Oklahoma Health Care Authority
MEDICAL ADVISORY COMMITTEE
September 3, 2026
1:00 – 3:00 PM
Charles Ed McFall Board Room

AGENDA

Please access via zoom: https://www.zoomgov.com/webinar/register/WN_I0a9jbn-RAqU0CBpuPZxdg

Telephone: 1-669-254-5252 Webinar ID: 160 578 3296

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

II. Action Item: Approval of Minutes of July 30th, 2026: **Medical Advisory Committee Meeting**

III. Public Comments (2 minute limit)

IV. MAC Member Comments/Discussion

V. Proposed Rule Changes:Presentation, Discussion, and Vote: **Heather Cox, Deputy State Medicaid Director**

A. **APA WF #26-04 HR1 Reduced Retroactive Eligibility & 6-Month Redeterminations**
B. **APA WF #26-06 HR1 Work Requirements**
C. **APA WF #26-12 Obstetrical Unbundling**

VI. Medicaid Directors Update: **Melissa Miller, State Medicaid Director**

VII. Member Advisory Task Force - Report/Update - **Wanda Felty, Co-Chair to the MATF**

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

IX. Next MAC Meeting: **Chairman, Jason Rhynes, O.D.**

November 5, 2026

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

Oklahoma Health Care Authority
MEDICAL ADVISORY COMMITTEE
MINUTES of the July 9th, 2026, Meeting
4345 N. Lincoln Blvd., Oklahoma City, OK 73105

1. **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, Dr. David Evans, Ms. Wanda Felty, Dr. Arlen Foulks (Virtual) Dr. Terry Mills, Dr. Daniel Post, and Dr. Jason Rhynes providing a quorum.

Alternates present were:

Ex-officio members present:

***Delegates absent without an alternate were*:** Ms. Cizek, Mr. Coble, Mr. Smith, and Ms. Weedn

Ex-officio members not present:

2. **Approval of March 5th, 2026, Minutes**
Medical Advisory Committee
The motion to approve the minutes was by Dr. Daniel Post, seconded by Ms. Wanda Felty and passed unanimously.

3. **Public Comments:**

4. **MAC Member Comments/Discussion:**

5. **Financial Update**
Tasha Black, Senior Director of Budget and Accounting

Ms. Black presented State Fiscal Year 2027 Budget work program. For operations, we increased $250 million over fiscal year 26. Telemedical program increased by $1.1 billion, or 12.5%. On the traditional side, we had 7% growth and expansion, 4.8% for a total of $1.1 billion. This group includes an additional claim week of $82 million. Every 6 years, when we see this, we pay claims once. So, other contributions to the growth, these are the mandates. We had House Bill 2268, That mandated a 25% rate increase. We have appropriate $2.5 million to assist with that. We have some little payment increases of $20.8 billion. Majority of that is attributed to ASPAC, the ambulance fees. And then we have Medicare Card A and D premium increases of $35 million, and CMRI non-emergency transportation of $7.1 million for total mandates of $71 million. As soon as our administrative changes, we had a decrease in administrative operations of $1.2 million. That's directly attributed to the decrease. Retirement contributions, there was a, legislation that was passed that decreased the contribution rate from 16.5% to 9.5% over the next 5 years. So that's, the decrease there. We had a slight increase in our professional service contracts. For more detailed information, see Attachment 5 in the committee packet.

6. Legislative Update

Bradley Downs, Legislative Liaison

Mr. Downs provided a brief update on several bills that OHCA is tracking and recent budget discussions. He added that this year, OHCA is primarily focused on the budget and working with the bill authors to ensure the agency's stance is known.

