Oklahoma Health Care Authority
MEDICAL ADVISORY COMMITTEE
September 8, 2022
1:00 – 3:30 PM
Charles Ed McFall Board Room

# AGENDA

**Public access via zoom:**
**https://okhca.zoom.us/webinar/register/WN_TDSdvS56SpmHRbCLMvJsiA**
**Telephone:**1-346-248-7799 **Webinar ID:** 845 3414 2939

***Please note: Since the physical address for the OHCA MAC Meeting has resumed, any livestreaming option provided as a courtesy. Should such livestreaming option fail or have technical issues, the OHCA MAC Meeting will not be suspended or reconvened because of this failure or technical issue.**

I. Welcome, Roll Call, and Public Comment Instructions: **Chairman, Jason Rhynes, O.D.**

II. Action Item: Approval of Minutes of the July 14th, 2022: **Medical Advisory Committee Meeting**

III. Public Comments (2 minute limit)

IV. MAC Member Comments/Discussion

V. Legislative Update**: Katelynn Burns, Legislative Liaison**

VI. Financial Report: **Tasha Black, Senior Director of Financial Services**

VII. Medicaid Directors Update: **Traylor Rains, State Medicaid Director**

A. **Pharmacy Update: Terry Cothran, Senior Pharmacy Director**

VIII. Proposed Rule Changes: Presentation, Discussion, and Vote: **Sandra Puebla, Deputy State Medicaid Director**

A. **APA WF#22-05 Ambulance Service Provider Access Payment Program**
B. **APA WF # 22-12 Staff Ratios and Staff Licensing Requirements for Out-of-State Psychiatric Providers**
C. **APA WF # 22-13Advanced Practice Registered Nurses (APRN) and Physician Assistants (PA) Rendering Physician-Required Psychiatric Services**
D. **APA WF # 22-14 Coverage for Donor Human Breast Milk**
E. **APA WF # 22-16 Statewide Health Information Exchange (HIE)**
F. **APA WF # 22-17 Covering Former Foster Care Youth from Another State**
G. **APA WF # 22-18 Mobile Dental Services**

IX. New Business: **Chairman, Jason Rhynes, O.D.**

X. Future Meeting: **Chairman, Jason Rhynes, O.D.**
November 10, 2022

XI. Adjourn **Chairman, Jason Rhynes, O.D.**

Oklahoma Health Care Authority
MEDICAL ADVISORY COMMITTEE
MINUTES of the July 14, 2022, Meeting
4345 N. Lincoln Blvd., Oklahoma City, OK 73105

## I. Welcome, Roll Call, and Public Comment Instructions:

Chairman, Dr. Jason Rhynes called the meeting to order at 1:00 PM.

***Delegates present were:*** Mr. Nick Barton, Ms. Joni Bruce, Mr. Brett Coble, Dr. Steven Crawford, Ms. Janet Cizek, Ms. Wanda Felty, Ms. Jennifer King, Ms. Melissa Miller, Dr. Daniel Post, Dr. Jason Rhynes, Dr. Eve Switzer and Dr. Whitney Yeates, providing a quorum.

**Alternates present were**:

***Delegates absent without an alternate were*:** Dr. Arlen Foulks, Ms. Tina Johnson, and Dr. Raymond Smith.

## II. Approval of the May 12th, 2022 Minutes

Medical Advisory Committee
**The motion to approve the minutes was by Dr. Steven Crawford and seconded by Dr. Daniel Post and passed unanimously.**

## III. Public Comments (2-minute limit):

There were no public comments.

## IV. MAC Member Comments/Discussion:

Dr. Eve Switzer requested an update on OHCA's coverage of Modifier 25. Mr. Rains responded that with some codes we allow Modifier 25 to be attached to it to identify services being provided during the same visit as rendering, having the same purpose and to do that, for it to go through the system you attach a Modifier 25. There have been some issues with billing a sick visit and a well-child visit at the same time and attach a 25, it is denying both services instead of just the extra service. That is happening because on some of those it will require additional documentation to show and demonstrate why it was separately provided.

Dr. Rhynes discussed the fee schedule changes on the OHCA website which is a result of CMS putting out their rates every January 1st, Medicaid chooses to wait 6 or 7 months before they go live with their newly amended rates being compliant.

Ms. Joni Bruce would like for a policy update to allow a second parent, or caretaker to ride home from the hospital via SoonerRide. The current policy allows only 1 parent to receive a ride home. Mr. Rains said OHCA is happy to look at the policy and see what can be done.

Mr. Brett Coble made a comment on the financial report that there is a reduction in the budget for nursing home expenditures into the next year, while this represents a rate that was set pre-pandemic and anticipates lower utilization in our setting it does not contemplate an additional supplemental payment, they have been receiving related to the PHE. Should it expire in the fourth quarter, nursing home facilities are going to be facing a flip and wanted member to be aware of that.

Vice-Chair, Wanda Felty supports Mr. Cobles comments but would like to add in the facilities that support individuals with intellectual disabilities. In Oklahoma, the rate that is paid for that population is significantly lower, so the facilities must restrict who they can support. They often don't allow admission of an individual who has intellectual disabilities who level of support is higher because there is not enough money and the limit to cover their support, which then leaves the responsibilities on the family of those with the higher support. She would like to encourage the state to look at how we can truly long-term support in the facility and in the community.

## V. Legislative Update:

Katelynn Burns, Legislative Liaison

Ms. Burns stated that in 2022, around 2,300 bills were filed this year and about 2,500 were carried over from the previous session but were all a part of the 58 legislative sessions. In total around 5,800 bills were filed and 1,100 were signed into law as of May 27th. SB1467 requires the OHCA to create and produce an annual review of forms of treatment for a medication for sickle cell disease to determine if Medicaid is adequately covering them. SB1369 is related to the health information exchange, it made some changes to that bill that went into effect July 1. SB1396 which corresponds with SB1337, it is related to the supplemental hospital offset payment program (SHOPP) which adjusts that. SB1661 OHCA worked with Steven Bucks group on to make changes on the definitions for non-state government owned medical facilities within the Medicaid program. SB1323 allows for self-funded and self-insured health plans, which are recognized by the insurance department and that meet certain standard procedures qualify under the Medicaid premium assistance program, such as Insure Oklahoma. SB1134 repealed the waitlist for the Home and Community Based Waiver Services through DHS.

Ms. Burns also talked about the special sessions that were called. The second special session was to look at the American Rescue Plan Act of 2021, and a few other things. The Governor calls a third special session that began on June 13th, which was specifically to focus on abolishing or reducing the states grocery tax and also reducing the states personal income tax, which is still on-going. HB1020 was filed during the special sessions that reduces the appropriations to the funds to the OHCA budget by about 200 million. This was passed by the House but has yet to be heard by the Senate.

## VI. Financial Report:

Tasha Black, Senior Director of Financial Services

Ms. Black presented the SFY 2023 budget Report Program. Starting with the history, appropriations and budgets, the medical programs, OHCA's program assumptions, expansion budget growth, Insure Oklahoma, OHCA Administration and other state agency programs. For more detailed information, see item, see item 6 in the MAC agenda.

**VII. Medicaid Directors Report:**

Traylor Rains, State Medicaid Director

Mr. Rains gave an update on a few different things going on with OHCA, starting with the Delivery System Reform and our goals. He also discussed about the program design, populations, covered benefits, network adequacy, quality and population health, financials, and the timeline. Mr. Rains talked about the Public Health Emergency giving a review of the background, the unwinding of the PHE, and eligibility data. Mr. Rains touched base on the recent expansion update as of June 20, 2022, there is 330,066 total enrollments through expansion. 209,569 are new members and 120, 497 members were previously enrolled in other programs, now eligible for more benefits. For more detailed information, see item 7 in the MAC agenda.

**VIII. Proposed Rule Changes: Presentation, Discussion, and Vote:**

Sandra Puebla, Senior Director of Federal & State Authorities

**APA WF # 22-15 Removing Provider Panel Limits in the Patient Centered Medical Home (PCMH) —** The proposed revisions will remove member cap limits for Physicians, Advanced Practice Registered Nurses (APRN), and Physician Assistants (PA) participating in SoonerCare Choice as a Patient Centered Medical Home provider. Currently, policy only allows 2,500 members for each physician, 1,250 members for each APRN, and 1,250 members for each PA. The proposed revisions will allow members easier access to care and will align policy with the current redesign of the PCMH model. **Budget Impact: Budget neutral.**

**Proposed Rule Timeline:**

**60-day Tribal Consultation Period:** February 19, 2022 – April 16, 2022
**Tribal Consultation:** March 1, 2022
**Public Comment Period:** June 27, 2022 – July 14, 2022
**OHCA Board Meeting:** September 21, 2022
**Requested Effective Date:** Upon Governor's signature or the 45th day post submission of the rules to the Governor (November 7, 2022)

**The rule change motion to approve was by Dr. Daniel Post and seconded by Dr. Whitney Yeates and passed unanimously.**

**IX. MAC Meeting Dates for Calendar 2022:**

Chairman, Jason Rhynes, O.D.

September 8, 2022
November 10, 2022

X. **New Business:**

Chairman, Jason Rhynes, O.D.

No new business was addressed.

**XI. Adjourn:**

Chairman, Jason Rhynes, O.D.
Chairman Rhynes asked for a motion to adjourn. Motion was provided by Dr. Steven Crawford and seconded by Mr. Nick Barton, there was no dissent and the meeting adjourned at 2:40pm.

# PHARMACY DEPARTMENT OVERVIEW

# DRUG PRICE INCREASES IMPACTING MEDICAID SPEND

- Medicaid Drug spend for FY 2019 was $66.7 billion on outpatient prescription drugs with $37.1 billion collected in rebates which produced a net spend of $29.6 billion

- Center for Medicare & Medicaid Services (CMS) projects a Medicaid drug spend increase of 5-6% annually over the next several years

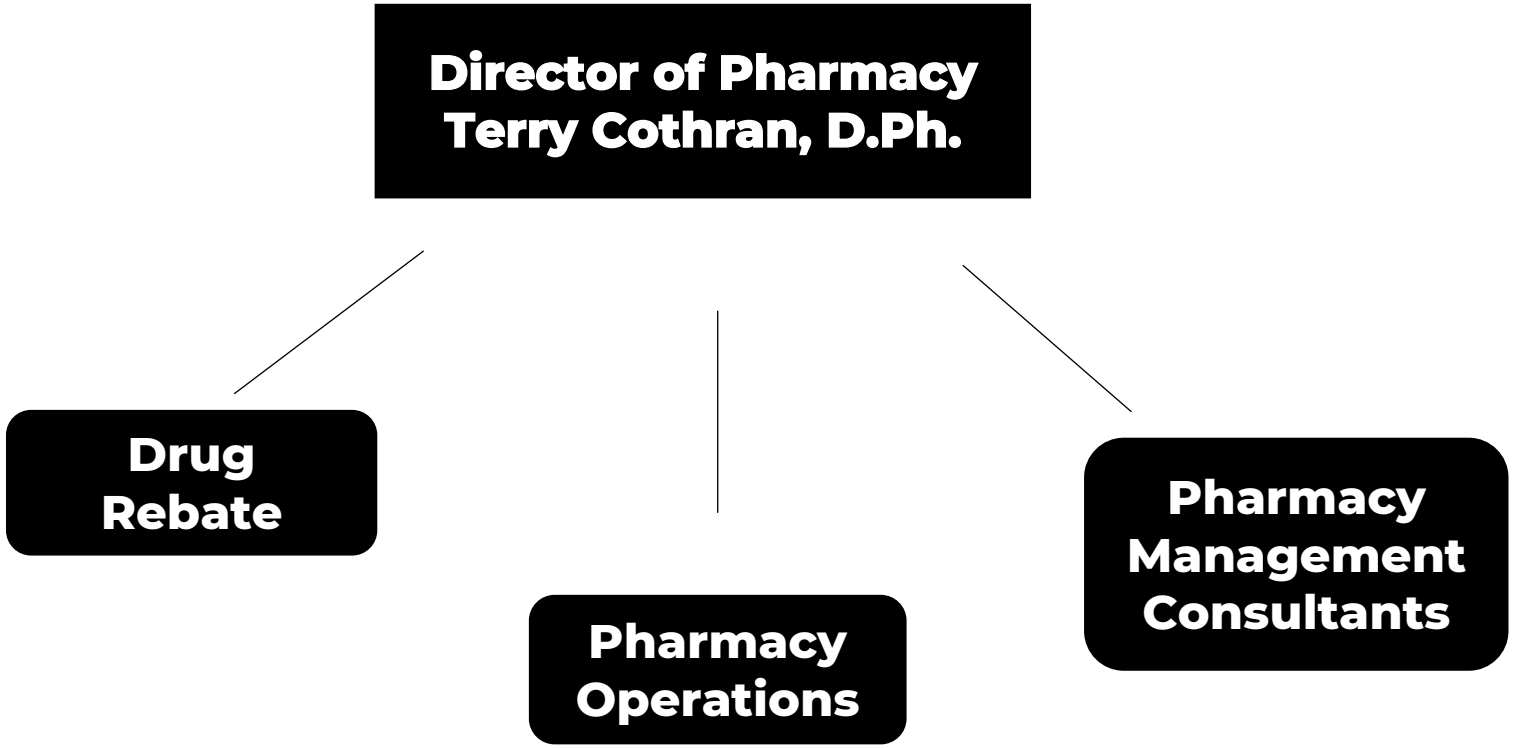
- Medicaid drug spend is increasingly driven by high-cost specialty drugs
  - 2010 -2015 increase from $4.8 billion to $9.9 billion (almost doubled)
  - 2019 specialty drugs accounted for 48.5 percent of pharmacy spend from only 1.3 percent of drug utilization

- Pharmaceutical Pipeline
  - Almost 8,000 products in development across all pharmaceutical areas
  - Included are nearly 400 cell and gene therapies (hemophilia A expected $2-$3 million)

# PHARMACY NUMBERS FOR STATE FISCAL YEAR (FY) 2021

- Total Drug Claims Paid – 5,417,167
- Members utilizing Pharmacy Services – 489,195
- Average cost per pharmacy claim – $130.27
- Drug expenditures for adults and children
  - Adults - $384,928,778 for 153,026 members
  - Children - $319,367,370 for 356,738 members

# PHARMACY DEPARTMENT



# DRUG REBATE TOTALS FOR STATE FISCAL YEAR (FY) 2021

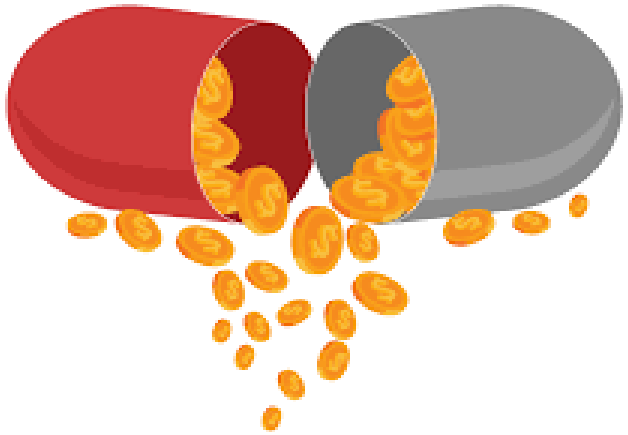
- Pharmacy Overall Spend - $705,680,160
- Drug Rebate Collections - $404,889,951
- Percentage of Pharmacy  spend – 57.4%
- Value-Based Agreement (VBA) Rebates - $2,141,098

# DRUG REBATE

- **Medicaid Drug Rebate Program (MDRP)** is where drug manufacturers pay state Medicaid agencies rebates that are related to the utilization of prescriptions and physician administered drugs in return for coverage of their products

- Bring in around $400 million in rebates to the agency on an annual basis

- OHCA Pharmacy recoups between 55 – 60% of expenditures through our five drug rebate programs



# REBATE PROGRAMS

- **Federal:** drug manufacturers sign agreement with federal government and must pay a rebate based on the utilization of their drug.
- **Supplemental:** Additional rebates drug manufacturers have agreed to pay the state in addition to the federal rebate on the drug.
- **340B:** drug manufacturers provide outpatient drugs to eligible organizations at reduced prices, then drug rebate invoices the eligible organizations for shared savings on the 340B drugs to keep net cost low.
- **Diabetic Supplies:** rebates specific to diabetic supplies
- **Value-Based Agreements (VBA):** a type of supplemental rebate agreement involving value-based purchasing arrangements with drug manufacturers that could produce extra rebates for the state if clinical outcomes are not achieved. Value-Based Agreements can link the payment of a drug to its effectiveness and the outcomes it achieves.
    - Oklahoma was the first state to get this rebate type approved by CMS and initiate a contract with a manufacturer.

