Oklahoma Health Care Authority
MEDICAL ADVISORY COMMITTEE
May 4, 2023
1:00 – 3:30 PM
Charles Ed McFall Board Room

AGENDA

Please access via zoom:
https://www.zoomgov.com/webinar/register/WN_4ZPrLCdkRSqYd3JnL6P16g
Telephone: 1-669-254-5252 **Webinar ID: 160 266 5142**

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

II. Action Item: Approval of Minutes of the March 2, 2023: **Medical Advisory Committee Meeting**

III. Public Comments (2 minute limit)

IV. MAC Member Comments/Discussion

V. Financial Report: **Aaron Morris, Chief Financial Officer**

VI. Legislative Update: **Christina Foss, Deputy Chief of Staff**

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

- **A.** Medical Update: **Paula Root, Senior Medical Director/Interim Chief Medical Officer**

VIII. Comprehensive Quality Strategy **Update: Chris Radley, Chief Quality Officer**

IX. Proposed Rule Changes: Presentation, Discussion, and Vote: **Kasie McCarty, Senior Director of Federal and State Authorities**

- **A. APA WF # 23-02 Insure Oklahoma Self-Funded/Self-Insured**
- **B. APA WF # 23-09 Copayment exemption for expansion adults**
- **C. APA WF # 23-10 Doula Services**
- **D. APA WF # 23-11 Private Duty Nursing (PDN) Reimbursement and Overtime —**
- **E. APA WF # 23-12 Enhanced Payment for Vocational & Day Services Provided in Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IIDs)**
- **F. APA WF # 23-14 Audio-only Telecommunications Health Service Delivery**

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

XI. Future Meeting: **Chairman, Jason Rhynes, O.D.**

July 6, 2023
September 7, 2023
November 2, 2023

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

Oklahoma Health Care Authority
MEDICAL ADVISORY COMMITTEE
MINUTES of the March 2, 2023, 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. Janet Cizek, Ms. Wanda Felty, Dr. Arlen Foulks, Ms. Tina Johnson, 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: Ms. Heather Pike, and Dr. Chad Douglas

***Delegates absent without an alternate were*:**

II. Approval of the January 5th, 2023 Minutes

Medical Advisory Committee
The motion to approve the minutes was by Dr. Daniel Post and seconded by Ms. Tina Johnson and passed unanimously.

III. Public Comments (2-minute limit):

Mr. Steven Goldman with legal aid services spoke regarding the February 13th press release from OHCA concerning unwinding mentioned the reliance on navigators of other community groups. This applies to us, but we have not received sufficient information to be able to help people. More information is needed from OHCA that unwinding is happening. Who should we be service and receiving phone called from. An example is the purple letter that states you are not currently eligible, twice. Naturally members are making calls to cancel their appointment, and not refill medications. We are looking to avoid a crash is provider appointments, refills, and other important matters. We would like further collaboration with OHCA to keep this from happening.

IV. MAC Member Comments/Discussion:

There were no comments.

V. Financial Report:

Tasha Black, Senior Director of Financial Services

Tasha Black presented the financial report ending in November 2022. OHCA is 5.2% over budget in revenues and 6.6% over budget in expenditures with the result that our budget variance is a negative $31,775,113. The budget variance is primarily attributed to the following: Medicaid Program Variance is a positive 32.6 million state dollars, and administration is a positive 0.7

million state dollars. For more detailed information, see item 5 in the MAC agenda. For more detailed information, see item 5 in the MAC agenda.

VI. Legislative Update: Christina Foss, Deputy Chief of Staff

Ms. Foss stated the first deadline was today. We have spent the last few months evaluating all 3000 bills on what effects OHCA. Four requests' bills were submitted this year regarding clean up from SB1337. HB1667 is one of our bills, which establishes unform process for enrolling credentialing providers. HB1658, another cleanup fromSB1337 requires all our contracted entities to be licensed and HMO. HB1791 allows us to recoup taxpayer's dollars more effectively. SB744 supplemental payment for public ground ambulance providers to continue in MCO environment. We're currently following HB1320 regarding OOS trying to keep dollars in Oklahoma. OHCA is also following HB165 SB563 keeping anesthesia fee schedule at the same fee for service as we move to MCO.

VII. Medicaid Director's Update

Traylor Rains, State Medicaid Director

Mr. Rains gave an update on where we are with SoonerSelect. We have begun conversations with both Liberty Dental and DenatQuest. Christina did mention there is legislative requirements because its currently just HMO, which they don't have. Were working in good faith with them until its finalized at the capital and we have signed contracts. We the bids for medical plans did close, so our evaluation team currently is in possession of those reviewing them. The evaluation will take about a month or more, but we did have six bids for medical and two for dental. Our timeline to award those is towards the end of May, give or take a couple weeks.

There was a Supreme Court filing made by a petitioner going by the name of Equity Route, who has a potential bidder on the SoonerSelect plan. They asked for us to rewrite portions of the RFP. Through our counsel and Attorney Generals Office filed a response to that. There is also a brief file by the Hospital Association in support of SoonerSelect. Oral arguments are scheduled towards the end of March, so we expect a decision by April.

A. PHE Unwinding:

April Anonsen, Senior Director of Eligibility & Coverage Services

Ms. Anonsen stated a lot has been happening since they've announced that their analysts are decoupling . The numbert hat we refer to as PHd protective group that are expecting to be rolled off. The number fluctuates but floats around 300,000. Members situations change all the time, so

the number is expected to fluctuate. We want to be Intentional, compassionate, and that we are doing our best for the most vulnerable for those who will lose their eligibility. We're looking at around 33,000 members a month who will lose their eligibility through this process. We start with a risk-based approach for the members. These members have a high FPL in addition with no children under 5 years old, and 3rd party coverage. Next factors are member who are in episode of care, with chronic health conditions to keep coverage and find options. Just week, we got everyone into a 'bucket' Members will receive a notice with when their renewal date as well as a purple paper notice that explains this is happening, along with the next steps. We really want to get their attention. April 30 will be last day of coverage and then the last group will be December 31st, 2023.

VIII. Proposed Rule Change: Presentation, Discussions, and Vote:

Kasie McCarty, Senior Director of Federal and State Authorities

APA WF # 22-23A&B ADvantage Waiver Rule Changes – The proposed revisions align policy with the recently approved waiver amendment, which added Assistive Technology and Remote Support services. Revisions outline and define the purpose and scope of remote support services, service description, provider requirements, guidelines, limitations, and service discontinuation. Additional revisions outline the assistive technology services and devices that are covered/non- covered. Further revisions correct formatting and grammatical errors.

Budget Impact: The estimated total cost for SFY 2023 is $958,875. The estimated total cost for SFY 2024 is $2,025,000. Oklahoma Human Services (OKDHS) is responsible for the projected cost of services.

The rule change motion to approve as by Dr. Eve Switzer and seconded by Dr. Arlen Foulks and passes unanimously.

APA WF # 22-24A&B Developmental Disabilities Services (DDS) Policy Changes – The proposed revisions update coverage limits for individual family training and group family training from $5,500 to $6,500 and remove outdated documentation requirements for family support services. The revisions add new criteria and standards for specialized foster care and criteria for providers of respite care and homemaker, remote, and agency companion services. The revisions also add optometry benefits to include routine eye examination and purchase of corrective lenses. Finally, revisions add language to support the increase of the public transportation limit, correct formatting/grammatical errors, and align policy with current business practices.

Budget Impact: Budget neutral.

The rule change motion to approve as by Dr. Daniel Post and seconded by Dr. Whitney Yeates and passes unanimously.

APA WF # 22-25 Behavioral Health Rules Cleanup – The proposed revisions clarify timely completion of the placement tool for a substance use disorder (SUD) admission or extension request and update service plan, documentation, and signature requirements. Furthermore, the proposed revisions require providers to report to OKDHS instances of child abuse/neglect in residential settings in accordance with state law. Revisions also include grammatical and formatting changes as needed.

Budget Impact: Budget neutral.

The rule change motion to approve as by Dr. Arlen Foulks and seconded by Ms. Tina Johnson and passes unanimously.

APA WF # 22-26 Crisis Intervention Rule Revisions – The proposed revisions clarify crisis intervention services (CIS) as the provision of these services is expanding in the State. Rule changes will clearly define mobile versus on-site CIS and include other grammatical and formatting changes as needed.

Budget Impact: Budget neutral.

The rule change motion to approve as by Dr. Arlen Foulks and seconded by Ms. Tina Johnson and passes unanimously.

APA WF # 22-27 Physician Assistant Rule Revisions – The proposed revisions ensure that previous amendments to the Physician Assistant Practice Act by the State's Legislature are reflected in the rules. Rule changes include: updating the term "supervising" physician to "delegating" physician; removing the application to practice requirements and replace it with the practice agreement requirements; and a new timeframe of 10 business days for providers to submit any updated copy of the practice agreement due to changes. Other revisions will involve limited rewriting aimed at improving readability and overall flow of policy language.

Budget Impact: Budget neutral.

The rule change motion to approve as by Dr. Arlen Foulks and seconded by Ms. Tina Johnson and passes unanimously.

APA WF # 22-28 Opioid Treatment Program (OTP) Rule Changes – The proposed revisions revise OTP rules to align with federal regulations with updates to the phase requirements. Further revisions update service plan signatures to clarify requirements according to the member's age.

Budget Impact: Budget neutral.

The rule change motion to approve as by Dr. Arlen Foulks and seconded by Ms. Tina Johnson and passes unanimously.

APA WF # 22-29 Laboratory Services Policy Cleanup – The proposed revisions combine the existing laboratory policies into one centralized location. This will allow for better access to the policies and an easier understanding of services covered under the laboratory benefit. Language will be placed into policy to clarify coverage of reference (outside) laboratories when an independent or hospital laboratory refers a service to another laboratory.

Budget Impact: Budget neutral.

The rule change motion to approve as by Dr. Daniel Post and seconded by Dr. Whitney Yeates and passes unanimously.

APA WF # 22-30 Outdated/Obsolete Policy Language Cleanup – The proposed revisions amend language to remove obsolete references and combine sections of policy to remove the overabundant number of sections that are currently in Title 317. These changes are necessary to comply with Oklahoma Executive Order 2020-03.

Budget Impact: Budget neutral.

The rule change motion to approve as by Dr. Arlen Foulks and seconded by Ms. Wanda Felty and passes unanimously.

APA WF # 22-31 Eliminate Certificate of Medical Necessity (CMN) Form Requirement for Most Medical Supplies, Equipment, and Appliances – The proposed revisions eliminate the requirement to include a CMN form when requesting the prior authorization (PA) for most medical supplies, equipment, and appliances. Rules will state that the CMN form continues to be required for enteral and parenteral nutrition.

Budget Impact: Budget neutral.

The rule change motion to approve as by Dr. Arlen Foulks and seconded by Ms. Wanda Felty and passes unanimously.

These proposed EMERGENCY rules were presented at the Jan. 3, 2023, Tribal Consultation, and were subject to at least a 15-day public comment period.
The Agency is requesting the effective date to be immediately upon receiving gubernatorial approval. The Governor will have until May 8, 2023, to approve or disapprove each rule, upon the Agency's submission for gubernatorial review.

APA WF # 23-01 State Plan Personal Care Services for Expansion Adults, TEFRA Eligible Children and Certain MAGI Populations – The proposed revisions will add new policy to delineate eligibility requirements, definitions, medical eligibility criteria for personal care, and the process for medical eligibility determinations. Additionally, rules add the current business practice for approving the TEFRA population and any EPSDT members who meet medical necessity to receive personal care services.

Budget Impact: The estimated budget impact, for SFY2023, will be an increase in the total amount of $91,173; with $25,200 in state share. The estimated budget impact, for SFY2024 will be an increase in the total amount of $273,520; with $88,921 in state share.

The rule change motion to approve as by Dr. Arlen Foulks and seconded by Ms. Wanda Felty and passes unanimously.

APA WF # 23-05 Notification of Date of Service (NODOS) Timeframe Change – The proposed revisions update rules on application procedures for filing a Notification of Date of Service (NODOS). The current five-day requirement for the hospital to file the electronic NODOS will remain in effect; however, after the electronic NODOS is filed, the applicant or someone acting on behalf of the applicant will have 40 days to submit a completed SoonerCare application instead of the current fifteen 15 days.