Bills discussed:

- SB 904 (Gollihare, Harris)
  - Prohibits public funds from being used for gender transition procedures.
  - Signed by the Governor
  - Effective Immediately (Emergency)
- SB 1427 (Hicks, Marti)
  - Permits all health care providers to screen for Type 1 diabetes in children in accordance with accepted medical practices.
  - To Secretary of State without Signature
  - Effective November 1, 2026
- HB 3650 (Stinson, Rosino)
  - Revises SoonerSelect rate floor by extending the minimum rate provisions through July 1, 2028.
  - Signed by the Governor
  - Effective November 1, 2026
- SB 1645 (Gollihare, Lawson)
  - Establishes standards and procedures for audits of providers by the Health Care Authority.
  - Signed by the Governor
  - Effective January 1, 2027
- HB 2268 (Stark, Stanley)
  - Makes an appropriation to OHCA for the PACE program.
  - Signed by the Governor
  - Effective Immediately (Emergency)

7. Medicaid Director Update:

Melissa Miller, State Medicaid Director

Ms. Miller discussed the agency's current budget position and the need for continued active cash management. The agency will continue to monitor cash flow on a monthly basis to identify whether supplemental funding may be necessary. Approximately $70 million in encumbered carryover had previously provided a financial buffer. Most of the carryover was directed by the legislature to fund

the SHOP gap, leaving approximately $5 million in unencumbered carryover. No provider rate cuts are anticipated at this time. HR1 Interim Final Rule (IFR) was released June 1 and has significant public concerns raised regarding the medical frailty provisions of the rule. The final requirements appear to be more stringent than initially anticipated. Twenty-six states have filed lawsuit against the federal government challenging implementation of HR1. One concern raised in the litigation is that the final rule may not fully align with prior guidance from CMS. Oklahoma is not among the states participating in the lawsuit and will continue to monitor the litigation and assess any potential impact.

8. New Business:

Chairman, Jason Rhynes

No new business was discussed.

9. Adjourn:

Chairman, Jason Rhynes

Dr. Rhynes asked for a motion to adjourn. Motion was provided by Dr. Daniel Post and seconded by Ms. Wanda Felty there was no dissent and the meeting was adjourned at 2:10pm.

September 3, 2026 MAC
Proposed Rule Amendment Summaries

The following proposed **EMERGENCY** rules were previously presented at Tribal Consultation.

The Agency is requesting an effective date of January 1, 2027, for the following items:

APA WF #26-04 HR1 Reduced Retroactive Eligibility & 6-Month Redeterminations — In compliance with requirements of HR1, the proposed emergency revisions implement 6-month redetermination cycles, reduced from 12 months, for certain Expansion adults effective January 1, 2027. American Indian/Alaska Native (AI/AN) populations are specifically excluded from the 6-month redetermination provisions and will remain on a 12-month redetermination cycle. Non-expansion groups are not subject to this requirement. The proposed emergency rule also implements reduced retroactive eligibility periods in compliance with HR1. Current policy provides up to three months of retroactive eligibility prior to the application date. Expansion adults will be eligible for one month of retroactive eligibility, while non-expansion populations will be eligible for two months. AI/AN populations are not excluded from this provision.

> **Budget Impact**: The Agency is evaluating the fiscal impact of implementing the federal requirements.
>
> **Emergency Justification**: These revisions are necessary to implement requirements of HR1 (2025), the One Big Beautiful Bill Act, Public Law No. 119-21.

APA WF #26-06 HR1 Work Requirements — In compliance with the requirements of HR1, the proposed revisions implement community engagement requirements effective January 1, 2027. Certain populations will be required to demonstrate community engagement as a condition of eligibility. Community engagement may include work, work programs, educational programs, or some combination thereof. Certain populations are excluded or exempted from these requirements, including American Indians/Alaska Natives (AI/ANs), children under age 19, Medicare enrollees, former foster youth under age 26, parents, guardians, or caretaker relatives of a child age 13 or younger or an individual with a disability, disabled veterans, medically frail individuals, TANF or SNAP enrollees, inmates, individuals participating in drug or alcohol addiction treatment programs, or pregnant/postpartum women. New applicants must demonstrate community engagement for at least the month immediately preceding their application; existing members must demonstrate for at least one month of their certification period, which may be 6 or 12 months depending on the population category. The Agency will first seek to determine compliance from existing data, including the case record and automated data exchange with other agencies, before requesting documentation from members.

> **Budget Impact**: The Agency is evaluating the fiscal impact of implementing the federal requirements.
>
> **Emergency Justification**: These revisions are necessary to implement requirements of HR1 (2025), the One Big Beautiful Bill Act, Public Law No. 119-21.