# PHARMACY OPERATIONS

- Responsible for oversight of the pharmacy benefit for Oklahoma Medicaid, a few examples listed below:
  - Keep the drug files up to date and accurate (30+ thousand active NDC's)
  - System programming/edits for pharmacy claims
  - Implementing and adjusting to the ongoing Public Health Emergency (Covid vaccines, test, treatment, counseling)
  - Collaborate with the Department of Mental Health (DMH) with regards to Medication Assisted Treatment (MAT) and Opioid Treatment Programs (OTP)
  - Medication Therapy Management (MTM) programs
  - Set pricing parameters on select drugs
  - Clinical support for drugs within the agency (ex: medical drug coverage)

# PHARMACY MANAGEMENT CONSULTANTS (PMC)

- Responsible for:
  - Pharmacy help desk
  - Prior Authorization (PA) services (24 hour turnaround)
  - Drug Utilization Review (DUR) services
  - Pharmacy lock-in program
  - Prescription Drug Management initiatives
  - Therapy Management programs
  - Academic Detailing
  - Value-Based Agreement (VBA) analysis

# PRIOR AUTHORIZATION DATA CY21

- 8,356 NDCs that require a Prior Authorization
- Total Cost of Prior Authorized Drugs – $217,960,663
  - Pharmacy - $176,988,560
  - Medical - $40,972,103

# Thank you!
# Questions & Comments

OKLAHOMA
Health Care Authority

# FINANCIAL REPORT

For the Fiscal Year Ended June 30, 2022
Submitted to the CEO & Board

- Revenues for OHCA through June, accounting for receivables, were **$6,785,568,180** or **.0% over/under** budget.

- Expenditures for OHCA, accounting for encumbrances, were **$6,278,746,745** or **.5% under** budget.

- The state dollar budget variance through June is a positive **$30,850,410**
- The budget variance is primarily attributable to the following (in millions):

| | | |
|---|---|---|
| **Expenditures:** | | |
| Medicaid Program Variance | | 28.0 |
| Administration | | 10.8 |
| **Revenues:** | | |
| Drug Rebate | | (2.2) |
| Medical Refunds | | (2.0) |
| Taxes and Fees | | (3.8) |
| **Total FY 22 Variance** | **$** | **30.8** |

**ATTACHMENTS**

# OKLAHOMA HEALTH CARE AUTHORITY
## Summary of Revenues & Expenditures: OHCA
## SFY 2022, For the Fiscal Year Ended June 30, 2022

| REVENUES | FY22 Budget YTD | FY22 Actual YTD | Variance | % Over/ (Under) |
|---|---|---|---|---|
| State Appropriations | $ 1,030,199,249 | $ 1,030,199,249 | $ - | 0.0% |
| Federal Funds | 4,673,611,883 | 4,698,690,081 | 25,078,198 | 0.5% |
| Tobacco Tax Collections | 46,567,529 | 46,030,904 | (536,626) | (1.2)% |
| Quality of Care Collections | 90,829,851 | 87,246,028 | (3,583,823) | (3.9)% |
| Prior Year Carryover | 38,492,360 | 38,492,360 | - | 0.0% |
| Federal Deferral - Interest | 154,862 | 154,862 | - | 0.0% |
| Rate Preservation Fund | 164,138,054 | 164,138,054 | - | 0.0% |
| Drug Rebates | 495,465,438 | 484,893,913 | (10,571,525) | (2.1)% |
| Medical Refunds | 43,009,916 | 32,926,961 | (10,082,955) | (23.4)% |
| Prior Year Carryover Supplemental Hospital Offset Payment Program | 3,415,272 | 3,415,272 | - | 0.0% |
| Supplemental Hospital Offset Payment Program | 194,417,721 | 194,417,721 | - | 0.0% |
| Other Revenues | 4,708,531 | 4,962,775 | 254,244 | 5.4% |
| **TOTAL REVENUES** | **$ 6,785,010,667** | **$ 6,785,568,180** | **$ 557,513** | **0.0%** |

| EXPENDITURES | FY22 Budget YTD | FY22 Actual YTD | Variance | % (Over)/ Under |
|---|---|---|---|---|
| **ADMINISTRATION - OPERATING** | **$ 67,107,461** | **$ 55,962,812** | **$ 11,144,648** | **16.6%** |
| **ADMINISTRATION - CONTRACTS** | **$ 152,448,690** | **$ 136,452,114** | **$ 15,996,576** | **10.5%** |
| **MEDICAID PROGRAMS** | | | | |
| Managed Care: | | | | |
| SoonerCare Choice | 60,853,578 | 52,110,223 | 8,743,355 | 14.4% |
| Acute Fee for Service Payments: | | | | |
| Hospital Services | 1,562,633,274 | 1,493,963,223 | 68,670,051 | 4.4% |
| Behavioral Health | 27,624,556 | 28,277,613 | (653,057) | (2.4)% |
| Physicians | 546,643,864 | 541,080,329 | 5,563,535 | 1.0% |
| Dentists | 221,589,927 | 189,283,148 | 32,306,779 | 14.6% |
| Other Practitioners | 66,781,135 | 70,180,193 | (3,399,058) | (5.1)% |
| Home Health Care | 34,533,965 | 30,895,440 | 3,638,524 | 10.5% |
| Lab & Radiology | 46,020,474 | 43,905,074 | 2,115,400 | 4.6% |
| Medical Supplies | 81,333,531 | 81,634,558 | (301,027) | (0.4)% |
| Ambulatory/Clinics | 481,779,474 | 503,740,894 | (21,961,420) | (4.6)% |
| Prescription Drugs | 1,140,274,685 | 1,169,743,162 | (29,468,478) | (2.6)% |
| OHCA Therapeutic Foster Care | 481,974 | 565,614 | (83,640) | (17.4)% |
| Other Payments: | | | | |
| Nursing Facilities | 674,203,352 | 756,347,152 | (82,143,801) | (12.2)% |
| Intermediate Care Facilities for Individuals with Intellectual Disabilities Private | 68,060,293 | 65,361,381 | 2,698,911 | 4.0% |
| Medicare Buy-In | 225,473,340 | 226,191,158 | (717,818) | (0.3)% |
| Transportation | 118,576,953 | 101,756,539 | 16,820,414 | 14.2% |
| Money Follows the Person-OHCA | 211,534 | 438,069 | (226,535) | (107.1)% |
| Electronic Health Records-Incentive Payments | 101,243 | 101,243 | - | 0.0% |
| Part D Phase-In Contribution | 70,236,151 | 69,502,327 | 733,824 | 1.0% |
| Supplemental Hospital Offset Payment Program | 650,503,878 | 650,503,878 | - | 0.0% |
| Telligen | 11,476,928 | 10,750,599 | 726,330 | 6.3% |
| **Total OHCA Medical Programs** | **6,089,394,110** | **6,086,331,818** | **3,062,291** | **0.1%** |
| OHCA Non-Title XIX Medical Payments | 89,382 | - | 89,382 | 0.0% |
| **TOTAL OHCA** | **$ 6,309,039,642** | **$ 6,278,746,745** | **$ 30,292,897** | **0.5%** |
| **REVENUES OVER/(UNDER) EXPENDITURES** | **$ 475,971,025** | **$ 506,821,435** | **$ 30,850,410** | |

# OKLAHOMA HEALTH CARE AUTHORITY
## Total Medicaid Program Expenditures
## by Source of State Funds
## SFY 2022, For the Fiscal Year Ended June 30, 2022

| Category of Service | Total | Health Care Authority | Quality of Care | Insure Oklahoma | SHOPP | BCC | Other State Agencies |
|---|---|---|---|---|---|---|---|
| SoonerCare Choice | $ 52,110,223 | $ 52,102,938 | $ - | $ - | $ - | $ 7,285 | $ - |
| Inpatient Acute Care | 1,615,535,920 | 883,589,684 | 486,687 | 1,183,950 | 503,121,262 | 1,030,737 | 226,123,600 |
| Outpatient Acute Care | 730,102,025 | 604,618,880 | 41,604 | 1,414,066 | 119,831,843 | 4,195,631 | - |
| Behavioral Health - Inpatient | 99,563,402 | 18,795,476 | - | 167,884 | 23,138,330 | - | 57,461,713 |
| Behavioral Health - Psychiatrist | 13,894,579 | 9,481,174 | - | - | 4,412,442 | 963 | - |
| Behavioral Health - Outpatient | 18,756,817 | - | - | - | - | - | 18,756,817 |
| Behaviorial Health-Health Home | 3,083,392 | - | - | - | - | - | 3,083,392 |
| Behavioral Health Facility- Rehab | 241,668,123 | - | - | - | - | 177,906 | 241,668,123 |
| Behavioral Health - Case Management | 6,489,856 | - | - | - | - | - | 6,489,856 |
| Behavioral Health - PRTF | 12,829,504 | - | - | - | - | - | 12,829,504 |
| Behavioral Health - CCBHC | 207,845,563 | - | | | | | 207,845,563 |
| Residential Behavioral Management | 19,574,274 | - | - | - | - | - | 19,574,274 |
| Targeted Case Management | 63,407,772 | - | - | - | - | - | 63,407,772 |
| Therapeutic Foster Care | 565,614 | 565,614 | - | - | - | - | - |
| Physicians | 660,112,890 | 538,418,108 | 58,101 | 1,476,795 | - | 2,604,121 | 117,555,766 |
| Dentists | 189,302,211 | 189,201,063 | - | 19,063 | - | 82,085 | - |
| Mid Level Practitioners | 1,420,784 | 1,419,642 | - | 785 | - | 356 | - |
| Other Practitioners | 68,876,060 | 68,217,354 | 446,364 | 115,865 | - | 96,476 | - |
| Home Health Care | 30,899,216 | 30,890,050 | - | 3,775 | - | 5,391 | - |
| Lab & Radiology | 44,084,512 | 43,782,474 | - | 179,438 | - | 122,600 | - |
| Medical Supplies | 81,677,304 | 78,860,402 | 2,711,532 | 42,746 | - | 62,625 | - |
| Clinic Services | 513,794,094 | 493,302,553 | - | 888,282 | - | 324,179 | 19,279,080 |
| Ambulatory Surgery Centers | 10,152,494 | 10,098,893 | - | 38,332 | - | 15,269 | - |
| Personal Care Services | 9,034,150 | - | - | - | - | - | 9,034,150 |
| Nursing Facilities | 756,347,152 | 398,065,955 | 358,272,904 | - | - | 8,293 | - |
| Transportation | 101,405,314 | 98,503,668 | 2,787,472 | 68,756 | - | 45,418 | - |
| IME/DME | 65,626,829 | - | - | - | - | - | 65,626,829 |
| ICF/IID Private | 65,361,381 | 47,067,437 | 18,293,945 | - | - | - | - |
| ICF/IID Public | 25,856,727 | - | - | - | - | - | 25,856,727 |
| CMS Payments | 295,693,486 | 295,265,341 | 428,145 | - | - | - | - |
| Prescription Drugs | 1,169,655,593 | 1,165,987,003 | - | (87,569) | - | 3,756,159 | - |
| Miscellaneous Medical Payments | 419,982 | 413,931 | - | - | - | 6,050 | - |
| Home and Community Based Waiver | 293,324,193 | - | - | - | - | - | 293,324,193 |
| Homeward Bound Waiver | 72,261,236 | - | - | - | - | - | 72,261,236 |
| Money Follows the Person | 957,939 | 438,069 | - | - | - | - | 519,871 |
| In-Home Support Waiver | 27,001,987 | - | - | - | - | - | 27,001,987 |
| ADvantage Waiver | 198,063,422 | - | - | - | - | - | 198,063,422 |
| Family Planning/Family Planning Waiver | 2,024,102 | - | - | - | - | - | 2,024,102 |
| Premium Assistance* | 43,326,587 | - | - | 43,326,587.28 | - | - | - |
| Telligen | 10,750,599 | 10,750,599 | - | - | - | - | - |
| Electronic Health Records Incentive Payments | 101,243 | 101,243 | - | - | - | - | - |
| **Total Medicaid Expenditures** | **$ 7,822,958,552** | **$ 5,039,937,551** | **$ 383,526,753** | **$ 48,838,757** | **$ 650,503,878** | **$ 12,541,543** | **$ 1,687,787,977** |

* Includes $42,871,086.04 paid out of Fund 245

**OKLAHOMA HEALTH CARE AUTHORITY**
**Summary of Revenues & Expenditures:**
**Other State Agencies**
**SFY 2022, For the Fiscal Year Ended June 30, 2022**

| REVENUE | FY22 Actual YTD |
|---|---|
| Revenues from Other State Agencies | 410,032,608 |
| Federal Funds | 1,362,026,348 |
| **TOTAL REVENUES** | **$ 1,772,058,956** |

| EXPENDITURES | Actual YTD |
|---|---|
| **Oklahoma Human Services** | |
| Home and Community Based Waiver | 293,324,193 |
| Money Follows the Person | 519,871 |
| Homeward Bound Waiver | 72,261,236 |
| In-Home Support Waivers | 27,001,987 |
| ADvantage Waiver | 198,063,422 |
| Intermediate Care Facilities for Individuals with Intellectual Disabilities Public | 25,856,727 |
| Personal Care | 9,034,150 |
| Residential Behavioral Management | 13,274,229 |
| Targeted Case Management | 55,491,942 |
| **Total Oklahoma Human Services** | **694,827,758** |
| | |
| **State Employees Physician Payment** | |
| Physician Payments | 117,555,766 |
| **Total State Employees Physician Payment** | **117,555,766** |
| | |
| **Education Payments** | |
| Indirect Medical Education | 38,096,396 |
| Direct Medical Education | 8,521,276 |
| DSH | 19,009,157 |
| **Total Education Payments** | **65,626,829** |
| | |
| **Office of Juvenile Affairs** | |
| Targeted Case Management | 2,046,972 |
| Residential Behavioral Management | 6,300,044 |
| **Total Office of Juvenile Affairs** | **8,347,016** |
| | |
| **Department of Mental Health & Substance Abuse Services** | |
| Case Management | 6,489,856 |
| Inpatient Psychiatric Free-standing | 57,461,713 |
| Outpatient | 18,756,817 |
| Health Homes | 3,083,392 |
| Psychiatric Residential Treatment Facility | 12,829,504 |
| Certified Community Behavioral Health Clinics | 207,845,563 |
| Rehabilitation Centers | 241,668,123 |
| **Total Department of Mental Health & Substance Abuse Services** | **548,134,968** |
| | |
| **State Department of Health** | |
| Children's First | 56,490 |
| Sooner Start | 1,213,816 |
| Early Intervention | 2,408,557 |
| Early and Periodic Screening, Diagnosis, and Treatment Clinic | 992,676 |
| Family Planning | 690,101 |
| Family Planning Waiver | 1,334,001 |
| Maternity Clinic | 5,449 |
| **Total Department of Health** | **6,701,090** |
| | |
| **County Health Departments** | |
| EPSDT Clinic | 367,766 |
| Family Planning Waiver | - |
| **Total County Health Departments** | **367,766** |
| | |
| **State Department of Education** | **195,959** |
| **Public Schools** | **3,207,852** |
| **Medicare DRG Limit** | **207,735,773** |
| **Native American Tribal Agreements** | **16,699,372** |
| **Department of Corrections** | **5,785,280** |
| **JD McCarty** | **12,602,547** |
| | |
| **Total OSA Medicaid Programs** | **$ 1,687,787,977** |
| | |
| **OSA Non-Medicaid Programs** | **$ 88,283,800** |
| | |
| **Accounts Receivable from OSA** | **$ 4,012,821** |