Budget Impact: The estimated total cost for SFY 2024 is $420,861 ($284,039 in federal share and $136,822 in state share). The estimated total cost for SFY 2025 is $561,147 ($378,718 in federal share and $182,429 in state share).

The rule change motion to approve as by Ms. Tina Johnson and seconded by Ms. Wanda Felty and passes unanimously.

APA WF # 23-06A&B Transition to SoonerSelect – These changes comply with Oklahoma Senate Bill SB1337 and Oklahoma Senate Bill 1396 (SB 1396), which directed the Oklahoma Health Care Authority to transition to a new health care program, called SoonerSelect. Policy will define terms, processes, and regulations from SB1337 and the published Model Contract/Request for Proposals (RFP). The proposed rule additions/revisions outline and address state-sanctions and complementary non-compliance remedies required of the medical contracted entities (CEs) and dental benefit managers (DBMs). Other rule additions include, but are not limited to, managed care mandatory and voluntary populations (American Indian/Alaskan Native (AI/AN) members), processes for network adequacy, provider requirements, termination of contracts, transition of care policies, medical necessity, required notices and grievances and appeals.

Budget Impact: The OHCA Board approved expenditure authority for the SoonerSelect RFP at the January 18, 2023 meeting. The goal of the SoonerSelect delivery model over the term of the contracts (first year, plus 5 renewal years) is budget neutrality.

The rule change motion to approve as by Dr. Eve Switzer and seconded by Dr. Daniel Post with one abstaining and passes unanimously.

IX. MAC Meeting Dates for Calendar 2023:

Chairman, Jason Rhynes, O.D.
May 4, 2023
July 6, 2023
September 7, 2023
November 2, 2023

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. Eve Switzer and seconded by Mr. Nick Barton, there was no dissent and the meeting adjourned at 2:30pm.

OKLAHOMA
Health Care Authority

FINANCIAL REPORT

For the Seven Month Period Ending January 31, 2023
Submitted to the CEO & Board

- Revenues for OHCA through January, accounting for receivables, were **$4,614,625,349** or **0.1% under** budget.

- Expenditures for OHCA, accounting for encumbrances, were **$4,392,035,918** or **0.3% under** budget.

- The state dollar budget variance through January is a positive **$7,899,890**
- The budget variance is primarily attributable to the following (in millions):

Expenditures:		
Medicaid Program Variance		(14.2)
Administration		(0.9)
Revenues:		
Drug Rebate		(1.5)
Medical Refunds		0.1
Taxes and Fees		24.4
Total FY 23 Variance	**$**	**7.9**

ATTACHMENTS

OKLAHOMA HEALTH CARE AUTHORITY
Summary of Revenues & Expenditures: OHCA
SFY 2023, For the Seven Month Period Ending January 31, 2023

REVENUES	FY23 Budget YTD	FY23 Actual YTD	Variance	% Over/ (Under)
State Appropriations	$ 671,874,288	$ 671,874,288	$ -	0.0%
Federal Funds	3,327,123,688	3,305,373,050	(21,750,639)	(0.7)%
Tobacco Tax Collections	27,251,292	25,973,888	(1,277,404)	(4.7)%
Quality of Care Collections	52,801,837	53,795,595	993,758	1.9%
Prior Year Carryover	10,941,101	10,941,101	-	0.0%
Federal Deferral - Interest	592,406	592,406	-	0.0%
Drug Rebates	329,707,295	322,552,904	(7,154,391)	(2.2)%
Medical Refunds	20,913,294	21,526,429	613,135	2.9%
Prior Year Carryover Supplemental Hospital Offset Payment Program	-	-	-	0.0%
Supplemental Hospital Offset Payment Program	174,418,257	199,061,517	24,643,259	14.1%
Other Revenues	2,866,890	2,934,172	67,282	2.3%
TOTAL REVENUES	**$ 4,618,490,348**	**$ 4,614,625,349**	**$ (3,865,000)**	**(0.1)%**

EXPENDITURES	FY23 Budget YTD	FY23 Actual YTD	Variance	% (Over)/ Under
ADMINISTRATION - OPERATING	**$ 38,204,693**	**$ 34,522,616**	**$ 3,682,078**	**9.6%**
ADMINISTRATION - CONTRACTS	**$ 76,445,034**	**$ 78,525,087**	**$ (2,080,053)**	**(2.7)%**
MEDICAID PROGRAMS				
Managed Care:				
SoonerCare Choice	33,923,951	33,740,753	183,198	0.5%
Acute Fee for Service Payments:				
Hospital Services	973,380,860	965,101,001	8,279,859	0.9%
Behavioral Health	19,023,347	18,062,298	961,048	5.1%
Physicians	350,110,531	347,894,475	2,216,057	0.6%
Dentists	140,275,645	138,093,203	2,182,442	1.6%
Other Practitioners	47,419,605	49,632,763	(2,213,158)	(4.7)%
Home Health Care	17,204,699	16,085,320	1,119,379	6.5%
Lab & Radiology	27,336,629	27,236,086	100,543	0.4%
Medical Supplies	55,948,133	55,839,317	108,817	0.2%
Ambulatory/Clinics	364,795,394	358,844,454	5,950,940	1.6%
Prescription Drugs	908,517,815	907,134,973	1,382,842	0.2%
OHCA Therapeutic Foster Care	328,166	252,423	75,743	23.1%
Other Payments:				
Nursing Facilities	485,212,210	486,499,909	(1,287,700)	(0.3)%
Intermediate Care Facilities for Individuals with Intellectual Disabilities Private	40,085,537	38,494,174	1,591,363	4.0%
Medicare Buy-In	144,484,712	143,835,458	649,254	0.4%
Transportation	67,357,936	73,621,358	(6,263,422)	(9.3)%
Money Follows the Person-OHCA	303,147	358,310	(55,163)	(18.2)%
Electronic Health Records-Incentive Payments	(14,380)	(14,380)	-	0.0%
Part D Phase-In Contribution	43,719,534	43,924,503	(204,969)	(0.5)%
Supplemental Hospital Offset Payment Program	562,321,548	568,023,116	(5,701,568)	(1.0)%
Telligen	7,326,681	6,328,704	997,977	13.6%
Total OHCA Medical Programs	**4,289,061,698**	**4,278,988,215**	**10,073,483**	**0.2%**
OHCA Non-Title XIX Medical Payments	89,382	-	89,382	0.0%
TOTAL OHCA	**$ 4,403,800,808**	**$ 4,392,035,918**	**$ 11,764,890**	**0.3%**
REVENUES OVER/(UNDER) EXPENDITURES	**$ 214,689,540**	**$ 222,589,430**	**$ 7,899,890**	

OKLAHOMA HEALTH CARE AUTHORITY

Total Medicaid Program Expenditures
by Source of State Funds
SFY 2023, For the Seven Month Period Ending January 31, 2023

Category of Service	Total	Health Care Authority	Quality of Care	Insure Oklahoma	SHOPP	BCC	Other State Agencies
SoonerCare Choice	$ 33,740,753	$ 33,737,421	$ -	$ -	$ -	$ 3,331	$ -
Inpatient Acute Care	1,087,214,005	537,297,624	283,901	(3,990)	401,854,440	424,973	147,357,058
Outpatient Acute Care	568,776,905	425,336,707	24,269	(3,594)	141,685,996	1,733,527	-
Behavioral Health - Inpatient	72,254,056	11,339,261	-	-	20,200,326	-	40,714,470
Behavioral Health - Psychiatrist	11,005,391	6,717,555	-	-	4,282,354	5,483	-
Behavioral Health - Outpatient	11,820,135	-	-	-	-	-	11,820,135
Behaviorial Health-Health Home	(2,398)	-	-	-	-	-	(2,398)
Behavioral Health Facility- Rehab	146,424,468	-	-	-	-	148,929	146,424,468
Behavioral Health - Case Management	3,710,581	-	-	-	-	-	3,710,581
Behavioral Health - PRTF	8,529,879	-	-	-	-	-	8,529,879
Behavioral Health - CCBHC	206,297,696	-					206,297,696
Residential Behavioral Management	11,391,040	-	-	-	-	-	11,391,040
Targeted Case Management	44,752,404	-	-	-	-	-	44,752,404
Therapeutic Foster Care	252,423	252,423	-	-	-	-	-
Physicians	424,617,786	347,052,269	33,892	(490)	-	808,314	76,723,802
Dentists	138,093,203	138,041,595	-	-	-	51,607	-
Mid Level Practitioners	855,958	854,793	-	-	-	1,165	-
Other Practitioners	48,776,805	48,478,295	260,379	-	-	38,131	-
Home Health Care	16,085,320	16,084,773	-	-	-	547	-
Lab & Radiology	27,236,086	27,184,527	-	-	-	51,558	-
Medical Supplies	55,839,317	54,234,049	1,581,727	-	-	23,540	-
Clinic Services	367,466,179	352,156,137	-	398	-	185,549	15,124,095
Ambulatory Surgery Centers	6,502,769	6,496,121	-	-	-	6,647	-
Personal Care Services	5,415,619	-	-	-	-	-	5,415,619
Nursing Facilities	486,499,909	233,146,721	253,352,697	-	-	491	-
Transportation	73,429,768	72,034,977	1,282,145	1,871	-	110,776	-
IME/DME	55,199,167	-	-	-	-	-	55,199,167
ICF/IID Private	38,494,174	25,178,939	13,315,235	-	-	-	-
ICF/IID Public	11,658,280	-	-	-	-	-	11,658,280
CMS Payments	187,759,960	187,484,085	275,876	-	-	-	-
Prescription Drugs	907,120,050	905,613,949	-	(14,923)	-	1,521,024	-
Miscellaneous Medical Payments	193,461	190,586	-	-	-	2,875	-
Home and Community Based Waiver	157,616,707	-	-	-	-	-	157,616,707
Homeward Bound Waiver	44,197,175	-	-	-	-	-	44,197,175
Money Follows the Person	1,748,873	358,310	-	-	-	-	1,390,563
In-Home Support Waiver	19,155,088	-	-	-	-	-	19,155,088
ADvantage Waiver	123,359,984	-	-	-	-	-	123,359,984
Family Planning/Family Planning Waiver	881,114	-	-	-	-	-	881,114
Premium Assistance*	23,923,935	-	-	23,923,934.63	-	-	-
Telligen	6,328,704	6,328,704	-	-	-	-	-
Electronic Health Records Incentive Payments	(14,380)	(14,380)	-	-	-	-	-
Total Medicaid Expenditures	**$ 5,434,608,347**	**$ 3,435,585,440**	**$ 270,410,120**	**$ 23,903,205**	**$ 568,023,116**	**$ 5,118,468**	**$ 1,131,716,926**

* Includes $23,685,233.91 paid out of Fund 245

OKLAHOMA HEALTH CARE AUTHORITY
Summary of Revenues & Expenditures:
Other State Agencies
SFY 2023, For the Seven Month Period Ending January 31, 2023

REVENUE	FY23 Actual YTD
Revenues from Other State Agencies	263,062,833
Federal Funds	915,801,703
TOTAL REVENUES	**$ 1,178,864,536**

