fiscal Year of Registration									
	2009 (N=1745)		2010 (N=2200)		2011 (N=2634)		2012 (N=3181)		2013 (N=2844)	
Pregnancy	N	%	N	%	N	%	N	%	N	%
Not Pregnant/ Not asked	1523	87.3%	1927	87.6%	2252	85.5%	2745	86.3%	2456	86.4%
Pregnant	156	8.9%	185	8.4%	273	10.4%	317	10.0%	288	10.1%
Planning Pregnancy	35	2.0%	51	2.3%	48	1.8%	61	1.9%	50	1.8%
Breastfeeding	31	1.8%	37	1.7%	61	2.3%	58	1.8%	50	1.8%

The SoonerQuit projects have transitioned to the OHCA's Member Services **Fax Referral** project, which helps connect pregnant SoonerCare members to Oklahoma Tobacco Helpline services. The Fax Referral program also helps the OHCA track the details of those members' tobacco quit plans and allow us to identify those who may need extra support.

Partners include the Oklahoma City Indian Health Clinic, the Choctaw Nation Tribal Clinic (Talihina), Oklahoma State University Department of Obstetrics (Tulsa), Mary Mahoney Memorial Health Center, Catholic Charities (Tulsa), the OSDH Vital Statistics Department and the March of Dimes. OHCA was the only Medicaid agency to receive this grant from the Centers for Medicare & Medicaid Services (CMS).

Text4baby Participants Who Enrolled Between 1/1/2013 and 2/28/2014, by Month with Estimated SoonerCare Status, Pregnant Women and Mothers, Oklahoma



	Jan 2013	Feb 2013	Mar 2013	Apr 2013	May 2013	Jun 2013	Jul 2013	Aug 2013	Sept 2013	Oct 2013	Nov 2013	Dec 2013	Jan 2014	Feb 2014
Other Pregnant Women/Mother Participants	175	94	122	164	122	118	201	155	130	152	165	100	135	113
Estimated SoonerCare Participants	123	163	150	215	151	161	325	197	169	152	114	172	173	117
Cumulative Estimated SoonerCare Participants	123	286	436	652	803	964	1,289	1,486	1,655	1,807	1,921	2,092	2,265	2,382
Cumulative Total Pregnant Women/Mother Participants	298	555	827	1,206	1,479	1,758	2,284	2,638	2,935	3,239	3,518	3,790	4,098	4,328

In fall 2013, CMS awarded Oklahoma a three-year contract to support **Text4baby** (T4B) implementation. The pilot project aims to increase enrollment of pregnant SoonerCare members into T4B (text4baby.org), a service that offers free mobile information addressing the health needs of pregnant women, infants and new parents. Topics include messages which encourage breastfeeding, postpartum appointments and well-baby check-ups. Although T4B is a national program, the pilot project allows for customized T4B messages that feature Oklahoma and SoonerCare-specific information and resources (e.g., messages that promote smoking cessation and discourage non-medically necessary early elective delivery). OHCA collaborates with multiple agencies and community partners statewide to promote this service. Providers are also encouraged to help get their pregnant patients enrolled.

What we've discussed here is by no means all-encompassing. OHCA is always researching new ways to improve the quality of child and maternal health as well as building upon the successes we've already made. So whereas SoonerCare provides our members access to the health services they need, these enhanced OHCA programs empower our members with information and resources to lead healthier lives. Isn't that what we all want for Oklahoma?

If you have ideas that you would like considered, please send them to us at MD-DDS.inquiries@okhca.org.

Shelly Patterson is OHCA's director of Health Promotion & Community Relations.

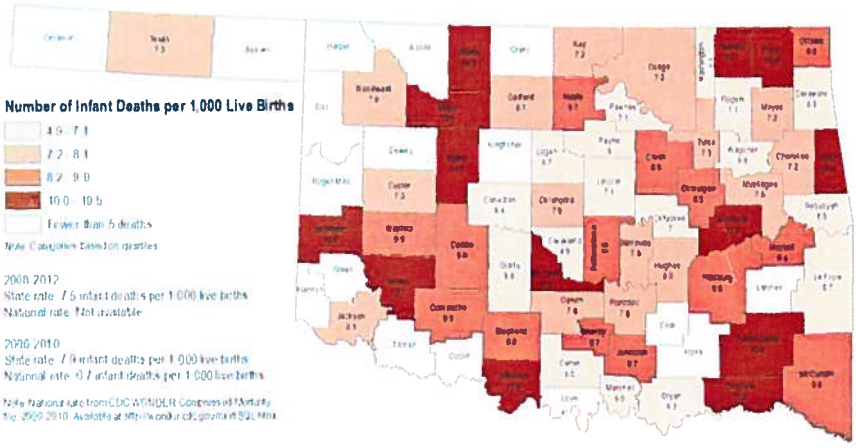
Infant Mortality

The infant mortality rate (IMR) is an important indicator of the health of a nation, and is also a reflection of maternal health, accessibility and quality of primary health care, and the availability of supportive services in the community.[28] The leading causes of infant death include congenital malformations (i.e., medical conditions present at birth), disorders related to short gestation (fewer than 37 weeks of pregnancy completed) and low birth weight (less than 5 lbs., 8 oz.), and Sudden Infant Death Syndrome (SIDS).[25] Oklahoma's IMR has declined 12.8% from its recent high of 8.6 deaths per 1,000 live births in 2006 to 7.5 deaths per 1,000 live births in 2012.[8] However, the rate is still significantly higher than the national (preliminary) rate of 6.05 infant deaths per 1,000 live births in 2011.[29] While organizations across Oklahoma have been working together to reduce infant mortality as part of the Preparing for a Lifetime, It's Everyone's Responsibility initiative,[30] there is still much work to do.

Racial disparities exist in IMR, with rates among Oklahoma's Black/African American infants being more than double the rates of White and Asian/Pacific Island infants. The IMR for Black/African American infants declined between 2003-2007 and 2008-2012 (16.4 to 14.6, respectively),[8] but is still extremely high.

From 2008-2012, the overall IMR for Oklahoma County was 7.9 deaths per 1,000 live births.[8] This rate is 5% higher than the state rate of 7.5 deaths per 1,000 live births[8] and 11% lower than the county rate from 2002-2006.[9] The IMR in Oklahoma County accounted for 36,150 years of potential life lost based on an average age of death in Oklahoma of 75 years.[8]

Infant Mortality Rate by County,
OSDH Vital Statistics, 2008-2012[8]



Receiving timely prenatal care is believed to reduce the risk of maternal and infant sickness and death as well as preterm delivery and low birth weight. From 2008-2012, 71.3% of women who had a live birth in Oklahoma County accessed prenatal care during the first trimester of their pregnancy.[26]

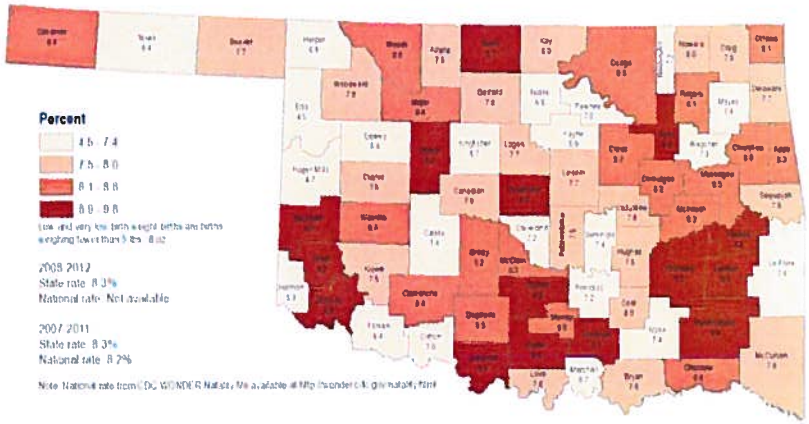
Low Birth Weight

Low birth weight and preterm births together are the second leading cause of death among children less than 1 year of age.[25] Low birth weight infants are more at risk of health problems compared to infants born of normal weight, including infection, gastrointestinal problems, delayed motor and social development, and learning disabilities. Low birth weight infants may also be at higher risk of high blood pressure, diabetes, and heart disease later in life.[31]

The percentage of Oklahoma babies born at low birth weight (i.e., weighing fewer than 5 pounds and 8 ounces, or 2500 grams) was 8.3% across 2008-2012.[26] This rate is similar to the latest national data (8.2% from 2007-2011).[32] In Oklahoma County, the rate of low birth weight births was 8.9% from 2008-2012,[26] which is similar to the rate from 2003-2007.[26]

As is seen with infant mortality, the percentage of low birth weight births is higher for Black/African American babies (14.1%) than babies of other races (White: 7.8%; American Indian: 7.3%; Asian/Pacific Island: 7.4%).[26]

Percent of Low and Very Low Birth Weight Births by County,
OSDH Vital Statistics, 2008-2012[26]



Recommendation 1: Prior Authorize Sovaldi™ (Sofosbuvir), Olysio™ (Simeprevir), Victrelis® (Boceprevir), and Incivek® (Telaprevir)

The coverage of hepatitis C treatments will be updated as new medications, new indications, and clinical guidelines become available.

The Drug Utilization Review Board recommends the prior authorization of Sovaldi™ (sofosbuvir), Olysio™ (simeprevir), Victrelis® (boceprevir), and Incivek® (telaprevir) with the following criteria:

Sovaldi™ (Sofosbuvir) Approval Criteria:

1. Member must be 18 years of age or older; and
2. An FDA approved diagnosis of Chronic Hepatitis C (CHC) with a METAVIR fibrosis score of F2 or greater; and
3. Sovaldi™ must be prescribed by a gastroenterologist, infectious disease specialist, or transplant specialist or the member must have been evaluated by a gastroenterologist, infectious disease specialist, or transplant specialist within the last three months; and
4. Sovaldi™ must be used as a component of a combination regimen; and
5. Member must be eligible for ribavirin (RBV) therapy. Approvals will not be granted for regimens without RBV; and
6. Hepatitis C Virus (HCV) genotype testing must be confirmed and indicated on prior authorization request; and
7. The following regimens and requirements based on genotype will apply:
    a. Genotype 1:
        i. Triple therapy: Sovaldi™ + Pegylated Interferon (PEG-IFN) + RBV x 12 weeks
        ii. Members who are PEG-IFN ineligible may be approved for total treatment duration of 24 weeks with a patient-specific, clinically significant reason why member cannot use PEG-IFN.
    b. Genotype 2:
        i. Dual therapy: Sovaldi™ + RBV x 12 weeks
    c. Genotype 3:
        i. Dual therapy: Sovaldi™ + RBV x 24 weeks
    d. Genotype 4:
        i. Triple therapy: Sovaldi™ + PEG-IFN + RBV x 12 weeks
    e. Hepatocellular Carcinoma:
        i. Dual therapy: Sovaldi™ + RBV x 48 weeks or until time of liver transplant (whichever occurs first)
        ii. Approvals will only be granted for HCV infected members (regardless of genotype) with hepatocellular carcinoma meeting the MILAN criteria (MILAN criteria defined as presence of a tumor 5cm or less in diameter in patients with single hepatocellular carcinomas and not more than three tumor nodules, each 3cm or less in diameter in patients with multiple tumors and no extrahepatic manifestations of the cancer or evidence of vascular invasion of tumor).
    f. New regimens will apply as approved by the FDA

8. Member must sign the intent to treat contract; and
9. Member must have no illicit IV drug use or alcohol abuse in the last six months and member must agree to no illicit IV drug use or alcohol use while on treatment and post-therapy; and
10. Must have documentation of initiation of immunization with the hepatitis A and B vaccines; and
11. Member must not have decompensated hepatic disease (Child Turcotte Pugh (CTP) class B or C); and
12. Female members must not be pregnant and must have a pregnancy test immediately prior to therapy initiation. Female partners of male patients should also be checked for pregnancy for informational purposes. Male and female members must be willing to use two forms of non-hormonal birth control while on therapy and for six months after therapy completion; and
13. Member must not be taking the following medications: rifampin, rifabutin, rifapentine, carbamazepine, phenytoin, oxcarbazepine, tipranavir/ritonavir, didanosine or St. John's wort; and
14. All other clinically significant issues must be addressed prior to starting therapy including but not limited to the following: neutropenia, anemia, thrombocytopenia, surgery, depression, psychosis, epilepsy, obesity, weight management, severe concurrent medical diseases, such as but not limited to, retinal disease or autoimmune thyroid disease.
15. Members must be adherent for continued approval. Treatment gaps of therapy longer than 3 days/month will result in denial of subsequent requests for continued therapy.

Olysio™ (Simeprevir) Approval Criteria:

1. Member must be 18 years of age or older; and
2. An FDA approved diagnosis of Chronic Hepatitis C (CHC) (genotype 1) with a METAVIR fibrosis score of F2 or greater; and
3. HCV genotype testing must be confirmed and indicated on prior authorization request; and
4. Members with genotype 1a must be screened for the NS3 Q80K polymorphism prior to initiation of therapy. Approvals will not be granted for members with this polymorphism; and
5. Olysio™ must be prescribed by a gastroenterologist, infectious disease specialist, or transplant specialist or the member must have been evaluated by a gastroenterologist, infectious disease specialist, or transplant specialist within the last three months; and
6. As indicated by the FDA, Olysio™ must be used as a component of a combination regimen.
    a. Olysio™ will be approved for combination therapy only.
    b. Triple therapy: Olysio™ + RBV + PEG-IFN x 12 weeks
    c. After completion of Olysio™ therapy member must continue on RBV and PEG-IFN therapy for:
        i. an additional 12 weeks for treatment naïve patients and prior relapsers including those with cirrhosis
        ii. an additional 36 weeks for prior non-responder patients (including partial and null-responders), including those with cirrhosis
    d. New regimens will apply as approved by the FDA

7. Member must not have previously failed treatment with a hepatitis C protease inhibitor (non-responder or relapsed); and
8. Member must not have decompensated hepatic disease (Child Turcotte Pugh (CTP) class B or C); and
9. Member must sign the intent to treat contract; and
10. Member must have no illicit IV drug use or alcohol abuse in the last six months and member must agree to no illicit IV drug use or alcohol use while on treatment and post-therapy; and
11. Must have documentation of initiation of immunization with the hepatitis A and B vaccines; and
12. Female members must not be pregnant and must have a pregnancy test immediately prior to therapy initiation. Female partners of male patients should also be checked for pregnancy for informational purposes. Male and female members must be willing to use two forms of non-hormonal birth control while on therapy and for six months after therapy completion; and
13. Member must not be taking the following medications: efavirenz, delavirdine, etravirine, nevirapine, ritanovir and any HIV protease inhibitor (boosted or not by ritanovir), rifampin, rifabutin, rifapentine, erythromycin, clarithromycin, telithromycin, carbamazepine, oxcarbazepine, phenobarbital, phenytoin, itraconazole, ketoconazole, posaconazole, fluconazole, voriconazole, dexamethasone, cisapride, didanosine, milk thistle, or St. John's wort; and
14. All other clinically significant issues must be addressed prior to starting therapy including but not limited to the following: neutropenia, anemia, thrombocytopenia, surgery, depression, psychosis, epilepsy, obesity weight management, severe concurrent medical diseases such as but not limited to retinal disease or autoimmune thyroid disease.
15. Members must be adherent for continued approval. Treatment gaps of therapy longer than 3 days/month will result in denial of subsequent requests for continued therapy.