# OKLAHOMA HEALTH CARE AUTHORITY

## SUMMARY OF REVENUES & EXPENDITURES:

### Fund 205: Supplemental Hospital Offset Payment Program Fund

### SFY 2022, For the Fiscal Year Ended June 30, 2022

| REVENUES | | FY 22 Revenue |
|---|---|---|
| SHOPP Assessment Fee | | 194,319,292 |
| Prior Year Carryover - SHOPP Expansion | | 3,415,272 |
| Federal Draws | $ | 540,469,125 |
| Interest | | 98,429 |
| Penalties | | - |
| TOTAL REVENUES | $ | 738,302,118 |

| EXPENDITURES | Quarter | Quarter | Quarter | Quarter | | FY 22 Expenditures |
|---|---|---|---|---|---|---|
| Program Costs: | 7/1/21 - 9/30/21 | 10/1/21 - 12/31/21 | 1/1/22 - 3/31/22 | 4/1/22 - 6/30/22 | | |
| Hospital - Inpatient Care | 92,858,282 | 83,639,436 | 73,677,501 | 77,752,900 | $ | 327,928,119 |
| Hospital -Outpatient Care | 22,248,247 | 20,973,326 | 16,900,037 | 18,934,158 | $ | 79,055,768 |
| Psychiatric Facilities-Inpatient | 4,362,577 | 3,920,470 | 3,500,773 | 3,500,773 | $ | 15,284,594 |
| Rehabilitation Facilities-Inpatient | 735,534 | 660,994 | 749,525 | 749,525 | $ | 2,895,579 |
| Hospital - Inpatient Care - Expansion | 32,182,661 | 46,700,968 | 45,838,728 | 50,470,786 | $ | 175,193,143 |
| Hospital -Outpatient Care - Expansion | 6,274,106 | 10,282,009 | 10,628,363 | 13,591,597 | $ | 40,776,075 |
| Psychiatric Facilities-Inpatient - Expansion | 1,433,128 | 2,185,256 | 2,117,676 | 2,117,676 | $ | 7,853,735 |
| Rehabilitation Facilities-Inpatient - Expansion | 241,626 | 368,436 | 453,400 | 453,400 | $ | 1,516,863 |
| Total OHCA Program Costs | 160,336,162 | 168,730,897 | 153,866,003 | 167,570,816 | | 650,503,878 |
| Total Expenditures | | | | | $ | 650,503,878 |

| | | |
|---|---|---|
| *SHOPP Revenue transferred to Fund 340 for Medicaid Program expense* | $ | 87,798,241 |

*** Expenditures and Federal Revenue processed through Fund 340

# OKLAHOMA HEALTH CARE AUTHORITY
## SUMMARY OF REVENUES & EXPENDITURES:
## Fund 230: Nursing Facility Quality of Care Fund
## SFY 2022, For the Fiscal Year Ended June 30, 2022

| REVENUES | Total Revenue | State Share |
|---|---|---|
| Quality of Care Assessment | $ 87,223,636 | $ 87,223,636 |
| *Quality of Care Penalties (*Non-Spendable Revenue)* | $ 215,933 | $ 215,933 |
| Interest Earned | 22,392 | $ 22,392 |
| **TOTAL REVENUES** | **$ 87,461,962** | **$ 87,461,962** |

| EXPENDITURES | FY 22 Total $ YTD | FY 22 State $ YTD | Total State $ Cost |
|---|---|---|---|
| **Program Costs** | | | |
| Nursing Facility Rate Adjustment | $ 246,128,816 | $ 50,628,643 | |
| Eyeglasses and Dentures | 238,581 | $ 49,076 | |
| Personal Allowance Increase | 2,966,040 | $ 610,112 | |
| Coverage for Durable Medical Equipment and Supplies | 2,711,532 | $ 557,762 | |
| Coverage of Qualified Medicare Beneficiary | 1,032,756 | $ 212,438 | |
| Part D Phase-In | 428,145 | $ 428,145 | |
| ICF/IID Rate Adjustment | 4,657,624 | $ 958,250 | |
| Acute Services ICF/IID | 7,080,914 | $ 1,456,537 | |
| Non-emergency Transportation - Soonerride | 2,787,472 | $ 573,338 | |
| NF Covid-19 Supplemental Payment | 108,939,467 | $ 22,321,697 | |
| ICF Covid-19 Supplemental Payment | 6,555,407 | $ 1,343,203 | |
| Ventilator NF DME Supplemental Payment | | $ - | |
| **Total Program Costs** | **$ 383,526,753** | **$ 79,139,201** | **$ 79,139,201** |
| **Administration** | | | |
| OHCA Administration Costs | $ 284,015 | $ 142,007 | |
| OHS-Ombudsmen | 429,197 | 429,197 | |
| OSDH-Nursing Facility Inspectors | - | - | |
| Mike Fine, CPA | 22,800 | 11,400 | |
| **Total Administration Costs** | **$ 736,012** | **$ 582,604** | **$ 582,604** |
| **Total Quality of Care Fee Costs** | **$ 384,262,764** | **$ 79,721,805** | |
| **TOTAL STATE SHARE OF COSTS** | | | **$ 79,721,805** |

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:
### Insure Oklahoma Program (Fund 245: HEEIA)
### SFY 2022, For the Fiscal Year Ended June 30, 2022

| REVENUES | FY 21 Carryover | FY 22 Revenue | Total Revenue |
|---|---|---|---|
| *Prior Year Balance* | $ 12,826,511 | | |
| *State Appropriations* | - | | |
| *Transfer to 340 for Expansion-prior year* | (12,929,712) | | |
| *Federal Draws - Prior Year* | 115,189 | | |
| Total Prior Year Revenue | | | 11,988 |
| *Transfer to 340 for Expansion-current year* | | (10,070,288) | (10,070,288) |
| Tobacco Tax Collections | - | 37,858,968 | 37,858,968 |
| Interest Income | - | 172,327 | 172,327 |
| Federal Draws | - | 35,481,378 | 35,481,378 |
| **TOTAL REVENUES** | **$ 11,988** | **$ 63,442,385** | **$ 63,454,373** |

| EXPENDITURES | | FY 21 Expenditures | FY 22 Expenditures | Total State $ YTD |
|---|---|---|---|---|
| **Program Costs:** | | | | |
| | Employer Sponsored Insurance | | **$ 42,871,086** | **$ 42,871,086** |
| | College Students/ESI Dental | | **455,501** | **93,728** |
| **Individual Plan** | | | | |
| | SoonerCare Choice | | $ - | $ - |
| | Inpatient Hospital | | 1,181,266 | 245,344 |
| | Outpatient Hospital | | 1,398,457 | 290,819 |
| | BH - Inpatient Services-DRG | | 166,444 | 34,574 |
| | BH -Psychiatrist | | - | - |
| | Physicians | | 1,457,657 | 302,816 |
| | Dentists | | 19,039 | 3,958 |
| | Mid Level Practitioner | | 785 | 163 |
| | Other Practitioners | | 114,972 | 23,872 |
| | Home Health | | 3,775 | 783 |
| | Lab and Radiology | | 176,978 | 36,772 |
| | Medical Supplies | | 40,959 | 8,517 |
| | Clinic Services | | 869,660 | 180,618 |
| | Ambulatory Surgery Center | | 38,332 | 7,968 |
| | Skilled Nursing | | - | - |
| | Prescription Drugs | | (92,360) | (17,803) |
| | Transportation | | 68,532 | 14,236 |
| | Premiums Collected | | | 36,714 |
| **Total Individual Plan** | | | **$ 5,444,497** | **$ 1,169,352** |
| | **College Students-Service Costs** | | **$ 67,673** | **$ 14,066** |
| **Total OHCA Program Costs** | | | **$ 48,838,757** | **$ 44,148,232** |
| **Administrative Costs** | | | | |
| | Salaries | $ 2,283 | $ 1,257,503 | $ 1,259,785 |
| | Operating Costs | 2,121 | 3,631 | 5,752 |
| | E&E Development DXC | - | - | - |
| | Contract - DXC | 7,584 | 1,440,837 | 1,448,421 |
| **Total Administrative Costs** | | **$ 11,988** | **$ 2,701,971** | **$ 2,713,958** |
| **Total Expenditures** | | | | **$ 46,862,191** |
| **NET CASH BALANCE** | | **$ 0** | **$ 16,592,182** | **$ 16,592,182** |

# OKLAHOMA HEALTH CARE AUTHORITY

## Combining Statement of Revenues, Expenditures and Changes in Fund Balance

## SFY 2022, For the Fiscal Year Ended June 30, 2022

| | Administration Fund 200 | Supplemental Hospital Offset Payment Program Fund 205 | Quality of Care Fund 230 | Rate Preservation Fund 236 | Federal Deferral Fund 240 | Health Employee and Economy Act Fund 245 | Belle Maxine Hilliard Breast & Cervical Cancer Treatment (Tobacco) Fund 250 | Medicaid Program (Tobacco) Fund 255 | Medicaid Program Fund 340 | Clearing Account 1807B | Total Cash Balance |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **June Beginning Fund Balance:** | | | | | | | | | | | |
| Prior year | 25,470,229 | 2,913,409 | 25,267 | 33,453,218 | 13,821,907 | (0) | - | - | 475,107,352 | 14,908,624 | 565,700,006 |
| Current year | 14,270,951 | (2,190,735) | (14,641) | 150,459,881 | 52,261,351 | 11,518,822 | - | - | 349,010,903 | - | 575,316,533 |
| Total | 39,741,180 | 722,674 | 10,626 | 183,913,099 | 66,083,259 | 11,518,822 | - | - | 824,118,255 | 14,908,624 | 1,141,016,539 |
| **June Revenues:** | | | | | | | | | | | |
| Prior year | - | - | - | - | - | - | - | - | - | - | - |
| Current year | 5,480,972 | 577 | 7,183,654 | - | 21,851 | 6,557,746 | 61,915 | 3,710,301 | 490,257,648 | 118,157,233 | 631,431,898 |
| Total | 5,480,972 | 577 | 7,183,654 | - | 21,851 | 6,557,746 | 61,915 | 3,710,301 | 490,257,648 | 118,157,233 | 631,431,898 |
| **June Expenditures:** | | | | | | | | | | | |
| Prior year | - | - | - | - | - | - | - | - | - | - | - |
| Current year | 14,265,857 | - | - | - | - | 3,889,115 | - | - | 671,964,718 | - | 690,119,690 |
| Total | 14,265,857 | - | - | - | - | 3,889,115 | - | - | 671,964,718 | | 690,119,690 |
| **Operating Transfers In** | | | | | | | | | | | |
| Prior year | | | | | | | | | | | |
| Current year | 6,728,842 | - | - | 13,678,173 | - | - | - | - | 74,597,603 | - | 95,004,618 |
| Total | 6,728,842 | - | - | 13,678,173 | - | - | - | - | 74,597,603 | - | 95,004,618 |
| **Operating Transfers Out** | | | | | | | | | | | |
| Prior year | 1,255,256 | - | - | - | - | - | - | - | - | | 1,255,256 |
| Current year | - | - | 7,036,006 | - | - | - | 61,915 | 3,710,301 | - | 14,908,624 | 25,716,847 |
| Total | 1,255,256 | - | 7,036,006 | - | - | - | 61,915 | 3,710,301 | - | 14,908,624 | 26,972,102 |
| ***Change in CY Fund Balance*** | ***12,214,907*** | ***(2,190,158)*** | ***133,007*** | ***164,138,054*** | ***52,283,203*** | ***14,187,453*** | ***-*** | ***-*** | ***241,901,436*** | ***103,248,609*** | ***585,916,512*** |
| **Ending Fund Balance** | **36,429,881** | **723,251** | **158,274** | **197,591,272** | **66,105,110** | **14,187,453** | **-** | **-** | **717,008,788** | **118,157,233** | **1,150,361,262** |

# OKLAHOMA HEALTH CARE AUTHORITY
## HEALTHY ADULT PROGRAM EXPENDITURES - OHCA
### SFY 2022, For the Fiscal Year Ended June 30, 2022

| PROGRAM / ACTIVITY | FY22 BUDGETED EXPENDITURES Full Year | FY22 BUDGETED EXPENDITURES Year to Date | FY22 ACTUAL EXPENDITURES YTD through June | BUDGET VARIANCE (Over)/ Under |
|---|---|---|---|---|
| **OHCA MEDICAID PROGRAMS** | | | | |
| **Managed Care** | | | | |
| SoonerCare Choice | 8,829,743 | 8,829,743 | 1,630,413 | 7,199,330 |
| **Total Managed Care** | **8,829,743** | **8,829,743** | **1,630,413** | **7,199,330** |
| **Fee for Service** | | | | |
| **Hospital Services:** | | | | |
| Inpatient Acute Care | 260,410,104 | 260,410,104 | 205,239,018 | 55,171,086 |
| SHOPP | 225,339,816 | 225,339,816 | 225,339,816 | - |
| Outpatient Acute Care | 205,586,924 | 205,586,924 | 184,486,104 | 21,100,820 |
| **Total Hospitals** | **691,336,844** | **691,336,844** | **615,064,938** | **76,271,906** |
| **Behavioral Mental Health:** | | | | |
| Inpatient Services - DRG | 8,223,477 | 8,223,477 | 15,712,960 | (7,489,483) |
| Outpatient | - | - | - | - |
| **Total Behavioral Mental Health** | **8,223,477** | **8,223,477** | **15,712,960** | **(7,489,483)** |
| **Physicians & Other Providers:** | | | | |
| Physicians | 165,635,032 | 165,635,032 | **123,842,389** | 41,792,644 |
| Dentists | 37,697,689 | 37,697,689 | 33,211,377 | 4,486,312 |
| Mid-Level Practitioner | 563,844 | 563,844 | 328,942 | 234,902 |
| Other Practitioners | 13,705,795 | 13,705,795 | 14,118,163 | (412,368) |
| Home Health Care | 6,852,897 | 6,852,897 | 706,247 | 6,146,651 |
| Lab & Radiology | 13,705,795 | 13,705,795 | 13,434,041 | 271,754 |
| Medical Supplies | 13,705,795 | 13,705,795 | 8,824,893 | 4,880,902 |
| Clinic Services | 135,583,034 | 135,583,034 | 101,100,748 | 34,482,285 |
| Ambulatory Clinics | 3,654,573 | 3,654,573 | 3,024,674 | 629,898 |
| **Total Physicians & Other Providers** | **391,104,453** | **391,104,453** | **298,591,474** | **92,512,979** |
| **Misc Medical & Health Access Network** | **277,667** | **277,667** | **71,398** | 206,269 |
| **Transportation** | **27,411,590** | **27,411,590** | **19,287,642** | 8,123,947 |
| **Health Access Network** | **-** | **-** | **1,745,093** | (1,745,093) |
| **Prescription Drugs** | **363,203,566** | **363,203,566** | **378,658,412** | (15,454,846) |
| **Total OHCA Medicaid Programs** | **1,490,387,341** | **1,490,387,341** | **1,330,762,332** | **159,625,010** |

**September MAC**
**Proposed Rules Amendment Summaries**

**APA WF # 22-05 Ambulance Service Provider Access Payment Program –** The proposed policy establishes rules consistent with the Oklahoma State Plan, which outlines the Ambulance Service Provider Access Payment Program (ASPAPP). The ASPAPP is a voluntary program designed to help assure access to quality emergency transports for SoonerCare members by assessing a fee to privately owned ambulance service providers and then issuing quarterly supplemental payments to those providers.