EXPENDITURES	Actual YTD
Oklahoma Human Services	
Home and Community Based Waiver	157,616,707
Money Follows the Person	1,390,563
Homeward Bound Waiver	44,197,175
In-Home Support Waivers	19,155,088
Advantage Waiver	123,359,984
Intermediate Care Facilities for Individuals with Intellectual Disabilities Public	11,658,280
Personal Care	5,415,619
Residential Behavioral Management	7,657,700
Targeted Case Management	39,272,500
Total Oklahoma Human Services	**409,723,615**
State Employees Physician Payment	
Physician Payments	76,723,802
Total State Employees Physician Payment	**76,723,802**
Education Payments	
Indirect Medical Education	39,124,998
Direct Medical Education	4,182,323
DSH	11,891,846
Total Education Payments	**55,199,167**
Office of Juvenile Affairs	
Targeted Case Management	1,219,619
Residential Behavioral Management	3,733,340
Total Office of Juvenile Affairs	**4,952,960**
Department of Mental Health & Substance Abuse Services	
Case Management	3,710,581
Inpatient Psychiatric Free-standing	40,714,470
Outpatient	11,820,135
Health Homes	(2,398)
Psychiatric Residential Treatment Facility	8,529,879
Certified Community Behavioral Health Clinics	206,297,696
Rehabilitation Centers	146,424,468
Total Department of Mental Health & Substance Abuse Services	**417,494,832**
State Department of Health	
Children's First	187,504
Sooner Start	765,064
Early Intervention	2,435,483
Early and Periodic Screening, Diagnosis, and Treatment Clinic	787,987
Family Planning	383,741
Family Planning Waiver	497,373
Maternity Clinic	7,861
Total Department of Health	**5,065,013**
County Health Departments	
EPSDT Clinic	253,062
Family Planning Waiver	-
Total County Health Departments	**253,062**
State Department of Education	**104,912**
Public Schools	**1,532,387**
Medicare DRG Limit	**131,591,288**
Native American Tribal Agreements	**13,310,121**
Department of Corrections	**2,558,009**
JD McCarty	**13,207,761**
Total OSA Medicaid Programs	**$ 1,131,716,926**
OSA Non-Medicaid Programs	**$ 55,254,967**
Accounts Receivable from OSA	**$ 8,107,357**

OKLAHOMA HEALTH CARE AUTHORITY

SUMMARY OF REVENUES & EXPENDITURES:

Fund 205: Supplemental Hospital Offset Payment Program Fund

SFY 2023, For the Seven Month Period Ending January 31, 2023

REVENUES		FY 23 Revenue
SHOPP Assessment Fee		**198,977,896**
Federal Draws	**$**	**476,161,522**
Interest		**83,620**
Penalties		**-**
TOTAL REVENUES	**$**	**675,223,038**

EXPENDITURES	Quarter	Quarter	Quarter	Quarter		FY 23 Expenditures
Program Costs:	**7/1/22 - 9/30/22**	**10/1/22 - 12/31/22**	**1/1/23 - 3/31/23**	**4/1/23 - 6/30/23**		
Hospital - Inpatient Care	**63,024,796**	**75,134,606**	**69,082,267**	**-**	**$**	**207,241,669**
Hospital -Outpatient Care	**17,328,429**	**37,624,389**	**36,801,379**	**-**	**$**	**91,754,197**
Psychiatric Facilities-Inpatient	**3,356,599**	**3,885,836**	**5,020,888**	**-**	**$**	**12,263,323**
Rehabilitation Facilities-Inpatient	**754,585**	**873,881**	**588,693**	**-**	**$**	**2,217,160**
Hospital - Inpatient Care - Expansion	**63,991,142**	**74,913,904**	**55,707,725**	**-**	**$**	**194,612,771**
Hospital -Outpatient Care - Expansion	**13,361,525**	**28,372,522**	**8,197,752**	**-**	**$**	**49,931,799**
Psychiatric Facilities-Inpatient - Expansion	**2,540,039**	**3,879,726**	**1,517,238**	**-**	**$**	**7,937,003**
Rehabilitation Facilities-Inpatient - Expansion	**754,446**	**872,507**	**438,240**	**-**	**$**	**2,065,194**
Total OHCA Program Costs	**165,111,562**	**225,557,371**	**177,354,182**	**-**		**568,023,116**
Total Expenditures					**$**	**568,023,116**

SHOPP Revenue transferred to Fund 340 for Medicaid Program expense	**$**	**107,199,923**

*** 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 2023, For the Seven Month Period Ending January 31, 2023

REVENUES	Total Revenue	State Share
FY22 EFMAP Surplus	**$ 7,740,157**	**$ 7,740,157**
Quality of Care Assessment	**$ 53,777,711**	**$ 53,777,711**
*Quality of Care Penalties (*Non-Spendable Revenue)*	**$ 126,880**	**$ 126,880**
Interest Earned	**$ 17,884**	**$ 17,884**
TOTAL REVENUES	**$ 61,662,632**	**$ 61,662,632**

EXPENDITURES	FY 23 Total $ YTD	FY 23 State $ YTD	Total State $ Cost
Program Costs			
Nursing Facility Rate Adjustment	$ 148,203,790	$ 31,163,740	
Eyeglasses and Dentures	141,311	$ 29,714	
Personal Allowance Increase	1,782,860	$ 375,022	
Coverage for Durable Medical Equipment and Supplies	1,581,727	$ 332,682	
Coverage of Qualified Medicare Beneficiary	602,441	$ 126,711	
Part D Phase-In	275,876	$ 275,876	
ICF/IID Rate Adjustment	2,959,393	$ 622,296	
Acute Services ICF/IID	4,291,570	$ 902,390	
Non-emergency Transportation - Soonerride	1,282,145	$ 269,750	
NF Covid-19 Supplemental Payment	103,224,736	$ 21,811,444	
ICF Covid-19 Supplemental Payment	6,064,272	$ 1,280,909	
Ventilator NF DME Supplemental Payment		$ -	
Total Program Costs	**$ 270,410,120**	**$ 57,190,533**	**$ 57,190,533**
Administration			
OHCA Administration Costs	$ 176,683	$ 88,341	
OHS-Ombudsmen	-	-	
OSDH-Nursing Facility Inspectors	-	-	
Mike Fine, CPA	-	-	
Total Administration Costs	**$ 176,683**	**$ 88,341**	**$ 88,341**
Total Quality of Care Fee Costs	**$ 270,586,803**	**$ 57,278,874**	
TOTAL STATE SHARE OF COSTS			**$ 57,278,874**

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 2023, For the Seven Month Period Ending January 31, 2023

REVENUES	FY 22 Carryover	FY 23 Revenue	Total Revenue
Prior Year Balance	$ 14,187,453		
State Appropriations	-		
Federal Draws - Prior Year	265,676		
Total Prior Year Revenue			14,453,129
Transfer to 340 for Expansion-current year		-	-
Tobacco Tax Collections	-	21,362,693	21,362,693
Interest Income	-	166,290	166,290
Federal Draws	-	19,344,972	19,344,972
TOTAL REVENUES	**$ 14,453,129**	**$ 40,873,955**	**$ 55,327,084**

EXPENDITURES		FY 22 Expenditures	FY 23 Expenditures	Total State $ YTD
Program Costs:				
	Employer Sponsored Insurance		$ 23,685,234	$ 23,685,234
	College Students/ESI Dental		238,701	50,163
Individual Plan				
	SoonerCare Choice		$ -	$ -
	Inpatient Hospital		(3,990)	(845)
	Outpatient Hospital		(3,775)	(804)
	BH - Inpatient Services-DRG		-	-
	BH -Psychiatrist		-	-
	Physicians		(490)	(135)
	Dentists		-	-
	Mid Level Practitioner		-	-
	Other Practitioners		-	-
	Home Health		-	-
	Lab and Radiology		-	-
	Medical Supplies		-	-
	Clinic Services		398	82
	Ambulatory Surgery Center		-	-
	Skilled Nursing		-	-
	Prescription Drugs		(14,923)	(3,158)
	Transportation		1,871	383
	Premiums Collected			-
Total Individual Plan			**$ (20,910)**	**$ (4,476)**
	College Students-Service Costs		**$ 181**	**$ 39**
Total OHCA Program Costs			**$ 23,903,205**	**$ 23,730,959**
Administrative Costs				
	Salaries	$ -	$ 810,113	$ 810,113
	Operating Costs	323	689	1,012
	E&E Development Gainwell	-	-	-
	Contract - Gainwell	375,519	554,887	930,407
			-	
Total Administrative Costs		**$ 375,842**	**$ 1,365,690**	**$ 1,741,532**
Total Expenditures				**$ 25,472,491**
Transfer to Fund 340 for Expansion Costs				**$ 12,820,651**
NET CASH BALANCE		**$ 14,077,287**	**$ 2,956,655**	**$ 17,033,942**

OKLAHOMA HEALTH CARE AUTHORITY

Combining Statement of Revenues, Expenditures and Changes in Fund Balance

SFY 2023, For the Seven Month Period Ending January 31, 2023

	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	Ambulance Service Provider Access Payment Program Fund 270	Medicaid Program Fund 340	Clearing Account 1807B	Total Cash Balance
January Beginning Fund Balance:												
Prior year	27,060,353	954,274	158,274	173,190,614	63,979,530	14,077,287	-	-	-	885,130,881	127,875,170	1,292,426,384
Current year	9,226,336	779,484	(37,782)	76,281,135	489,618	7,347,252	-	-	1,054,199	10,895,658	2,604,149	108,640,047
Total	36,286,689	1,733,758	120,491	249,471,749	64,469,148	21,424,539	-	-	1,054,199	896,026,539	130,479,319	1,401,066,431
January Revenues:												
Prior year	307,621	-	-	-	(3,003,170)	-	-	-	-	-	-	(2,695,550)
Current year	6,433,611	75,661,055	7,778,501	-	102,788	5,921,797	66,332	3,975,121	49,208	800,808,016	20,984,464	921,780,893
Total	6,741,231	75,661,055	7,778,501	-	(2,900,382)	5,921,797	66,332	3,975,121	49,208	800,808,016	20,984,464	919,085,343
January Expenditures:												
Prior year	-	-	-	-	-	-	-	-	-	-	-	-
Current year	11,101,919	-	-	-	-	3,335,385	-	-	-	798,668,015	-	813,105,319
Total	11,101,919	-	-	-	-	3,335,385	-	-	-	798,668,015		813,105,319
Operating Transfers In												
Prior year												
Current year	5,855,393	-	-	13,678,171	-	-	-	-	-	175,035,440	-	194,569,004
Total	5,855,393	-	-	13,678,171	-	-	-	-	-	175,035,440	-	194,569,004
Operating Transfers Out												
Prior year	1,187,440	-	-	-	-	-	-	-	-	-		1,187,440
Current year	-	75,931,428	7,757,742	-	-	6,931,284	66,332	3,975,121	-	-	127,875,170	222,537,078
Total	1,187,440	75,931,428	7,757,742	-	-	6,931,284	66,332	3,975,121	-	-	127,875,170	223,724,517
Change in CY Fund Balance	***10,413,420***	***509,111***	***(17,024)***	***89,959,306***	***592,406***	***3,002,380***	***-***	***-***	***1,103,407***	***188,071,099***	***(104,286,558)***	***189,347,547***
Ending Fund Balance	**36,593,954**	**1,463,385**	**141,250**	**263,149,920**	**61,568,766**	**17,079,667**	**-**	**-**	**1,103,407**	**1,073,201,980**	**23,588,613**	**1,477,890,942**

OKLAHOMA HEALTH CARE AUTHORITY
HEALTHY ADULT PROGRAM EXPENDITURES - OHCA
SFY 2023, For the Seven Month Period Ending January 31, 2023

PROGRAM / ACTIVITY	FY23 BUDGETED EXPENDITURES Full Year	FY23 BUDGETED EXPENDITURES Year to Date	FY23 ACTUAL EXPENDITURES YTD through January	BUDGET VARIANCE (Over)/ Under
OHCA MEDICAID PROGRAMS				
Managed Care				
SoonerCare Choice	4,516,290	2,634,502	2,501,530	132,972
Total Managed Care	**4,516,290**	**2,634,502**	**2,501,530**	**132,972**
Fee for Service				
Hospital Services:				
Inpatient Acute Care	273,604,093	159,821,592	141,447,769	18,373,823
SHOPP	324,314,903	254,546,941	254,546,767	174
Outpatient Acute Care	261,235,739	152,466,773	161,862,001	(9,395,229)
Total Hospitals	**859,154,735**	**566,835,305**	**557,856,537**	**8,978,768**
Behavioral Mental Health:				
Inpatient Services - DRG	23,311,919	13,449,184	13,914,433	(465,249)
Outpatient	-	-	-	-
Total Behavioral Mental Health	**23,311,919**	**13,449,184**	**13,914,433**	**(465,249)**
Physicians & Other Providers:				
Physicians	165,125,830	96,909,132	105,410,258	(8,501,125)
Dentists	60,063,072	34,651,772	34,379,679	272,093
Mid-Level Practitioner	470,555	271,474	260,862	10,612
Other Practitioners	17,826,615	10,284,586	13,172,264	(2,887,678)
Home Health Care	1,057,567	610,135	683,836	(73,701)
Lab & Radiology	18,732,473	10,807,196	12,018,751	(1,211,555)
Medical Supplies	16,939,513	9,772,796	9,754,973	17,823
Clinic Services	167,207,329	98,109,998	95,546,914	2,563,084
Ambulatory Clinics	3,935,341	2,270,389	2,710,507	(440,118)
Total Physicians & Other Providers	**451,358,294**	**263,687,477**	**273,938,044**	**(10,250,567)**
Misc Medical & Health Access Network	**81,869**	**47,232**	**68,343**	(21,111)
Transportation	**31,325,278**	**18,072,276**	**17,169,729**	902,547
Health Access Network	**-**	**-**	**18,265**	(18,265)
Prescription Drugs	**696,573,925**	**400,892,649**	**404,695,577**	(3,802,928)
Total OHCA Medicaid Programs	**2,066,322,309**	**1,265,618,626**	**1,270,162,458**	**(4,543,832)**

MAC PRESENTATION

Dr. Paula Root

Senior Medical Director/Interim Chief Medical Officer

5/4/2023

TOTAL CERVICAL DISC ARTHROPLASTY

TOTAL CERVICAL DISC ARTHROPLASTY

What is Total Cervical Disc Arthroplasty?