Victrelis® (Boceprevir) and Incivek® (Telaprevir) Approval Criteria:

1. Use of Victrelis® or Incivek® requires a patient-specific, clinically significant reason why the member cannot use Olysio™ (simeprevir).
2. Those members currently receiving Victrelis® or Incivek® for the diagnosis of hepatitis C will be grandfathered for therapy completion.

Recommendation 2: Prior Authorize Trokendi XR™ (Topiramate ER), Aptiom® (Eslicarbazepine Acetate), Qudexy™ XR (Topiramate ER), and Generic Divalproex ER

The Drug Utilization Review Board recommends the prior authorization of Trokendi XR™ (topiramate extended-release), Aptiom® (eslicarbazepine acetate), Qudexy™ XR (topiramate extended-release), and generic divalproex extended-release with the following criteria:

1. **Trokendi XR™ (Topiramate Extended-Release) Approval Criteria:**

a. An FDA approved diagnosis of partial onset or primary generalized tonic-clonic seizures or as adjunctive therapy in seizures associated with Lennox-Gastaut syndrome; and
b. A patient-specific, clinically significant reason why member cannot use the short-acting formulation, Topamax® (topiramate).
c. A quantity limit of 30 per 30 days will apply on the lower strength capsules (25mg, 50mg, and 100mg) and 60 per 30 days on the higher strength capsules (200mg).

2. **Aptiom® (Eslicarbazepine Acetate) Approval Criteria:**
   a. An FDA approved diagnosis of partial-onset seizures as adjunctive therapy; and
   b. Member must be on current antiepileptic drug therapy (Aptiom® is only indicated for adjunctive treatment); and
   c. Member must not currently be taking oxcarbazepine (concurrent use is contraindicated); and
   d. A patient-specific, clinically significant reason why member cannot use oxcarbazepine.
   e. A quantity limit of 30 per 30 days will apply on the lower strength tablets (200mg and 400mg) and 60 per 30 days on the higher strength tablets (600mg and 800mg).
3. **Qudexy™ XR (Topiramate Extended-Release) Approval Criteria:**
   a. An FDA approved diagnosis of partial onset or primary generalized tonic-clonic seizures or as adjunctive therapy in seizures associated with Lennox-Gastaut syndrome; and
   b. A patient-specific, clinically significant reason why member cannot use the short-acting formulation, Topamax® (topiramate).
   c. A quantity limit of 30 per 30 days will apply on the lower strength capsules (25mg, 50mg, and 100mg) and 60 per 30 days on the higher strength capsules (150mg and 200mg).
4. **Divalproex Extended-Release Approval Criteria:**
   a. Generic divalproex ER will require a patient-specific, clinically significant reason why member cannot use brand name Depakote® ER.
   b. Brand name Depakote® ER will be the preferred product and will not require prior authorization.

Recommendation 3: Prior Authorize Ophthalmic Anti-Inflammatory Medications

The Drug Utilization Review Board recommends establishing a Product Based Prior Authorization category for ophthalmic NSAIDs and ophthalmic corticosteroids to ensure appropriate cost-effective utilization in accordance with current treatment guidelines. The DUR Board recommends the following tier list and criteria to the OHCA Board of Directors based on cost and clinical effectiveness for approval before referral to the Oklahoma Health Care Authority.

In addition, at the direction of the DUR Board, the College of Pharmacy will implement an educational initiative consisting of a targeted mailing to all prescribers of ophthalmic anti-inflammatory medications in the SoonerCare population in the previous 12 months. The mailing may include information regarding approval criteria of ophthalmic anti-inflammatory medications and a link to the OHCA web page which will contain the updated tier chart.

Ophthalmic Non-Steroidal Anti-Inflammatory Drug (NSAIDs) Tier-2 Approval Criteria:

1. Documented trials of all Tier-1 ophthalmic NSAIDs (from different product lines) in the last 30 days that did not yield adequate relief of symptoms or resulted in intolerable adverse effects; or
2. Contraindication to all lower tiered medications; or
3. A unique indication for which the Tier-1 anti-inflammatories lack.

Ophthalmic NSAIDs (Non-Steroidal Anti-Inflammatory Drugs)	
Tier-1	**Tier-2**
Voltaren® (diclofenac) Solution 0.1%	Nevanac™ (nepafenac) 0.1% Suspension
Acular® (ketorolac) Solution 0.5%	Acuvail® (ketorolac) Solution 0.45%
Acular LS ® (ketorolac) Solution 0.4%	Ilevro™ (nepafenac) 0.3 % Suspension
Ocufen® (flurbiprofen) Solution 0.03%	Prolensa™ (bromfenac) 0.07% Solution
	Bromfenac 0.09% Solution

Ophthalmic Corticosteroid Tier-2 Approval Criteria:

1. Documented trials of all Tier-1 ophthalmic corticosteroids (from different product lines) in the last 30 days that did not yield adequate relief of symptoms or resulted in intolerable adverse effects; or
2. Contraindication to all lower tiered medications; or
3. A unique indication for which the Tier-1 anti-inflammatories lack.

Ophthalmic Corticosteroids	
Tier-1	**Tier-2**
Dexamethasone Sodium Phosphate Solution 0.1%	Lotemax® (loteprednol) Gel 0.5%
Maxidex™ (dexamethasone) Suspension 0.1%	Lotemax® (loteprednol) Ointment 0.5%
FML Liquifilm® (fluorometholone) Suspension 0.1%	Pred Forte® (prednisolone Acetate) Suspension 1%
Flarex® (fluorometholone) Suspension 0.1%	FML Forte® (fluorometholone) Suspension 0.25%
Lotemax® (loteprednol) Suspension 0.5%	FML S.O.P® (fluorometholone) Ointment 0.1%

Omnipred® (prednisolone Acetate) Suspension 1%	
Durezol® (difluprednate) Emulsion 0.05%	
Pred Mild® (prednisolone Acetate) Suspension 0.12%	
Prednisolone Sodium Phosphate Solution 1%	
Vexol® (rimexolone) Suspension 1%	

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 35. RURAL HEALTH CLINICS

317:30-5-355.1. Definition of services

The RHC benefit package, as described in Title 42 of the Code of Federal Regulations (CFR), part 440.20, consists of two components: RHC Services and Other Ambulatory Services.

(1) **RHC services.** RHC services are covered when furnished to a member at the clinic or other location, including the member's place of residence. These services are described in this Section.

(A) **Core services.** As set out in Federal Regulations at 42 CFR 440.20(b), RHC "core" services include, but are not limited to:

(i) Physician's services;

(ii) Services and supplies incident to a physician's services;

(iii) Services of advanced practice nurses (APNs), physician assistants (PAs), nurse midwives (NMs) or specialized advanced practice nurse practitioners;

(iv) Services and supplies incident to the services of APNs and PAs (including services furnished by nurse midwives);

(v) Visiting nurse services to the homebound;

(vi) Clinical psychologist (CP) and clinical social worker (CSW) services;

(vii) Services and supplies incident to the services of CPs and CSWs.

(B) **Physicians' services.** In addition to the professional services of a physician, and services provided by an APN, PA and NMW which would be covered as RHC services under Medicare, certain primary preventive services are covered under the SoonerCare RHC benefit. The services must be furnished by or under the direct supervision of a RHC practitioner who is a clinic employee:

(i) prenatal and postpartum care;

(ii) screening examination under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program for members under 21;

(iii) family planning services;

(iv) medically necessary screening mammography and follow-up mammograms when medically necessary.

(C) **Services and supplies "incident to".** Services and supplies incident to the service of a physician, physician assistant, advanced practice nurse, clinical psychologist, or clinical social worker are covered if the service or supply is:

(i) a type commonly furnished in physicians' offices;
(ii) a type commonly rendered either without charge or included in the rural health clinic's bill;
(iii) furnished as an incidental, although integral, part of a physician's professional services;
(iv) Drugs and biologicals which cannot be self-administered or are specifically covered by Medicare law, are included within the scope of RHC services. Drugs and biologicals commonly used in life saving procedures, such as analgesics, anesthetics (local), antibiotics, anticonvulsants, antidotes and emetics, serums and toxoids are not billed separately.

(D) **Visiting nurse services.** Visiting nurse services are covered if:

(i) the RHC is located in an area in which the Centers for Medicare and Medicaid Services (CMS) has determined there is a shortage of home health agencies;
(ii) the services are rendered to members who are homebound;
(iii) the member is furnished nursing care on a part time or intermittent basis by a registered nurse, licensed practical nurse or licensed vocational nurse who is employed by or receives compensation for the services from the RHC; and
(iv) the services are furnished under a written plan of treatment.

(E) **RHC encounter.** RHC "core" services (including preventive services, i.e., prenatal, EPSDT or family planning) are part of an all-inclusive visit. A "visit" means a face-to-face encounter between a clinic patient and a RHC health professional (i.e., physicians, physician assistants, advanced practice nurses, nurse midwives, clinical psychologists and clinical social workers). Encounters with more than one health professional and multiple encounters with the same health professional that takes place on the same day and a single location, constitute a single visit except when the member, after the first encounter, suffers illness or injury requiring additional diagnosis or treatment. Payment is made for one encounter per member per day. Prior authorization establishing medical necessity is required for additional visits for children. Payment is also limited to four visits per member per month for adults.

(F) **Off-site services.** RHC services provided off-site of the clinic are covered as long as the RHC has a compensation arrangement with the RHC practitioner that SoonerCare reimbursement is made to the RHC and the RHC practitioner receives his or her compensation from the RHC. The rural health clinic must have a written contract with the physician and other RHC "core" practitioners that specifically identify how the rural health clinic services provided off-site are to

be billed to SoonerCare. It is expected that services provided in off-site settings are, in most cases, temporary and intermittent, i.e., when the member cannot come to the clinic due to health reasons.

(2) **Other ambulatory services.** A Rural Health Clinic must provide other items and services which are not "RHC services" as described in (a)(1) of this Section, and are separately billable to the SoonerCare program. Coverage of services are based upon the scope of coverage under the SoonerCare program.

(A) Other ambulatory services include, but are not limited to:

(i) dental services for members under age 21;

(ii) optometric services;

(iii) clinical lab tests performed in the RHC lab, including the lab tests required for RHC certification;

(iv) technical component of diagnostic tests such as x-rays and EKGs (interpretation of the test provided by the RHC physician is included in the encounter rate);

(v) durable medical equipment;

(vi) emergency ambulance transportation;

(vii) prescribed drugs;

(viii) 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;

(ix) specialized laboratory services furnished away from the clinic;

(x) inpatient services;

(xi) outpatient hospital services.

(B) Payment is made directly to the RHC on an encounter basis for on-site dental services by a licensed dentist or optometric services by a licensed optometrist for members under age 21. Encounters are billed as one of the following:

(i) **EPSDT dental screening.** An EPSDT dental screening includes oral examination, prophylaxis and fluoride treatment, charting of needed treatment, and, if necessary, x-rays (including two bite wing films). This service must be filed on claim form ADM-36-D for EPSDT reporting purposes.

(ii) **Dental encounter.** A dental encounter consists of all dental treatment other than a dental screening. This service must be billed on the ADM-36-D.

(iii) **Visual analysis.** Visual analysis (initial or yearly) for a child with glasses, or a child who needs glasses, or a medical eye exam. This includes the refraction and medical eye health evaluation. Glasses must be billed separately. Payment is limited to two glasses per year. Any glasses beyond this limit must be prior authorized and determined to be medically necessary.

(C) Services listed in (a)(2)(A), (v)-(viii), of this

Section, furnished on-site, require separate provider agreements with the OHCA. Service item (a)(2)(A)(iii) does not require a separate contract when furnished on-site, however, certain conditions of participation apply. (Refer to OAC 317:30-5-361 for conditions.)

(D) Other ambulatory services provided off-site by independent practitioners (through subcontracting agreements or arrangements for services not available at the clinic) must be billed to the SoonerCare program by the provider rendering the service. Independent practitioners must meet provider eligibility criteria and must have a current contract with the OHCA.

317:30-5-356. Coverage for adults

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

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

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

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

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

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

(B) **Family planning services.** Family planning services are

available only to members with reproductive capability. Family planning visits do not count as one of the four RHC visits per month.

(2) **Other ambulatory services.** Services defined as "other ambulatory" services are not considered a part of a RHC visit and are therefore billable to the SoonerCare program by the RHC or provider of service on the appropriate claim forms. Other ambulatory services are subject to the same scope of coverage as other SoonerCare services billed to the program, i.e., limited adult services and some services for under 21 subject to same prior authorization process. Refer to OAC 317:30-1, General Provisions, and OAC 317:30-3-57, 317:30-5-59, and 317:30-3-60 for general coverage and exclusions under the SoonerCare program. Some specific limitations are applicable to other ambulatory services as set forth in specific provider rules and excerpted as follows: Coverage under optometrists for adults is limited to treatment of eye disease not related to refractive errors. There is no coverage for eye exams for the purpose of prescribing eyeglasses, contact lenses or other visual aids. (See OAC 317:30-5-431.)

317:30-5-357. Coverage for children

Coverage for rural health clinic services and other ambulatory services for children include the same services as for adults in addition to the following:

(1) The receipt of an Early and Periodic Screening, Diagnosis and Treatment (EPSDT) examination by a Medicaid eligible individual under age 21 renders that individual child eligible for all necessary follow-up care, whether or not the medically necessary services are covered under the Medicaid program. An EPSDT exam performed by a RHC must be billed on the appropriate claim form with the appropriate Preventative Medicine procedure code from the Current Procedural Terminology Manual (CPT). If an EPSDT screening is billed, a RHC encounter should not be billed on the same day. Refer to OAC 317:30-3-47 through 317:30-3-54 for coverages under EPSDT).

(2) Under EPSDT, coverage is allowed for visual screenings and eyeglasses to correct visual defects. Payment is limited to two glasses per year. Any glasses beyond this limit must be prior authorized and determined to be medically necessary.

(3) An EPSDT screening is considered a comprehensive examination. A provider billing the Medicaid program for an EPSDT screen may not bill any other visits for that patient on that same day. It is expected that the screening provider will perform necessary treatment as part of the screening charge. Additional services such as tests, immunizations, etc., required at the time of screening may be billed independently from the screening.

(4) The administration fee for immunizations should be billed if provided at the same time as a scheduled EPSDT examination.

(5) Payment may be made directly to the RHC for the professional services of physician assistants performing EPSDT screenings within the certified RHC. The claim form must include the signature of the supervising physician.

317:30-5-361. Billing

(a) **Encounters.** Payment is made for one ~~type of~~ encounter per member per day. Prior authorization establishing medical necessity is required for additional visits for children. Payment is also limited to four visits per member per month for adults. Rural health clinics must bill the combined fees of all "core" services provided during an encounter on the appropriate claim form. Claims must include reasonable and customary charges.

(1) **RHC.** The appropriate revenue code is required. No HCPC or CPT code is required.

(2) **Mental health.** Mental health services must include a revenue code and a HCPCS code.

(3) **Obstetrical care.** The appropriate revenue code and HCPCS code are required. The date the member is first seen is required. The primary pregnancy diagnosis code is also required. Secondary diagnosis codes are used to describe complications of pregnancy. Delivery must be billed by the independent practitioner who has a contract with the OHCA.

(4) **Family planning.** Family planning encounters require a revenue code, HCPCS code, and a family planning diagnosis.

(5) **EPSDT screening.** EPSDT screenings must be billed by the attending provider using the appropriate Preventative Medicine procedure code from the Current Procedural Terminology Manual (CPT).

(6) **Dental.** Dental services for children must be billed on the appropriate dental claim form.

(7) **Visual analysis.** Optometric services for children are billed using the appropriate revenue code and a HCPCS code.