APA WF #26-12 Obstetrical Unbundling — The proposed policy changes revise billing policy for obstetric services to align with upcoming changes to the Current Procedural Terminology (CPT) codes. CPT codes, which are maintained by the American Medical Association (AMA), are the foundation of claims-based billing used in a fee-for-service healthcare delivery model. The AMA has proposed comprehensive changes to the way maternity and obstetric services are billed

and reimbursed. Currently, obstetric services are billed and reimbursed using a single bundled code. The bundled code will be discontinued on January 1, 2027. The AMA is developing and revising codes for each obstetric service. The proposed policy changes update billing guidance to reflect the new obstetric billing structure.

Budget Impact: The proposed changes are expected to be budget neutral. The proposed changes do not create coverage for new services; they change how covered services are billed. OHCA cannot complete a comprehensive budget analysis at this time because rates for the newly-created and revised codes have not been released by CMS.

Emergency Justification: The proposed rule changes are necessary to implement changes to the Current Procedural Terminology (CPT) codes used to bill for obstetric services effective January 1, 2027. The American Medical Association (AMA) has proposed substantial changes to the applicable CPT codes. CMS requires states to use CPT codes for Medicaid billing and is expected to formally adopt the proposed codes in November 2026.

SUBCHAPTER 6. SOONERCARE FOR PREGNANT WOMEN AND FAMILIES WITH CHILDREN
PART 7. CERTIFICATION, REDETERMINATION AND NOTIFICATION

317:35-6-60. Certification for SoonerCare for pregnant women and families with children

(a) **General rules of certification.**

(1) An individual determined eligible for SoonerCare may be certified for a prospective period of coverage on or after the date of certification.

(2) In accordance with 42 Code of Federal Regulations (C.F.R.) § 435.915 and Oklahoma Administrative Code (OAC) 317:35-6-60.2, an individual may also be determined eligible and certified for a retroactive period of coverage during the ~~three (3)~~two (2) month period directly prior to the date of application, or one (1) month period for expansion adult members. This only applies if the individual received covered medical services at any time during that period and would have been eligible for SoonerCare at the time he or she received the services, regardless of whether the individual is alive when application for Medicaid is made. An individual may be eligible for the retroactive period even though ineligible for the prospective period.

(3) The individual who is categorically needy and related to pregnancy-related services retains eligibility for the period covering prenatal, delivery, and postpartum periods without regard to eligibility for other household members in the case. Eligibility during the postpartum period does not apply to women receiving pregnancy-related coverage under Title XXI.

(b) **Certification as a TANF (cash assistance) recipient.** A categorically needy individual who is determined eligible for Temporary Assistance for Needy Families (TANF) is certified effective the first day of the month of TANF eligibility.

(c) **Certification of non-cash assistance individuals related to the children and parent and caretaker relative groups.** The certification period for the individual related to the children or parent and caretaker relative groups is twelve (12) months. The certification period can be less than twelve (12) months if the individual:

(1) Is certified as eligible in a money payment case during the twelve-month (12-month) period;

(2) Is certified for long-term care during the twelve-month (12-month) period;

(3) Becomes ineligible for SoonerCare after the initial month, except for children who are eligible for twelve months continuous coverage; or

(4) Becomes financially ineligible.

(A) If an income change after certification causes the case to exceed the income standard, the case is closed.

(B) Individuals, however, who are determined pregnant and financially eligible continue to be eligible for pregnancy-related services through the prenatal, delivery and postpartum period, regardless of income changes. A pregnant individual included in a TANF case which closes continues to be eligible for pregnancy-related services through the postpartum period.

(d) **Certification of individuals related to pregnancy-related services.** The certification period for the individual related to pregnancy-related services will cover the prenatal, delivery and postpartum periods. The postpartum period is defined as the twelve (12) months following

the month the pregnancy ends. Financial eligibility is based on the income received in the first month of the certification period. No consideration is given to changes in income after certification.