**Budget Impact:** The estimated total cost for SFY 2023 is $5,802,463 ($4,392,464 in federal share and $1,409,999 in state share). The estimated total cost for SFY 2024 is $5,802,463 ($3,908,539 in federal share and $1,893,924 in state share). Both SFY 2023 and SFY 2024 will include a $200,000 administrative cost collection from a provider tax.

**Proposed Rule Timeline:**
**Tribal Consultation:** Nov. 2, 2021
**15-Day Public Comment Period:** Aug. 16, 2022 - Aug. 31, 2022
**OHCA Board Meeting:** Sept. 21, 2022
**Emergency Rule Requested Effective Date:** Contingent upon Governor's approval or the 45th day post submission of the rules to the Governor (Nov. 7, 2022)

**APA WF # 22-12 Staff Ratios and Staff Licensing Requirements for Out-of-State Psychiatric Providers –** The proposed rule changes allow out-of-state inpatient psychiatric providers to utilize the staffing ratios and staff licensing requirements of the state in which the facility/provider is located.

**Budget Impact:** Budget neutral.

**Proposed Rule Timeline:**
**Tribal Consultation:** July 5, 2022
**15-Day Public Comment Period:** Aug. 16, 2022 – Aug. 31, 2022
**OHCA Board Meeting:** Sept. 21, 2022
**Emergency Rule Requested Effective Date:** Contingent upon Governor's approval or the 45th day post submission of the rules to the Governor (Nov. 7, 2022).

**APA WF # 22-13 Advanced Practice Registered Nurses (APRN) and Physician Assistants (PA) Rendering Physician-Required Psychiatric Services –** The proposed rules allow APRNs with psychiatric certifications and PAs to provide psychiatric services. Presently, psychiatric service provision is only allowed by psychiatrists to members in inpatient settings. The psychiatric services provided by APRNs and PAs will now also include psychiatric evaluations and weekly individual treatment hours. The proposed rule aims to address physician shortages and extend the reach of behavioral health treatments such as psychiatric evaluations and weekly individual treatment hours by allowing inpatient psychiatric providers to utilize APRNs with psychiatric certifications and PAs.

**Budget Impact:** Budget neutral.

**Proposed Rule Timeline:**
**Tribal Consultation:** July 5, 2022
**15-Day Public Comment Period:** Aug. 16, 2022 – Aug. 31, 2022
**OHCA Board Meeting:** Sept. 21, 2022

**Emergency Rule Requested Effective Date:** Contingent upon Governor's approval or the 45th day post submission of the rules to the Governor (Nov. 7, 2022).

**APA WF # 22-14 Coverage for Donor Human Breast Milk –** The Agency proposes to add this benefit as a new service covered under the Medical Suppliers section of policy. Proposed rules outline medical necessity, provider qualifications, coverage, and reimbursement for donor human breast milk. Further proposed revisions to the Enteral Nutrition section of policy removes human breast milk as a non-covered item.

**Budget Impact:** The estimated total cost for SFY 2023 is $229,211 ($169,410 in federal share and $59,801 in state share). The estimated total cost for SFY 2024 is $343,816 total ($231,663 in federal share and $112,153 in state share).

**Proposed Rule Timeline:**
**Tribal Consultation:** July 5, 2022
**15-day Public Comment Period:** Aug. 16, 2022 – Aug. 31, 2022
**OHCA Board Meeting:** Sept. 21, 2022
**Emergency Rule Requested Effective Date:** Contingent upon Governor's signature or the 45th day post submission of the rules to the Governor (Nov. 7, 2022).

**APA WF # 22-16 Statewide Health Information Exchange (HIE) –** The proposed revisions update policy to comply with OK Senate Bill 1369 which changed the statewide HIE. The revisions include repealing all previously approved language; adding the Office of the State Coordinator for HIE; designating that the Office of the State Coordinator for HIE will oversee the state-designated entity for HIE; and revising the definition of "health information exchange organization" to indicate that it is an organization governed by its stakeholders. Additional revisions state that beginning July 1, 2023, all qualified health care providers, as defined by OHCA rules and who are licensed by and located in Oklahoma, shall be actively engaged with the HIE in the onboarding process of connecting to the HIE. This ensures that the legislative requirement of data reporting capabilities and utilizing the state-designated entity for HIE are met.

**Budget Impact:**
The proposed rules are budget neutral for the agency; however, there will be a cost for providers to connect to the statewide HIE. The cost varies depending on the type and size of the organization.

**Proposed Rule Timeline:**
**Tribal Consultation:** Sept. 6, 2022
**30-day Public Comment Period:** Aug. 16, 2022 – Sept. 15, 2022
**OHCA Board Meeting:** Sept. 21, 2022
**Emergency Rule Requested Effective Date:** Contingent upon Governor's approval or the 45th day post submission of the rules to the Governor (November 7, 2022).

**APA WF # 22-17 Covering Former Foster Care Youth from Another State –** The proposed revisions implement changes in federal law requiring SoonerCare to grant eligibility to individuals in the former foster care youth category who were enrolled in Medicaid when they aged out of foster care in another state on Jan. 1, 2023, or later, and who now reside in Oklahoma. Prior to the federal law changes, SoonerCare was only required to grant eligibility former foster care youth who were enrolled in Medicaid when they aged out of foster care in Oklahoma.

**Budget Impact:** The estimated total cost for SFY 2023 is $187,650 ($135,784 in federal share and $51,866 in state share). The estimated total cost for SFY 2024 is $375,300 total ($252,802 in federal share and $122,498 in state share).

**Proposed Rule Timeline:**
**Tribal Consultation:** July 5, 2022
**15-day Public Comment Period:** Aug. 16 – Aug. 31, 2022
**OHCA Board Meeting:** Sept. 21, 2022
**Emergency Rule Requested Effective Date:** Jan. 1, 2023

**APA WF # 22-18 Mobile Dental Services –** Current policy allows mobile or portable dental providers to render services to only children and the services are limited to screenings, fluoride varnish, and sealants. The proposed rule changes allow mobile dental providers to render more services that currently covered under SoonerCare for dental providers and authorizes mobile dental services for both children and adults. These changes will help SoonerCare members access dental care where there are shortage areas in the State.

**Budget Impact:**
The proposed rule changes regarding mobile dental services are budget neutral. This change is only allowing more dental providers through mobile units to render services currently covered by SoonerCare; no new dental services will be added.

**Proposed Rule Timeline:**
**OHCA Tribal Consultation:** July 5, 2022
**15-day Public Comment Period:** Aug. 16, 2022 – Aug. 31, 2022
**OHCA Board Meeting:** Sept. 21, 2022
**Proposed Effective Date:** Contingent upon Governor's approval or the 45th day post submission of the rules to the Governor (November 7, 2022).

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

## SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

## PART 33. TRANSPORTATION BY AMBULANCE

**317:30-5-345. Ambulance Service Provider Access Payment Program (ASPAPP)**

(a) **Purpose.** The Ambulance Service Provider Access Payment Program (ASPAPP) is an ambulance service provider (ASP) assessment fee that is eligible for federal matching funds when used to reimburse SoonerCare services in accordance with Section 3242.1 through 3242.6 of Title 63 of the Oklahoma Statutes (O.S.).

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

(1) **"Air ambulance"** means ambulance services provided by fixed or rotor wing ambulance services.

(2) **"Alliance"** means the Oklahoma Ambulance Alliance or its successor association.

(3) **"Ambulance"** means a motor vehicle that is primarily used or designated as available to provide transportation and basic life support or advanced life support.

(4) **"Ambulance service"** or **"ambulance service provider (ASP)"** means any private firm or governmental agency licensed by the Oklahoma State Department of Health (OSDH) to provide levels of medical care based on certification rules or standards promulgated by the state Commissioner of Health.

(5) **"Emergency"** or **"emergent"** means a serious situation or occurrence that happens unexpectedly and demands immediate action, such as a medical condition manifesting itself by acute symptoms of sufficient severity including severe pain such that the absence of immediate medical attention could reasonably be expected, by a reasonable and prudent layperson, to result in placing the patient's health in serious jeopardy, serious impairment to bodily function or serious dysfunction of any bodily organ or part.

(6) **"Emergency transport"** means the movement of an acutely ill or injured patient from the scene to a health care facility or the movement of an acutely ill or injured patient from one health care facility to another health care facility.

(7) **"Medicaid"** means the medical assistance program established in Title XIX of the Social Security Act and administered in Oklahoma by the Oklahoma Health Care Authority (OHCA).

(8) **"Net operating revenue"** means the gross revenues earned for providing emergency transports in Oklahoma excluding revenues earned for providing air ambulance services, non-emergency transports, and amounts refunded to or recouped, offset, or otherwise deducted by a patient or payer for ground medical transportation.

(9) **"Non-emergency transport"** as defined in Part 33, 317:30-5-335.1, means the movement of any patient in an ambulance other than an emergency transport.

(10) **"Upper payment limit"** means the lesser of the customary charges of the ASP or the prevailing charges in the locality of the ASP for comparable services under comparable circumstances, calculated according to methodology in an approved state plan amendment for the state Medicaid program.

(11) **"Upper payment limit gap"** means the difference between the upper payment limit of

the ASP and the Medicaid payments not financed using the ASP assessments made to all ASPs, provided that the upper payment limit gap shall not include air ambulance services.

(c) **ASPAPP exemptions.**

(1) Pursuant to 63 O.S. §§ 3242.1 through 3242.6 the OHCA is mandated to assess ASPs licensed in Oklahoma, unless exempted under (c) (2) of this Section, an ASP access payment program fee.

(2) The following ASPs are exempt from the ASPAPP fee:

(A) Owned or operated by the state or a state agency, the federal government, a federally recognized Indian tribe, or the Indian Health Service.

(B) Eligible for Supplemental Hospital Offset Payment Program (SHOPP) Medicaid reimbursement;

(C) Provides air ambulance services only; or

(D) Provides non-emergency transports only.

(d) **The ASPAPP assessment.**

(1) The ASPAPP assessment is imposed on each ambulance service provider, except those exempted under (c)(2) of this Section, for each calendar year in an amount calculated as a percentage of each ambulance service provider's net operating revenue.

(2) The assessment rate shall be determined annually based upon the percentage of net operating revenue needed to generate an amount up to the non-federal portion of the upper payment limit gap, plus the annual fee paid to OHCA for administrative expenses incurred in performing the activities, not to exceed $200,000 each year, plus the state share of ASP access payments for ASPs that participate in the assessment. At no time will the assessment rate exceed the maximum rate allowed by federal law or regulation.

(3) OHCA will review and determine the amount of annual assessment in December of each year in consultation with the Oklahoma Ambulance Alliance.

(4) The annual assessment is due and payable quarterly. However, a payment of the assessment will not be due and payable until:

(A) OHCA issues written notice stating that the payment methodologies to the ASPs under 63 O.S. §§ 3242.1 through 3242.6 have been approved by the Centers for Medicare and Medicaid Services (CMS) and the waiver under 42. C.F.R. § 433.68 for the assessment, if necessary, has been granted by CMS.

(B) OHCA has made all quarterly installments of the ASP access payments that were otherwise due, consistent with the effective date of the approved state plan.

(5) The method of collection of net operating revenue is as follows:

(A) Annually, no later than January 31, OHCA will send all licensed ASPs the net operating revenue form. ASPs shall complete the forms and deliver them to OHCA or its contractor no later than March 31 of that year. ASPs that fail to return the net operating revenue form will have their assessment calculated based on the state per capita average assessment for that year. OHCA will send a notice of assessment to each ASP informing the provider of the assessment rate and the estimated annual amount owed by the ASP for the applicable calendar year.

(B) The first notice of assessment will be sent within forty-five (45) days of receipt by OHCA of notice from the Centers for Medicare and Medicaid Services that the payments under 63 O.S. §§ 3242.1 through 3242.6, and if necessary, the waiver granted under 42 C.F.R. § 433.68 have been approved.

(C) Annual notices of assessment will be sent at least forty-five (45) days before the due date for the first quarterly assessment payment of each calendar year. The ASP shall have thirty (30) days from the date of its receipt of a notice of assessment to review and verify the assessment rate and the estimated assessment amount.

(D) If an ASP operates, conducts, or maintains more than one (1) ASP in the state, the ASP will pay the assessment for each ASP separately. However, if the ASP operates more than one (1) ASP under one (1) Medicaid provider number, the ASP provider may pay the assessment for all such ASPs in the aggregate.

(6) The method of collection of the assessment fee is as follows:

(A) After the initial installment has been paid, each subsequent quarterly payment of an assessment will be due and payable by the 15th day on the first month of the applicable quarter (i.e., January 15th, April 15th, etc.)

(B) Failure to pay the amount by the 15th or failure to have the payment mailing postmarked by the 13th will result in a debt to the State of Oklahoma and is subject to penalties of five percent (5%) of the amount and interest of one and one-quarter percent (1.25%) per month.

(e) **Penalties and adjustments**

(1) If an ASP fails to timely pay the full amount of a quarterly assessment, OHCA will add to the assessment:

(A) A penalty equal to five percent (5%) of the quarterly amount not paid on or before the due date, and

(B) An additional five percent (5%) penalty on any unpaid quarterly and unpaid penalty amounts on the last day of each quarter after the due date until the assessed amount and the penalty imposed under subpart (A) of this paragraph are paid in full.

(2) The quarterly assessment including applicable penalties and interest must be paid regardless of any appeals action requested by the facility. If an ASP fails to pay the OHCA the assessment within the timeframes noted on the invoice to the provider, the assessment, applicable penalty, and interest will be deducted from the ASP's payment.

(3) Any change in payment amount resulting from an appeals decision will be adjusted in future payments.

(4) If Medicaid reimbursement rates are adjusted, ASP rates may not be adjusted less favorably than the average percentage-rate reduction or increase applicable to the majority of other provider groups.

(f) **Closure, merger, and new Ambulance Service Providers (ASPs).**

(1) If an ASP ceases to operate as an ASP for any reason or ceases to be subject to the fee, the assessment for the year in which the cessation occurs is adjusted by multiplying the annual assessment by a fraction, the numerator of which is the number of days in the year during which the ASP is subject to the assessment and the denominator of which is three hundred sixty-five (365). Within thirty (30) days of ceasing to operate as an ASP, or otherwise ceasing to be subject to the assessment, the ASP will pay the assessment for the year as so adjusted, to the extent not previously paid.

(2) The ASP also shall receive payments under 63 O.S. §§ 3242.1 through 3242.6, for the calendar year in which the cessation occurs, which will be adjusted by the same fraction as its annual assessment.

(3) For new ASPs, the OHCA will calculate revenue to be assessed based on the population

of the county for which the ASP is licensed. The per capita amount will be assigned and calculated based on the average net operating revenue per capita for all other ASPs in the state that are currently being assessed. Average revenue per capita will be used in this way through the end of the second calendar year.

(4) Any assessment paid by a provider on revenue subject to another health care related tax as defined in 42 CFR § 433.68 shall be a credit against any assessment due under these rules.