- Also known as artificial disc replacement.
- Cervical artificial disc replacement surgery is a joint replacement procedure.
- This procedure involves inserting an artificial disc between the vertebrae to replace a natural spinal disc after it has been removed.
- The artificial disc is designed to maintain motion in the treated vertebral segment.

TOTAL CERVICAL DISC ARTHROPLASTY

The Goal:

- To remove the damaged cervical disc.
- Relieve pressure on the nerves and/or spinal cord.
- Restore spinal mobility.

TOTAL CERVICAL DISC ARTHROPLASTY

- Total cervical disc arthroplasty is currently covered by OHCA.
- OHCA seeks to create a Prior Authorization for this procedure.
- OHCA requires a PA for spinal fusions and would like to PA all spinal arthroplasty procedures as this will assist with coverage for future associated codes.

TOTAL CERVICAL DISC ARTHROPLASTY APPROVAL CRITERIA

INDICATIONS

Cervical disc arthroplasty may be considered medically necessary when criteria are met:

- Age greater than or equal to 18 years old.
- Radiculopathy related to nerve root compression.
- Myelopathy or myeloradiculopathy related to central spinal stenosis.
- Symptoms did not improve after conservative treatment measures (exercise, pain relievers, physical therapy).
- Treatment required is at only one level.

OSTEOPATHIC MANIPULATIVE TREATMENT (OMT)

OSTEOPATHIC MANIPULATIVE TREATMENT (OMT)

What is Osteopathic Manipulative Treatment (OMT)?

- OMT is the therapeutic application of manually guided forces by an osteopathic physician to improve physiologic function and/or support homeostasis that has been altered by somatic dysfunction.
- OMT is a distinct, hands-on procedure used by physicians that aims to optimize a patient's health and function.
- OMT is used to treat many forms of bodily dysfunction including pain, discomfort and limited range of motion caused by illness or injury.

OSTEOPATHIC MANIPULATIVE TREATMENT (OMT)

What is the goal with OMT?

- To remove the barriers contributing to bodily dysfunction in order to achieve wellness.
- OMT is appropriately provided by a doctor of osteopathic medicine (DO), or by a doctor of medicine (MD) who has been trained in osteopathic manipulative treatment.

OSTEOPATHIC MANIPULATIVE TREATMENT (OMT)

OMT is currently covered by OHCA.

OHCA seeks to increase the coverage for OMT services for adults from 2 per month to 4 per month with a Prior Authorization (PA) override.

OMT PA OVERRIDE CRITERIA

Prior authorization requests for additional visits must include all the following:

- Information that supports the medical necessity for the additional visit(s); and
- Detailed description of the ailment(s) and/or issue(s) that necessitate additional visit(s); and
- Documentation of all OMT services previously provided for that month; and
- Information about why necessary services cannot be provided within the regular benefit allowed.

OKLAHOMA
Health Care Authority

GET IN TOUCH

4345 N. Lincoln Blvd.
Oklahoma City, OK 73105

oklahoma.gov/ohca
mysoonercare.org

Agency: 405-522-7300
Helpline: 800-987-7767

SOONERSELECT QUALITY STRATEGY

INTRODUCTION AND OVERVIEW

INTRODUCTIONS

- Chris Radley, Chief Quality Officer
- KFMC Health Improvement Partners

WHY WE ARE HERE

- Comprehensive Quality Strategy (CQS)
- SoonerSelect Quality Strategy (QS)
  - Update to the Comprehensive Quality Strategy
  - Transition from fee-for-service (FFS) to value-based payments
  - Required by CMS similar delivery models
  - Evaluation and monitoring of contracted entities (CEs)
  - Routinely updated every 3 years

MEDICAID PROGRAM GOALS

- Improve health outcomes for Medicaid members and the State as a whole
- Ensure budget predictability through shared risk and accountability
- Ensure access to care, quality measures, and member satisfaction
- Ensure efficient and cost-effective administrative systems and structures
- Ensure a sustainable delivery system that is a provider-led effort and that is operated and managed by providers to the maximum extent possible

PROGRAMS

- SoonerSelect Medical
  - Children
  - Pregnant women
  - Newborns
  - Parents and caretaker relatives
  - Expansion population
- Children's Specialty Plan
  - Children in foster care
  - Former foster care children
  - Juvenile justice-involved children
  - Children receiving adoption assistance
- Dental
  - All of the above

QUALITY STRATEGY DEVELOPMENT

QUALITY STRATEGY DEVELOPMENT

- Leaders from the quality department
- KFMC Health Improvement Partners
- Best practices from other states
- Regulations

QUALITY STRATEGY DEVELOPMENT

- Stakeholder feedback-CQS
  - Member Advisory Task Force (MATF)
  - Tribal consultation
  - SoonerCare providers
  - Other state agencies
  - Member town hall
  - Provider town hall
- Stakeholder feedback-SoonerSelect QS
  - Tribal consultation
  - Medical Advisory Council
  - MATF
  - State Department of Health
- OHCA Board review
- Posted on OHCA's website for public comment

CONTRACTORS

CONTRACTOR SELECTION

- Quarter 4, 2022: Requests for proposals opened
  - SoonerSelect Medical Program
  - SoonerSelect Children's Specialty Program
  - SoonerSelect Dental Program
- Contracts awarded in 2023
- Contractors with strong Oklahoma experience receive preference

CONTRACTOR REQUIREMENTS

- Accredited or in the process of accreditation
- Oklahoma office
- Key staff members in Oklahoma
- Contract with at least one local Oklahoma provider organization

QUALITY ASSESSMENT

QUALITY ASSESSMENT

- Healthcare Effectiveness Data and Information Set (HEDIS®) quality metrics
- CMS Adult Core Set
- CMS Child Core Set
- Consumer Assessment of Healthcare Providers and Systems (CAHPS) measures
- State-specified measures

HEDIS MEASURES

- Effectiveness of care
  - Breast cancer screening
  - Cervical cancer screening
  - Controlling high blood pressure
  - Comprehensive diabetes care
  - Antidepressant medication management
- Access and availability of care
  - Annual dental visit
  - Prenatal and postpartum care
- Utilization
  - Acute hospital utilization
  - Emergency department utilization

CMS CORE SET MEASURES

- Primary care access and preventative care
  - Flu vaccination
  - Well-child visits
  - Lead screening in children
- Maternal and perinatal health
  - Contraceptive care
  - Postpartum care
- Care of acute and chronic conditions
  - Hemoglobin A1c control
  - Heart failure admission rate
- Behavioral health care
  - Screening for depression and follow-up plan
- Dental and oral health services (child core set)

PIPS

- Performance improvement projects
  - Designed to achieve sustained, significant improvement
    - Health outcomes
    - Enrollee satisfaction
  - Conducted annually
  - Physical and behavioral health
  - Dental health
  - Topics identified by CMS, OHCA or contractor

HEALTH EQUITY

- Collect data stratified by race, ethnicity and other relevant demographics
- Implement strategies to reduce identified disparities
- Provide enrollee information in manner and format easily understood and accessible to all members
- Health equity representatives
- Must achieve Health Equity Accreditation

NETWORK ADEQUACY

- Primary care (adult and pediatric)
- OB/GYN
- Specialists
- Behavioral health
- Hospital
- Pharmacy
- Indian Health
- Dental
- Telehealth

EXTERNAL QUALITY REVIEW

- Independent third-party reviewer
- Evaluate:
  - Timeliness
  - Quality outcomes
  - Accessibility of services
- Validate:
  - Performance improvement projects
  - Performance measures
  - Network adequacy
  - Compliance with federal requirements

BENEFITS OF SOONERSELECT FOR ENROLLEES

BENEFITS TO ENROLLEES

- Care management
- Future additional benefits

ENROLLEE RIGHTS

TRANSITIONS OF CARE

- 90-day continuity of care period
- Moving between contractors or care settings
- Upon SoonerSelect enrollment or transition out of SoonerSelect
- Continue existing services
- Continue using current providers
- Prior authorizations remain in place
- Policy in enrollee handbook and contractor website

GRIEVANCE AND APPEAL

- Right to appeal an adverse benefit determination
- Right to file a grievance at any time
- Filed by enrollee, provider or authorized representative
- Filed orally or in writing
- Instructions in enrollee handbook and contractor website

QUESTIONS

May MAC
Proposed Rules Amendment Summaries

These proposed EMERGENCY rules were presented at either the Jan. 3 or the Mar. 7, 2023, Tribal Consultation meeting and were subject to at least a 15-day public comment period.

The Agency is requesting the effective date to be immediately upon Governor's approval or July 1, 2023. The Governor will have until Aug. 12, 2023, to approve or disapprove each rule, upon the Agency's submission for gubernatorial review.

APA WF # 23-02 Insure Oklahoma Self-Funded/Self-Insured Plans — The proposed rules will update Insure Oklahoma policy to comply with Oklahoma Senate Bill 1323, which added language to Title 56 Oklahoma Statutes (O.S.) § 1010.1. The policy additions mirror the bill's language regarding self-funded/self-insured plans to address that qualified benefit plans may become a self-funded or self-insured benefit plan if certain criteria are met.

Budget Impact: Budget neutral

APA WF # 23-09 Copayment exemption for expansion adults — The Affordable Care Act (ACA) requires states to cover preventive services for expansion adults without any cost sharing. The proposed rules will update the list of services exempted from copayments to ensure the ACA requirement is reflected in the rule as well as exempt vaccine administration from cost sharing for all members eligible to incur a copay.

Budget Impact: The estimated budget impact, for SFY2023, will be an increase in the total amount of $81,123; with $8,122 in state share. The estimated budget impact, for SFY2024 will be an increase in the total amount of $81,123; with $8,112 in state share.

APA WF # 23-10 Doula Services — The proposed additions will implement doula services as a covered benefit to SoonerCare members. The policy additions will outline what a doula is and the specific services/requirements including but not limited to, certification requirements from one of the Agency-recognized organizations, a referral from a licensed medical provider (physician, physician's assistant (PA), obstetrician, certified nurse midwife), and be at least 18 years of age. Furthermore, policy will outline that members will have eight doula visits, including one for labor and delivery care. Finally, additions will state that reimbursement for doula services is outlined in the Oklahoma Medicaid State Plan.

Budget Impact: The estimated budget impact for SFY 2024 will be an increase in the total amount of $2,734,572; with $861,732 in state share. The estimated budget impact for SFY 2025 will be an increase in the total amount of $2,734,572; with $887,916 in state share.

APA WF # 23-11 Private Duty Nursing (PDN) Reimbursement and Overtime — The proposed revisions will add clarification regarding the reimbursement for Private Duty Nursing (PDN) services, including when overtime payment is appropriate. Further revisions will state that overtime is only available for nursing staff who are providing services to members with tracheostomies or who are medically dependent on a ventilator for life support at least six (6) hours per day. This excludes members who are on non-invasive C-PAP or Bi-PAP devices only.