(e) **Certification of newborn child deemed eligible.**

(1) Every newborn child is deemed eligible on the date of birth for SoonerCare when the child is born to a woman who is eligible for and enrolled in pregnancy-related services as categorically needy. The newborn child is deemed eligible through the last day of the month the newborn child attains the age of one (1) year. The newborn child's eligibility is not dependent on the mother's continued eligibility. The mother's coverage may expire at the end of the postpartum period; however, the newborn child is deemed eligible until age one (1). The newborn child's eligibility is based on the original eligibility determination of the mother for pregnancy-related services, and consideration is not given to any income or resource changes that occur during the deemed eligibility period.

(2) The newborn child is deemed eligible for SoonerCare as long as he/she continues to live in Oklahoma. In accordance with 42 C.F.R. § 435.117, no other conditions of eligibility are applicable, including social security number enumeration, child support referral, and citizenship and identity verification. However, it is recommended that social security number enumeration be completed as soon as possible after the newborn child's birth. It is also recommended that a child support referral be completed, if needed, as soon as possible and sent to the Oklahoma Child Support Services (OCSS) division at DHS. The referral enables child support services to be initiated.

(3) When a categorically needy newborn child is deemed eligible for SoonerCare, he/she remains eligible through the end of the month that the newborn child reaches age one (1). If the child's eligibility is moved from the case where initial eligibility was established, it is required that the newborn receive the full deeming period. The certification period is shortened only in the event the child:

(A) Loses Oklahoma residence; or

(B) Expires.

(4) A newborn child cannot be deemed eligible when the mother's only coverage was presumptive eligibility, and continued eligibility was not established.

(f) **Certification of individuals related to expansion adults.**

(a) Prior to January 1, 2027, the certification period for the individual related to the expansion adult group is twelve (12) months.

(b) On and after January 1, 2027, the certification period for the individual related to the expansion adult group is six (6) months, pursuant to Section 71107 of Public Law 119-21, while in force and as amended from time to time; however, certification periods for American Indian/Alaska Native (AI/AN) individuals remain twelve (12) months, even when determined eligible and related to the expansion adult group.

317:35-6-60.2. Retroactive eligibility.

(a) Retroactive eligibility, as outlined in this section, shall be available to pregnant women and/or members under the age of nineteen (19) and expansion adults. For retroactive eligibility rules related to other SoonerCare population groups, refer to Oklahoma Administrative Code (OAC) 317:35-7-60(b).

(b) In addition to the period of eligibility specified in Oklahoma Administrative Code (OAC) 317:35-6-60, an applicant, or individuals within the applicant's household, shall be eligible for SoonerCare benefits up to ~~three (3)~~two (2) months prior to the date of application, or one (1) month for expansion adults, if all of the following requirements are met:

(1) The individual for whom retroactive coverage is being requested would have been eligible for SoonerCare coverage if an application for SoonerCare had been made during the retroactive month.

(A) The individual does not have to be eligible for the month of application to be found eligible for one (1) of the ~~three (3)~~two (2) retroactive months.

(B) The eligibility factors (e.g. income, residency, household composition, etc.) are evaluated separately for each retroactive month for which retroactive eligibility is being requested.

(2) The applicant completes the retroactive eligibility application form and provides, within six (6) months of the date the services were provided, documentation for verification purposes as requested by SoonerCare.

(3) The individual applying for retroactive coverage states that the individual for whom retroactive coverage is being requested received reimbursable SoonerCare services which were provided by a SoonerCare-contracted provider during the retroactive month.

(4) An applicant cannot be approved for retroactive coverage for a month in which his or her application was previously denied.

(c) Per 42 Code of Federal Regulations (CFR) ~~§~~ 435.915(b), if an applicant is determined to be eligible for retroactive coverage at any time during the requested retroactive month, then coverage will begin on the first (1st) day of the month and be effective for the entire month.

(d) If the applicant is applying for SoonerCare benefits due to pregnancy, then the applicant must have been pregnant during the requested retroactive month.

(e) Regardless of retroactive eligibility being granted, the requirement for the claim to be filed timely, per OAC 317:30-3-11, is still in effect.

(f) Retroactive coverage for SoonerCare health services received during a retroactive month will be secondary to any third-party which has primary responsibility for payment. If the individual eligible for retroactive coverage has already paid for the health services, the provider may refund the payment and bill SoonerCare in accordance with the timely filing requirements in OAC 317:30-3-11.