(g) **Disbursement of payment to ASPs.**

(1) To preserve and improve access to ambulance services, for ambulance services rendered on or after the approval of the ASPAPP by CMS, OHCA shall make ASP payments as set forth in this section. These payments are considered supplemental payments and do not replace any currently authorized Medicaid payments for ambulance services.

(2) OHCA shall pay all quarterly ASP access payments within ten (10) calendar days of the due date for the quarterly assessment payments established in subsection (d) of this section.

(3) OHCA shall calculate the ASP access payment amount as the balance of the ASPAPP Fund plus any federal matching funds earned on the balance up to but not to exceed the upper payment limit gap for all ASPs.

(4) All ASPs shall be eligible for ASP access payments each year as set forth in this subsection except ambulance services excluded or exempted in subsection (c)(2) of this section.

(5) Access payments shall be made on a quarterly basis.

(6) ASPs eligible to receive ASP access payments are those providers:

(A) Subject to this assessment; and

(B) That apply to receive the ASP access payment as provided in Section 317:30-5-345.

(7) An application by the ASP shall be submitted to OHCA to be eligible to receive payments.

(A) Not less than one-hundred eighty (180) days prior to the beginning of each state fiscal year, OHCA will send all qualified licensed ASPs an application for ASP access payments.

(B) The application will:

(i) Allow the ASP to submit all information needed to calculate that ASP's average commercial rate;

(ii) Provide that the application must be received by OHCA on a date which will be no less than one- hundred twenty (120) days prior to the beginning of the calendar year;

(iii) Explain that unless exempt from payment by law, the ASP will be required to pay the ASP assessment even if the provider fails to apply for the ASP access payments;

(iv) Explain that if the ASP fails to supply the Net Operating Revenue Survey, the assessment will be calculated based on the state per capita average assessment for that year; and

(v) Explain that the ASP will not be eligible to receive ASP access payments in the next calendar year if the application is not timely filed but will still be assessed based on the average assessment.

(C) An ASP that has previously received ASP access payments is required to make an application for such payments and provide the revenue survey no less than every three (3) years.

(8) The Average Commercial Rate will be calculated as follows:

(A) The ASP access payment shall be determined in a manner to bring the payments for these services up to the average commercial rate level as described in Section 317:30-5-345. The average commercial rate level is defined as the average amount payable by the commercial payers for the same service.

(B) OHCA shall align the paid Medicaid claims with the Medicare fees for each healthcare common procedure coding system (HCPCS) or current procedure terminology (CPT) code for the ASP and calculate the Medicare payment for those claims.

(C) OHCA shall calculate an overall Medicare to commercial conversion factor for each qualifying ASP that submits an ASP access payment application by dividing the total amount of the average commercial payments for the claims by the total Medicare payments for the claims.

(D) The commercial to Medicare ratio for each provider will be redetermined every three (3) years.

# TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
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## SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

## PART 6. INPATIENT PSYCHIATRIC AND SUBSTANCE USE DISORDER SERVICES

**317:30-5-95. General provisions and eligible providers**

(a) **Eligible settings for inpatient psychiatric services.** The following individuals may receive SoonerCare-reimbursable inpatient psychiatric services in the following eligible settings:

(1) Individuals under twenty-one (21) years of age, in accordance with OAC 317:30-5-95.23, may receive SoonerCare-reimbursable inpatient psychiatric services in a psychiatric unit of a general hospital, a psychiatric hospital, or a PRTF; and may receive chemical dependency detoxification/withdrawal management services in a psychiatric unit of a general hospital or in a psychiatric hospital.

(2) Individuals ages twenty-one (21) and older may receive SoonerCare-reimbursable inpatient psychiatric and/or chemical dependency detoxification/withdrawal management services in a psychiatric unit of a general hospital or in a psychiatric hospital.

(b) **Psychiatric hospitals and psychiatric units of general hospitals.** To be eligible for payment under this Part, inpatient psychiatric programs must be provided to eligible SoonerCare members in a hospital that:

(1) Is a psychiatric hospital that:

(A) Successfully underwent a State survey to determine whether the hospital meets the requirements for participation in Medicare as a psychiatric hospital per 42 C.F.R. § 482.60; or

(B) Is accredited by a national organization whose psychiatric accrediting program has been approved by CMS; or

(2) Is a general hospital with a psychiatric unit that:

(A) Successfully underwent a State survey to determine whether the hospital meets the requirements for participation in Medicare as a hospital as specified in 42 C.F.R. Part 482; or

(B) Is accredited by a national accrediting organization whose accrediting program has been approved by CMS; and

(3) Meets all applicable federal regulations, including, but not limited to:

(A) Medicare Conditions of Participation for Hospitals (42 C.F.R. Part 482), including special provisions applying to psychiatric hospitals (42 C.F.R. § 482.60-.62);

(B) Medicaid for Individuals Age 65 or over in Institutions for Mental Diseases (42 C.F.R. Part 441, Subpart C);

(C) Inpatient Psychiatric Services for Individuals under Age 21 in Psychiatric Facilities or Programs (42 C.F.R. Part 441, Subpart D); and/or

(D) Utilization Control [42 C.F.R. Part 456, Subpart C (Utilization Control: Hospitals) or Subpart D (Utilization Control: Mental Hospitals)]; and

(4) Is contracted with the OHCA; and

(5) If located within Oklahoma and serving members under eighteen (18) years of age, is appropriately licensed by the Oklahoma Department of Human Services (OKDHS) as a

residential child care facility (10 O.S. §§ 401 to 402) that is providing services as a residential treatment facility in accordance with OAC 340:110-3-168.

(6) If located out of state, services must be provided within the licensure for each facility and scope of practice for each provider and supervising or rendering practitioner for the state in which the facility/provider is located. Services must be in compliance with the state-specific statutes, rules and regulations of the applicable practice act.

(c) **PRTF.** Every PRTF must:

(1) Be individually contracted with OHCA as a PRTF;

(2) Meet all of the state and federal participation requirements for SoonerCare reimbursement, including, but not limited to, 42 C.F.R. § 483.354, as well as all requirements in 42 C.F.R. 483 Subpart G governing the use of restraint and seclusion;

~~(3) Be appropriately licensed by OKDHS as a residential child care facility (10 O.S. § 401 to 402) that is providing services as a residential treatment facility in accordance with OAC 340:110-3-168;~~

(3) Be appropriately licensed and/or certified:

(A) If an in-state facility, by OKDHS as a residential child care facility (10 O.S. § 401 to 402) that is providing services as a residential treatment facility in accordance with OAC 340:110-3-168; or

(B) If an out-of-state facility, by the licensing or certifying authority of the state in which the facility does business and must provide an attestation to OHCA that the PRTF is in compliance with the condition of participation for restraint and seclusion, as is required by federal law.

(4) Be appropriately certified by the State Survey Agency, the Oklahoma State Department of Health (OSDH) as meeting Medicare Conditions of Participation; and

(5) Be accredited by TJC, the Council on Accreditation of Rehabilitation Facilities (CARF), or the Council on Accreditation (COA).

~~(d) **Out-of-state PRTF.** Any out-of-state PRTF must be appropriately licensed and/or certified in the state in which it does business, and must provide an attestation to OHCA that the PRTF is in compliance with the condition of participation for restraint and seclusion, as is required by federal law. Any out-of-state PRTF must also be accredited in conformance with OAC 317:30-5-95(c)(5).~~

~~(e)~~(d) **Required documents.** The required documents for enrollment for each participating provider can be downloaded from the OHCA's website.

**317:30-5-95.24. Prior authorization of inpatient psychiatric services for individuals under twenty-one (21)**

(a) All inpatient psychiatric services for members under twenty-one (21) years of age must be prior authorized by the OHCA or its designated agent. All inpatient Acute, Acute II, and PRTF services will be prior authorized for an approved length of stay. Admission requirements for services must be provided in accordance with 42 C.F.R. Part 441 and 456. Additional information will be required for SoonerCare-compensable approval on enhanced treatment units or in special population programs.

(b) Unit staffing ratios shall always meet the requirements in OAC 317:30-5-95.24 (c), (d), (h) and (i). Out-of-state facilities may adhere to the staffing requirements of the state in which the services are provided if the staff ratio is sufficient to ensure patient safety and that patients have reasonable and prompt access to services. The facility cannot use staff that is also on duty in other units of the

facility in order to meet the unit staffing ratios. Patients shall be grouped for accommodation by gender, age, and treatment needs. At a minimum, children, adolescent, and adult treatment programs shall be separate with distinct units for each population. A unit is determined by separate and distinct sleeping, living, and treatment areas often separated by walls and/or doors. A unit that does not allow clear line of sight due to the presence of walls or doors is considered a separate unit. Each individual unit shall have assigned staff to allow for appropriate and safe monitoring of patients and to provide active treatment.
(c) In Acute and Acute II settings, at least one (1) registered nurse (RN) must be on duty per unit at all times, with additional RNs to meet program needs. RNs must adhere to Oklahoma State Department of Health (OSDH) policy at OAC 310:667-15-3 and 310:667-33-2(a)(3).
(d) Acute, non-specialty Acute II, and non-specialty PRTF programs require a staffing ratio of one (1) staff: six (6) patients during routine waking hours and one (1) staff: eight (8) patients during time residents are asleep with twenty-four (24) hour nursing care supervised by an RN for management of behaviors and medical complications. For PRTF programs, at a minimum, a supervising RN must be available by phone and on-site within one (1) hour. If the supervising RN is off-site, then an RN or licensed practical nurse (LPN) must be on-site to adhere to a twenty-four (24) hour nursing care coverage ratio of one (1) staff: thirty (30) patients during routine waking hours and one (1) staff: forty (40) patients during time residents are asleep.
(e) Specialty treatment at Acute II or PRTF is a longer-term treatment that requires a higher staff-to-member ratio because of the need for constant, intense, and immediate reinforcement of new behaviors to develop an understanding of the behaviors. The environment of specialized residential treatment centers requires special structure and configuration (e.g., sensory centers for autistic members) and specialized training for the staff in the area of the identified specialty. The physician, Advanced Practice Registered Nurse (APRN) with psychiatric certification or Physician Assistant (PA) will see the child at least one (1) time a week.
(f) An Acute II or PRTF will not be considered a specialty treatment program for SoonerCare without prior approval of the OHCA behavioral health unit.
(g) A treatment program that has been approved as a specialized treatment program must maintain medical records that document the degree and intensity of the psychiatric care delivered to the members and must meet active treatment requirements found at OAC 317:30-5-95.34.
(h) Criteria for classification as a specialty Acute II will require a staffing ratio of one (1) staff: four (4) patients at a minimum during routine waking hours and one (1) staff: six (6) patients during time residents are asleep with twenty-four (24) hour nursing care supervised by a RN for management of behaviors and medical complications. The specialty Acute II will be a secure unit, due to the complexity of needs and safety considerations. Admissions and authorization for continued stay for a specialty Acute II will be restricted to members who meet the medical necessity criteria at OAC 317:30-5-95.29 and OAC 317:30-5-95.30 for the respective level of care and meet the additional criteria found in the Behavioral Health Services Medical Necessity Criteria Manual, available on OHCA's website, ~~www.okhca.org.~~www.oklahoma.gov/ohca.
(i) Criteria for classification as a specialty PRTF will require a staffing ratio of one (1) staff: four (4) patients at a minimum during routine waking hours and one (1) staff: six (6) patients during time residents are asleep with twenty-four (24) hour nursing care supervised by a RN for management of behaviors and medical complications. The specialty PRTF will be a secure unit, due to the complexity of needs and safety considerations. Admissions and authorization for continued stay in a specialty PRTF will be restricted to members who meet the medical necessity

criteria at OAC 317:30-5-95.29 and OAC 317:30-5-95.30 for the respective level of care and meet the additional criteria found in the Behavioral Health Services Medical Necessity Criteria Manual, available on OHCA's website, ~~www.okhca.org.~~www.oklahoma.gov/ohca.
(j) Non-authorized inpatient psychiatric services will not be SoonerCare compensable.
(k) For out-of-state placement policy, refer to OAC 317:30-3-89 through 317:30-3-92. A prime consideration for placements will be proximity to the family or guardian in order to involve the family or guardian in active treatment, including discharge and reintegration planning. Out-of-state facilities are responsible for insuring appropriate medical care, as needed under SoonerCare provisions, as part of the per-diem rate.
(l) Reimbursement for inpatient psychiatric services in all psychiatric units of general hospitals, psychiatric hospitals, and PRTFs are limited to the approved length of stay. OHCA, or its designated agent, will approve lengths of stay using the current OHCA Behavioral Health medical necessity criteria as described in OAC 317:30-5-95.25 through OAC 317:30-5-95.30. The approved length of stay applies to both facility and physician services.

**317:30-5-95.40. Other required standards**

The provider is required to maintain all programs and services according to applicable C.F.R. requirements, the Joint Commission' (TJC) and American Osteopathic Association' (AOA) standards for behavioral health care, Oklahoma State Department of Health's (OSDH) hospital standards for psychiatric care, and Oklahoma Department of Human Services' (OKDHS) licensing standards for residential treatment facilities. PRTFs may substitute the Commission on Accreditation of Rehabilitation Facilities (CARF) accreditation in lieu of TJC or AOA accreditation. In addition to federal requirements, out-of-state inpatient psychiatric facilities must adhere to OAC 317:30-5-95 and 317:30-5-95.24.

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**317:30-5-95.6. Medical, psychiatric, and social evaluations for adults aged twenty-one (21) to sixty-four (64)**

The record for an adult member aged twenty-one (21) to sixty-four (64) must contain complete medical, psychiatric, and social evaluations.

(1) The evaluations must be completed as follows:

(A) History and ~~Physical~~physical must be completed within twenty-four (24) hours of admission by a licensed independent practitioner [~~MD, DO~~Allopathic Doctor, Osteopathic Doctor, Advanced Practice ~~Register~~Registered Nurse (APRN), or Physician Assistant (PA)].

(B) Psychiatric ~~Evaluation~~evaluation must be completed within sixty (60) hours of admission by an Allopathic ~~Or~~or Osteopathic Physician with a current license and a board certification/eligible in psychiatry, an APRN with a psychiatric certification or a PA.

(C) Psychosocial ~~Evaluation~~evaluation must be completed within seventy-two (72) hours of admission by a licensed independent practitioner (~~MD, DO,~~Allopathic Doctor, Osteopathic Doctor, APRN, or PA), ~~a licensed behavioral health professional~~an LBHP, or a licensure candidate as defined in OAC 317:30-5-240.3.

(2) The evaluations must be clearly identified as such and must be signed and dated by the evaluator.

**317:30-5-95.16. Medical psychiatric and social evaluations for persons sixty-five (65) years of age or older receiving inpatient acute psychiatric services**

The record of a member sixty-five (65) years of age or older receiving inpatient acute psychiatric services must contain complete medical, psychiatric, and social evaluations.

(1) The evaluations must be completed as follows:

(A) History and ~~Physical~~physical must be completed within twenty-four (24) hours of admission by a licensed independent practitioner [~~MD, DO~~Allopathic Doctor, Osteopathic Doctor, Advanced Practice ~~Register~~Registered Nurse (APRN), or Physician Assistant (PA)].

(B) Psychiatric ~~Evaluation~~evaluation must be completed within sixty (60) hours of admission by an allopathic or osteopathic physician with a current license and a board certification/eligible in psychiatry, an APRN with a psychiatric certification or a PA.

(C) Psychosocial ~~Evaluation~~evaluation must be completed within seventy-two (72) hours of admission by a licensed independent practitioner (Allopathic Doctor, Osteopathic Doctor, APRN, or PA), ~~a licensed behavioral health professional (LBHP)~~an LBHP, or licensure candidate as defined in OAC 317:30-5-240.3.

(2) The evaluations must be clearly identified as such and must be signed and dated by the evaluator.