Budget Impact: The estimated budget impact, for SFY2023, will be an increase in the total amount of $733,401; with $157,241 in state share. The estimated budget impact for SFY2024 will be an increase in the total amount of $4,368,349; with $1,420,150 in state share.

APA WF # 23-12 Enhanced Payment for Vocational & Day Services Provided in Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IIDs) — The proposed revisions will implement changes to comply with Oklahoma Senate Bill 1074 which authorizes the Oklahoma Health Care Authority (OHCA) to implement an enhanced payment program for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID) that offer vocational services or day program services or both. The purpose of the enhanced payment is to offset the costs incurred by ICFs/IID in these services as these services are currently funded by donations/charity. The enhanced payment will be in addition to all other reimbursement from the OHCA.

Budget Impact: The estimated budget impact for SFY 2023, will be an increase in the total amount of $2,414,603; with $782,392 in state share. The estimated budget impact for SFY 2024 will be an increase in the total amount of $7,243,810; with $2,347,175 in state share.

APA WF # 23-14 Audio-only Telecommunications Health Service Delivery — The proposed policy revisions allow for the audio-only telecommunications health service delivery for medically necessary covered primary care and other approved health services. Audio-only telecommunications delivery means healthcare services delivered through the use of audio-only technology, permitting real-time communication between a patient and the provider, for the purpose of diagnosis, consultation, or treatment, and does not include the use of facsimile or email nor the delivery of health care services that are customarily delivered by audio-only technology and customarily not billed as separate services by the provider, such as the sharing of laboratory results. The proposed rules include definitions and requirements for service provision and reimbursement.

Budget Impact: The estimated budget impact for SFY 2024, will be an increase in the total amount of $1,759,405; with $554,433 in state share. The estimated budget impact for SFY 2025 will be an increase in the total amount of $1,759,405; with $521,279 in state share.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 45. INSURE OKLAHOMA

SUBCHAPTER 5. INSURE OKLAHOMA QUALIFIED BENEFIT PLANS

317:45-5-1. Qualified Benefit Plan requirements

(a) Participating qualified benefit plans must offer, at a minimum, benefits that include:

(1) ~~hospital~~Hospital services;

(2) ~~physician~~Physician services;

(3) ~~clinical~~Clinical laboratory and radiology;

(4) ~~pharmacy~~Pharmacy;

(5) ~~office~~ visits;

(6) ~~well~~Well baby/well child exams;

(7) ~~age~~Age appropriate immunizations as required by law; and

(8) ~~emergency~~Emergency services as required by law.

(b) The benefit plan, if required, must be approved by the Oklahoma Insurance Department for participation in the Oklahoma market. All benefit plans must share in the cost of covered services and pharmacy products in addition to any negotiated discounts with network providers, pharmacies, or pharmaceutical manufacturers. If the benefit plan requires co-payments or deductibles, the co-payments or deductibles cannot exceed the limits described in this subsection.

(1) An annual in-network out-of-pocket maximum cannot exceed $3,000 per individual, excluding separate pharmacy deductibles.

(2) Office visits cannot require a co-payment exceeding $50 per visit.

(3) Annual in-network pharmacy deductibles cannot exceed $500 per individual.

(c) Qualified benefit plans will provide an EOB, an expense summary, or required documentation for paid and/or denied claims subject to member co-insurance or member deductible calculations. The required documentation must contain, at a minimum, the:

(1) ~~provider's~~Provider's name;

(2) ~~patient's~~Patient's name;

(3) ~~date(s)~~Date(s) of service;

(4) ~~code(s)~~Code(s) and/or description(s) indicating the service(s) rendered, the amount(s) paid or the denied status of the claim(s);

(5) ~~reason~~Reason code(s) and description(s) for any denied service(s);

(6) ~~amount~~Amount due and/or paid from the patient or responsible party; and

(7) ~~provider~~Provider network status (in-network or out-of-network provider).

(d) A qualified benefit plan that is participating in the Insure Oklahoma program on or before November 1, 2022 may become a self-funded or self-insured benefit plan if the following conditions are met:

(1) The qualified benefit plan has continuously participated in the premium assistance program without interruption up to the date it becomes a self-funded or self-insured health care plan;

(2) The self-funded or self-insured benefit plan continues to be recognized as a benefit plan by the Oklahoma Insurance Department; and

(3) The self-funded or self-insured benefit plan continues to cover all essential health benefits listed in (a) of this section in addition to all other health benefits that are required under applicable federal laws.

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

SUBCHAPTER 3. GENERAL PROVIDER POLICIES

PART 1. GENERAL SCOPE AND ADMINISTRATION

317:30-3-5. Assignment and cost sharing

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

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

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

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

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

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

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

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

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

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

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

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

(d) **Cost sharing/co-payment.** Section 1902(a)(14) of the Social Security Act permits states to

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

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

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

(B) Members in nursing facilities (NF) and intermediate care facilities for individuals with intellectual disabilities (ICF/IID).

(C) Home and Community-Based Services (HCBS) waiver members except for prescription drugs.

(D) American Indian and Alaska Native members, per Section 5006 of the American Recovery and Reinvestment Act of 2009 and as established in the federally-approved Oklahoma Medicaid State Plan.

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

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

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

(A) Family planning services. This includes all contraceptives and services rendered.

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

(C) Services furnished to pregnant women.

(D) Smoking and tobacco cessation counseling and products.

(E) Blood glucose testing supplies and insulin syringes.

(F) Medication-assisted treatment (MAT) drugs.

(G) Vaccine administration.

(H) Preventive services for expansion adults.

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

(A) Inpatient hospital stays.

(B) Outpatient hospital visits.

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

(D) Encounters with the following rendering providers:

(i) Physicians;

(ii) Advanced practice registered nurses;

(iii) Physician assistants;

(iv) Optometrists;

(v) Home health agencies;

(vi) Certified registered nurse anesthetists;

(vii) Anesthesiologist assistants;

(viii) Durable medical equipment providers; and

(ix) Outpatient behavioral health providers.

(E) Prescription drugs.

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

(4) Medicaid premiums and cost sharing incurred by all individuals in the Medicaid household may not exceed an aggregate limit of five percent (5%) of the family's income applied on a monthly basis, as specified by the agency.

(5) Providers will be required to refund any co-payment amounts the provider collected from the member in error and/or above the family's aggregate cost sharing maximum.

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 114. DOULA SERVICES

317:30-5-1215. General

(a) A doula or birth worker is a trained professional who provides emotional, physical, and informational support services during the prenatal, labor and delivery, and postpartum periods. Doulas are non-clinical and do not provide medical care. Services should not replace the services of other licensed and trained medical professionals including, but not limited to, physicians, physicians assistants, advanced practice registered nurses, and certified nurse midwives.
(b) All Title XIX, CHIP, expansion adult, and Soon-to-be-Sooners (STBS) members who are pregnant or within the postpartum period are eligible for doula services.
(c) Doula services are available for twelve (12) months postpartum, depending on the members continued SoonerCare eligibility.

317:30-5-1216. Eligible providers

(a) **Provider requirements.**
(1) Must be eighteen (18) years of age;
(2) Obtain and maintain a National Provider Identifier (NPI); and
(3) Use the taxonomy number required by the State.
(b) **Certifications.** Possess one of the following certifications:
(1) Birth doula;
(2) Postpartum doula;
(3) Full-spectrum doula;
(4) Community-based doula.
(b) **Certifying organization.** Be certified by one of the State's recognized certifying organizations found at www.oklahoma.gov/ohca/.

317:30-5-1217. General coverage

(a) **Covered benefits.**
(1) **Prenatal/postpartum visits.** There is a total of eight (8) visits allowed for the member. The doula must work with the member to determine how best to utilize the benefit to meet the needs of the member.
(2) **Labor and delivery.** There is one (1) visit allowed, regardless of the duration.
(b) **Visit requirements.**
(1) The minimum visit length is sixty (60) minutes.
(2) Visits must be face-to-face.
(A) Prenatal and postpartum visits may be conducted via telehealth.
(B) Labor and delivery services may not be conducted via telehealth.
(c) **Service locations.**
(1) **Prenatal and postpartum.**
(A) Doulas must coordinate directly with the member and their family to determine the most appropriate service location for prenatal and postpartum visits.
(B) Service locations may include the following:

(i) Member's place of residence;
(ii) Doula's office;
(iii) Physician's office;
(iv) Hospital; or
(v) In the community.

(2) **Labor and delivery services.** There is no coverage for home birth(s).

(d) **Referral requirements.** Doula services must be recommended by a physician or other licensed practitioner of the healing arts who is operating within the scope of their practice under State law.

(1) The following providers may recommend doula services:
(A) Obstetricians;
(B) Certified Nurse Midwifes;
(C) Physicians;
(D) Physician Assistants; or
(E) Certified Nurse Practitioners.

(2) The SoonerCare Referral Form must be completed and submitted, noting the recommendation for doula services.

(e) **Prior authorization (PA) requirements.**

(1) A PA is not required to access the standard doula benefit package.

(2) A PA may be submitted, for members with extenuating medical circumstances, if there is need for additional visits beyond the eight (8) prenatal/postpartum visits.

(f) **Medical records requirements.** The medical record must include, but is not limited to, the following:

(1) Date of service;
(2) Person(s) to whom services were rendered;
(3) Start and stop time for the service(s);
(4) Specific services performed by the doula on behalf of the member;
(5) Member/family response to the service;
(6) Any new needs identified during the service; and
(7) Original signature of the doula, including the credentials of the doula.

(g) **Auditing review**. All doula services are subject to post-payment reviews and audits by the OHCA.

(h) **Reimbursement.**

(1) All doula services, that are outlined in Part 114 of this Chapter, are reimbursed per the methodology established in the Oklahoma Medicaid State Plan.

(2) There are no allotted incentive payments.

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 62. PRIVATE DUTY NURSING

317:30-5-561. Private duty nursing (PDN) payment rates

(a) All PDN services, including overtime, are reimbursed per the methodology described in the Oklahoma Medicaid State Plan.

(b) Overtime payment for PDN services is only available for nursing staff who are providing services to members with tracheostomies or who are medically dependent on a ventilator for life support at least six (6) hours per day. This excludes members who are on non-invasive C-PAP or Bi-PAP devices only.

(c) In accordance with the Department of Fair Labor Standards Act, a worker must receive overtime pay for every hour that is worked over forty (40) hours in a workweek. A workweek is defined as any set seven (7) day period.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY

CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 9. LONG-TERM CARE FACILITIES

317:30-5-136.2 Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID) Enhanced Payment Program

(a) **Overview.** This program provides enhanced payment for private ICFs/IID that provide vocational services or day program services or both. The purpose of the enhanced payment is to offset the costs incurred by ICFs/IID in the provision of vocational services or day program services or both. Residents who qualify for the enhanced program cannot receive the same services or reimbursement under another program.

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

"Day program services" means a life enrichment program that is conducted in a dedicated service location. The organized scheduled programming will vary but must meet the specific program qualifications for participation. Day services programs provide diverse opportunities for residents to participate in the broader community based on the resident's specific care plan.

"Direct costs" means the costs for activities or items associated with day services and/or vocational services programs. These items include salaries and wages of activities staff, day services and vocational staff, and job coaches.

"Other costs" means overhead costs attributable to the provision of day and vocational services. For example, rent, utilities, etc., not already paid for by Medicaid.

"Quality Review Committee" means a committee responsible for the oversight of monitoring and analyzing the accessibility and appropriateness of services being delivered.

"Vocational services" means the provision of paid employment in a structured vocational training program for residents outside of the resident's home. The type of work will vary but each provider must meet the specific program qualifications for participation. Vocational service programs provide pre-vocational services training, that prepare the residents for employment in a structured educational program. These programs will utilize either a certified job coach or a designated staff, to assist a resident eighteen (18) years and older, in achieving gainful employment. Other achievements may include, sheltered employment, ongoing employment support, job skills training and/or workshop experience in the community.