(b) **Services billed separately from encounters.** Other ambulatory services and preventive services itemized separately from encounters must be billed using the appropriate revenue, HCPC and/or CPT codes. Claims must include reasonable and customary charges.

(1) **Laboratory.** The rural health clinic must be CLIA certified for specialized laboratory services performed. Laboratory services must be itemized separately using the appropriate CPT or HCPCS code.

(2) **Radiology.** Radiology must be identified using the appropriate CPT or HCPC code with the technical component modifier. Radiology services are paid at the technical component rate. The professional component is included in the encounter rate.

(3) **Immunizations.** The administration fee for immunizations provided on the same day as the EPSDT exam is billed separately.

(4) **Contraceptives.** Contraceptives are billed independently from the family planning encounter. A revenue code and the appropriate CPT or HCPC codes are required. The following are examples:

(A) DepoProvera 150 mg. (Medroxyprogesterone Acetate).

(B) Insertion and implantation of a subdermal contraceptive device.

(C) Removal, implantable contraceptive devices.

(D) Removal, with reinsertion, implantable contraceptive device.

(E) Insertion of intrauterine device (IUD).

(F) Removal of intrauterine device.

(G) ParaGard IUD.

(H) Progestasert IUD.

(5) **Glasses.** Glasses prescribed by a licensed optometrist are billed using the appropriate revenue code and HCPCS code. Payment is limited to two glasses per year. Any glasses beyond this limit must be prior authorized and determined to be medically necessary.

(6) **Telemedicine.** The originating site facility fee for telemedicine services is not a rural health clinic service. When a rural health clinic serves as the originating site, the originating site facility fee is paid separately from the clinic's all-inclusive rate.

PART 75. FEDERALLY QUALIFIED HEALTH CENTERS

317:30-5-664.3. Health Center encounters

(a) Health Center encounters that are billed to the OHCA must meet the definition in this Section and are limited to services covered by OHCA. Only encounters provided by the authorized health care professional on the approved FQHC state plan pages within the scope of their licensure trigger a PPS encounter rate.

(b) An encounter is defined as a face-to-face contact between a health care professional and a member for the provision of defined services through a Health Center within a 24-hour period ending at midnight, as documented in the member's medical record.

(c) ~~For information about multiple encounters, refer to OAC 317:30-5-664.4.~~A Health Center may bill for one medically necessary encounter per 24 hour period. Prior authorization establishing medical necessity is required for additional visits for children. Payment is limited to four visits per member per month for adults.

(d) Services considered reimbursable encounters (including any related medical supplies provided during the course of the encounter) include:

(1) medical;

(2) diagnostic;

(3) dental, medical and behavioral health screenings;

(4) vision;

(5) physical therapy;

(6) occupational therapy;
(7) podiatry;
(8) behavioral health;
(9) speech;
(10) hearing;
(11) medically necessary Health Center encounters with a RN or LPN and related medical supplies (other than drugs and biologicals) furnished on a part-time or intermittent basis to home-bound members (refer to OAC 317:30-5-661.3);
(12) any other medically necessary health services (i.e. optometry and podiatry) are also reimbursable as permitted within the Health Center's scope of services when medically reasonable and necessary for the diagnosis or treatment of illness or injury, and must meet all applicable coverage requirements.

(e) Services and supplies incident to a physician's professional service are reimbursable within the encounter if the service or supply is:
(1) of a type commonly furnished in physicians' offices;
(2) of a type commonly rendered either without a charge or included in the health clinic's bill;
(3) furnished as an incidental, although integral, part of a physician's professional services;
(4) furnished under the direct, personal supervision of a physician; and
(5) in the case of a service, furnished by a member of the clinic's health care staff who is an employee of the clinic.

(f) Only drugs and biologicals which cannot be self-administered are included within the scope of this benefit.

317:30-5-664.4. Multiple encounters at Health Centers [REVOKED]

~~(a) A Health Center may bill for more than one medically necessary encounter per 24 hour period under certain conditions.~~
~~(b) It is intended that multiple medically necessary encounters will occur on an infrequent basis.~~
~~(c) A Center may not develop Center procedures that routinely involve multiple encounters for a single date of service, unless medical necessity warrant multiple encounters.~~
~~(d) Each service must have distinctly different diagnoses in order to meet the criteria for multiple encounters. For example, a medical visit and a dental visit on the same day are considered different services with distinctly different diagnoses.~~
~~(e)Similar services, even when provided by two different health care practitioners, are not considered multiple encounters.~~

317:30-5-664.12. Determination of Health Center PPS rate

(a) **Methodology.** The methodology for establishing each facility's PPS rate is found in Attachment 4.19 B of the OHCA's State Plan, as amended effective January 1, 2001, and incorporated herein by reference.

(b) **Scope of service adjustment.** If a Center significantly changes its scope of services, the Center may request in writing that new baseline encounter rates be determined. Adjustments to encounter rates are made ~~only if the change in the scope of services results in the inclusion of behavioral health services or dental services or a difference of at least five percent from the Center's current costs (other than overhead).~~if it is determined that a significant change in the scope-of-service has occurred which impacts the base rate, as indicated within the State Plan. If there is a change in scope-of-service, it is the responsibility of the FQHC to request OHCA to review services that have had a change to the scope-of-service. The OHCA may initiate a rate adjustment in accordance with procedures in the State Plan, based on audited financial statements or cost reports, if the scope of services has been modified ~~to include behavioral health services or dental services~~ or would otherwise result in a change~~ of at least five percent from~~ to the Center's current rate. If a new rate is set, the rate ~~change takes effect on the latter of the change of services date or the date of application to the OHCA for rate change.~~will be effective on the date the change in scope-of-service was implemented.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 9. LONG TERM CARE FACILITIES

317:30-5-126. Therapeutic leave and Hospital leave

Therapeutic leave is any planned leave other than hospitalization that is for the benefit of the patient. Hospital leave is planned or unplanned leave when the patient is admitted to a licensed hospital. Therapeutic leave must be clearly documented in the patient's plan of care before payment for a reserved bed can be made.

(1) Effective July 1, 1994, the nursing facility may receive payment for a maximum of seven (7) days of therapeutic leave per calendar year for each recipient to reserve the bed.

(2) ~~Effective January 1, 1996, the nursing facility may receive payment for a maximum of five days of hospital leave per calendar year for each recipient to reserve the bed when the patient is admitted to a licensed hospital.~~No payment shall be made to a nursing facility for hospital leave.

(3) The Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) may receive payment for a maximum of 60 days of therapeutic leave per calendar year for each recipient to reserve a bed. No more than 14 consecutive days of therapeutic leave may be claimed per absence. Recipients approved for ICF/IID on or after July 1 of the year will only be eligible for 30 days of therapeutic leave during the remainder of that year. No payment shall be made for hospital leave.

(4) Midnight is the time used to determine whether a patient is present or absent from the facility. The day of discharge for therapeutic leave is counted as the first day of leave, but the day of return from such leave is not counted. ~~For hospital leave, the day of hospital admission is the first day of leave. The day the patient is discharged from the hospital is not counted as a leave day.~~

(5) Therapeutic ~~and hospital~~ leave balances are recorded on the Medicaid Management Information System (MMIS). When a patient moves to another facility, it is the responsibility of the transferring facility to forward the patient's leave records to the receiving facility.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 3. HOSPITALS

317:30-5-56. Utilization review

All inpatient services are subject to post-payment utilization review by the Oklahoma Health Care Authority, or its designated agent. These reviews will be based on OHCA's, or its designated agent's, admission criteria on severity of illness and intensity of treatment. In addition to the random sample of all admissions, retrospective review policy includes the following:

(1) Hospital stays less than three days in length will be reviewed for medical necessity and appropriateness of care. (Discharges involving healthy mother and healthy newborns may be excluded from this review requirement.) If it is determined that the inpatient stay was unnecessary or inappropriate, the prospective payment for the inpatient stay will be denied.

(2) Cases which indicate transfer from one acute care hospital to another will be monitored to help ensure that payment is not made for inappropriate transfers.

(3) Readmissions occurring within ~~15~~30 days of prior acute care admission for a related condition will be reviewed to determine medical necessity and appropriateness of care or whether the readmission was potentially preventable. If it is determined that either or both admissions were unnecessary or inappropriate or potentially preventable, payment for either or both admissions may be denied. Such review may be focused to exempt certain cases at the sole discretion of the OHCA.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 3. GENERAL PROVIDER POLICIES
PART 1. GENERAL SCOPE AND ADMINISTRATION

317:30-3-5. Assignment and Cost Sharing

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

(1) **"Fee-for-service contract"** means the provider agreement specified in OAC 317:30-3-2. This contract is the contract between the Oklahoma Health Care Authority and medical providers which provides for a fee with a specified service involved.

(2) **"Within the scope of services"** means the set of covered services defined at OAC 317:25-7 and the provisions of the SoonerCare Choice contracts in the SoonerCare Program.

(3) **"Outside of the scope of the services"** means all medical benefits outside the set of services defined at OAC 317:25-7 and the provisions of the SoonerCare Choice contracts in the SoonerCare Program.

(b) **Assignment in fee-for-service.** The OHCA's Medicaid State Plan provides that participation in the medical program is limited to providers who accept, as payment in full, the amounts paid by OHCA plus any deductible, coinsurance, or co-payment required by the State Plan to be paid by the member and make no additional charges to the member or others.

(1) OHCA presumes acceptance of assignment upon receipt of an assigned claim. This assignment, once made, cannot be rescinded, in whole or in part by one party, without the consent of the other party.

(2) Once an assigned claim has been filed, the member must not be billed and the member is not responsible for any balance except the amount indicated by OHCA. The only amount a member may be responsible for is a co-payment, or the member may be responsible for services not covered under the medical programs. In any event, the member should not be billed for charges on an assigned claim until the claim has been adjudicated or other notice of action received by the provider. Any questions regarding amounts paid should be directed to OHCA, Provider Services.

(3) When potential assignment violations are detected, the OHCA will contact the provider to assure that all provisions of the assignment agreement are understood. When there are repeated or uncorrected violations of the assignment agreement, the OHCA is required to suspend further payment to the provider.

(c) **Assignment in SoonerCare.** Any provider who holds a fee for service contract and also executes a contract with a provider in the SoonerCare Choice program must adhere to the rules of this subsection regarding assignment.

(1) If the service provided to the member is outside of the scope of the services outlined in the SoonerCare Contract, then the provider may bill or seek collection from the member.

(2) In the event there is a disagreement whether the services are in or out of the scope of the contracts referenced in (1) of this subsection, the Oklahoma Health Care Authority shall be the final authority for this decision.

(3) Violation of this provision shall be grounds for a contract termination in the fee-for-service and SoonerCare programs.

(d) **Cost Sharing-Copayment.** Section 1902(a)(14) of the Social Security Act permits states to require certain members to share some of the costs of SoonerCare by imposing upon them such payments as enrollment fees, premiums, deductibles, coinsurance, co-payments, or similar cost sharing charges. OHCA requires a co-payment of some SoonerCare members for certain medical services provided through the fee for service program. A co-payment is a charge which must be paid by the member to the service provider when the service is covered by SoonerCare. Section 1916(e) of the Act requires that a provider participating in the SoonerCare program may not deny care or services to an eligible individual based on such individual's inability to pay the co-payment. A person's assertion of their inability to pay the co-payment establishes this inability. This rule does not change the fact that a member is liable for these charges and it does not preclude the provider from attempting to collect the co-payment.

(1) Co-payment is not required of the following members:

(A) Individuals under age 21. Each member's date of birth is available on the REVS system or through a commercial swipe card system.

(B) Members in nursing facilities and intermediate care facilities for the mentally retarded.

(C) Home and Community Based Service waiver members except for prescription drugs.

(D) Native Americans providing documentation of ethnicity in accordance with 317:35-5-25 who receive items and services furnished by the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization or through referral under contract health services.

(E) Individuals who are categorically eligible for SoonerCare through the Breast and Cervical Cancer

Treatment program.

(F) Individuals receiving hospice care, as defined in section 1905(o) of the Social Security Act.

(2) Co-payment is not required for the following services:

(A) Family planning services. Includes all contraceptives and services rendered.

(B) Emergency services provided in a hospital, clinic, office, or other facility.

(C) Services furnished to pregnant women, if those services relate to the pregnancy or to any other medical condition which may complicate the pregnancy.

(3) Co-payments are required in an amount not to exceed the federal allowable for the following:

(A) Inpatient hospital stays.

(B) Outpatient hospital visits.

(C) Ambulatory surgery visits including free-standing ambulatory surgery centers.

(D) Encounters with the following rendering providers:

(i) Physicians,

(ii) Advanced Practice Nurses,

(iii) Physician Assistants,

(iv) Optometrists,

(v) Home Health Agencies,

(vi) Certified Registered Nurse Anesthetists,

(vii) Anesthesiologist Assistants,

(viii) Durable Medical Equipment providers, and

(ix) Outpatient behavioral health providers.

(E) Prescription drugs.

~~(i) Zero for preferred generics.~~

~~(ii) $0.65 for prescriptions having a SoonerCare allowable payment of $0.00-$10.00.~~

~~(iii) $1.20 for prescriptions having a SoonerCare allowable payment of $10.01-$25.00.~~

~~(iv) $2.40 for prescriptions having a SoonerCare allowable payment of $25.01-$50.00.~~

~~(v) $3.50 for prescriptions having a SoonerCare allowable payment of $50.01 or more.~~

(F) Crossover claims. Dually eligible Medicare/SoonerCare members must make a co-payment in an amount that does not exceed the federal allowable per visit/encounter for all Part B covered services. This does not include dually eligible HCBS waiver members.

(4) Aggregate cost-sharing liabilities in a given calendar year may not exceed 5% of the member's gross annual income.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 79. DENTISTS

317:30-5-696. Coverage by category

Payment is made for dental services as set forth in this Section.

(1) **Adults.**

(A) Dental coverage for adults is limited to:

(i) medically necessary extractions and~~/~~ approved boney adjustments. Surgical tooth extraction must have medical need documented if not apparent on images of tooth. In the SoonerCare program, it is usually performed for those teeth which are damaged to such extent that no tooth is visible above the gum line, the tooth fractures, the tooth is impacted, or tooth can't be grasped with forceps~~.~~;

(ii) Smoking and Tobacco Use Cessation Counseling; and

(iii) medical and surgical services performed by a dentist or physician to the extent such services may be performed under State law when those services would be covered if performed by a physician.

(B) Payment is made for dental care for adults residing in private Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) and who have been approved for ~~ICF/MR~~ICF/IID level of care, similar to the scope of services available to individuals under age 21.

(C) Pregnant women are covered under a limited dental benefit plan (Refer to (a)(4)of this Section).

(2) **Home and community based waiver services (HCBWS) for the intellectually disabled.** All providers participating in the HCBWS must have a separate contract with the OHCA to provide services under the HCBWS. Dental services are defined in each waiver and must be prior authorized.

(3) **Children.** The OHCA Dental Program provides the basic medically necessary treatment. The services listed below are compensable for members under 21 years of age without prior authorization. All other dental services must be prior authorized. Anesthesia services are covered for children in the same manner as adults. All providers performing preventive services must be available to perform needed restorative services for those members receiving any evaluation and preventive services.

(A) **Comprehensive oral evaluation.** This procedure is performed for any member not seen by any dentist for more than 12 months.

(B) **Periodic oral evaluation.** This procedure may be provided for a member of record if not seen by any dentist for more than six months.