(g) Retroactive coverage for SoonerCare reimbursable health services that require prior authorization shall not be denied solely because of a failure to secure prior authorization. Medical necessity, however, must be established before reimbursement can be made.

(h) Denials of requests for retroactive eligibility may be appealed in accordance with OAC 317:2-1-2(d)(1)(F).

317:35-6-61. Redetermination of eligibility for persons receiving SoonerCare

(a) A periodic redetermination of eligibility for SoonerCare is required for all members. The redetermination is made prior to the end of the initial certification period and each twelve (12) months thereafter or each six (6) months thereafter for expansion adult members who are not American Indian/Alaska Native per OAC 317:35-6-60(f). A deemed newborn is eligible through the last day of the month the newborn child attains the age of one year, without regard to eligibility of other household members in the case.

(b) Effective January 1, 2014, when the agency has sufficient information available electronically to redetermine eligibility, eligibility will be redetermined on that basis and a notice will be sent to the household explaining the action taken by the agency. The member is responsible for notifying the agency if any information used to redetermine eligibility is incorrect. If the agency does not have sufficient information to redetermine eligibility, the agency will send notice to that effect, and the member is responsible for providing the necessary information to redetermine eligibility.
(c) A member's case is closed if he/she does not return the form(s) and any verification necessary for redetermination timely. If the member submits the form(s) and verification necessary for redetermination within ninety (90) days after closure of the case, benefits are reopened effective the date of the closure, provided the member is eligible and benefits were closed because the redetermination process was not completed.
(d) Effective January 1, 2024, a child who meets the criteria for continuous eligibility shall remain eligible for SoonerCare, until the earlier of:

(1) Twelve (12) months from the effective date of the child's most recent certification period; or
(2) The child's nineteenth (19th) birthday.

SUBCHAPTER 7. MEDICAL SERVICES
PART 7. CERTIFICATION, REDETERMINATION AND NOTIFICATION

317:35-7-60. Certification for SoonerCare

(a) **General.** The rules in this Section apply to the following categories of eligibles:

(1) Categorically needy SoonerCare members who are categorically related to Aged, Blind, and Disabled (ABD);
(2) Categorically needy SoonerCare members who are categorically related to ABD, and are eligible for one of the following:
(A) Qualified Medicare Beneficiary Plus (QMBP);
(B) Qualified Disabled and Working Individual (QDWI);
(C) Specified Low-Income Medicare Beneficiary (SLMB);
(D) Tuberculosis (TB) related services;
(E) Qualifying Individual (QI); or
(F) Tax Equity and Fiscal Responsibility Act (TEFRA).

(b) **Certification of individuals categorically needy and categorically related to ABD**. The certification period for the categorically needy individual who is categorically related to ABD can be up to twelve (12) months from the date of certification. The individual must meet all factors of eligibility for each month of the certification period. The certification can be for a retroactive period of coverage, during the ~~three (3)~~two (2) months directly before the month of application, if the individual received covered medical services at any time during those ~~three (3)~~two (2) months and would have been eligible for SoonerCare at the time he or she received the services. The cash payment portion of the State Supplemental Payment (SSP) may not be paid for any period prior to the month of application.

(1) The certification period is twelve (12) months unless the individual:

(A) Is certified as eligible in a money payment case during the twelve (12) month period;
(B) Is certified for long-term care during the twelve (12) month period;
(C) Becomes ineligible for medical assistance after the initial month;
(D) Becomes ineligible as categorically needy; or
(E) Is deceased.

(2) If any of the situations listed in subparagraph (1) of this paragraph occur after the initial month, the case is closed by the worker.

(A) If income and/or resources change after certification causing the case to exceed the categorically needy maximums, the case is closed.
(B) A pregnant individual included in an ABD case which closes continues to be eligible for pregnancy related services through the postpartum period.

(c) **Certification of individuals categorically related to ABD and eligible as QMBP**. The SoonerCare benefit may be certified on the first day of the third month prior to the month of application or later. If the individual receives Medicare and is eligible for SSP, the effective date of certification for the Medicare Part B premium buy-in is the month of certification for SSP. If the individual receives Medicare and is not eligible for SSP, the effective date of certification for the Medicare Part B premium buy-in is the first day of the month following the month in which the eligibility determination is made (regardless of when application was made).