(c) **Care criteria.** Facilities will comply with the following care criteria to receive the enhanced payment:

(1) **Vocational services.** Facilities will provide twenty (20) hours of vocational services to at least forty percent (40%) of their residents each week. Residents must participate at least nine (9) out of twelve (12) weeks.

(2) **Day services.** Facilities will provide twenty (20) hours of day services to at least sixty percent (60%) of the facility's residents who do not participate in the facility's vocational program. Residents must participate at least nine (9) out of twelve (12) weeks.

(d) **Performance Review.** Performance reviews will be completed quarterly to ensure the integrity and accountability of the vocational and/or day treatment services provided. Facilities shall provide documentation as requested and directed by the Oklahoma Health Care Authority (OHCA) within fifteen (15) business days of request. Program payments will be withheld from facilities that fail to meet performance review standards.

(e) **Appeals.** Facilities can file an appeal related to their performance review with the Quality Review Committee and in accordance with the grievance procedures found at Oklahoma Administrative Code (OAC) 317:2-1-2 and 317:2-1-17.

(f) **Reimbursement methodology and payment.** Reimbursement and payment for the ICF/IID Enhanced Payment Program are provided in accordance with the Oklahoma Medicaid State Plan.

(g) **Cost audit.** Each facility will be audited annually as part of the annual cost report reviews to ensure only allowable costs prescribed by Medicare/Medicaid cost reporting principles are reported. As part of the annual audit, OHCA will ensure that there are no duplicative costs attributable to base rate and the enhanced payments. Payments will be recouped from facilities that report unallowable costs. Additional audits can be conducted anytime at the discretion of the OHCA.

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

SUBCHAPTER 3. GENERAL PROVIDER POLICIES

PART 1. GENERAL SCOPE AND ADMINISTRATION

317:30-3-27. Telehealth

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

(1)**"Remote patient monitoring"** means the use of digital technologies to collect medical and other forms of health data (e.g., vital signs, weight, blood pressure, blood sugar) from individuals in one (1) location and electronically transmit that information securely to health care providers in a different location for assessment and recommendations.

(2)"**School-based services"** means medically necessary health-related and rehabilitative services that are provided by a qualified school provider to a student under the age of twenty-one (21), pursuant to an Individualized Education Program (IEP), in accordance with the Individuals with Disabilities Education Act. See Oklahoma Administrative Code (OAC) 317:30-5-1020.

(3)**"Store and forward technologies"** means the transmission of a patient's medical information from an originating site to the health care provider at the distant site; provided, photographs visualized by a telecommunications system shall be specific to the patient's medical condition and adequate for furnishing or confirming a diagnosis or treatment plan. Store and forward technologies shall not include consultations provided by telephone audio-only communication, electronic mail, text message, instant messaging conversation, website questionnaire, nonsecure video conference, or facsimile transmission.

(4)**"Telehealth"** means the practice of health care delivery, diagnosis, consultation, evaluation and treatment, transfer of medical data or exchange of medical education information by means of a two-way, real-time interactive communication, not to exclude store and forward technologies, between a patient and a ~~health care~~healthcare provider with access to and reviewing the patient's relevant clinical information prior to the telemedicine visit. Telehealth shall not include consultations provided by telephone audio-only communication, electronic mail, text message, instant messaging conversation, website questionnaire, nonsecure video conference, or facsimile transmission. For audio-only health service delivery, see OAC 317:30-3-27.1.

(5)**"Telehealth medical service"** means, for the purpose of the notification requirements of OAC 317:30-3-27(d)(2), telehealth services that expressly do not include physical therapy, occupational therapy, and/or speech and hearing services.

(b) **Applicability and scope.** The purpose of this Section is to implement telehealth policy that improves access to ~~health care~~healthcare services, while complying with all applicable state and federal laws and regulations. Telehealth services are not an expansion of SoonerCare-covered services, but an option for the delivery of certain covered services. However, if there are technological difficulties in performing an objective, thorough medical assessment, or problems in the member's understanding of telehealth, hands-on-assessment and/or in-person care must be provided for the member. Any service delivered using telehealth technology must be appropriate for telehealth delivery and be of the same quality and otherwise on par with the same service delivered in person. A telehealth encounter must maintain the confidentiality and security of

protected health information in accordance with applicable state and federal law, including, but not limited to, 42 Code of Federal Regulations (CFR) Part 2, 45 CFR Parts 160 and 164, and 43A Oklahoma Statutes (O.S.) § 1-109. For purposes of SoonerCare reimbursement, telehealth is the use of interactive audio, video, or other electronic media for the purpose of diagnosis, consultation, or treatment that occurs in real-time and when the member is actively participating during the transmission.

(c) **Requirements.** The following requirements apply to all services rendered via telehealth.

(1) Interactive audio and video telecommunications must be used, permitting encrypted, real-time communication between the physician or practitioner and the SoonerCare member. The telecommunication service must be secure and adequate to protect the confidentiality and integrity of the telehealth information transmitted. As a condition of payment the member must actively participate in the telehealth visit.

(2) The telehealth equipment and transmission speed and image must be technically sufficient to support the service billed. If a peripheral diagnostic scope is required to assess the member, it must provide adequate resolution or audio quality for decision making. Staff involved in the telehealth visit need to be trained in the use of the telehealth equipment and competent in its operation.

(3) The medical or behavioral health related service must be provided at an appropriate site for the delivery of telehealth services. An appropriate telehealth site is one that has the proper security measures in place; the appropriate administrative, physical, and technical safeguards should be in place that ensures the confidentiality, integrity, and security of electronic protected health information. The location of the room for the encounter at both ends should ensure comfort, privacy, and confidentiality. Both visual and audio privacy are important, and the placement and selection of the rooms should consider this. Appropriate telehealth equipment and networks must be used considering factors such as appropriate screen size, resolution, and security. Providers and/or members may provide or receive telehealth services outside of Oklahoma when medically necessary; however, prior authorization may be required, per OAC 317:30-3-89 through 317:30-3-91.

(4) The provider must be contracted with SoonerCare and appropriately licensed or certified, in good standing. Services that are provided must be within the scope of the practitioner's license or certification. If the provider is outside of Oklahoma, the provider must comply with all laws and regulations of the provider's location, including health care and telehealth requirements.

(5) If the member is a minor, the provider must obtain the prior written consent of the member's parent or legal guardian to provide services via telehealth, that includes, at a minimum, the name of the provider; the provider's permanent business office address and telephone number; an explanation of the services to be provided, including the type, frequency, and duration of services. Written consent must be obtained annually, or whenever there is a change in the information in the written consent form, as set forth above. The parent or legal guardian need not attend the telehealth session unless attendance is therapeutically appropriate. The requirements of subsection OAC 317:30-3-27(c)(5), however, do not apply to telehealth services provided in a primary or secondary school setting.

(6) If the member is a minor, the telehealth provider shall notify the parent or legal guardian that a telehealth service was performed on the minor through electronic communication whether a text message or email.

(7) The member retains the right to withdraw at any time.

(8) All telehealth activities must comply with Oklahoma Health Care Authority (OHCA)

policy, and all other applicable State and Federal laws and regulations, including, but not limited to, 59 O.S. § 478.1.

(9) The member has access to all transmitted medical information, with the exception of live interactive video as there is often no stored data in such encounters.

(10) There will be no dissemination of any member images or information to other entities without written consent from the member or member's parent or legal guardian, if the member is a minor.

(11) A telehealth service is subject to the same SoonerCare program restrictions, limitations, and coverage which exist for the service when not provided through telehealth; provided, however, that only certain telehealth codes are reimbursable by SoonerCare. For a list of the SoonerCare-reimbursable telehealth codes, refer to the OHCA's Behavioral Health Telehealth Services and Medical Telehealth Services, available on OHCA's website, www.okhca.org.

(12) Where there are established service limitations, the use of telehealth to deliver those services will count towards meeting those noted limitations. Service limitations may be set forth by Medicaid and/or other ~~third party~~third-party payers.

(d) **Additional requirements specific to telehealth services in a school setting.** In order for OHCA to reimburse medically necessary telehealth services provided to SoonerCare members in a primary or secondary school setting, all of the requirements in (c) above must be met, with the exception of (c)(5), as well as all of the requirements shown below, as applicable.

(1) **Consent requirements.** Advance parent or legal guardian consent for telehealth services must be obtained for minors, in accordance with 25 O.S. §§ 2004 through 2005. Additional consent requirements shall apply to school-based services provided pursuant to an IEP, per OAC 317:30-5-1020.

(2) **Notification requirements.** For telehealth medical services provided in a primary or secondary school setting, the telehealth practitioner must provide a summary of the service, including, but not limited to, information regarding the exam findings, prescribed or administered medications, and patient instructions, to:

(A) The SoonerCare member, if he or she is an adult, or the member's parent or legal guardian, if the member is a minor; or

(B) The SoonerCare member's primary care provider, if requested by the member or the member's parent or legal guardian.

(3) **Requirements specific to physical therapy, occupational therapy, and/or speech and hearing services.** Even though physical therapy, occupational therapy, and/or speech and hearing services are not subject to the notification requirements of OAC 317:30-3-27(d)(2), said services must still comply with all other State and Federal Medicaid requirements, in order to be reimbursable by Medicaid. Accordingly, for those physical therapy, occupational therapy, and/or speech and hearing services that are provided in a primary or secondary school setting, but that are not school-based services (i.e., not provided pursuant to an IEP), providers must adhere to all state and federal requirements relating to prior authorization and prescription or referral, including, but not limited to, 42 C.F.R. § 440.110, OAC 317:30-5-291, 317:30-5-296, and 317:30-5-676.

(e) **Reimbursement.**

(1) Health care services delivered by telehealth such as Remote Patient Monitoring, Store and Forward, or any other telehealth technology, must be compensable by OHCA in order to be reimbursed.

(2) Services provided by telehealth must be billed with the appropriate modifier.

(3) If the technical component of an X-ray, ultrasound or electrocardiogram is performed

during a telehealth transmission, the technical component can be billed by the provider that provided that service. The professional component of the procedure and the appropriate visit code should be billed by the provider that rendered that service.

(4) The cost of telehealth equipment and transmission is not reimbursable by SoonerCare.

(5) For reimbursement of audio-only health service delivery, see OAC 317:30-3-27.1.

(f) **Documentation.**

(1) Documentation must be maintained by the rendering provider to substantiate the services rendered.

(2) Documentation must indicate the services were rendered via telehealth, and the location of the services.

(3) All other SoonerCare documentation guidelines apply to the services rendered via telehealth. Examples include but are not limited to:

(A) Chart notes;

(B) Start and stop times;

(C) Service provider's credentials; and

(D) Provider's signature.

(g) **Final authority.** The OHCA has discretion and the final authority to approve or deny any telehealth services based on agency and/or SoonerCare members' needs.

317:30-3-27.1 Audio-only health service delivery

(a) **Definition.** "Audio-only health service delivery" means the delivery of healthcare services through the use of audio-only telecommunications, permitting real-time communication between a patient and the provider, for the purpose of diagnosis, consultation, or treatment, and does not include the use of facsimile or email nor the delivery of health care services that are customarily delivered by audio-only telecommunications and customarily not billed as separate services by the provider, such as the sharing of laboratory results. This definition includes health services delivered via audio-only when audio-visual is unavailable or when a member chooses audio-only.

(b) **Purpose.** Health services delivered via audio-only telecommunications are intended to improve access to healthcare services, while complying with all applicable state and federal laws and regulations. Audio-only telecommunications is an option for the delivery of certain covered services and is not an expansion of SoonerCare-covered services.

(c) **Applicability and scope.**

(1) Health service delivery via audio-only telecommunications is applicable to medically necessary covered primary care and other approved health services. Refer to the Oklahoma Health Care Authority (OHCA) website, www.okhca.org, for a complete list of the SoonerCare-reimbursable audio-only health services codes.

(2) If there are technological difficulties in performing an objective, thorough medical assessment through audio-only telecommunications, then hands-on-assessment and/or in-person care must be provided for the member. Any service delivered using audio-only telecommunications must be appropriate for audio-only delivery and be of the same quality and otherwise on par with the same service delivered in person.