(C) **Emergency examination/limited oral evaluation.** This procedure is not compensable within two months of a periodic oral examination or if the member is involved in active treatment unless trauma or acute infection is the presenting complaint. This procedure is only compensable to the same dentist or practice for two visits prior to an examination being completed.

(D) **Radiographs (x-rays).** To be SoonerCare compensable, x-rays must be of diagnostic quality and medically necessary. A clinical examination must precede any radiographs, and chart documentation must include member history, prior radiographs, caries risk assessment and both dental and general health needs of the member. The referring dentist is responsible for providing properly identified x-rays of acceptable quality with a referral, if that provider chooses to expose and submit for reimbursement prior to referral. Periapical radiograph must include at least 3 millimeters beyond the apex of the tooth being x-rayed. Panoramic films and full mouth radiographs (minimum of 12 periapical films and two posterior bitewings) are allowable once in a three year period and must be of diagnostic quality. Individually listed intraoral radiographs by the same dentist/—dental office are considered a complete series if the fee for individual radiographs equals or exceeds the fee for a complete series. Panoramic films are only compensable when chart documentation clearly indicates the test is being performed to rule out or evaluate non-caries related pathology discovered by prior examination. Prior authorization and a detailed medical need narrative are required for additional panoramic films taken within three years of the original set.

(E) **Dental sealants.** Tooth numbers 2, 3, 14, 15, 18, 19, 30 and 31 must be caries free on the interproximal and occlusal surfaces to be eligible for this service. This service is available through 18 years of age and is compensable only once per lifetime. Replacement of sealants is not a covered service under the SoonerCare program.

(F) **Dental prophylaxis.** This procedure is provided once every 184 days including topical application of fluoride.

(G) **Composite restorations.**

(i) This procedure is compensable for primary incisors as follows:

(I) tooth numbers O and P to age 4 years;
(II) tooth numbers E and F to age 6 years;
(III) tooth numbers N and Q to 5 years; and
(IV) tooth numbers D and G to 6 years.

(ii) The procedure is also allowed for use in all vital and successfully treated non-vital permanent anterior teeth.

(iii) Class I and II composite restorations are allowed in posterior teeth; however, the OHCA has certain restrictions for the use of this restorative material. (See OAC 317:30-5-699).

(H) **Amalgam.** Amalgam restorations are allowed in:

(i) posterior primary teeth when:
(I) 50 percent or more root structure is remaining;
(II) the teeth have no mobility; or
(III) the procedure is provided more than 12 months prior to normal exfoliation.

(ii) any permanent tooth, determined as medically necessary by the treating dentist.

(I) **Stainless steel crowns for primary teeth.** The use of any stainless steel crowns is allowed as follows:

(i) Stainless steel crowns are allowed if:
(I) the child is five years of age or under;
(II) 70 percent or more of the root structure remains; or
(III) the procedure is provided more than 12 months prior to normal exfoliation.

(ii) Stainless steel crowns are treatment of choice for:
(I) primary teeth with pulpotomies or pulpectomies, if the above conditions exist;
(II) primary teeth where three surfaces of extensive decay exist; or
(III) primary teeth where cuspal occlusion is lost due to decay or accident.

(iii) Preoperative periapical x-rays and/or written documentation explaining the extent of decay must be available for review, if requested.

(iv) Placement of a stainless steel crown includes all related follow up service for a period of two years. No other restorative procedure on that tooth is compensable during that period of time. A stainless steel crown is not a temporizing treatment to be used while a permanent crown is being fabricated.

(J) **Stainless steel crowns for permanent teeth**. The use of any stainless steel crowns is allowed as follows:

(i) Stainless steel crowns are the treatment of choice

for:

(I) posterior permanent teeth that have completed endodontic therapy if three or more surfaces of tooth is destroyed;

(II) posterior permanent teeth that have three or more surfaces of extensive decay; or

(III) where cuspal occlusion is lost due to decay prior to age 16 years.

(ii) Preoperative periapical x-rays and/or written documentation explaining the extent of decay must be available for review, if requested.

(iii) Placement of a stainless steel crown includes all related follow up service for a period of two years. No other restorative procedure on that tooth is compensable during that period of time. A stainless steel crown is not a temporizing treatment to be used while a permanent crown is being fabricated.

(K) **Pulpotomies and pulpectomies.**

(i) Therapeutic pulpotomies are allowable for molars and teeth numbers listed below. Pre-and post-operative periapical x-rays must be available for review, if requested.

(I) Primary molars having at least 70 percent or more of their root structure remaining or more than 12 months prior to normal exfoliation;

(II) Tooth numbers O and P before age 5 years;

(III) Tooth numbers E and F before 6 years;

(IV) Tooth numbers N and Q before 5 years;

(V) Tooth numbers D and G before 5 years.

(ii) Pulpectomies are allowed for primary teeth if exfoliation of the teeth is not expected to occur for at least one year or if 70 percent or more of root structure is remaining.

(L) **Endodontics.** Payment is made for the services provided in accordance with the following:

(i) This procedure is allowed when there are no other missing anterior teeth in the same arch requiring replacement.

(ii)The provider documents history of member's improved oral hygiene and flossing ability in records.

(iii) Prior authorization is required for members who have a treatment plan requiring more than two anterior and/or two posterior root canals.

(iv) Teeth with less than 60 percent of clinical crown should not be treatment-planned for root canal therapy.

(v) Pre and post-operative periapical x-rays must be available for review.

(vi) ~~Pulpotomy~~Pulpal debridement may be performed for the relief of pain while waiting for the decision from the OHCA.

(vii) Providers are responsible for any follow-up treatment required due to a failed root canal therapy for 24 month post completion.

(viii) Endodontically treated teeth should be restored to limited occlusal function and all contours should be replaced. These teeth are not automatically approved for any type of crown.

(M) **Space maintainers.** Certain limitations apply with regard to this procedure. Providers are responsible for recementation of any maintainer placed by them for six months post insertion.

(i) **Band and loop type space maintenance.** This procedure must be provided in accordance with the following guidelines:

(I) This procedure is compensable for all primary molars where permanent successor is missing or where succedaneous tooth is more than 5mm below the crest of the alveolar ridge or where the successor tooth would not normally erupt in the next 12 months.

(II) First primary molars are not allowed space maintenance if the second primary and first permanent molars are present and in cuspal interlocking occlusion regardless of the presence or absence of normal relationship.

(III) If there are missing posterior teeth bilaterally in the same arch, under the above guidelines, bilateral space maintainer is the treatment of choice.

(IV) The teeth numbers shown on the claim should be those of the missing teeth.

(V) Post-operative bitewing x-rays must be available for review.

(VI) Bilateral band and loop space maintainer is allowed if member does not have eruption of the four mandibular anterior teeth in position or if sedation case that presents limitations to fabricate other space maintenance appliances.

(ii) **Lingual arch bar.** Payment is made for the services provided in accordance with the following:

(I) Lingual arch bar is used when permanent incisors are erupted and the second primary molar (K or T) is missing in the same arch.

(II) The requirements are the same as for band and loop space maintainer.

(III) Multiple missing upper anterior primary incisors may be replaced with the appliance to age 4 years to prevent abnormal swallowing habits.

(IV) Pre and post-operative x-rays must be available.

(iii) **Interim partial dentures.** This service is for anterior permanent tooth replacement or if the member is missing three or more posterior teeth to age 16 years.

(N) **Analgesia.** Analgesia services are reimbursable in accordance with the following:

(i) **Inhalation of nitrous oxide.** Use of nitrous oxide is compensable for four occurrences per year and is not separately reimbursable, if provided on the same date by the same provider as IV sedation, non-intravenous conscious sedation or general anesthesia. The medical need for this service must be documented in the member's record.

(ii) **Non-intravenous conscious sedation.** Non-intravenous conscious sedation is not separately reimbursable, if provided on the same date by the same provider as analgesia, anxiolysis, inhalation of nitrous oxide, IV sedation or general anesthesia. Non-intravenous conscious sedation is reimbursable when determined to be medically necessary for documented handicapped members, uncontrollable members or justifiable medical or dental conditions. The report must detail the member's condition. No services are reimbursable when provided primarily for the convenience of the member and /or the dentist, it must be medically necessary.

(O) **Pulp caps.** Indirect and direct pulp cap must be ADA accepted calcium hydroxide or Mineral Trioxide Aggregate materials, not a cavity liner or chemical used for dentinal hypersensitivity. Indirect and direct pulp cap codes require specific narrative support addressing materials used, intent and reasons for use. Application of chemicals used for dentinal hypersensitivity is not allowed as indirect pulp cap. Utilization of these codes is verified by post payment review.

(P) **Protective restorations.** This restoration includes removal of decay, if present, and ~~are~~is reimbursable for the same tooth on the same date of service with a direct or indirect pulp cap, if needed. Permanent restoration of the tooth is allowed after 60 days unless the tooth becomes symptomatic and requires pain relieving treatment.

(Q) **History and physical.** Payment is made for services

for the purpose of admitting a patient to a hospital for dental treatment.

(R) **Local anesthesia.** This procedure is included in the fee for all services.

(S) **Smoking and Tobacco Use Cessation Counseling.** Smoking and Tobacco Use Cessation Counseling is covered when performed utilizing the five intervention steps of asking the member to describe his/her smoking, advising the member to quit, assessing the willingness of the member to quit, assisting with referrals and plans to quit, and arranging for follow-up. Up to eight sessions are covered per year per individual who has documented tobacco use. It is a covered service when provided by physicians, physician assistants, nurse practitioners, nurse midwives, and Oklahoma State Health Department and FQHC nursing staff in addition to other appropriate services rendered. Chart documentation must include a separate note, separate signature, and 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.

(T) **Periodontal scaling and root planing**. This procedure is designed for the removal of calculus or tissue that is contaminated and requires anesthesia and some soft tissue removal. This procedure requires that each tooth have 3 or more of the 6 point measurements 5 millimeters or greater, or have multiple areas of radiographic bone loss and subgingival calculus and must involve two or more teeth per quadrant for consideration. This procedure is not allowed on members under age 10. This procedure is not allowed in conjunction with any other periodontal surgery.

~~(4) **Pregnant Women.** Dental coverage for this special population is provided regardless of age.~~

~~(A) Proof of pregnancy is required (Refer to OAC 317:35-5-6).~~

~~(B) Coverage is limited to a time period beginning at the diagnosis of pregnancy and ending upon 60 days post partum.~~

~~(C) In addition to dental services for adults, other services available include:~~

~~(i) Comprehensive oral evaluation must be performed and recorded for each new member, or established member not seen for more than 24 months;~~

~~(ii) Periodic oral evaluation as defined in OAC 317:30-5-696(3)(B);~~

~~(iii) Emergency examinations/limited oral evaluation. This procedure is not allowed within two months of an~~

~~oral examination by the same provider for the same member, or if the member is under active treatment;~~
~~(iv) Radiographs as defined in OAC 317:30-5-696(3)(D);~~
~~(v) Dental prophylaxis as defined in OAC 317:30-5-696(3)(F);~~
~~(vi) Composite restorations:~~
~~(I) Any permanent tooth that has an opened lesion seen on radiograph or that is a documented food trap will be deemed medically necessary for this program and will be allowed for all anterior teeth.~~
~~(II) Class I One and two surface posterior composite resin restorations are allowed in posterior teeth that qualify;~~
~~(vii) Amalgam. Any permanent tooth that has an opened lesion that is a food trap will be deemed as medically necessary and will be allowed; and~~
~~(viii) Analgesia. Analgesia services are reimbursable in accordance with OAC 317:30-5-696(3)(N).~~
~~(D) Services requiring prior authorization (Refer to OAC 317:30-5-698).~~
~~(E) Periodontal scaling and root. Procedure is designed for the removal of calculus or tissue that is contaminated and requires anesthesia and some soft tissue removal. This procedure requires that each tooth have 30 or more of the 6 point measurements 5 millimeters or greater, or have multiple areas of radiographic bone loss and subgingival calculus and must involve two or more teeth per quadrant for consideration. This procedure is not allowed on members under age 10. This procedure is not allowed in conjunction with any other periodontal surgery.~~

~~(5)~~(4) **Individuals eligible for Part B of Medicare.**

(A) Payment is made based on the member's coinsurance and deductibles.

(B) Services which have been denied by Medicare as non-compensable should be filed directly with the OHCA with a copy of the Medicare EOB indicating the reason for denial.

317:30-5-698. Services requiring prior authorization

(a) Providers must have prior authorization for certain specified services before delivery of that service, unless the service is provided on an emergency basis (See OAC 317:30-5-695(d)(2). Requests for dental services requiring prior authorization must be accompanied by sufficient documentation. X-rays, six point periodontal charting and comprehensive treatment plans are required. Study models and narratives may be requested by OHCA or representatives of OHCA. If the quality of the supporting material is such that a determination of

authorization cannot be made, the material is returned to the provider. Any new documentation must be provided at the provider's expense. Submitted documentation used to base a decision will not be returned.

(b) Requests for prior authorization are filed on the currently approved ADA form. OHCA notifies the provider on the determination of prior authorization using OHCA Prior Authorization Request Decision form. Prior authorized services must be billed exactly as they appear on the prior authorization. Payment is not made for any services provided prior to receiving authorization except for the relief of pain.

(c) Prosthodontic services provided to members who have become ineligible mid-treatment are covered if the member was eligible for SoonerCare on the date the final impressions were made.

(d) Listed below are examples of services requiring prior authorization for members under 21 and eligible ICF/IID residents. Minimum required records to be submitted with each request are right and left mounted bitewing x-rays or images and periapical films or images of tooth/teeth involved or the edentulous areas if not visible in the bitewings. X-rays must be submitted with film mounts and each film or print must be of diagnostic quality. X-rays and/or images must be identified by the tooth number and include date of exposure, member name, member ID, provider name, and provider ID. All x-rays or images, regardless of the media, must be submitted together with a completed and signed comprehensive treatment plan that details all needed treatment at the time of examination, and a completed current ADA form requesting all treatments requiring prior authorization. The film, digital media or printout must be of sufficient quality to clearly demonstrate for the reviewer, the pathology which is the basis for the authorization request. If radiographs are not taken, provider must include in narrative sufficient information to confirm diagnosis and treatment plan.

(1) **Endodontics.** Root canal therapy is not considered an emergency procedure unless due to trauma to an anterior tooth. The provider must document that the member has improved oral hygiene and flossing ability over a minimum of two months, in the member's records. ~~Pulpotomy~~Pulpal debridement may be performed for the relief of pain while waiting for the decision from the OHCA on request for endodontics.

(A) Prior authorization is required for members who have a treatment plan requiring more than two anterior and/or two posterior root canals. All rampant, active caries must be removed prior to requesting anterior endodontics. Payment is made for services provided in accordance with the following:

(i) Permanent teeth only.
(ii) Accepted ADA materials must be used.
(iii) Pre and post-operative periapical x-rays must be available for review.
(iv) Providers are responsible for any follow-up treatment required by a failed endodontically treated tooth within 24 months post completion.
(v) A tooth will not be approved if it appears there is not adequate natural tooth structure remaining to establish good tooth/restorative margins or if crown to root ratio is poor.
(vi) An endodontic procedure may not be approved if the tooth requires a post and core to retain a crown.