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

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

(1) **"Active treatment"** means implementation of a professionally developed and supervised individual plan of care (IPC) that involves the member and his or her family or guardian from the time of an admission, and through the treatment and discharge process.
(2) **"Discharge/transition planning"** means a patient-centered, interdisciplinary process that begins with an initial assessment of the member's needs at the time of admission and continues throughout the member's stay. Active collaboration with the member, family, and all involved outpatient practitioners and agencies should be ongoing throughout treatment so that effective connections remain intact. Needed services may consist of the wraparound process through Systems of Care, counseling, case management, and other supports in the member's community. The linkages with these supports should be made prior to discharge to allow for a smooth transition.
(3) **"Expressive group therapy"** means art, music, dance, movement, poetry, drama, psychodrama, structured therapeutic physical activities, and experiential (e.g., ropes course), recreational, or occupational therapies that encourage the member to express themselves emotionally and psychologically.
(4) **"Family therapy"** means interaction between an LBHP or licensure candidate, member, and family member(s) to facilitate emotional, psychological, or behavioral changes and promote successful communication and understanding.
(5) **"Group rehabilitative treatment"** means behavioral health remedial services, as specified in the individual care plan, which are necessary for the treatment of the existing primary behavioral health disorders and/or any secondary alcohol and other drug (AOD) disorders in order to increase the skills necessary to perform activities of daily living (ADL).
(6) **"Individual rehabilitative treatment"** means a face-to-face, one-on-one interaction which is performed to assist a member who is experiencing significant functional impairment due to the existing primary behavioral health disorder and/or any secondary AOD disorder, in order to increase the skills necessary to perform ADL.
(7) **"Individual therapy"** means a method of treating existing primary behavioral health disorders and/or any secondary AOD disorders using face-to-face, one-on-one interaction between an LBHP or licensure candidate and a member to promote emotional or psychological change to alleviate disorders.
(8) **"Process group therapy"** means a method of treating existing primary behavioral health disorders and/or secondary AOD disorders using the interaction between an LBHP or licensure candidate, and two (2) or more members to promote positive emotional and/or behavioral change.

(b) Inpatient psychiatric programs must provide "active treatment". Families and/or guardians must be notified of the dates and times of treatment team meetings and be welcomed to attend. Family members must attend family therapy weekly for continued SoonerCare reimbursement. Reasons for exceptions to this requirement must be well-documented in the member's treatment plan. Family therapy attendance by family members is not a requirement for individuals in the age range of eighteen (18) up to twenty-one (21). Active treatment also includes ongoing assessment, diagnosis, intervention, evaluation of care and treatment, and planning for discharge and aftercare under the direction of a physician.
(c) For individuals ages eighteen (18) up to twenty-one (21), the active treatment program must be appropriate to the needs of the member and be directed toward restoring and maintaining optimal levels of physical and psychiatric-social functioning. The services and the IPC must be recovery-focused, trauma-informed, specific to culture, age, and gender, and provided face to face. Services, including type and frequency, will be specified in the IPC.

(d) A treatment week consists of seven (7) calendar days. In an Acute setting, the treatment week begins the day of admission. In Acute II and PRTF, the treatment week starts on Sunday and ends on Saturday. Active treatment service components are provided as per item (e) below if the services are provided within a seven (7) day treatment week. A chart outlining active treatment component requirements and timelines may also be found at www.okhca.org. If a member has a length of stay of less than seven (7) days, the treatment week is considered a partial treatment week. Active treatment requirements, when provided during a partial treatment week, are delivered as per item (f) below. An hour of treatment must be sixty (60) minutes. When appropriate to meet the needs of the child, the sixty (60) minute timeframe may be split into sessions of no less than fifteen (15) minutes each, on the condition that the active treatment requirements are fully met by the end of the treatment week.

(e) For individuals under age eighteen (18), the components of active treatment consist of face-to-face integrated therapies that are provided on a regular basis and will remain consistent with the member's ongoing need for care. The services and IPC must be recovery-focused, trauma-informed, and specific to culture, age, and gender. Individuals receiving services in an Acute setting must receive seventeen (17) hours of documented active treatment services each week, with seven (7) of those hours dedicated to core services as described in (1) below. Individuals in Acute II and PRTFs must receive fourteen (14) hours of documented active treatment services each week, with four and a half (4.5) of those hours dedicated to core services as described in (1) below. Upon fulfilling the core service hours requirement, the member may receive either the elective services listed in (2) below or additional core services to complete the total required hours of active treatment. The following components meet the minimum standards required for active treatment, although an individual child's needs for treatment may exceed this minimum standard:

(1) **Core services.**

(A) **Individual treatment provided by the physician, Advanced Practice Registered Nurse (APRN), or Physician Assistant (PA).** Individual treatment provided by the physician, APRN with psychiatric certification or PA is required three (3) times per week for Acute and one (1) time a week in Acute II and PRTFs. Individual treatment provided by the physician, APRN with psychiatric certification or PA will never exceed ten (10) calendar days between sessions in Acute II and PRTFs, and never exceed seven (7) calendar days in a specialty Acute II and specialty PRTF. Individual treatment provided by the physician, APRN with psychiatric certification or PA may consist of therapy or medication management intervention for Acute, Acute II, and PRTF programs.

(B) **Individual therapy.** LBHPs or licensure candidates performing this service must use and document an approach to treatment such as cognitive behavioral treatment, narrative therapy, solution-focused brief therapy, or another widely accepted theoretical framework for treatment. Ongoing assessment of the member's status and response to treatment, as well as psycho-educational intervention, are appropriate components of individual therapy. Individual therapy must be provided in a confidential setting. The therapy must be goal-directed, utilizing techniques appropriate to the member's plan of care and the member's developmental and cognitive abilities. Individual therapy must be provided two (2) hours per week in Acute and one (1) hour per week in Acute II and PRTFs by an LBHP or licensure candidate. One (1) hour of family therapy may be substituted for one (1) hour of individual therapy at the treatment team's discretion.

(C) **Family therapy.** The focus of family therapy must be directly related to the goals and objectives on the individual member's plan of care. Family therapy must be provided one (1) hour per week in Acute, Acute II, and PRTFs. One (1) hour of individual therapy

addressing relevant family issues may be substituted for a family session in an instance in which the family is unable to attend a scheduled session by an LBHP or licensure candidate.

(D) **Process group therapy.** The focus of process group therapy must be directly related to goals and objectives on the individual member's plan of care. The individual member's behavior and the focus of the group must be included in each member's medical record. This service does not include social skills development or daily living skills activities and must take place in an appropriate confidential setting, limited to the therapist, appropriate hospital staff, and group members. Group therapy must be provided three (3) hours per week in Acute and two (2) hours per week in Acute II and PRTFs by an LBHP or licensure candidate. In lieu of one (1) hour of process group therapy, one (1) hour of expressive group therapy provided by an LBHP, licensure candidate, or licensed therapeutic recreation specialist may be substituted.

(E) **Transition/discharge planning.** Transition/discharge planning must be provided one (1) hour per week in Acute and thirty (30) minutes per week in Acute II and PRTFs. Transition/discharge planning can be provided by any level of inpatient staff.

(2) **Elective services.**

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

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

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

(D) **Recreation therapy.** Services are provided to reduce psychiatric and behavioral impairment and to restore, remediate, and rehabilitate an individual's level of functioning and independence in life activities. Services are provided to promote health and wellness, as well as reduce or eliminate barriers caused by illness or disabling conditions that limit or restrict a member from participating in life activities. Recreational therapy can be provided in an individual or group setting. If the only activities prescribed for the individual are primarily diversional in nature, (i.e., to provide some social or recreational outlet for the individual), it will not be regarded as active treatment. If provided, recreational therapy must be a planned therapeutic activity, facilitated by a licensed therapeutic recreation specialist.

(E) **Occupational therapy.** Services are provided to address developmental and/or

functional needs related to the performance of self-help skills, adaptive behavioral, and/or sensory, motor, and postural development. Services include therapeutic goal-directed activities and/or exercises used to improve mobility and ADL functions when such functions have been impaired due to illness or injury. Services must be provided by an occupational therapist appropriately licensed in the state in which he or she practices.

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

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

(f) Active treatment components, furnished during a partial treatment week, are provided as per item (1) through (4) below. A chart outlining active treatment component requirements and timelines may also be found at www.okhca.org. Assessments/evaluations may serve as the initial individual or family session if completed by an LBHP or licensure candidate. Start and stop time must be documented. Active treatment begins the day of admission. Days noted are calendar days.

(1) **Individual treatment provided by the physician, APRN or PA.**

(A) In Acute, by day two (2), one (1) visit is required. By day four (4), two (2) visits are required. By day seven (7), three (3) visits are required.

(B) In Acute II and PRTFs, one (1) visit during admission week is required. In PRTFs, one (1) visit during the admission week is required, then once a week thereafter. Individual treatment provided by the physician, APRN with psychiatric certification or PA will never exceed ten (10) days between sessions in Acute II and PRTFs, never exceed seven (7) days in specialty Acute II and specialty PRTFs. The completion of a psychiatric evaluation or a combined psychiatric evaluation and a history and physical (H&P) evaluation may count as the first visit ~~by the physician~~ if the evaluation was personally rendered by the psychiatrist, APRN with psychiatric certification or PA. If the member is admitted on the last day of the admission week, then the member must be seen by a physician, APRN with psychiatric certification or PA within sixty (60) hours of admission time.

(2) **Individual therapy.**

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

(B) In Acute II and PRTFs, by day six (6), thirty (30) minutes of treatment must be documented. Beginning on day seven (7), one (1) hour of treatment is required each week. The treatment week is defined as Sunday through Saturday. Individual therapy may not exceed a total of ten (10) days between sessions. This does not include admission assessment/evaluation or psychosocial evaluations unless personally (face to face) rendered by the LBHP or licensure candidate.

(3) **Family therapy.**

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

(B) In Acute II and PRTFs, by day six (6), thirty (30) minutes of treatment must be documented. Beginning on day seven (7), one (1) hour of treatment is required each week. This does not include admissions assessment/evaluation or psychosocial evaluation unless personally (face to face) rendered by the LBHP or licensure candidate and the assessment/evaluation or psychosocial evaluation has not been used to substitute the initial individual therapy requirement. Family therapy provided by the LBHP or licensure candidate should not exceed ten (10) days in between sessions.

(4) **Process group therapy.**

(A) In Acute, by day three (3), one (1) hour of treatment is required. By day five (5), two (2) hours of treatment are required. Beginning on day seven (7), three (3) hours of treatment are required each week.

(B) In Acute II and PRTFs, by day five (5), one (1) hour of treatment is required. Beginning on day seven (7), two (2) hours of treatment are required each week.

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

**317:30-5-95.37. Medical, psychiatric, and social evaluations for inpatient services for children**

The member's medical record must contain complete medical, psychiatric, and social evaluations.

(1) These evaluations are considered critical documents to the integrity of care and treatment and must be completed as follows:

(A) History and physical evaluation must be completed within twenty-four (24) hours of admission by a licensed independent practitioner ~~(M.D., D.O., A.P.N., or P.A.)~~ [Allopathic Doctor, Osteopathic Doctor, Advanced Practice Registered Nurse (APRN), or Physician Assistant (PA)] in Acute, Acute II, and PRTFs.

(B) Psychiatric evaluation must be completed within sixty (60) hours of admission by an allopathic or osteopathic physician with a current license and a board certification/eligible in psychiatry. APRN with a psychiatric certification or PA in Acute, Acute II, and PRTFs.

(C) Psychosocial evaluation must be completed within seventy-two (72) hours of an Acute admission, and within seven (7) calendar days of admission to Acute II and PRTFs by a licensed independent practitioner ~~(M.D., D.O., A.P.N., or P.A.)~~(Allopathic Doctor, Osteopathic Doctor, APRN, or PA), LBHP, or licensure candidate.

(2) Each of the evaluations must be clearly identified as such and must be signed and dated by the evaluators.

(3) Each of the evaluations must be completed when the member changes levels of care if the existing evaluation is more than thirty (30) calendar days from admission. For continued stays at the same level of care, evaluations remain current for twelve (12) months from the date of admission and must be updated annually within seven (7) calendar days of that anniversary

date.

(4) Existing evaluations of thirty (30) days or less may be used when a member changes provider or level of care. The evaluation(s) must be reviewed, updated as necessary, and signed and dated by the appropriate level of professional as defined by the type of evaluation.

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

## SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

## PART 17. MEDICAL SUPPLIERS

### 317:30-5-210. Eligible providers

All eligible medical suppliers must have a current contract with the Oklahoma Health Care Authority (OHCA). The supplier must comply with all applicable state and federal laws. All suppliers of medical supplies, equipment, and appliances must be accredited by a Medicare deemed accreditation organization for quality standards for durable medical equipment (DME) suppliers in order to bill the SoonerCare program. OHCA may make exceptions to this standard based on the exemptions provided by the Centers for Medicare and Medicaid Services (CMS) for Medicare accreditation, if the provider is a government-owned entity, or at a provider's request and at the discretion of OHCA based on access issues and/or agency needs for SoonerCare members. Additionally, unless an exception is granted from the OHCA, all DME providers must meet the following criteria:

(1) DME providers are required to have a physical location in the State of Oklahoma, or within a designated range of the Oklahoma State border, as determined by the OHCA. The OHCA may make exceptions to this requirement if a DME provider provides a specialty item, product, or service, which is not otherwise available to SoonerCare members within the State of Oklahoma. Provider contracts for out-of-state DME providers will be reviewed on a case-by-case basis for specialty items only. The OHCA has discretion and the final authority to approve or deny any provider contract.

(2) DME providers are required to comply with Medicare DME Supplier Standards for medical supplies, equipment, and appliances provided to SoonerCare members, except the requirement to meet surety bond requirements, as specified in 42 Code of Federal Regulations (C.F.R.) 424.57(c).

(3) Complex rehabilitation technology (CRT) suppliers are considered DME providers. Only CRT suppliers may bill CRT procedure codes. A CRT supplier means a company or entity that:

(A) Is accredited by a recognized accrediting organization as a supplier of CRT;

(B) Is an enrolled Medicare supplier and meets the supplier and quality standards established for DME suppliers, including those for CRT, under the Medicare program;

(C) Employs as a W-2 employee at least one (1) qualified CRT professional, also known as assistive technology professional, for each location to:

(i) Analyze the needs and capacities of complex-needs patients in consultation with qualified health care professionals;

(ii) Participate in selecting appropriate CRT items for such needs and capacities; and

(iii) Provide the complex-needs patient technology related training in the proper use and maintenance of the CRT items.

(D) Requires a qualified CRT professional be physically present for the evaluation and determination of the appropriate CRT;

(E) Has the capability to provide service and repair by qualified technicians for all CRT items it sells; and

(F) Provides written information to the complex-needs patient prior to ordering CRT as to how to access service and repair.

(4) For additional requirements regarding DME providers of donor human breast milk, please refer to OAC 317:30-5-211.29.

**317:30-5-211.20. Enteral nutrition**

(a) **Enteral nutrition.** Enteral nutrition is the delivery of nutrients directly into the stomach, duodenum, or jejunum.

(b) **Medical necessity.** Enteral nutrition supplies must be determined by a provider to be medically necessary and documented in the member's plan of care as medically necessary and used for medical purposes. Requests by qualified providers for enteral nutrition supplies in and of itself shall not constitute medical necessity. The Oklahoma Health Care Authority (OHCA) shall serve as the final authority pertaining to all determinations of medical necessity. Refer to Oklahoma Administrative Code (OAC) 317:30-5-211.2 and 317:30-3-1(f) for policy on medical necessity.