(3) An audio-only health service delivery contact must maintain the confidentiality and security of protected health information in accordance with applicable state and federal law, including, but not limited to, 42 Code of Federal Regulations (CFR) Part 2, 45 CFR Parts 160 and 164, and 43A Oklahoma Statutes (O.S.) § 1-109.

(4) For purposes of SoonerCare reimbursement, audio-only health service delivery is the use of interactive audio technology for the purpose of diagnosis, consultation, or treatment that

occurs in real-time and when the member is actively participating during the transmission.

(d) **Requirements.** The following requirements apply to all services rendered via audio-only health service delivery:

(1) Interactive audio telecommunications must be used, permitting real-time communication between the physician or practitioner and the SoonerCare member. As a condition of payment, the member must actively participate in the audio-only telecommunications health service visit.

(2) The audio telecommunications technology used to deliver the services must meet the standards required by state and federal laws governing the privacy and security of protected health information (PHI).

(3) The provider must be contracted with SoonerCare and appropriately licensed or certified, in good standing. Services that are provided must be within the scope of the practitioner's license or certification.

(4) Either the provider or the member must be located at the freestanding clinic that is providing services pursuant to 42 CFR § 440.90 and Oklahoma Administrative Code (OAC) 317:30-5-575.

(5) If the member is a minor, the provider must obtain the prior written consent of the member's parent or legal guardian to provide services via audio-only telecommunications, that includes, at a minimum, the name of the provider; the provider's permanent business office address and telephone number; an explanation of the services to be provided, including the type, frequency, and duration of services. Written consent must be obtained annually, or whenever there is a change in the information in the written consent form, as set forth above. The parent or legal guardian need not attend the audio-only telecommunications session unless attendance is therapeutically appropriate.

(6) The member retains the right to withdraw at any time.

(7) All audio-only health service delivery activities must comply with Oklahoma Health Care Authority (OHCA) policy, and all other applicable State and Federal laws and regulations.

(8) A health service delivered via audio-only telecommunications is subject to the same SoonerCare program restrictions, limitations, and coverage which exist for the service when not delivered via audio-only telecommunications.

(9) A health service delivered by audio-only telecommunications must be designated for reimbursement by SoonerCare.

(10) Where there are established service limitations, the use of audio-only telecommunications to deliver those services will count towards meeting those noted limitations. Service limitations may be set forth by Medicaid and/or other third-party payers.

(d) **Reimbursement.**

(1) Health care services delivered via audio-only telecommunications must be compensable by OHCA in order to be reimbursed.

(2) Services delivered via audio-only telecommunications must be billed with the appropriate modifier.

(3) Health care services delivered via audio-only telecommunications are reimbursed pursuant to the fee-for-service fee schedule approved under the Oklahoma Medicaid State Plan.

(4) An RHC and an FQHC shall be reimbursed for services delivered via audio-only telecommunications at the fee-for-service rate per the fee-for-service fee schedule.

(5) An I/T/U shall be reimbursed for services delivered via audio-only telecommunications at the Office of Management and Budget (OMB) all-inclusive rate.

(6) The cost of audio-only telecommunication equipment and other service related costs are

not reimbursable by SoonerCare.

(e) **Documentation.**

(1) Documentation must be maintained by the rendering provider to substantiate the services rendered.

(2) Documentation must indicate the services were rendered via audio-only telecommunications, and the location of the services.

(3) All other SoonerCare documentation guidelines apply to the services rendered via audio-only telecommunications. Examples include but are not limited to:

(A) Chart notes;

(B) Start and stop times;

(C) Service provider's credentials; and

(D) Provider's signature.

(f) **Final authority.** The OHCA has discretion and the final authority to approve or deny any services delivered via audio-only telecommunications based on agency and/or SoonerCare members' needs.

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 21. OUTPATIENT BEHAVIORAL HEALTH AGENCY SERVICES

317:30-5-241.2. Psychotherapy

(a) **Individual psychotherapy.**

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

(2) **Interactive complexity**. Psychotherapy is considered to involve "interactive complexity" when there are communication factors during a visit that complicate delivery of the psychotherapy by the qualified practitioner. Sessions typically involve members who have other individuals legally responsible for their care (i.e., minors or adults with guardians); members who request others to be involved in their care during the session (i.e., adults accompanied by one or more participating family members or interpreter or language translator); or members that require involvement of other third parties (i.e., child welfare, juvenile justice, parole/probation officers, schools, etc.). Psychotherapy should only be reported as involving interactive complexity when at least one (1) of the following communication factors is present:

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

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

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

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

(3) **Qualified practitioners**. Psychotherapy must be provided by an ~~LBHP~~Licensed Behavioral Health Practitioner (LBHP) or licensure candidate in a setting that protects and assures confidentiality.

(4) **Documentation requirements.** Providers must comply with documentation requirements in ~~OAC~~Oklahoma Administrative Code (OAC) 317:30-5-248.

(5) **Limitations**. A maximum of four (4) units per day per member is compensable. A cumulative maximum of eight (8) units of individual psychotherapy and family psychotherapy per week per member is compensable. Except for psychotherapy involving interactive complexity as described in this Section, only the member and the qualified practitioner should be present during the session. Individual psychotherapy is not reimbursable for a child younger than the age of thirty-six (36) months. Limitations exclude outpatient behavioral health services provided in a foster care setting.

(b) **Group psychotherapy**.

(1) **Definition**. Group psychotherapy is a method of treating behavioral disorders using the face-to-face psychotherapeutic interaction between the qualified practitioner and two (2) or more individuals to promote positive emotional or behavioral change. The focus of the group must be directly related to the goals and objectives in the individual member's current service plan. This service does not include social or daily living skills development as described under behavioral health rehabilitation services.

(2) **Group sizes**. Group psychotherapy is limited to a total of eight (8) adult [eighteen (18) and over] individuals except when the individuals are residents of an ~~ICF/IID~~Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) where the maximum group size is six (6). For all children under the age of eighteen (18), the total group size is limited to six (6).

(3) **Multi-family and conjoint family therapy**. Sessions are limited to a maximum of eight (8) families/units. Billing is allowed once per family unit, though units may be divided amongst family members.

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

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

(6) **Limitations**. A maximum of six (6) units per day per member is compensable, not to exceed twelve (12) units per week. Group psychotherapy is not reimbursable for a child younger than the age of thirty-six (36) months. Limitations exclude outpatient behavioral health services provided in a foster care setting.

(c) **Family psychotherapy**.

(1) **Definition**. Family psychotherapy is a face-to-face psychotherapeutic interaction between a qualified practitioner and the member's family, guardian, and/or support system. It is

typically inclusive of the identified member but may be performed if indicated without the member's presence. When the member is an adult, his/her permission must be obtained in writing. Family psychotherapy must be provided for the direct benefit of the SoonerCare member to assist him/her in achieving his/her established treatment goals and objectives and it must take place in a confidential setting. This service may include the evidence-based practice "Family Psychoeducation". For children under the age of thirty-six (36) months, family psychotherapy is focused on the infant/young child and parent (or primary caregiver) interactions and the relationship needs of the infant/young child.

(2) **Qualified practitioners**. Family psychotherapy must be provided by an LBHP or licensure candidate.

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

(4) **Limitations**. A maximum of four (4) units per day per member/family unit is compensable. A cumulative maximum of eight (8) units of individual psychotherapy and family psychotherapy per week per member is compensable. Family psychotherapy for a child younger than thirty-six (36) months must be medically necessary and meet established child [zero (0) through thirty-six (36) months of age] criteria as set forth in the Prior Authorization Manual. Limitations exclude outpatient behavioral health services provided in a foster care setting.

PART 35. RURAL HEALTH CLINICS

317:30-5-354. Definitions

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

"**APRN**" means advanced practice registered nurse.

"**C.F.R.**" means the U.S. Code of Federal Regulations.

"**CLIA**" means the Clinical Laboratory Improvement Amendments.

"**CMS**" means the Centers for Medicare and Medicaid Services.

"**CNM**" means certified nurse midwife.

"Core services" means outpatient services that may be covered when furnished to a patient at the rural health clinic (RHC) or other location, including the patient's place of residence.

"**CP"** means clinical psychologist.

"**CPT**" means current procedural terminology.

"**CSW**" means clinical social worker.

"EPSDT" means the Early and Periodic Screening, Diagnostic and Treatment program for members under twenty-one (21)**.**

"FFS" means the current OHCA's fee-for-service reimbursement rate.

"**HCPCS**" means Healthcare Common Procedure Coding System.

"**OAC**" means the Oklahoma Administrative Code.

"**OHCA**" means the Oklahoma Health Care Authority.

"Other ambulatory services" means other outpatient health services covered under the Oklahoma Medicaid State Plan other than core services.

"**PA**" means physician assistant.

"Physician" means:

(A) A doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which the function is performed or who is a licensed physician

employed by the Public Health Service;

(B) Within limitations as to the specific services furnished, a doctor of dentistry or dental, a doctor of optometry, or a doctor of podiatry.

"Physicians' services" means professional services that are performed by a physician at the RHC (or are performed away from the Center, excluding inpatient hospital services) whose agreement with the RHC provides that he or she will be paid by the RHC for such services.

"PPS" means prospective payment system all-inclusive per visit rate method specified in the Oklahoma Medicaid State Plan.

"**RHC**" means rural health clinic.

"Visit" means a face-to-face encounter between a clinic patient and a physician, ~~PA, APRN, CNM, CP or CSW PA~~Physician Assistant (PA), ~~APRN~~Advanced Practice Registered Nurse (APRN), ~~CNM~~Certified Nurse Midwife (CMN), ~~CP~~Clinical Psychologist (CP), or ~~CSW~~Clinical Social Worker whose services are reimbursed under the RHC PPS payment method. Encounters with more than one (1) health care professional and multiple encounters with the same health care professional that take place on the same day and at a single location constitute a single visit, except when the patient, after the first encounter, suffers illness or injury requiring additional diagnosis or treatment. Services delivered via audio-only telecommunications and reimbursed pursuant to the fee-for-service (FFS) fee schedule do not constitute a visit and/or an encounter.

317:30-5-355.2. Covered services

The ~~RHC~~Rural Health Center benefit package, as described in 42 C.F.R. § 440.20, consists of RHC services and other ambulatory services.

(1) **RHC services.** RHC services are covered when medically necessary and furnished at the clinic or other outpatient setting, including the member's place of residence, or delivered via telehealth or via audio-only telecommunications pursuant to Oklahoma Administrative Code (OAC) 317:30-3-27 and OAC 317:30-3-27.1.

(A) **Core services.** RHC "core" services include, but are not limited to:

(i) Services furnished by a physician, ~~PA~~Physician Assistant (PA), ~~APRN~~Advanced Practice Registered Nurse (APRN), ~~CNM~~Certified Nurse Midwife (CMN), ~~CP~~Clinical Psychologist (CP), or ~~CSW~~Clinical Social Worker.

(ii) Services and supplies incident to services provided by a physician, PA, APRN, CNM, CP, or CSW are covered in accordance with 42 C.F.R §§ 405.2413 and 405.2415, if the service or supply is:

(I) Furnished in accordance with State law;

(II) A type commonly furnished in physicians' offices;

(III) A type commonly rendered either without charge or included in the RHC's bill;

(IV) Furnished as an incidental, although integral, part of a physician's professional services, PA, APRN, CNM, CP or CSW; or

(V) Furnished under the direct supervision of a contracted physician PA, APRN, or CNM; and

(VI) Drugs and biologicals which cannot be self-administered or are specifically covered by Medicare law, are included within the scope of RHC services. Drugs and biologicals commonly used in life saving procedures, such as analgesics, anesthetics (local), antibiotics, anticonvulsants, antidotes and emetics, serums and toxoids are not billed separately.

(iii) Visiting nurse services to the homebound are covered if:

(I) The RHC is located in an area in which the Secretary of Health and Human Services has determined there is a shortage of home health agencies;
(II) The services are rendered to members who are homebound;
(III) The member is furnished nursing care on a part-time or intermittent basis by a registered nurse, licensed practical nurse, or licensed vocational nurse who is employed by or receives compensation for the services from the RHC; and
(IV) The services are furnished under a written plan of treatment as required by 42 C.F.R § 405.2416.

(iv) Certain virtual communication services.