(B) **Posterior endodontics.** The guidelines for this procedure are as follows:
(i) The provider documents that the member has improved oral hygiene and flossing ability over a minimum of two months, in this member's records.
(ii) Teeth that ~~would require~~ require pre-fabricated post and cores to retain a restoration due to lack of natural tooth structure should not be treatment planned for root canal therapy.
(iii) Pre and post-operative periapical x-rays must be available for review.
(iv) Providers are responsible for any follow-up treatment required by a failed endodontically treated tooth within 24 months post completion.
(v) A tooth will not be approved if it appears there is not adequate natural tooth structure remaining to establish good tooth/restorative margins or if there is a poor crown to root ratio or weakened root furcation area. Approval of second molars is contingent upon proof of medical necessity.
(vi) Only ADA accepted materials are acceptable under the OHCA policy.
(vii) Posterior endodontic procedure may not be approved if the tooth requires a post and core in order to present adequate structure to retain a crown.
(viii) Endodontics will not be considered if:
(I) an opposing tooth has super erupted;
(II) loss of tooth space is one third or greater;
(III) opposing second molars are involved unless prior authorized; or
(IV) the member has multiple teeth failing due to previous inadequate root canal therapy or follow-up~~.~~;
(V) all rampant, active caries must be removed prior

to requesting posterior endodontics.

(ix) Endodontically treated teeth must be restored to limited occlusal function and all contours must be replaced. Core build-up code is only available for use if other restorative codes are not sufficient. These teeth will not be approved for a crown if it appears the apex is not adequately sealed.

(2) **Crowns for permanent teeth.** Crowns are compensable for restoration of natural teeth for members who are 16 years of age or older and adults residing in private Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) and who have been approved for (ICF/IID) level of care. Certain criteria and limitations apply.

(A) The following conditions must exist for approval of this procedure.

(i) all rampant, active caries must be removed prior to requesting any type of crown.

~~(i)~~(ii) The tooth must be decayed to such an extent to prevent proper cuspal or incisal function.

~~(ii)~~(iii) The clinical crown is fractured or destroyed by one-half or more.

~~(iii)~~(iv)Endodontically treated teeth must have three or more surfaces restored or lost due to carious activity to be considered for a crown.

(B) The conditions listed in (A)(i) through (A)~~(iii)~~(iv) of this paragraph should be clearly visible on the submitted x-rays when a request is made for any type of crown.

(C) Routine build-up(s) for authorized crowns are included in the fee for the crown. Non authorized restorative codes may be used if available.

(D) A crown will not be approved if adequate tooth structure does not remain to establish cleanable margins, there is invasion of the biologic width, poor crown to root ratio, or the tooth appears to retain insufficient amounts of natural tooth structure. Cast dowel cores are not allowed for molar or pre-molar teeth.

(E) Preformed post(s) and core build-up(s) are not routinely provided with crowns for endodontically treated teeth.

(F) Provider is responsible for replacement or repair of all crowns if failure is caused by poor laboratory processes or procedure by provider for 48 months post insertion.

(3) **Cast frame partial dentures.** This appliance is the treatment of choice for replacement of missing anterior permanent teeth or two or more missing posterior teeth in the

same arch for members 16 through 20 years of age. Provider must indicate which teeth will be replaced. Members must have excellent oral hygiene documented for at least 18 months in the requesting provider's records and submitted with prior authorization request to be considered. Provider is responsible for any needed follow up for a period of two years post insertion.

(4) **Acrylic partial.** This appliance is the treatment of choice for replacement of three or more missing teeth in the same arch for members 12 through 16 years of age. Provider must indicate tooth numbers to be replaced. This appliance includes all necessary clasps and rests.

(5) **Occlusal guard.** Narrative of medical necessity must be sent with prior authorization. Model should not be made or sent unless requested.

(6) **Fixed cast non-precious metal or porcelain/metal bridges.** Only members 17 through 20 years of age will be considered for this treatment. Destruction of healthy teeth to replace a single missing tooth is not considered medically necessary. Members must have excellent oral hygiene documented for at least 18 months in the requesting provider's records and submitted with prior authorization request to be considered. Provider is responsible for any needed follow up until member loses eligibility.

(7) **Periodontal scaling and root planing.** Procedure is designed for the removal of calculus or tissue that is contaminated and requires anesthesia and some soft tissue removal. This procedure requires that each tooth have 3 or more of the six point measurements 5 millimeters or greater, or have multiple areas of radiographic bone loss and subgingival calculus and must involve two or more teeth per quadrant for consideration. This procedure is not allowed on members under the age 10. This procedure is not allowed in conjunction with any other periodontal surgery.

317:30-5-699. Restorations

~~(a) **Use of posterior composite resins.** Payment is not made for certain restorative services when posterior composite resins are used in restorations involving:~~

~~(1) replacement of any occlusal cusp or~~

~~(2) sub-gingival margins~~

~~(b)~~(a) **Utilization parameters.** The Oklahoma Health Care Authority utilization parameters allow only one permanent restorative service to be provided per tooth per 24 months. Additional restorations may be authorized upon approval of OHCA in cases of trauma. Teeth receiving a restoration are eligible within three months for consideration of single crown if

endodontically treated. Providers must document type of isolation used in treatment progress notes. The provider is responsible for follow-up or any required replacement of a failed restoration, if the member is currently SoonerCare eligible. Fees paid for the original restorative services may be recouped if any additional treatments are required on the same tooth by a different provider within 12 months due to defective restoration or recurrent decay. If it is determined by the Dental Director that a member has received poorly rendered or insufficient treatment from a provider, the Dental Director may prior authorize corrective procedures by a second provider.

~~(c)~~(b)**Coverage for dental restorations.** Restoration of incipent lesions is not considered medically necessary treatment. Any diagnosis not supported by radiographs requires documentation of the medical need on which the diagnosis was made. Services for dental restorations are covered as follows:

(1) If the mesial occlusal pit and the distal occlusal pit on an upper molar tooth are restored at the same appointment, this is a one surface restoration.

(2) If any two separate surfaces on a posterior tooth are restored at the same appointment, it is a two surface restoration.

(3) If any three separate surfaces on a posterior tooth are restored at the same appointment, it is a three surface restoration.

(4) If the mesial, distal, facial and/or lingual of an upper anterior tooth is restored at the same appointment, this is a four surface restoration.

(5) If any two separate surfaces on an anterior tooth are restored at the same appointment, it is a two surface restoration.

(6) If any three separate surfaces on an anterior tooth are restored at the same appointment, it is a three surface restoration.

(7) An incisal angle restoration is defined as one of the angles formed by the junction of the incisal and the mesial or distal surface of an anterior tooth. If any of these surfaces are restored at the same appointment, even if separate, it is considered as a single incisal angle restoration.

(8) When four or more separate surfaces on a posterior tooth are restored at the same appointment it is a four surface restoration.

(9) Wide embrasure cavity preparations do not become extra surfaces unless at least one half of cusp or surface is involved in the restoration. An MODFL restoration would have

to include the mesial-occlusal-distal surfaces as well as either the buccal groove pit or buccal surface or at least one half the surface of one of the buccal cusps. The same logic applies for the lingual surface.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 17. MEDICAL SUPPLIERS

317:30-5-211.11. Oxygen and oxygen equipment

(a) **Medical necessity.** Oxygen and oxygen supplies are covered when medically necessary. Medical necessity is determined from results of arterial blood gas analysis (ABG) or pulse oximetry (SaO2) tests ~~(pO2)~~. ABG data are not required for children, but may be used if otherwise available. The test results to document Medical Necessity must be within 30 days of the date of the ~~physician's prescription.~~qualified medical practitioner's Certificate of Medical Necessity. Prior authorization is required after the initial three months of billing whether qualifying tests were done at rest, during sleep, or during exercise. Appropriate documentation of ABG or SaO2 data from the member's chart should be attached to the prior authorization request(PAR).~~A copy of a report from an inpatient or outpatient hospital or emergency room setting will meet the requirement.~~

(1) ~~For initial certification for oxygen, the ABG study or oximetry analysis used to determine medical necessity may not be performed by the DMEPOS or a related corporation. In addition, neither the study nor the analysis may be performed by a physician with a significant ownership interest in the DMEPOS performing such tests. These prohibitions include relationships through blood or marriage. A referring physician may perform the test in his/her office as part of routine member care.~~ The ABG or oximetry test used to determine medical necessity must be performed by a medical professional qualified to conduct such testing. The test may not be performed or paid for by a DMEPOS supplier, or a related corporation. A referring qualified medical practitioner may perform the test in his/her office as part of routine member care.

(2) ~~Initial certification is for no more than three months. Except in the case of sleep-induced hypoxemia, ABG or oximetry is required within the third month of the initial certification period if the member has a continued need for supplemental oxygen. Re-certification will be required every 12 months.~~

~~(A) **Adults.** Initial requests for oxygen must include ABG or resting oximetry results. The arterial blood saturation can not exceed 89% at rest on room air; the pO2 level can not exceed 59mm Hg.~~

~~(B) **Children**. Requests for oxygen for children that do~~

~~not meet the following requirements should include documentation of the medical necessity based on the child's clinical condition and are considered on a case-by-case basis. Members 20 years of age or less must meet the following requirements:~~

~~(i) birth through three years, SaO2 level equal to or less than 94%; and~~

~~(ii) ages four and above, SaO2 level equal to or less than 90%.~~In addition to ABG data, the following three tests are acceptable for determining medical necessity for oxygen prescription:

(A) At rest and awake "spot oximetry."

(B) During sleep:

i. Overnight Sleep Oximetry done inpatient or at home.

ii. Polysomnogram, which may be used only if medically necessary for concurrent evaluation of another condition while in a chronic stable state.

(C) During exercise with all three of the following performed in the same testing session.

i. At rest, off oxygen showing a non-qualifying result.

ii. During exercise, off oxygen showing a qualifying event.

iii. During exercise, on oxygen showing improvement over test (C) ii above.

(3) Certification criteria:

(A) All qualifying testing must meet the following criteria:

(B) Adults. Initial requests for oxygen must include ABG or resting oximetry results. At rest and on room air, the arterial blood saturation (SaO2) cannot exceed 89% or the pO2 cannot exceed 59mm Hg.

(C) Children. Members 20 years of age or less must meet the following requirements:

(i) birth through three years, SaO2 equal to or less than 94%;or

(ii) ages four and above, SaO2 level equal to or less than 90%.

(iii)Requests from the qualified medical practitioner for oxygen for children who do not meet these requirements should include documentation of the medical necessity based on the child's clinical condition. These requests are considered on a case-by-case basis.

(b) **Certificate of medical necessity.**

(1) The ~~medical~~DMEPOS supplier must have a fully completed

current CMN(CMS-484 or HCA-32 must be used for members 20 years of age and younger) on file to support the claims for oxygen or oxygen supplies, and to establish whether coverage criteria are met and to ensure that the oxygen services provided are consistent with the physician's prescription (refer to instructions from Palmetto Government Benefits Administration, the Oklahoma Medicare Carrier, for further requirements for completion of the CMN).

(2) ~~The CMN must be signed by the physician prior to submitting the initial claim. When a physician prescription for oxygen is renewed, a CMN, including the required retesting, must be completed by the physician prior to the submission of claims. The medical and prescription information on the CMN may be completed by a non physician clinician, or an employee of the physician for the physician's review and signature. In situations where the physician has prescribed oxygen over the phone, it is acceptable to have a cover letter containing the same information as the CMN, stating the physician's orders, as long as the CMN has been signed by the physician or as set out above.~~ The CMN must be signed by the qualified medical practitioner prior to submitting the initial claim. If a verbal order containing qualifying data is received by the DME provider, oxygen and supplies may be dispensed using the verbal order date as the billing date. The CMN initial date, the verbal order date, and the date of delivery should be the same date. It is acceptable to have a cover letter containing the same information as the CMN, stating the qualified medical practitioner's orders. The CMN signed by the qualified medical practitioner must be attached to the PAR.

(3) ~~Prescription for oxygen services must be updated at least annually and at any time a change in prescription occurs during the year. All DMEPOS suppliers are responsible for maintaining the prescription(s) for oxygen services and CMN in each member's file. If any change in prescription occurs, the physician must complete a new CMN that must be maintained in the member's file by the DME supplier. The OHCA or its designated agent will conduct ongoing monitoring of prescriptions for oxygen services to ensure guidelines are followed. Payment adjustments will be made on claims not meeting these requirements.~~ The medical and prescription information on the CMN may be completed by a non-physician clinician, or an employee, for the qualified medical practitioner's review and signature.

(4) When a Certificate of Medical Necessity for oxygen is recertified, a prior authorization request will be required.

(5) Re-certification and related retesting will be required every 12 months.
(6) CMN for oxygen services must be updated at least annually and at any time a change in prescription occurs during the year. All DMEPOS suppliers are responsible for maintaining the prescription(s) for oxygen services and CMN in each member's file.
(7) The OHCA or its designated agent will conduct ongoing monitoring of prescriptions for oxygen services to ensure guidelines are followed. Payment adjustments will be made on claims not meeting these requirements.

317:30-5-211.12. Oxygen rental

A monthly rental payment is made for rental of liquid oxygen systems, gaseous oxygen systems and oxygen concentrators. The rental payment for a stationary system includes all contents and supplies, such as, regulators, tubing, masks, etc that are medically necessary. An additional monthly payment may be made for a portable liquid or gaseous oxygen system based on medical necessity.

(1) Oxygen concentrators are covered items for members residing in their home or in a nursing facility.
(2) For members who meet medical necessity criteria, SoonerCare covers portable liquid or gaseous oxygen systems. Portable oxygen contents are not covered for adults. The need for a portable oxygen system must be stated on the CMN. A portable system that is used as a backup system only is not a covered item.
(3) When ~~six~~four or more liters of oxygen are medically necessary, an additional payment will be paid up to 150% of the allowable for a stationary system when billed with the appropriate modifier.

317:30-5-211.16. Coverage for nursing facility residents

(a) For residents in a nursing facility, most DMEPOS are considered part of the facility's per diem rate. The following are not included in the per diem rate and may be billed by the appropriate medical supplier:

(1) Services requiring prior authorization:
(A) ventilators and supplies;
(B) total parenteral nutrition (TPN), and supplies;
(C) custom seating for wheelchairs; ~~and~~
(D) external breast prosthesis and support accessories~~.~~; and
(E) oxygen and oxygen concentrators, after the initial three months.
(i) **PRN oxygen.** Members in nursing facilities

requiring oxygen PRN will be serviced by oxygen kept on hand as part of the per diem rate.

(ii) **Billing for Medicare eligible nursing home members**. Oxygen supplied to Medicare eligible nursing home members may be billed directly to OHCA. It is not necessary to obtain a denial from Medicare prior to filing the claim with OHCA.

(2) Services not requiring prior authorization:

(A) permanent indwelling or male external catheters and catheter accessories;

(B) colostomy and urostomy supplies;

(C) tracheostomy supplies; and

(D) catheters and catheter accessories;.

~~(E) oxygen and oxygen concentrators.~~

~~(i) **PRN oxygen.** Members in nursing facilities requiring oxygen PRN will be serviced by oxygen kept on hand as part of the per diem rate.~~

~~(ii) **Billing for Medicare eligible nursing home members**. Oxygen supplied to Medicare eligible nursing home members may be billed directly to OHCA. It is not necessary to obtain a denial from Medicare prior to filing the claim with OHCA.~~

(b) Items not covered include but are not limited to:

(1) diapers;

(2) underpads;

(3) medicine cups;

(4) eating utensils; and

(5) personal comfort items.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 3. GENERAL PROIVDER POLICIES
PART 3. GENERAL MEDICAL PROGRAM INFORMATION

317:30-3-57. General SoonerCare coverage - categorically needy

The following are general SoonerCare coverage guidelines for the categorically needy:

(1) Inpatient hospital services other than those provided in an institution for mental diseases.