(c) **Documentation.** All documentation submitted to request services must demonstrate, through adequate objective medical records, evidence sufficient to justify the member's need for the service, in accordance with OAC 317:30-3-1(f)(2). Documentation must include:

(1) Diagnosis;
(2) Certificate of medical necessity (CMN);
(3) Ratio data;
(4) Route;
(5) Caloric intake; and
(6) Prescription.
(7) For full guidelines, please refer to www.okhca.org/mau.

(d) **Reimbursement.**

(1) Extension sets and Farrell bags are not covered when requested separately from the supply kits;

(2) Enteral nutrition for individuals in long-term care facilities is not separately reimbursed as this is included in the per diem rate.

(e) **Non-covered items.** The following are non-covered items:

(1) Orally administered enteral products and/or related supplies;
(2) Formulas that do not require a prescription unless administered by tube;
(3) Food thickeners~~, human breast milk,~~ and infant formula;
(4) Pudding and food bars; and
(5) Nursing services to administer or monitor the feedings of enteral nutrition.

**317:30-5-211.29. Donor Human Breast Milk**

(a) **Donor human breast milk.** Donor human breast milk is pasteurized donor human milk which has been donated to a Human Milk Banking Association of North America (HMBANA) milk bank. Upon donation, it is screened, pooled, and tested so that it can be dispensed. All donor mothers require screening and approval by a HMBANA milk bank, and additionally, all donor milk is logged, pasteurized, and monitored.

(b) **Provider qualifications.** Donor human breast milk must be obtained from a milk bank accredited by, and in good standing with, the HMBANA and be contracted with the Oklahoma Health Care Authority (OHCA) as a Durable Medical Equipment (DME) provider.

(c) **Medical necessity criteria.** To qualify to receive donor human breast milk the infant must

meet medically necessary criteria, which can include but not limited to the following conditions:

(1) Other feeding options have been exhausted or are contraindicated; and

(2) Baby's biological mother's milk is contraindicated, unavailable due to medical or psychosocial condition, or mother's milk is available but is insufficient in quantity or quality to meet the infant's dietary needs, as reflected in medical records or by a physician (MD or DO), physician's assistant, or advanced practice nurse; and

(3) Donor human breast milk must be procured through a HMBANA entity and delivered through a contracted provider, facility, or the supplier (HMBANA-accredited milk bank); and

(A) Requests for coverage over thirty-five (35) ounces per day, per infant, shall require review and approval by an OHCA Medical Director; and

(B) Coverage shall be extended for as long as medically necessary, but not to exceed an infant's twelve (12) months of age; and

(C) A new prior authorization will be required every ninety (90) days.

(4) The infant has one (1) or more of the following conditions:

(A) Infant born at Very Low Birth Weight (VLBW) (less than 1,500 grams) or lower; or

(B) Gastrointestinal anomaly, metabolic/digestive disorder, or recovery from intestinal surgery where digestive needs require additional support; or

(C) Diagnosed failure to thrive; or

(D) Formula intolerance with either documented feeding difficulty or weight loss; or

(E) Infant hypoglycemia; or

(F) Congenital heart disease; or

(G) Pre or post organ transplant; or

(H) Other serious health conditions where the use of donor human breast milk has been deemed medically necessary and will support the treatment and recovery of the infant as reflected in the medical records or by a physician (MD or DO), physician's assistant, or advanced practice nurse.

(5) For full guidelines, including the medically necessary criteria, please refer to www.okhca.org/mau.

(d) **Documentation.** All documentation submitted to request services must demonstrate, through adequate objective medical records, evidence sufficient to justify the member's need for the service, in accordance with OAC 317:30-5-211.20(c). Documentation must include:

(1) A prescription from a contracted provider [a physician (MD or DO), physician's assistant, or advanced practice nurse]. The prescription must include but not limited to:

(A) Name of infant, address and diagnoses;

(B) Parent name and phone number or email;

(C) Donor human breast milk request form;

(D) Number of ounces per day, week, or month needed; and

(E) Prescriptions must be written on a prescription notepad and signed off by an authorized provider.

(F) For full guidelines, please refer to www.okhca.org/mau.

(2) Donor human breast milk is excluded from requiring a CMN.

(e) **Reimbursement.** Donor human breast milk is reimbursed as follows:

(1) When donor human breast milk is provided in the inpatient setting, it will be reimbursed within the prospective Diagnosis Related Group (DRG) payment methodology for hospitals as authorized under the Oklahoma Medicaid State Plan.

(2) When donor human breast milk is provided in an outpatient setting as a medical supply benefit, it will be reimbursed as a durable medical equipment, supplies, and appliances (DME) item in accordance the OHCA fee schedule.

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

## SUBCHAPTER 3. GENERAL PROVIDER POLICIES

## PART 1. GENERAL SCOPE AND ADMINISTRATION

**317:30-3-35. Oklahoma ~~State Health Information Network and Exchange (OKSHINE)~~Statewide Health Information Exchange**

(a) **Authority.** This rule is promulgated under the authority granted in Title 63 of the Oklahoma Statutes Section 1-133 (63 O.S. § 1-133). This Section is intended to be read in conjunction with applicable Oklahoma statutes and federal law.

(b) **Applicability and purpose.**

(1) **Applicability.** This section shall apply to and govern the establishment and operation of the statewide health information exchange (HIE)~~, herein referred to as OKSHINE~~.

(2) **Purpose.** ~~OKSHINE is the state-designated organization that facilitates the exchange of health information to and from authorized individuals and health care organizations in the state for the purpose of improving health outcomes, as per 63 O.S. § 1-133.~~The Office of the State Coordinator for HIE is the office within the Oklahoma Health Care Authority (OHCA) that holds the power and duty to oversee the state-designated entity for health information exchange, as described under 63 O.S. § 1-133.

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

~~(1) "**OKSHINE**" means an organization that oversees, governs, and facilitates health information exchange among health care providers that are not related health care organizations as defined in the Oklahoma Statutes, to improve the security of patient information, coordination of patient care, and the efficiency of health care delivery.~~

~~(2) "**Participant**" means an organization, health care practitioner or institution, health plan, or health care clearinghouse who has executed a written participation agreement (PA) and business associate agreement (BAA) with OKSHINE.~~

~~(3) "**Participant agreement**" means the agreement between OKSHINE and a participant which authorizes the participant to have access to OKSHINE and outlines the policies and procedures for access, protection, and use of the electronic protected health information.~~

~~(4) "**Oklahoma Statewide Health Information Exchange (OKHIE)**" means a certified HIE as referenced in 63 O.S. ' 1-133 whose primary business activity is health information exchange.~~

(1) **"Health care provider"** means the following individuals and organizations who are licensed pursuant to the laws of the State of Oklahoma and includes organizations who employ or contract with such licensed individuals for the purpose of providing services associated with their licenses to residents of Oklahoma:

(A) A hospital or related institution licensed pursuant to 63 O.S. § 1-702;

(B) Nursing facilities licensed pursuant to 63 O.S. § 1-1903;

(C) Doctors as specified in 59 O.S. § 725.2, subsection A, paragraphs 1 through 9;

(D) Physical therapists as specified in 59 O.S. § 887.2, paragraph 3;

(E) Physician assistants as specified in 59 O.S. § 519.2, paragraph 5;

(F) Pharmacists as specified in 59 O.S. § 353.1, paragraph 15;

(G) Nurses as specified in 59 O.S. § 567.3a, paragraphs 3 through 10;

(H) Licensed Mental Health Professionals as specified in 43a O.S. § 1-103; and

(I) Home Health Care Agencies and/or providers licensed pursuant to 63 O.S. § 1-1965.

(2) **"Health care provider organization"** means the legal entity that offers the services of health care providers to patients in Oklahoma.

(3) **"Report data to"** means that health care providers shall establish a direct, secure connection to the state designated entity for HIE and submit data in the form and format as defined on the Office of the State Coordinator for HIE website.

(4) **"State designated entity (SDE)"** means the health information exchange organization designated by the State of Oklahoma under 63 O.S. § 1-133. The name and contact information for the state designated entity for HIE is found on the Office of the State Coordinator for HIE website.

(5) **"Utilize"** means to actively use the HIE services to securely access records during and/or in support of patient treatment or health care operations.

~~(d) **OKHIE Certification.** Per 63 O.S. § 1-133, an initial certification and an annual recertification will be required for health information exchanges to qualify as an OKHIE. In order to receive certification, the applying HIE must submit an application to the Oklahoma Health Care Authority (OHCA) and provide all requested documentation. The application and standards for certification shall be posted on the OHCA OKSHINE public website.~~

~~(1) The OHCA shall establish a health information exchange certification with input from stakeholders.~~

~~(2) Until such time as the health information exchange certification is established by the OHCA, an OKSHINE or an HIE organization that was previously certified by the Oklahoma Health Information Exchange Trust (OHIET) shall be deemed an OKHIE.~~

~~(3) An HIE must provide documentation of certification from OHIET to OHCA in order to receive initial OKHIE certification.~~

~~(e) **Fees.**~~

~~(1) **Certification fees.** Each health information exchange which applies for certification, will be required to pay annual certification/recertification fees. The OHCA will develop the certification criteria and will publish the criteria and associated fees, when available, on the OHCA OKSHINE public website.~~

~~(2) **Participant fees.** Each participant, as defined in this section, will be required to pay an annual participation fee as outlined in the participant agreement. The OHCA will develop the criteria for the fees and will publish the criteria when available. The participant agreement and fee schedule will be posted on the OHCA OKSHINE public website.~~

(d) **Required participation.**

(1) By July 1, 2023, all health care providers as defined above and who are licensed by and located in the state of Oklahoma shall report data to and utilize the SDE.

(2) The state acknowledges that establishing the connection to the HIE can take substantial time to complete. A health care provider will be considered to have met the requirement to report data to the SDE as long as the provider is actively engaged with the HIE in the onboarding process of connecting to the HIE, and as reported by the SDE.

(3) In order to meet the requirement to utilize the SDE, each health care provider or their health care provider organization shall secure access to HIE services by the following:

(A) Completing and maintaining an active participation agreement with the SDE for HIE;

(B) Executing annually an order form electing at a minimum the set of core services relevant to the provider practice or organization; and

(C) Maintaining good standing as a participating organization in the SDE for HIE by remaining compliant with the terms and conditions, network policies and procedures, and paying all fees associated with the services elected on the order form.

(4) Each health care provider or health care provider organization will provide a utilization report from the SDE to the Office of the State Coordinator for HIE on an annual basis. Utilization metrics and benchmarks will be determined annually by the Office of the State Coordinator for HIE in consultation with the board of directors of the SDE and will be published three (3) months prior to the commencement of each State Fiscal Year.

(e) **Hardship exemption.**

(1) The Office of the State Coordinator for HIE may allow exemptions from the requirement to report data to and utilize the SDE beginning July 1, 2023, on the basis of financial hardship, size, or technological capability of a health care provider or organization or such other bases as may be provided by rules promulgated by OHCA.

(2) Any health care provider or health care provider organization as defined above that believes they will fall under hardship in order to meet the requirements to report data to and utilize the SDE must submit a request for exemption providing detailed justification as to the hardship they will sustain as specified on the Office of the State Coordinator for HIE website.

(3) The authorization of a hardship exemption does not exclude the provider from having to meet the requirements to report data to and utilize the SDE but will provide additional time for the provider to mitigate their hardship in doing so.

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

## SUBCHAPTER 5. ELIGIBILITY AND COUNTABLE INCOME

## PART 1. DETERMINATION OF QUALIFYING CATEGORICAL RELATIONSHIP

### 317:35-5-2. Categorically related programs

~~(a) In order to be eligible for SoonerCare, an individual must first meet the description of a member eligibility group. For individuals related to the aged, blind, or disabled groups, categorical relationship is established using the same definitions of age, disability and blindness as used by the Social Security Administration (SSA) in determining eligibility for Supplemental Security Income (SSI) or SSA benefits. If the individual is an SSA/SSI recipient in current payment status (including presumptive eligibility), a Temporary Assistance for Needy Families (TANF) recipient, an adoption assistance or kinship guardianship assistance recipient, or is under age nineteen (19), categorical relationship is automatically established. For individuals related to expansion adults the categorical relationship is established and defined by 42 Code of Federal Regulations (C.F.R.) § 435.119. Categorical relationship to the pregnancy group is established when the determination is made by medical evidence that the individual is or has been pregnant. Verification of pregnancy is only required if the individual's declaration that she is pregnant is not reasonably compatible with other information available to the agency. Pregnancy-related services include all medical services provided within the scope of the program during the prenatal, delivery and postpartum periods for women in this pregnancy group; see Subchapter 22 of this Chapter for services for unborn children covered under Title XXI. For an individual age nineteen (19) or over to be related to the parent and caretaker relative group, the individual must have a minor dependent child. For an individual to be related to the former foster care children group, the individual must not be eligible for the Title XIX pregnancy or parent or caretaker relative groups, must be aged nineteen (19) to twenty-six (26), and must have been receiving SoonerCare as a foster care child when he/she aged out of foster care in Oklahoma. There is no income or resource test for the former foster care children group. Categorical relationship to refugee services is established in accordance with OAC 317:35-5-25. Categorical relationship for the Breast and Cervical Cancer (BCC) treatment program is established in accordance with Subchapter 21 of this Chapter. Categorical relationship for the SoonerPlan family planning program is established in accordance with OAC 317:35-5-8. Categorical relationship for pregnancy related benefits covered under Title XXI is established in accordance with Subchapter 22 of the Chapter. Benefits for pregnancies covered under Title XXI medical services are provided within the scope of the program during the prenatal, delivery and postpartum care when included in the global delivery payment. To be eligible for SoonerCare benefits, an individual must be related to one (1) of the following eligibility groups and as defined above in this Section:~~

~~(1) Aged;~~
~~(2) Disabled;~~
~~(3) Blind;~~
~~(4) Pregnancy;~~
~~(5) Children, including newborns deemed eligible;~~
~~(6) Parents and caretaker relatives;~~

~~(7) Refugee;~~
~~(8) BCC treatment program;~~
~~(9) SoonerPlan family planning program;~~
~~(10) Benefits for pregnancies covered under Title XXI;~~
~~(11)Former foster care children; or~~
~~(12) Expansion adults.~~

~~(b) The Authority may provide SoonerCare to reasonable categories of individuals under age twenty-one (21).~~

~~(1) Individuals eligible for SoonerCare benefits include individuals between the ages of nineteen (19) and twenty-one (21):~~

~~(A) For whom a public agency is assuming full or partial financial responsibility who are in custody as reported by OKDHS and in foster homes, private institutions or public facilities; or~~

~~(B) In adoptions subsidized in full or in part by a public agency; or~~

~~(C) Individuals under age twenty-one (21) receiving active treatment as inpatients in public psychiatric facilities or programs if inpatient psychiatric services for individuals under age twenty-one (21) are provided under the State Plan and the individuals are supported in full or in part by a public agency; or~~

~~(2) Individuals eligible for SoonerCare benefits include individuals between the ages of eighteen (18) and twenty-one (21) if they are in custody as reported by OKDHS on their eighteenth (18th) birthday and living in an out-of-home placement.~~

(a) In order to be eligible for SoonerCare, an individual must first meet the description of a member eligibility group.

(1) For individuals related to the aged, blind, or disabled groups, categorical relationship is established using the same definitions of age, disability, and blindness as used by the Social Security Administration (SSA) in determining eligibility for Supplemental Security Income (SSI) or SSA benefits.

(2) If the individual is a SSA/SSI recipient in current payment status (including presumptive eligibility), a Temporary Assistance for Needy Families (TANF) recipient, an adoption assistance or kinship guardianship assistance recipient, or is under age nineteen (19), categorical relationship is automatically established.