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

(i) Prenatal and postpartum care;
(ii) Screening examination under the EPSDT program for members under twenty-one (21);
(iii) Family planning services; and
(iv) Medically necessary screening mammography and follow-up mammograms.

(C) **Off-site services.** RHC services provided off-site of the clinic are covered if the RHC has a compensation arrangement with the RHC practitioner. SoonerCare reimbursement is made to the RHC and the RHC practitioner receives his or her compensation from the RHC. The RHC must have a written contract with the physician and other RHC "core" practitioners that specifically identify how the RHC services provided off-site are to be billed to SoonerCare. It is expected that services provided in off-site settings are, in most cases, temporary and intermittent, i.e., when the member cannot come to the clinic due to health reasons.

(2) **Other ambulatory services.** Other ambulatory services that may be provided by an RHC include non-primary care services covered by the Oklahoma Medicaid State Plan but are not included in the RHC's core services. These services are separately billable and may be provided by the RHC if the RHC meets the same standards as other contracted providers of those services.

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

(i) Dental services for members under the age of twenty-one (21) provided by other than a licensed dentist;
(ii) Optometric services provided by other than a licensed optometrist;
(iii) Laboratory tests performed in the RHC lab, including the lab tests required for RHC certification;
(I) Chemical examinations of urine by stick or tablet method or both (including urine ketones);
(II) Hemoglobin or hematocrit;
(III) Blood glucose;
(IV) Examination of stool specimens for occult blood;
(V) Pregnancy tests; and
(VI) Primary culturing for transmittal to a certified laboratory.
(iv) Technical component of diagnostic tests such as x-rays and EKGs (interpretation of the test provided by the RHC physician is included in the encounter rate);

(v) Durable medical equipment;
(vi) Transportation by ambulance;
(vii) Prescribed drugs;
(viii) Prosthetic devices (other than dental) which replace all or part of an internal body organ (including colostomy bags) and supplies directly related to colostomy care and the replacement of such devices;
(ix) Specialized laboratory services furnished away from the clinic;
(x) Inpatient services;
(xi) Outpatient hospital services; and
(xii) Applied behavior analysis (ABA); and
(xiii) Diabetes self-management education and support (DSMES) services.

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

PART 64. CLINIC SERVICES

317:30-5-575. General information

(a) **Clinic services.** Clinic services means preventive, diagnostic, therapeutic, rehabilitative, or palliative services that are furnished by a facility that is not part of a hospital but is organized and operated to provide medical care to outpatients. The term includes the following services furnished to outpatients:

(1) Services furnished at the clinic by or under the direction of a physician or a dentist.

(2) Services furnished outside the clinic, by clinic personnel under the direction of a physician, to an eligible individual who does not reside in a permanent dwelling or does not have a fixed home or mailing address.

(3) Teleheath and audio-only health service delivery requires either the provider or the member to be located at the freestanding clinic that is providing services pursuant to 42 Code of Federal Regulations (CFR) § 440.90. Refer to section Oklahoma Administrative Code (OAC) 317:30-3-27 for telehealth policy and OAC 317:30-3-27.1 for audio-only telecommunication policy.

(b) **Prior authorization.** OHCA requires prior authorization for certain procedures to validate the medical need for the service.

(c) **Medical necessity.** Medical necessity requirements are listed at OAC 317:30-3-1(f).

PART 75. FEDERALLY QUALIFIED HEALTH CENTERS

317:30-5-664.3. ~~FQHC~~Federally Qualified Health Center (FQHC) encounters

(a) FQHC encounters that are billed to the ~~OHCA~~Oklahoma Health Care Authority (OHCA) must meet the definition in this Section and are limited to services covered by OHCA. Only encounters provided by an authorized health care professional listed in the approved FQHC State Plan pages within the scope of their licensure trigger a ~~PPS~~Prospective Payment System (PPS) encounter rate.

(b) An encounter is defined as a face-to-face contact between a health care professional and a member for the provision of defined services through a FQHC within a twenty-four (24) hour period ending at midnight, as documented in the member's medical record. Services delivered via audio-only telecommunications do not constitute an encounter.

(c) An FQHC may bill for one (1) medically necessary encounter per twenty-four (24) hour period

when the appropriate modifier is applied. Medical review will be required for additional visits for children. For information about multiple encounters, refer to ~~OAC~~Oklahoma Administrative Code (OAC) 317:30-5-664.4. Payment is limited to four (4) visits per member per month for adults. This limit may be exceeded if the SoonerCare Choice member has elected the FQHC as his/her/their Patient Centered Medical Home/Primary Care Provider.

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

(1) Medical;
(2) Diagnostic;
(3) Dental, medical and behavioral health screenings;
(4) Vision;
(5) Physical therapy;
(6) Occupational therapy;
(7) Podiatry;
(8) Behavioral health;
(9) Speech;
(10) Hearing;
(11) Medically necessary FQHC encounters with a registered nurse or licensed practical nurse and related medical supplies (other than drugs and biologicals) furnished on a part-time or intermittent basis to home-bound members (refer to OAC 317:30-5-661.3); and
(12) Any other medically necessary health services (i.e. optometry and podiatry) are also reimbursable as permitted within the FQHCs scope of services when medically reasonable and necessary for the diagnosis or treatment of illness or injury, and must meet all applicable coverage requirements.

(e) Services and supplies incident to the services of a physician, PA, APRN, CNM, CP and CSW are reimbursable within the encounter, as described in 42 C.F.R § 405.2413 and OAC 317:30-5-661.1.

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

317:30-5-664.10. Health Center reimbursement

(a) In accordance with Section 702 of the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000, reimbursement is provided for core services and other health services at a Health Center facility-specific Prospective Payment System (PPS) rate per visit (encounter) determined according to the methodology described in ~~OAC~~Oklahoma Administrative Code (OAC) 317:30-5-664.12.

(b) As claims/encounters are filed, reimbursement for SoonerCare Choice members is made for all medically necessary covered primary care and other approved health services at the PPS rate, except for services delivered via audio-only telecommunications which are reimbursed at the fee-for-service (FFS) rate pursuant to the FFS fee schedule.

(c) Primary and preventive behavioral health services rendered by health care professionals authorized in the ~~FQHC~~Federally Qualified Health Center (FQHC) approved state plan pages will be reimbursed at the PPS encounter rate, except for services delivered via audio-only telecommunications which are reimbursed at the FFS rate pursuant to the FFS fee schedule.

(d) Vision services provided by Optometrists within the scope of their licensure for non-dual eligible members and allowed under the Medicaid State Plan are reimbursed pursuant to the SoonerCare ~~fee-for-service~~FFS fee schedule.

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

317:30-5-1087. Terms and definitions

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

(1) **"American Indian/Alaska Native (AI/AN)"** means an individual of Native American descent who has or is eligible for a Certificate of Degree of Indian Blood (CDIB) card.

(2) **"Audio-only health service delivery"** means the delivery of healthcare services through the use of audio-only telecommunications, permitting real-time communication between a patient and the provider, for the purpose of diagnosis, consultation, or treatment, and does not include the use of facsimile or email nor the delivery of health care services that are customarily delivered by audio-only telecommunications and customarily not billed as separate services by the provider, such as the sharing of laboratory results. This definition includes health services delivered via audio-only when audio-visual is unavailable or when a member chooses audio-only.

~~(2)~~(3) **"Behavioral Health services"** means professional medical services for the treatment of a mental health and/or substance use disorder.

~~(3)~~(4) **"CFR"** means the Code of Federal Regulations.

~~(4)~~(5) **"CMS"** means the Centers for Medicare and Medicaid Services.

~~(5)~~(6) **"Encounter"** means a ~~face to face~~ contact between a health care professional and an IHS eligible SoonerCare member for the provision of medically necessary Title XIX or Title XXI covered services through an IHS or Tribal 638 facility or an urban Indian clinic within a ~~24 hour~~twenty-four (24) hour period ending at midnight, as documented in the patient's record.

~~(6)~~(7) **"Licensed Behavioral Health Professional (LBHP)"** means a licensed psychologist, licensed clinical social worker (LCSW), licensed marital and family therapist (LMFT), licensed professional counselor (LPC), licensed behavioral practitioner (LBP) or licensed alcohol and drug counselor (LADC).

~~(7)~~(8) **"OHCA"** means the Oklahoma Health Care Authority.

~~(8)~~(9) **"OMB rate"** means the Medicaid reimbursement rate negotiated between CMS and IHS. Inpatient and outpatient Medicaid reimbursement rates for I/T/Us are published annually in the Federal Register or Federal Register Notices. The outpatient rate is also known as the I/T/U encounter rate. The encounter rate is available only to I/T/U facilities that appear on the IHS maintained listing of IHS-operated and Indian health care facilities operating under a 638 agreement. It is the sole responsibility of the facility to petition IHS for placement on this list.

~~(9)~~(10) **"Physician"** means a doctor of medicine or osteopathy legally authorized to practice medicine and surgery or who is a licensed physician employed by the Federal Government in an IHS facility or who provides services in a 638 Tribal Facility.

~~(10)~~(11) **"State Administering Agency (SAA)"** is the Oklahoma Health Care Authority.

(12) **"Telehealth"** means the practice of health care delivery, diagnosis, consultation, evaluation and treatment, transfer of medical data or exchange of medical education information by means of a two-way, real-time interactive communication, not to exclude store and forward technologies, between a patient and a healthcare provider with access to and reviewing the patient's relevant clinical information prior to the telemedicine visit. Telehealth shall not include consultations provided by telephone audio-only communication, electronic

mail, text message, instant messaging conversation, website questionnaire, nonsecure video conference, or facsimile transmission.

~~(11)~~(13) **"638 Tribal Facility"** is a facility that is operated by a tribe or tribal organization and funded by Title I or Title III of the Indian Self Determination and Education Assistance Act (Public Law 93-638).

317:30-5-1098. ~~I/T/U~~Indian Health Services, Tribal Programs, and Urban Indian clinics (I/T/Us) outpatient encounters

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

(1) An I/T/U encounter means a face to face, ~~or~~a telehealth contact, or an audio-only telecommunications contact between a health care professional and an ~~IHS~~Indian Health Services (IHS) eligible SoonerCare member for the provision of medically necessary Title XIX or Title XXI covered services through an IHS or Tribal 638 facility or an urban Indian clinic within a ~~24-hour~~twenty-four (24) period ending at midnight, as documented in the patient's record.

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

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

(1) Medical;
(2) Diagnostic;
(3) Behavioral Health services [refer to OAC 317:30-5-1094];
(4) Dental, Medical and Mental Health Screenings;
(5) Vision;
(6) Physical Therapy;
(7) Occupational Therapy;
(8) Podiatry;
(9) Speech;
(10) Hearing;
(11) Visiting Nurse Service [refer to OAC 317:30-5-1093];
(12) Smoking and Tobacco Use Cessation Counseling;
(13) Other Title XIX or XXI services as allowed under OHCA's SoonerCare State Plan and OHCA Administrative Rules;
(14) Drugs or medication treatments provided during a clinic visit are part of the encounter rate. For example, a member has come into the clinic with high blood pressure and is treated at the clinic with a hypertensive drug or drug sample. Drug samples are included in the encounter rate. Prescription drugs are reimbursed pursuant to OAC 317:30-5-78(b)(4)(B).
(15) Encounters with a registered professional nurse or a licensed practical nurse and related medical supplies (other than drugs and biologicals) furnished on a part-time or intermittent basis to home-bound members; and
(16) I/T/U Multiple Outpatient Encounters.

(A) OHCA will cover one medically necessary outpatient medical encounter per member per day unless if due to an emergency, the same member returns on the same day for a

second visit with a different diagnosis. Then, a second encounter is allowed.

(B) OHCA will cover one dental encounter per member per day regardless of how many procedures are done or how many providers are seen unless if due to an emergency, the same member returns on the same day for a second visit and has a different diagnosis. Then, a second encounter is allowed.

(C) OHCA will cover one behavioral health professional outpatient encounter per member per day unless if due to an emergency, the same member returns on the same day for a second visit and has a different diagnosis. Then, a second encounter is allowed.

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

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

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

(1) Medical Services;

(2) Dental Services;

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

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

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

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

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