(A) Adult coverage for inpatient hospital stays as described at OAC 317:30-5-41.

(B) Coverage for members under 21 years of age is not limited. All admissions must be medically necessary. All psychiatric admissions require prior authorization for an approved length of stay.

(2) Emergency department services.

(3) Dialysis in an outpatient hospital or free standing dialysis facility.

(4) Outpatient therapeutic radiology or chemotherapy for proven malignancies or opportunistic infections.

(5) Outpatient surgical services - facility payment for selected outpatient surgical procedures to hospitals which have a contract with OHCA.

(6) Outpatient Mental Health Services for medical and remedial care including services provided on an outpatient basis by certified hospital based facilities that are also qualified mental health clinics.

(7) Rural health clinic services and other ambulatory services furnished by rural health clinic.

(8) Optometrists' services - only as listed in Subchapter 5, Part 45, Optometrist specific rules of this Chapter.

(9) Maternity Clinic Services.

(10)Outpatient diagnostic x-rays and lab services. Other outpatient services provided to adults, not specifically addressed, are covered only when prior authorized by the agency's Medical Authorization Unit.

(11)Medically necessary screening mammography. Additional follow-up mammograms are covered when medically necessary.

(12)Nursing facility services (other than services in an institution for tuberculosis or mental diseases).

(13)Early and Periodic Screening, Diagnosis and Treatment Services (EPSDT) are available for members under 21 years of age to provide access to regularly scheduled examinations and evaluations of the general physical and mental health, growth, development, and nutritional status of infants, children, and youth. Federal regulations also require that diagnosis and treatment be provided for conditions identified

during a screening whether or not they are covered under the State Plan, as long as federal funds are available for these services. These services must be necessary to ameliorate or correct defects and physical or mental illnesses or conditions and require prior authorization. EPSDT/OHCA Child Health services are outlined in OAC 317:30-3-65.2 through 317:30-3-65.4.

(A) Child health screening examinations for eligible children by a medical or osteopathic physician, physician assistant, or advanced practice nurse practitioner.

(B) Diagnostic x-rays, lab, and/or injections when prescribed by a provider.

(C) Immunizations.

(D) Outpatient care.

(E) Dental services as outlined in OAC 317:30-3-65.8.

(F) Optometrists' services. The EPSDT periodicity schedule provides for at least one visual screening and glasses each 12 months. In addition, payment is made for glasses for children with congenital aphakia or following cataract removal. Interperiodic screenings and glasses at intervals outside the periodicity schedule for optometrists are allowed when a visual condition is suspected. Payment is limited to two glasses per year. Any glasses beyond this limit must be prior authorized and determined to be medically necessary.

(G) Hearing services as outlined in OAC 317:30-3-65.9.

(H) Prescribed drugs.

(I) Outpatient Psychological services as outlined in OAC 317:30-5-275 through OAC 317:30-5-278.

(J) Inpatient Psychotherapy services and psychological testing as outlined in OAC 317:30-5-95 through OAC 317:30-5-97.

(K) Transportation. Provided when necessary in connection with examination or treatment when not otherwise available.

(L) Inpatient hospital services.

(M) Medical supplies, equipment, appliances and prosthetic devices beyond the normal scope of SoonerCare.

(N) EPSDT services furnished in a qualified child health center.

(14) Family planning services and supplies for members of child-bearing age, including counseling, insertion of intrauterine device, implantation of subdermal contraceptive device, and sterilization for members 21 years of age and older who are legally competent, not institutionalized and have signed the "Consent Form" at least 30 days prior to procedure. Reversal of sterilization procedures for the purposes of conception is not covered. Reversal of

sterilization procedures are covered when medically indicated and substantiating documentation is attached to the claim.
(15) Physicians' services whether furnished in the office, the member's home, a hospital, a nursing facility, ~~ICF/MR~~ICF/IID, or elsewhere. For adults, payment is made for compensable hospital days described at OAC 317:30-5-41. Office visits for adults are limited to four per month except when in connection with conditions as specified in OAC 317:30-5-9(b).
(16) Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law. See applicable provider section for limitations to covered services for:
(A) Podiatrists' services
(B) Optometrists' services
(C) Psychologists' services
(D) Certified Registered Nurse Anesthetists
(E) Certified Nurse Midwives
(F) Advanced Practice Nurses
(G) Anesthesiologist Assistants
(17) Free-standing ambulatory surgery centers.
(18) Prescribed drugs not to exceed a total of six prescriptions with a limit of two brand name prescriptions per month. Exceptions to the six prescription limit are:
(A) unlimited medically necessary monthly prescriptions for:
(i) members under the age of 21 years; and
(ii)residents of Nursing Facilities or Intermediate Care Facilities for ~~the Mentally Retarded~~Individuals with Intellectual Disabilities.
(B) seven medically necessary generic prescriptions per month in addition to the six covered under the State Plan are allowed for adults receiving services under the 1915(c) Home and Community Based Services Waivers. These additional medically necessary prescriptions beyond the two brand name or thirteen total prescriptions are covered with prior authorization.
(19) Rental and/or purchase of durable medical equipment.
(20) Adaptive equipment, when prior authorized, for members residing in private ~~ICF/MR's~~ICF/IID's.
(21) Dental services for members residing in private ~~ICF/MR's~~ICF/IID's in accordance with the scope of dental services for members under age 21.
(22) Prosthetic devices limited to catheters and catheter accessories, colostomy and urostomy bags and accessories, tracheostomy accessories, nerve stimulators, hyperalimentation and accessories, home dialysis equipment

and supplies, external breast prostheses and support accessories, oxygen/oxygen concentrator equipment and supplies, respirator or ventilator equipment and supplies, and those devices inserted during the course of a surgical procedure.
(23) Standard medical supplies.
(24) Eyeglasses under EPSDT for members under age 21. Payment is also made for glasses for children with congenital aphakia or following cataract removal. Payment is limited to two glasses per year. Any glasses beyond this limit must be prior authorized and determined to be medically necessary.
(25) Blood and blood fractions for members when administered on an outpatient basis.
(26) Inpatient services for members age 65 or older in institutions for mental diseases, limited to those members whose Medicare, Part A benefits are exhausted for this particular service and/or those members who are not eligible for Medicare services.
(27) Nursing facility services, limited to members preauthorized and approved by OHCA for such care.
(28) Inpatient psychiatric facility admissions for members under 21 are limited to an approved length of stay effective July 1, 1992, with provision for requests for extensions.
(29) Transportation and subsistence (room and board) to and from providers of medical services to meet member's needs (ambulance or bus, etc.), to obtain medical treatment.
(30) Extended services for pregnant women including all pregnancy-related and postpartum services to continue to be provided, as though the women were pregnant, for 60 days after the pregnancy ends, beginning on the last date of pregnancy.
(31) Nursing facility services for members under 21 years of age.
(32) Personal care in a member's home, prescribed in accordance with a plan of treatment and rendered by a qualified person under supervision of a R.N.
(33) Part A deductible and Part B Medicare Coinsurance and/or deductible.
(34) Home and Community Based Waiver Services for the intellectually disabled.
(35) Home health services limited to 36 visits per year and standard supplies for 1 month in a 12-month period. The visits are limited to any combination of Registered Nurse and nurse aide visits, not to exceed 36 per year.
(36) Medically necessary solid organ and bone marrow/stem cell transplantation services for children and adults are covered services based upon the conditions listed in (A)-(D) of this paragraph:

(A) Transplant procedures, except kidney and cornea, must be prior authorized to be compensable.
(B) To be prior authorized all procedures are reviewed based on appropriate medical criteria.
(C) To be compensable under the SoonerCare program, all transplants must be performed at a facility which meets the requirements contained in Section 1138 of the Social Security Act.
(D) Finally, procedures considered experimental or investigational are not covered.

(37) Home and community-based waiver services for intellectually disabled members who were determined to be inappropriately placed in a NF (Alternative Disposition Plan - ADP).

(38) Case Management services for the chronically and/or severely mentally ill.

(39) Emergency medical services including emergency labor and delivery for illegal or ineligible aliens.

(40) Services delivered in Federally Qualified Health Centers. Payment is made on an encounter basis.

(41) Early Intervention services for children ages 0-3.

(42) Residential Behavior Management in therapeutic foster care setting.

(43) Birthing center services.

(44) Case management services through the Oklahoma Department of Mental Health and Substance Abuse Services.

(45) Home and Community-Based Waiver services for aged or physically disabled members.

(46) Outpatient ambulatory services for members infected with tuberculosis.

(47) Smoking and Tobacco Use Cessation Counseling for children and adults.

(48) Services delivered to American Indians/Alaskan Natives in I/T/Us. Payment is made on an encounter basis.

(49) OHCA contracts with designated agents to provide disease state management for individuals diagnosed with certain chronic conditions. Disease state management treatments are based on protocols developed using evidence-based guidelines.

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

317:30-3-65.7. Vision services

(a) At a minimum, vision services include diagnosis and treatment for defects in vision, including eyeglasses once each 12 months. In addition, payment is made for glasses for children with congenital aphakia or following cataract removal (refer to OAC 317:30-5-2(b)(5) for amount, duration, and scope). Payment

is limited to two glasses per year. Any glasses beyond this limit must be prior authorized and determined to be medically necessary. The following schedule outlines the services required for vision services adopted by the OHCA.

(1) Each newborn should have an assessment of the anatomy of the lids, alignment of the eyes and clarity of the ocular media with particular attention to documenting the presence of a normal red reflex. The history should document either a normal birth or other condition such as prematurity.

(2) Red reflex and external appearance should be repeated and recorded on infants between one and four months of age.

(3) At six months of age, repeat red reflex and external exam and add an evaluation of ocular alignment with a corneal light reflex test.

(4) One screen should occur between nine and 12 months to mirror the six month screening.

(5) One screening from age three to five including alignment and an acuity test e.g., Allen Cards, Snellen chart or HOTV Test in each eye.

(6) Objective visual acuity testing should be provided at ages five through ten, and once during ages 11 through 18. All other years are subjective by history.

(b) Interperiodic vision examinations are allowed at intervals outside the periodicity schedule when a vision condition is suspected.

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 45. OPTOMETRISTS

317:30-5-432.1. Corrective lenses and optical supplies

(a) Payment will be made for children for lenses, frames, low vision aids and certain tints when medically necessary including to protect children with monocular vision. ~~Coverage includes one set of lenses and frames per year.~~ Payment is limited to two glasses per year. Any glasses beyond this limit must be prior authorized and determined to be medically necessary.

(b) Corrective lenses must be based on medical need. Medical need includes a change in prescription or replacement due to normal lens wear.

(c) SoonerCare provides frames when medically necessary. Frames are expected to last at least one year and must be reusable. If a lens prescription changes, the same frame must be used if possible. Payment for frames includes the dispensing fee.

(d) SoonerCare reimbursement for frames or lenses represents payment in full. No difference can be collected from the patient, family or guardians.

(e) Replacement of or additional lenses and frames are allowed when medically necessary. Prior authorization is not required~~;~~

unless the number of glasses exceeds two per year. ~~however, the~~The provider must always document in the patient record the reason for the replacement or additional eyeglasses. The OHCA or its designated agent will conduct ongoing monitoring of replacement frequencies to ensure guidelines are followed. Payment adjustments will be made on claims not meeting these requirements.

(f) Bifocal lenses for the treatment of accommodative esotropia are a covered benefit. Progressive lenses, trifocals, photochromic lenses and tints for children require prior authorization and medical necessity. Polycarbonate lenses are covered for children when medically necessary. Payment is limited to two glasses per year. Any glasses beyond this limit must be prior authorized and determined to be medically necessary.

(g) Progressive lenses, aspheric lenses, tints, coatings and photochromic lenses for adults are not compensable and may be billed to the patient.

(h) Replacement of lenses and frames due to abuse and neglect by the member is not covered.

(i) Bandage contact lenses are a covered benefit for adults and children. Contact lenses for medically necessary treatment of conditions such as aphakia, keratoconus, following keratoplasty, aniseikonia/anisometropia or albinism are a covered benefit for adults and children. Other contact lenses for children require prior authorization and medical necessity.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 25. SOONERCARE CHOICE
SUBCHAPTER 7. SOONERCARE
PART 3. ENROLLMENT CRITERIA

317:25-7-13. Enrollment ineligibility

Members in certain categories are excluded from participation in the SoonerCare Choice program. All other members are enrolled in the SoonerCare Choice program and subject to the provisions of this Subchapter. Members excluded from participation in SoonerCare Choice include:

(1) Individuals receiving services in a nursing facility, in an ~~intermediate care facility for the mentally retarded (ICF-MR)~~Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) or through a Home and Community Based Waiver.

(2) Individuals privately enrolled in an HMO.

(3) Individuals who would be traveling more than 45 miles or an average of 45 minutes to obtain primary care services.

(4) Children who are known to the OHCA to be in custody, as reported by the Oklahoma Department of Human Services.

(5) Individuals who are eligible for SoonerCare solely due to presumptive eligibility.

(6) Non-qualified or ineligible aliens.

(7) Children in subsidized adoptions.

(8) Individuals who are dually-eligible for SoonerCare and Medicare.

(9) Individuals who are in an Institution for Mental Disease (IMD).

(10) Individuals who have other primary medical insurance.

PART 5. ENROLLMENT PROCESS

317:25-7-28. Disenrolling a member from SoonerCare

(a) The OHCA may disenroll a member from SoonerCare if:

(1) the member is no longer eligible for SoonerCare services;

(2) the member has been incarcerated;

(3) the member dies;

(4) disenrollment is determined to be necessary by the OHCA;

(5) the status of the member changes, rendering him/her ineligible for SoonerCare;

(6) the member is already enrolled in the SoonerCare Program, when they are taken or found to be in custody as reported by the Oklahoma Department of Human Services;

(7) the member is authorized to receive services in a nursing facility, in an ~~intermediate care facility for the mentally retarded (ICF-MR)~~Intermediate Care Facility for Individuals

with Intellectual Disabilities (ICF/IID) or through a Home and Community Based Waiver; ~~or~~

(8) the member becomes dually-eligible for SoonerCare and Medicare~~.~~; or

(9) the member becomes covered under other primary medical insurance.

(b) The OHCA may disenroll the member at any time if the member is disenrolled for good cause, as it is defined in OAC 317:25-7-27. The OHCA will inform the PCP of any disenrollments from his or her member roster.

(c) OHCA may disenroll a member upon the PCP's request as described in (1) through (5) of this subsection.

(1) The PCP may file a written request asking OHCA to take action including, but not limited to, disenrolling a member when the member:

(A) is physically or verbally abusive to office staff, providers and/or other patients;

(B) is habitually non-compliant with the documented medical directions of the PCP; or

(C) regularly fails to arrive for scheduled appointments without cancelling and the PCP has made all reasonable efforts to accommodate the member.

(2) The request from the PCP for disenrollment of a member must include one of more of the following:

(A) documentation of the difficulty encountered with the member including the nature, extent and frequency of abusive or harmful behavior, violence, and/or inability to treat or engage the member;

(B) identification and documentation of unique religious or cultural issues that may be effecting the PCP's ability to provide treatment effectively to the member; or

(C) documentation of special assistance or intervention offered.

(3) The PCP may not request disenrollment because of a change in the member's health status, the member's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from the member's special needs except when the member's enrollment with the PCP seriously impairs his/her ability to furnish services to this member or other members.

(4) The PCP must document efforts taken to inform the member orally or in writing of any actions that have interfered with the effective provision of covered services, as well as efforts to explain what actions or language of the member are acceptable and unacceptable and the consequences of unacceptable behavior, including disenrollment from the PCP.