(3) For individuals related to expansion adults the categorical relationship is established and defined by 42 Code of Federal Regulations (C.F.R.) § 435.119.

(4) Categorical relationship to the pregnancy group is established when the determination is made by medical evidence that the individual is or has been pregnant. Verification of pregnancy is only required if the individual's declaration that she is pregnant is not reasonably compatible with other information available to the agency. Pregnancy-related services include all medical services provided within the scope of the program during the prenatal, delivery and postpartum periods for women in this pregnancy group; see Subchapter 22 of this Chapter for services for unborn children covered under Title XXI.

(5) For an individual age nineteen (19) or over to be related to the parent and caretaker relative group, the individual must have a minor dependent child.

(6) For an individual to be related to the former foster care children group, the individual must have been receiving Medicaid benefits as a foster care child in Oklahoma or another state when he/she attained the age of eighteen (18), or aged out of foster care, until he/she reaches the age of twenty-six (26). If the individual aged out of foster care in a state other than

Oklahoma, the date of ageing out had to occur on January 1, 2023, or later, and the individual must now be residing in Oklahoma. There is no income or resource test for the former foster care children group.

(7) Categorical relationship to refugee services is established in accordance with OAC 317:35-5-25.

(8) Categorical relationship for the Breast and Cervical Cancer (BCC) treatment program is established in accordance with Subchapter 21 of this Chapter.

(9) Categorical relationship for the SoonerPlan family planning program is established in accordance with OAC 317:35-5-8.

(10) Categorical relationship for pregnancy related benefits covered under Title XXI is established in accordance with Subchapter 22 of the Chapter. Benefits for pregnancies covered under Title XXI medical services are provided within the scope of the program during the prenatal, delivery and postpartum care when included in the global delivery payment.

(b) To be eligible for SoonerCare benefits, an individual must be related to one (1) of the following eligibility groups and as defined above in this Section:

(1) Aged;
(2) Disabled;
(3) Blind;
(4) Pregnancy;
(5) Children, including newborns deemed eligible;
(6) Parents and caretaker relatives;
(7) Refugee;
(8) BCC treatment program;
(9) SoonerPlan family planning program;
(10) Benefits for pregnancies covered under Title XXI;
(11)Former foster care children; or
(12) Expansion adults.

(c) The Authority may provide SoonerCare to reasonable categories of individuals under age twenty-one (21).

(1) Individuals eligible for SoonerCare benefits include individuals between the ages of nineteen (19) and twenty-one (21):

(A) For whom a public agency is assuming full or partial financial responsibility who are in custody as reported by Oklahoma Human Services (OKDHS) and in foster homes, private institutions or public facilities; or

(B) In adoptions subsidized in full or in part by a public agency; or

(C) Individuals under age twenty-one (21) receiving active treatment as inpatients in public psychiatric facilities or programs if inpatient psychiatric services for individuals under age twenty-one (21) are provided under the State Plan and the individuals are supported in full or in part by a public agency; or

(2) Individuals eligible for SoonerCare benefits include individuals between the ages of eighteen (18) and twenty-one (21) if they are in custody as reported by OKDHS on their eighteenth (18th) birthday and living in an out-of-home placement.

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

## SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

## PART 80. ~~MOBILE AND/OR PORTAL DENTAL TREATMENT FACILITIES~~MOBILE AND PORTABLE DENTAL SERVICES

### 317:30-5-706. ~~Definitions~~Mobile Dental Units

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

~~**"Individual provider"** means a dentist, dental hygienist, or dental assistant who provides dental services at a mobile and/or portable dental treatment facility.~~

~~**"Mobile and/or portable dental treatment facilities"** means the following, limited places of treatment, as authorized by the Oklahoma State Dental Act: group homes for juveniles; public and private schools; and mobile dental clinics. The rules in this Part expressly shall not apply to SoonerCare reimbursement of dental services provided at any other authorized place of service, including, but not limited to: "dental offices," as defined by 59 O.S. ' 328.3; federal, tribal, state, or local public health facilities; federally qualified health centers; and hospitals or dental ambulatory surgery centers.~~

(a) **Definition.** Mobile dental unit means a motor vehicle or trailer that contains dental equipment and is used to provide dental services to eligible SoonerCare members on-site in accordance with Title 59 of Oklahoma Statutes (O.S.), Section 328.3 (59 O.S. §328.3).

(b) **Eligible providers.** For dental services provided at a mobile dental unit to be eligible for SoonerCare reimbursement, a dental group shall meet all applicable requirements set forth in the Oklahoma Board of Dentistry rules, the Oklahoma State Dental Act (59 O.S., Ch. 7), and the requirements in this Section, including but not limited to, all licensing and permitting requirements.

(1) All dentists working at a mobile dental unit shall be currently licensed in good standing with the Oklahoma Board of Dentistry. All other contracted providers of the dental group, working at a mobile dental unit, shall meet all credentialing/certification requirements, as per their specialty. In addition, all members of the dental group working at a mobile dental unit shall comply with the requirements at Oklahoma Administrative Code (OAC) 317:30-5-695.

(2) The license, certification, accreditation, and/or permit (or a photocopy of these documents) of every individual provider in the dental group shall be prominently displayed at the mobile dental unit, pursuant to 59 O.S., Section (§) 328.21.

(3) For services provided in a mobile dental unit, the permit to operate the mobile dental unit shall be prominently displayed in the mobile dental unit vehicle, pursuant to 59 O.S. §328.40a.

(4) In accordance with OAC 317:30-5-695.1, every dental group providing services at a mobile dental unit must be fully contracted with the Oklahoma Health Care Authority (OHCA) as a dental group provider and must also be fully contracted with OHCA as a mobile dental unit.

(5) Every individual dentist practicing at a mobile dental unit must be fully contracted with the OHCA as a dentist.

(6) Dental groups and individual providers providing dental services at a mobile dental unit shall comply with all applicable state and federal Medicaid laws, including, but not limited to,

OHCA administrative rules, the Code of Federal Regulations, and the Oklahoma State Medicaid Plan.

(c) **Coverage.** Refer to OAC 317:30-5-696 for dental coverage descriptions for children and adults.

(d) **Description of services.** Mobile dental units must treat both children and adults and provide urgent, preventive, and restorative dental services that are appropriate to provide in this setting.

(1) All current dental rules at OAC 317, Part 79, still apply to all mobile dental services including, but not limited to, prior authorizations, medically necessity criteria, documentation, and limitations.

(2) Endodontics, orthodontics, prosthodontics, periodontics, and permanent crowns will not be covered in mobile clinic.

(3) Mobile dental units will be required to refer a member to a SoonerCare contracted dental provider for any follow-up care when needed or to access services that cannot be provided in the mobile unit.

(e) **Limited provider service area.** Mobile dental units should serve members in SoonerCare dental provider shortage areas. Dental provider shortage areas mean Oklahoma counties that have less than ten (10) Medicaid general dental providers.

(f) **Billing and reimbursement.** Billing and reimbursement policies in accordance with OAC 317:30-5-704 through 317:30-5-705 apply to mobile dental services.

(g) **Post Care.** Each member receiving dental care at a mobile dental unit must receive an information sheet at the end of the visit. The information sheet must contain:

(1) The name of the dentist, dental hygienist, and/or dental assistant who provided the dental services at the mobile dental unit;

(2) Valid contact information which can include a business telephone number, email address and/or other emergency contact number for the dental group and/or dentist that provided the dental services at the mobile dental unit;

(3) A listing of the treatment rendered, including, when applicable, billing codes, fees, and tooth numbers;

(4) A description of any follow-up treatment that is needed or recommended; and

(5) Referrals to specialists or other dentists if the mobile dental unit providers were unable to provide the necessary treatment and/or additional care is needed.

(6) All dental records including radiographs from that visit should be provided to the member and/or forwarded to the dental provider providing follow-up care. Electronic and/or printed forms of records are acceptable.

**317:30-5-707. ~~Eligible providers~~Portable Dental Units**

~~(a) In order for dental services provided at a mobile and/or portable dental treatment facility to be eligible for SoonerCare reimbursement, a dental group shall meet all applicable requirements set forth in the Oklahoma Board of Dentistry rules and the Oklahoma State Dental Act, including, but not limited to, all licensing and permitting requirements.~~

~~(1) All dentists and dental hygienists working at a mobile and/or portable dental treatment facility shall be currently licensed in good standing with the Oklahoma Board of Dentistry. All dental assistants working at a mobile and/or portable dental treatment facility shall be currently permitted by the Oklahoma Board of Dentistry.~~

~~(2) The license or permit (or a photocopy of the license or permit) of every individual provider shall be prominently displayed at the mobile and/or portable dental treatment facility, pursuant to 59 O.S. ' 328.21.~~

~~(3) For services provided in a mobile dental clinic, the permit to operate the mobile dental clinic shall be prominently displayed in the mobile dental clinic vehicle, pursuant to 59 O.S. ' 328.40a.~~

~~(b) In accordance with OAC 317:30-5-695.1, every dental group providing services at a mobile and/or portable dental treatment facility must be fully contracted with the OHCA as a dental group provider and must be fully contracted with OHCA as a mobile and/or portable dental treatment facility.~~

~~(c) Every individual dentist practicing at a mobile and/or portable dental treatment facility must be fully contracted with the OHCA as a dentist.~~

~~(d) Dental groups and individual providers providing dental services at a mobile and/or portable dental treatment facility shall comply with all state and federal Medicaid law, including, but not limited to, OHCA administrative rules, the Code of Federal Regulations, and the Oklahoma State Medicaid Plan.~~

(a) **Definition.** Portable dental unit means a non-facility in which dental equipment used in the practice of dentistry is transported to and used on a temporary basis at an out-of-office location at either group homes for juveniles or public and private schools.

(b) **Eligible providers.** For dental services provided at a portable dental unit to be eligible for SoonerCare reimbursement, a dental group shall meet all applicable requirements set forth in the Oklahoma Board of Dentistry rules, the Oklahoma State Dental Act (59 O.S., Ch. 7), and the requirements in this Section, including but not limited to, all licensing and permitting requirements.

(1) All dentists working at a portable dental unit shall be currently licensed in good standing with the Oklahoma Board of Dentistry. All other contracted providers of the dental group, working at a portable dental unit, shall meet all credentialing/certification requirements, as per their specialty. In addition, all members of the dental group working at a portable dental unit shall comply with the requirements at Oklahoma Administrative Code (OAC) 317:30-5-695.

(2) The license or permit (or a photocopy of the license or permit) of every individual provider shall be prominently displayed at the portable dental unit site, pursuant to Title of 59 O.S. § 328.21.

(3) In accordance with OAC 317:30-5-695.1, every dental group providing services at a portable dental unit must be fully contracted with the OHCA as a dental group provider.

(4) Every individual dentist practicing at a portable dental unit must be fully contracted with the OHCA as a dentist.

(5) Dental groups and individual providers providing dental services at a portable dental unit shall comply with all state and federal Medicaid laws, including, but not limited to, OHCA administrative rules, the Code of Federal Regulations, and the Oklahoma State Medicaid Plan.

(c) **Coverage.** Portable dental unit services are only available for SoonerCare-eligible individuals under the age of twenty-one (21) and limited to the services noted in (1) through (3) of this Subsection. All portable dental units must have a SoonerCare-contracted, Oklahoma-licensed dentist onsite to supervise all other portable dental unit staff. Coverage for dental services provided to children/adolescents at a portable dental unit is limited to:

(1) One (1) fluoride application per member per twelve (12) months;

(2) One (1) dental screening annually that is performed by a SoonerCare-contracted, Oklahoma-licensed dentist; and

(3) Dental sealants on tooth numbers 2, 3, 14, 15, 18, 19, 30, and 31. The OHCA will not reimburse the application of dental sealants for a given OHCA member more than once every thirty-six (36) months, regardless of whether the services are provided at a portable dental unit, or at some other authorized place of service.

(d) **Post Care.** Each member receiving dental care at a portable dental unit must receive an information sheet at the end of the visit. The information sheet must contain:

(1) The name of the dentist, dental hygienist, and/or dental assistant who provided the dental services at the portable dental unit;

(2) A valid business telephone number and/or other emergency contact number for the dental group and/or dentist that provided the dental services at the portable dental unit;

(3) A listing of the treatment rendered, including, when applicable, billing codes, fees, and tooth numbers;

(4) A description of any follow-up treatment that is needed or recommended; and

(5) Referrals to specialists or other dentists if the portable dental unit providers were unable to provide the necessary treatment and/or additional care is needed.

(e) **Billing.** Refer to OAC 317:30-5-704 through 317:30-5-705 for billing instructions and guidelines. Please note that for any dental service provided through a portable dental unit that is billed to SoonerCare, the appropriate place of service must be identified on the claim to receive reimbursement.

**317:30-5-708. Parental consent requirements**

Individual providers at a ~~mobile and/or portable dental treatment facility~~mobile or portable dental unit shall not perform any service on a minor without having obtained, prior to the provision of services, a signed, written consent from the minor's parent or legal guardian, that includes, at a minimum, the:

(1) Name of the dental group and/or dentist providing the dental services at the mobile and/or portable dental ~~treatment facility~~unit;

(2) Permanent business mailing address of the dental group and/or dentist providing the dental services at the mobile and/or portable dental ~~treatment facility~~unit;

(3) Business telephone number of the dental group and/or dentist providing the dental services at the mobile and/or portable dental ~~treatment facility~~unit. This telephone number must be available for emergency calls;

(4) Full printed name of the child to receive services;

(5) Child's SoonerCare Member ID number; and

(6) An inquiry of whether the child has had dental care in the past twelve (12) months and if the child has a dental appointment scheduled with his/her regular dentist. If applicable, parent should list the name and address of the dentist and/or dental office where the care is provided.

**317:30-5-709. Coverage [REVOKED]**

~~Payment is made only to contracted dental groups for Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services provided to SoonerCare-eligible individuals under the age of twenty-one (21). All mobile and/or portable dental treatment facilities must have a SoonerCare-contracted, Oklahoma-licensed dentist onsite to supervise staff and provide certain services.~~

~~Coverage for dental services provided to children/adolescents at a mobile and/or portable dental treatment facility is limited to:~~

~~(1) One (1) fluoride application per member per twelve (12) months;~~

~~(2) One (1) dental assessment annually that is performed by a SoonerCare-contracted, Oklahoma-licensed dentist; and~~

~~(3) Dental sealants on tooth numbers 2, 3, 14, 15, 18, 19, 30, and 31. The Oklahoma Health Care Authority (OHCA) will not reimburse the application of dental sealants for a given OHCA member more than once every thirty-six (36) months, regardless of whether the services are provided at a mobile and/or portable dental treatment facility, or at some other authorized place of service.~~

**317:30-5-710. Post-care [REVOKED]**

~~Each member receiving dental care at a mobile and/or portable dental treatment facility must receive an information sheet at the end of the visit. The information sheet must contain:~~

~~(1) The name of the dentist, dental hygienist, and/or dental assistant who provided the dental services at the mobile and/or portable dental treatment facility;~~

~~(2) A valid business telephone number and/or other emergency contact number for the dental group and/or dentist that provided the dental services at the mobile and/or portable dental treatment facility;~~

~~(3) A listing of the treatment rendered, including, when applicable, billing codes, fees, and tooth numbers;~~

~~(4) A description of any follow-up treatment that is needed or recommended; and~~

~~(5) Referrals to specialists or other dentists if the individual providers were unable to provide the necessary treatment, and additional care is needed.~~

**317:30-5-711. Billing [REVOKED]**

~~Refer to Oklahoma Administrative Code (OAC) 317:30-5-704 through 317:30-5-705 for billing instructions and guidelines. Please note that for any dental service provided at a mobile and/or portable dental treatment facility that is billed to SoonerCare, the appropriate place of service must be identified on the claim.~~