(5) The OHCA will give written notice of the disenrollment request to the member.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 21. OUTPATIENT BEHAVIORAL HEALTH SERVICES

317:30-5-241.2. Psychotherapy

(a) **Psychotherapy**.

(1) **Definition**. Psychotherapy is a face-to-face treatment for mental illnesses and behavioral disturbances, in which the clinician, through definitive therapeutic communication, attempts to alleviate the emotional disturbances, reverse or change maladaptive patterns of behavior and encourage growth and development. Insight oriented, behavior modifying and/or supportive psychotherapy refers to the development of insight of affective understanding, the use of behavior modification techniques, the use of supportive interactions, the use of cognitive discussion of reality, or any combination of these items to provide therapeutic change. Ongoing assessment of the member's status and response to treatment as well as psycho-educational intervention are appropriate components of individual therapy. The therapy must be goal directed, utilizing techniques appropriate to the service plan and the member's developmental and cognitive abilities.

(2) **Interactive Complexity**. Psychotherapy is considered to involve "interactive complexity" when there are communication factors during a visit that complicate delivery of the psychotherapy by the LBHP. Sessions typically involve members who have other individuals legally responsible for their care (i.e. minors or adults with guardians); members who request others to be involved in their care during the session (i.e. adults accompanied by one or more participating family members or interpreter or language translator); or members that require involvement of other third parties (i.e. child welfare, juvenile justice, parole/probation officers, schools, etc.). Psychotherapy should only be reported as involving interactive complexity when at least one of the following communication factors is present:

(A) The need to manage maladaptive communication (i.e. related to high anxiety, high reactivity, repeated questions, or disagreement) among participants that complicate delivery of care.

(B) Caregiver emotions/behavior that interfere with implementation of the service plan.

(C) Evidence/disclosure of a sentinel event and mandated report to a third party (i.e. abuse or neglect with report to state agency) with initiation of discussion of the sentinel event and/or report with patient and other visit

participants.

(D) Use of play equipment, physical devices, interpreter or translator to overcome barriers to therapeutic interaction with a patient who is not fluent in the same language or who has not developed or lost expressive or receptive language skills to use or understand typical language.

(3) **Qualified professionals**. Psychotherapy must be provided by a Licensed Behavioral Health Professional (LBHP) in a setting that protects and assures confidentiality.

(4) **Limitations**. A maximum of 6 units per day per member is compensable. Except for psychotherapy involving interactive complexity as described in this Section, only the member and the Licensed Behavioral Health Professional (LBHP) should be present during the session. Psychotherapy for a child younger than three must be medically necessary and meet established Child (0-36 months of Age) criteria as set forth in the Prior Authorization Manual.

(b) **Group Psychotherapy**.

(1) **Definition**. Group psychotherapy is a method of treating behavioral disorders using the interaction between the LBHP and two or more individuals to promote positive emotional or behavioral change. The focus of the group must be directly related to the goals and objectives in the individual member's current service plan. This service does not include social or daily living skills development as described under Behavioral Health Rehabilitation Services.

(2) **Group sizes**. Group Psychotherapy is limited to a total of eight adult (18 and over) individuals except when the individuals are residents of an ICF/IID where the maximum group size is six. For all children under the age of 18, the total group size is limited to six.

(3) **Multi-family and conjoint family therapy**. Sessions are limited to a maximum of eight families/units. Billing is allowed once per family unit, though units may be divided amongst family members.

(4) **Qualified professionals**. Group psychotherapy will be provided by a LBHP. Group Psychotherapy must take place in a confidential setting limited to the LBHP, an assistant or co-therapist, if desired, and the group psychotherapy participants.

(5) **Limitations**. A maximum of 12 units per day per member is compensable. Group Psychotherapy for a child younger than three must be medically necessary and meet established Child (0-36 months of Age) criteria as set forth in the Prior Authorization Manual.

(c) **Family Psychotherapy**.

(1) **Definition**. Family Psychotherapy is a face-to-face psychotherapeutic interaction between a LBHP and the member's family, guardian, and/or support system. It is typically inclusive of the identified member, but may be performed if indicated without the member's presence. When the member is an adult, his/her permission must be obtained in writing. Family psychotherapy must be provided for the direct benefit of the SoonerCare member to assist him/her in achieving his/her established treatment goals and objectives and it must take place in a confidential setting. This service may include the Evidence Based Practice titled Family Psychoeducation.

(2) **Qualified professionals**. Family Psychotherapy must be provided by a LBHP.

(3) **Limitations**. A maximum of 12 units per day per member/family unit is compensable. The provider may not bill any time associated with note taking and/or medical record upkeep. The provider may only bill the time spent in direct face-to-face contact. Provider must comply with documentation requirements listed in OAC 317:30-5-248.

(d) **Multi-Systemic Therapy (MST)**.

(1) **Definition**. MST intensive outpatient program services are limited to children within an Office of Juvenile Affairs (OJA) MST treatment program which provides an intensive, family and community-based treatment targeting specific BH disorders in children with SED who exhibit chronic, aggressive, antisocial, and/or substance abusing behaviors, and are at risk for out of home placement. Case loads are kept low due to the intensity of the services provided.

(2) **Qualified professionals**. Masters level professionals who work with a team that may include bachelor level staff.

(3) **Documentation requirements**. Providers must comply with documentation requirements in 317:30-5-248.

(4) **Service limitations**. Partial billing is not allowed, when only one service is provided in a day, providers should not bill for services performed for less than 8 minutes.

(e) **Children/Adolescent Partial Hospitalization Program (PHP)**.

(1) **Definition**. Partial hospitalization services are services that (1) Are reasonable and necessary for the diagnosis or active treatment of the member's condition; (2) Are reasonably expected to improve the member's condition and functional level and to prevent relapse or hospitalization and (3) Include the following:

(A) Assessment, diagnostic and service plan services for mental illness and/or substance use disorders provided by LBHPs.

(B) Individual/Group/Family (primary purpose is treatment

of the member's condition) psychotherapies provided by LBHPs.

(C) Substance use disorder specific services are provided by LBHPs qualified to provide these services.

(D) Drugs and biologicals furnished for therapeutic purposes.

(E) Family counseling, the primary purpose of which is treatment of the member's condition.

(F) Behavioral health rehabilitation services to the extent the activities are closely and clearly related to the member's care and treatment, provided by a Certified Behavioral Health Case Manager II, Certified Alcohol and Drug Counselor (CADC)or LBHP who meets the professional requirements listed in 317:30-5-240.3.

(G) Care Coordination of behavioral health services provided by certified behavioral health case managers.

(2) **Qualified professionals**.

(A) All services in the PHP are provided by a clinical team, consisting of the following required professionals:

(i) A licensed physician;

(ii) Registered nurse; and

(iii) One or more of the licensed behavioral health professionals (LBHP) listed in 30-5-240.3(a).

(B) The clinical team may also include a Certified Behavioral Health Case Manager.

(C) The service plan is directed under the supervision of a physician and the number of professionals and paraprofessionals required on the clinical team is dependent on the size of the program.

(3) **Qualified providers**. Provider agencies for PHP must be accredited by one of the national accrediting bodies; The Joint Commission (TJC), Commission on Accreditation of Rehabilitation Facilities (CARF) or The Council on Accreditation (COA) for partial hospitalization and enrolled in SoonerCare. Staff providing these services are employees or contractors of the enrolled agency.

(4) **Limitations**. Services are limited to children 0-20 only. Children under age 6 are not eligible for behavioral health rehabilitation services, unless a prior authorization for children ages 4 and 5 has been granted by OHCA or its designated agent based on a finding of medical necessity. Services must be offered at a minimum of 3 hours per day, 5 days per week. Therapeutic services are limited to 4 billable hours per day. PHP services are all inclusive with the exception of physician services and drugs that cannot be self-administered, those services are separately billable. Group size is limited to a maximum of 8 individuals as

clinically appropriate given diagnostic and developmental functioning. Occupational, Physical and Speech therapy will be provided by the Independent School District (ISD). Academic instruction, meals, and transportation are not covered.

(5) **Service requirements**.

(A) Therapeutic Services are to include the following:

(i) Psychiatrist/physician face-to-face visit 2 times per month;

(ii) Crisis management services available 24 hours a day, 7 days a week;

(B) Psychotherapies to be provided a minimum of four (4) hours per week and include the following:

(i) Individual therapy - a minimum of 1 session per week;

(ii) Family therapy - a minimum of 1 session per week; and

(iii) Group therapy - a minimum of 2 sessions per week;

(C) Interchangeable services which include the following:

(i) Behavioral Health Case Management (face-to-face);

(ii) Behavioral health rehabilitation services/alcohol and other drug abuse education (except for children under age 6, unless a prior authorization has been granted for children ages 4 and 5);

(iii) Medication Training and Support; and

(iv) Expressive therapy.

(6) **Documentation requirements**. Documentation needs to specify active involvement of the member's family, caretakers, or significant others involved in the individual's treatment. A nursing health assessment must be completed within 24 hours of admission. A physical examination and medical history must be coordinated with the Primary Care Physician. Service plan updates are required every three (3) months or more frequently based on clinical need. Records must be documented according to Section OAC 317:30-5-248.

(7) **Staffing requirements**. Staffing requirements must consist of the following:

(A) RN trained and competent in the delivery of behavioral health services as evidenced by education and/or experience that is available onsite during program hours to provide necessary nursing care and/or psychiatric nursing care (1 RN at a minimum can be backed up by an LPN but an RN must always be onsite). Nursing staff administers medications, follows up with families on medication compliance, and restraint assessments.

(B) Medical director must be a licensed psychiatrist.

(C) A psychiatrist/physician must be available 24 hours a day, 7 days a week.

(f) **Children/Adolescent Day Treatment Program**.

(1) **Definition**. Day Treatment Programs are for the stabilization of children and adolescents with severe emotional and/or behavioral disturbances. Treatment is designed for children who have difficulty functioning in mainstream community settings such as classrooms, and who need a higher intensity of services than outpatient counseling provides. Treatment is time limited and includes therapeutically intensive clinical services geared towards reintegration to the home, school, and community.

(2) **Qualified professionals**. All services in Day Treatment are provided by a team, which must be composed of one or more of the following participants: physician, registered nurse, licensed behavioral health professional (LBHP), a case manager, or other certified Behavioral Health/Substance Abuse paraprofessional staff. Services are directed by an LBHP.

(3) **Qualified providers**. Provider agencies for Day Treatment must be accredited by one of the national accrediting bodies; The Joint Commission (TJC), Commission on Accreditation of Rehabilitation Facilities (CARF) or The Council on Accreditation (COA).

(4) **Limitations**. Services must be offered at a minimum of 4 days per week at least 3 hours per day. Behavioral Health Rehabilitation Group size is limited to a maximum of 8 individuals as clinically appropriate given diagnostic and developmental functioning. Children under age 6 are not eligible for behavioral health rehabilitation services, unless a prior authorization for children ages 4 and 5 has been granted by OHCA or its designated agent based on a finding of medical necessity.

(5) **Service requirements**. On-call crisis intervention services must be available 24 hours a day, 7 days a week (When members served have psychiatric needs, psychiatric services are available which include the availability of a psychiatrist 24 hours a day, 7 days a week. A psychiatrist can be available either on site or on call but must be available at all times). Day treatment program will provide assessment and diagnostic services and/or medication monitoring, when necessary.

(A) Treatment activities are to include the following every week:

(i) Family therapy at least one hour per week (additional hours of FT may be substituted for other day treatment services);

(ii) Group therapy at least two hours per week; and

(iii) Individual therapy at least one hour per week.

(B) Additional services are to include at least one of the following services per day:

(i) Medication training and support (nursing) once monthly if on medications;

(ii) Behavioral health rehabilitation services to include alcohol and other drug education if the child meets the criteria established in 317:30-5-241.3 and is clinically necessary and appropriate (except for children under age 6, unless a prior authorization has been granted for children ages 4 and 5);

(iii) Behavioral health case management as needed and part of weekly hours for member;

(iv) Occupational therapy as needed and part of weekly hours for member; and

(v) Expressive therapy as needed and part of weekly hours for the member.

(6) **Documentation requirements**. Service plans are required every three (3) months.

317:30-5-241.3. Behavioral Health Rehabilitation (BHR) services

(a) **Definition**. Behavioral Health Rehabilitation (BHR) services are goal oriented outpatient interventions that target the maximum reduction of mental and/or behavioral health impairments and strive to restore the members to their best possible mental and/or behavioral health functioning. BHR services must be coordinated in a manner that is in the best interest of the member and may be provided in a variety of community and/or professional settings that protect and assure confidentiality. For purposes of this Section, BHR includes Psychosocial Rehabilitation, Outpatient Substance Abuse Rehabilitation, and Medication Training and Support.

(b) **Psychosocial Rehabilitation (PSR).**

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

(2) **Clinical restrictions**. This service is generally performed with only the members and the qualified provider, but may include a member and the member's family/support system when providing educational services from a curriculum that focuses on the member's diagnosis, symptom management,

and recovery. A member who at the time of service is not able to cognitively benefit from the treatment due to active hallucinations, substance abuse, or other impairments is not suitable for this service. Family involvement is allowed for support of the member and education regarding his/her recovery, but does not constitute family therapy, which requires a licensed provider.

(3) **Qualified providers**. A Certified Behavioral Health Case Manager II (CM II), CADC, and LBHP may perform PSR, following development of a service plan and treatment curriculum approved by a LBHP. The CM II and CADC must have immediate access to a fully licensed LBHP who can provide clinical oversight and collaborate with the qualified PSR provider in the provision of services. A minimum of one monthly face-to-face consultation with a fully licensed LBHP is required for PSR providers~~ regularly rendering services in an agency setting~~. A minimum of one face-to-face consultation per week with ~~a fully licensed~~ a LBHP is required for PSR providers regularly rendering services away from the outpatient behavioral health agency site.

(4) **Group sizes**. The maximum staffing ratio is fourteen members for each qualified provider for adults and eight to one for children under the age of eighteen.

(5) **Limitations.**

(A) **Transportation**. Travel time to and from PSR treatment is not compensable. Group PSR services do not qualify for the OHCA transportation program, but OHCA will arrange for transportation for those who require specialized transportation equipment.

(B) **Time**. Breaks, lunchtime and times when the member is unable or unwilling to participate are not compensable and must be deducted from the overall billed time.

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

(D) **Eligibility for PSR services.** ~~PSR services are intended for adults with Serious Mental Illness (SMI), children with Serious Emotional Disturbance (SED), and children with other emotional or behavioral disorders. The following members are not eligible for PSR services:~~All PSR services require prior authorization and must meet established medical necessity criteria.

(i)Adults. PSR services for adults are limited to members who have a history of psychiatric hospitalization or admissions to crisis centers, have been determined disabled by the SSA for mental health reasons, are residing in residential care facilities or are receiving services through a specialty court program.

(ii) Children. PSR services for children are limited to members who have a history of psychiatric hospitalization or admissions to crisis centers; have been determined disabled by the SSA for mental health reasons; have a current Individual Education Plan (IEP) or 504 Plan for emotional disturbance; or have been evaluated by a school psychologist, licensed psychologist or psychiatrist and determined to be "at risk" as outlined in the Prior Authorization Manual.

(iii) The following members are not eligible for PSR services:

~~(i)~~(I) Residents of ICF/IID facilities, unless authorized by OHCA or its designated agent;

~~(ii)~~(II) children under age 6, unless a prior authorization for children ages 4 and 5 has been granted by OHCA or its designated agent based on the criteria in (5)(D)(ii) above as well as a finding of medical necessity;

~~(iii)~~(III) children receiving RBMS in a group home or therapeutic foster home, unless authorized by OHCA or its designated agent;

~~(iv)~~(IV) inmates of public institutions;

~~(v)~~(V) members residing in inpatient hospitals or IMDs; and

~~(vi)~~(VI) members residing in nursing facilities.

(E) **Billing limits**. PSR services are time-limited services designed to be provided over the briefest and most effective period possible and as adjunct (enhancing) interventions to compliment more intensive behavioral health therapies. Service limits are based on the member's needs according to the CAR or other approved tool, the requested placement based on the level of functioning rating, medical necessity, and best practice. Service limitations are designed to help prevent rehabilitation diminishing return by remaining within reasonable age and developmentally appropriate daily limits. PSR services authorized under this Section are separate and distinct from, but should not duplicate the structured services required for children residing in group home or therapeutic foster care settings, or receiving services in

Day Treatment or Partial Hospitalization Programs. Children under an ODMHSAS Systems of Care program and adults residing in residential care facilities may be prior authorized additional units as part of an intensive transition period. PSR is billed in unit increments of 15 minutes with the following limits:

(i) **Group PSR**. The maximum is 24 units per day for adults and 16 units per day for children.

(ii) **Individual PSR**. The maximum is six units per day.

(iii) **Per-Member service levels and limits.** Unless otherwise specified, group and/or individual PSR services provided in combination may not exceed the monthly limits established in the individual's prior authorization. Limits on PSR services are established based on the level for which the member has been approved.

(iv) **EPSDT.** Pursuant to OAC 317:30-3-65 et seq., billing limits may be exceeded or may not apply if documentation demonstrates that the requested services are medically necessary and are needed to correct or ameliorate defects, physical or behavioral illnesses or conditions discovered through a screening tool approved by OHCA or its designated agent. The OHCA has produced forms for documenting an EPSDT child health checkup screening which the provider can access on the OHCA website.

(F) **Progress Notes.** In accordance with OAC 317:30-5-241.1, the behavioral health service plan developed by the LBHP must include the member's strengths, functional assets, weaknesses or liabilities, treatment goals, objectives and methodologies that are specific and time-limited, and defines the services to be performed by the practitioners and others who comprise the treatment team. When PSR services are prescribed, the plan must address objectives that are specific, attainable, realistic, and time-limited. The plan must include the appropriate treatment coordination to achieve the maximum reduction of the mental and/or behavioral health disability and to restore the member to their best possible functional level. Progress notes for PSR day programs may be in the form of daily summary or weekly summary notes. Progress notes for all Behavioral Health Rehabilitation services must include the following:

(i) Curriculum sessions attended each day and/or dates attending during the week;

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

(iii) Specific goal(s) and objectives addressed during the week;
(iv) Type of Skills Training provided each day and/or during the week including the specific curriculum used with member;
(v) Member satisfaction with staff intervention(s);
(vi) Progress, or barrier to, made towards goals, objectives;
(vii) New goal(s) or objective(s) identified;
(viii) Signature of the lead qualified provider; and
(ix) Credentials of the lead qualified provider;

(G) **Additional documentation requirements.**

(i) a list/log/sign in sheet of participants for each Group rehabilitative session and facilitating qualified provider must be maintained; and
(ii) Documentation of ongoing consultation and/or collaboration with a LBHP related to the provision of PSR services.

(H) **Non-Covered Services.** The following services are not considered BHR and are not reimbursable:

(i) Room and board;
(ii) educational costs;
(iii) supported employment; and
(iv) respite.

(c) **Outpatient Substance Abuse Rehabilitation Services.**

(1) **Definition.** Covered outpatient substance abuse rehabilitation services are provided in non-residential settings in regularly scheduled sessions intended for individuals not requiring a more intensive level of care or those who require continuing services following more intensive treatment regimes. The purpose of substance abuse rehabilitation services is to begin, maintain, and/or enhance recovery from alcoholism, problem drinking, drug abuse, drug dependency addiction or nicotine use and addiction. Rehabilitation services may be provided individually or in group sessions, and they take the format of curriculum based education and skills training.

(2) **Limitations**. Group sessions may not be provided in the home.

(3) **Eligibility.** Members eligible for substance abuse rehabilitation services must meet the criteria for ASAM PCC Treatment Level 1, Outpatient Treatment.

(4) **Qualified providers.** CM II, CADC or LBHP.

(5) **Billing limits.** Group rehabilitation is limited to two (2) hours per session. Group and/or individual outpatient substance abuse rehabilitation services provided in

combination may not exceed the monthly limits established in the individual's prior authorization. Limits on services are established based on the level for which the member has been approved. There are no limits on substance abuse rehabilitation services for individuals determined to be Level 4.

(6) **Documentation requirements**. Documentation requirements are the same as for PSR services as set forth in 30-5-241.3(b)(5)(F).

(d) **Medication training and support**.

(1) **Definition**. Medication Training and Support is a documented review and educational session by a registered nurse, advanced practice nurse, or physician assistant focusing on a member's response to medication and compliance with the medication regimen. The review must include an assessment of medication compliance and medication side effects. Vital signs must be taken including pulse, blood pressure and respiration and documented within the medical or clinical record. A physician is not required to be present, but must be available for consult. Medication Training and Support is designed to maintain the member on the appropriate level of the least intrusive medications, encourage normalization and prevent hospitalization.

(2) **Limitations**.

(A) Medication Training and Support may not be billed for SoonerCare members who reside in ICF/IID facilities.

(B) Two units are allowed per month per patient.

(C) Medication Training & Support is not allowed to be billed on the same day as an evaluation and management (E/M) service provided by a psychiatrist.

(3) **Qualified professionals**. Must be provided by a licensed registered nurse, an advanced practice nurse, or a physician assistant as a direct service under the supervision of a physician.

(4) **Documentation requirements.** – Medication Training and Support documented review must focus on:

(A) a member's response to medication;

(B) compliance with the medication regimen;

(C) medication benefits and side effects;

(D) vital signs, which include pulse, blood pressure and respiration; and

(E) documented within the progress notes/medication record.

JOEL NICO GOMEZ
CHIEF EXECUTIVE OFFICER

MARY FALLIN
GOVERNOR

STATE OF OKLAHOMA

OKLAHOMA HEALTH CARE AUTHORITY

State Plan Amendment Rate Committee (SPARC)
June 24, 2014
Blood Glucose Supplies

1. **Is this a "Rate Change" or a "Method Change"?**
   Methodology Change

1b. Is this change an increase, decrease, or no impact?
Decrease

2. **Presentation of issue – Why is change being made?**
   The Oklahoma Health Care Authority (OHCA) recommends a revision to the current rates and reimbursement structure for blood glucose supplies. Our current State Plan requires OHCA to follow Medicare's rates / methodology. Medicare went to a competitive bid rate July 1, 2013. OHCA could elect to change the State Plan to no longer follow Medicare's methodology however this change also coincides with a time that OHCA has a budget shortfall and changes are necessary to reduce the Agency's spending to balance the state budget in accordance with Article 10, Section 23 of the Oklahoma Constitution, which prohibits a state agency from spending more money than is allocated.

   Federal Requirements
   State Medicaid programs generally have considerable flexibility in determining the reimbursement methodology and resulting rate for services, within federally-imposed upper limits and specific restrictions. Section 1902(a)(30)(A) of the Social Security Act requires that State Medicaid programs must assure that payment rates:

   - Be consistent with efficiency, economy and quality of care;
   - Are sufficient to enlist enough providers so that Medicaid care and services are available under the state plan at least to the extent that such care and services are available to the general population in that geographic area.

3. **Current methodology and/or rate structure.**
   Currently, OHCA pays 60% of the 2010 Medicare rate; the rate is $19.96 for over the counter and $16.97 for mail order. With 91% of supplies being provided over the counter and 9% being provided through mail order the average rate is $19.69.

4. **New methodology or rate.**
   July 1, 2013 Medicare implemented a competitive bid rate of $10.41. OHCA seeks to implement this rate.

5. **Budget estimate.**
   The estimated annual change is a decrease in the amount of $797,964; $297,401 state share.

6. **Agency estimated impact on access to care.**
   A reduction of the per unit blood glucose supply rate should not negatively impact access and quality of care to SoonerCare members.

7. **Rate or Method change in the form of a motion.**
   The agency requests the State Plan Amendment Rate Committee to approve reducing payment for blood glucose supplies to the competitive bid national rate of $10.41 per unit.

8. **Effective date of change.**
   July 1, 2014

State Plan Amendment Rate Committee (SPARC)
June 24, 2014
Physician and Other Medicare Part B Crossovers Co-Insurance Claims

1. **Is this a "Rate Change" or a "Method Change"?**
   Methodology change

1b. **Is this change an increase, decrease, or no impact?**
   Decrease

2. **Presentation of issue – Why is change being made?**
   The Oklahoma Health Care Authority (OHCA) recommends a revision to the current rates and reimbursement structure for physician and other Part B crossover claims. Changes are necessary to reduce the Agency's spending to balance the state budget in accordance with Article 10, Section 23 of the Oklahoma Constitution , which prohibits a state agency from spending more money than is allocated.

   Federal Requirements
   State Medicaid programs generally have considerable flexibility in determining the reimbursement methodology and resulting rate for services, within federally-imposed upper limits and specific restrictions. Section 1902(a)(30)(A) of the Social Security Act requires that State Medicaid programs must assure that payment rates :

   - Be consistent with efficiency, economy and quality of care;
   - Are sufficient to enlist enough providers so that Medicaid care and services are available under the state plan at least to the extent that such care and services are available to the general population in that geographic area.

3. **Current methodology and/or rate structure.**
   Currently physician and other Medicare Part B crossover claims are reimbursed 100% of the deductible and co-insurance amounts.

4. **New methodology or rate.**
   Federal regulations require State's payments for crossover claims, when combined with Medicare's payment, to at least equal the Medicaid allowed amount. Currently the Medicaid allowed amount is 96.75% of Medicare; that would translate to a payment of 83.75% of the co-insurance amount. Since OHCA plans to reduce payments further to 89.25% of Medicare (an additional 7.75%) the cumulative effect would be a payment of 46.25% of Medicare co-insurance amount. We do not seek to make any changes in the deductible amount; OHCA will continue to pay 100% of the deductible.

5. **Budget estimate.**
   The estimated annual change is a decrease in the amount of $29,693,982; $11,194,631 state share.

6. **Agency estimated impact on access to care.**
   A reduction in payment of the co-insurance amount should not negatively impact access and quality of care to SoonerCare members.

7. **Rate or Method change in the form of a motion.**
   The agency requests the State Plan Amendment Rate Committee to approve a rate change for physician and other part B crossover claims from 100% to 46.25% of co-insurance amount.

8. **Effective date of change.**
   July 1, 2014

State Plan Amendment Rate Committee (SPARC)
June 24, 2014
Providers 7.75% Rate Reduction

1. **Is this a "Rate Change" or a "Method Change"?**
   Rate change

1b. **Is this change an increase, decrease, or no impact?**
   Decrease

2. **Presentation of issue – Why is change being made?**
   The Oklahoma Health Care Authority (OHCA) recommends a revision, in the amount of a 7.75% reduction, to the current rates and reimbursement structure in the SoonerCare program. Changes are necessary to reduce the Agency's spending to balance the state budget in accordance with Article 10, Section 23 of the Oklahoma Constitution, which prohibits a state agency from spending more money than is allocated.

   Federal Requirements
   State Medicaid programs generally have considerable flexibility in determining the reimbursement methodology and resulting rate for services, within federally-imposed upper limits and specific restrictions. Section 1902(a)(30)(A) of the Social Security Act requires that State Medicaid programs must assure that payment rates :

   - Be consistent with efficiency, economy and quality of care;
   - Are sufficient to enlist enough providers so that Medicaid care and services are available under the state plan at least to the extent that such care and services are available to the general population in that geographic area.

3. **Current methodology and/or rate structure.**
   Oklahoma currently reimburses under a variety of different rate structures; diagnostic related group (DRG), per diem, max fee, percent of Medicare and a percent of costs are some examples. Our current rates reflect a 3.25% reduction from the applicable rate structure; this was implemented in 2010.

4. **New methodology or rate.**
   We seek to decrease the current rates by 7.75%; an effective rate of 89.25% of the applicable rate structure.

   The proposed rate reduction excludes services financed through appropriations to other state agencies, services provided under a waiver and services where a reduction could severely limit access or not cover costs (in the aggregate). Below are examples of the exclusions. While the list below is fairly comprehensive it is not exhaustive.

   - Capitation / Care Coordination payments and incentive payments
   - Child abuse exams
   - Emergency and non-emergency transportation
   - Insure Oklahoma
   - Long term care facilities
   - Payments for drug ingredients / physician supplied drugs
   - Private duty nursing
   - Services provided under a waiver
   - Services paid for by other state agencies, excluding school based services
   - Services provided to Native Americans through Indian Health Services / Indian/Tribal/Urban Clinics

5. **Budget estimate.**
   The estimated annual change is a decrease in the amount of $128,916,969; $48,047,354 state share.

6. **Agency estimated impact on access to care.**
   A 7.75% decrease to the rates should not negatively impact access and quality of care to SoonerCare members.

7. **Rate or Method change in the form of a motion.**
   The agency requests the State Plan Amendment Rate Committee to approve the 7.75% rate reduction for all providers excluding those providers/services that have an exception provision.

8. **Effective date of change.**
   July 1, 2014

State Plan Amendment Rate Committee (SPARC)
June 24, 2014
Regular Nursing Facilities

1. **Is this a rate change or a method change?**
   Rate Change – The statewide average rate will remain the same ($143.52). Individual Nursing Facility rates are modified due to a change in the pool amount consisting of the Direct Care Cost Component and Other Cost Component.

1b. Is this change an increase, decrease or no impact?
No Impact

2. **Presentation of Issue:**
   The change is made to reflect adherence to the State Plan methodology for reallocation of Direct Care Costs and changes to the Direct Care Cost Component Pool as a result in the decline in Medicaid days.

3. **Current Methodology/Rate Structure:**
   The current rate methodology calls for the establishment of a prospective rate which consists of the following four components:
   (A) A Base Rate Component defined as $107.24 per day.
   (B) A Focus on Excellence (FOE) Component defined by the points earned under this performance program as defined in the state plan. The bonus component paid may be from $1.00 to $5.00 per day based on points earned.
   (C) An Other Component which is defined as the per day amount derived from dividing 30% of the pool of funds available after meeting the needs of the Base and FOE Components by the total estimated Medicaid days for the rate period.
   (D) A Direct Care Component which is defined as the per day amount derived from allocating 70% of the pool of funds available after meeting the needs of the Base and FOE Components to the facilities. This component is determined separately and is different for each facility. The method (as approved in the State Plan) allocates the 70% pool funds to each facility (on a per day basis) based on their relative expenditures for direct care.

4. **Budget Estimate:**
   This has no impact on the budget.

5. **Estimated impact on access to care:**
   The agency does not anticipate this change will impact access to care.

6. **Requested changes:**
The agency requests an amendment to remove specific dollar pool amounts from the State Plan. If this request cannot be accomplished, the agency further request the pool amounts be revised as indicated below:
   - ***Pool Amount*** – decrease the pool amount in the state plan for the "Other" and "Direct Care" Components from $162,205,189 to $158,391,182.

7. **Effective Date of Change:**
   July 1, 2014