(1) An individual determined eligible for QMBP benefits is assigned a certification period of twelve (12) months. At any time during the certification period that the individual becomes ineligible, the case is closed using regular negative action procedures.
(2) At the end of the certification period a redetermination of QMBP eligibility is required, using the same forms and procedures as for ABD categorically needy individuals.

(d) **Certification of individuals categorically related to ABD and eligible as QDWI**. The Social Security Administration (SSA) is responsible for referrals of individuals potentially eligible for QDWI. Eligibility factors verified by the SSA are Medicare Part A eligibility and discontinuation of disability benefits due to excessive earnings. When the OKDHS State office receives referrals from the SSA, the county will be notified and is responsible for obtaining an application and establishing other factors of eligibility. If an individual contacts the county office stating he/she has been advised by SSA that he/she is a potential QDWI, the county takes a SoonerCare application. The effective date of certification for QDWI benefits is based on the date of application and the date all eligibility criteria, including enrollment for Medicare Part A, are met. For example, if an individual applies for benefits in October and is already enrolled in Medicare Part A, eligibility can be effective October 1 [or up to three (3) months prior to October 1, if all eligibility criteria are met during the three (3) month period]. However, if in the example, the individual's enrollment for Part A is not effective until November 1, eligibility cannot be effective until that date. Eligibility can never be effective prior to July 1, 1990, the effective date of this provision. These cases will be certified for a period of twelve (12) months. At the end of the twelve (12) month period, eligibility redetermination is required. If the individual becomes ineligible at any time during the certification period, the case is closed.

(e) **Certification of individuals categorically related to ABD and eligible as SLMB**. The effective date of certification of SLMB benefits may begin on the first day of the third month prior to the month of application or later. A certification can never be earlier than the date of entitlement of Medicare Part A. An individual determined eligible for SLMB benefits is assigned a certification period of twelve (12) months. At any time during the certification period the

individual becomes ineligible, the case is closed using standard negative action procedures. At the end of the certification period a redetermination of SLMB eligibility is required. A redetermination of SLMB eligibility must also be done at the same time a dually eligible individual has a redetermination of eligibility for other SoonerCare benefits such as long-term care.

(f) **Certification of individuals categorically related to disability and eligible for TB related services.**

(1) An individual determined eligible for TB related services may be certified the first day of the third month prior to the month of application or later, but no earlier than the first day of the month the TB infection is diagnosed.

(2) A certification period of twelve (12) months will be assigned. At any time during the certification period that the individual becomes ineligible, the case is closed using the regular negative action procedures.

(3) At the end of the certification period a new application will be required if additional treatment is needed.

(g) **Certification of individuals categorically related to ABD and eligible as QI.** The effective date of certification for the QI-1 may begin on the first day of the third month prior to the month of application or later. A certification can never be earlier than the date of entitlement of Medicare Part A. An individual determined eligible for QI benefits is assigned a certification period of twelve (12) months. At any time during the certification period the individual becomes ineligible, the case is closed using standard negative action procedures. At the end of the certification period, a redetermination of QI eligibility is required.

(1) Since the State's allotment to pay Medicare premiums for this group of individuals is limited, the State must limit the number of QIs so that the amount of assistance provided during the year does not exceed the State's allotment for that year.

(2) Persons selected to receive assistance are entitled to receive assistance with their Medicare premiums for the remainder of the federal fiscal year, but not beyond, as long as they continue to qualify. The fact that an individual is selected to receive assistance at any time during the year does not entitle the individual to continued assistance for any succeeding year.

(h) **Certification of individuals related to Aid to the Disabled for TEFRA.** The certification period for individuals categorically related to the Disabled for TEFRA is twelve (12) months.

CHAPTER 35. MEDICAL ASSISTANCE FOR ADULTS AND CHILDREN-ELIGIBILITY
SUBCHAPTER 5. ELIGIBILITY AND COUNTABLE INCOME
PART 3. NON-MEDICAL ELIGIBILITY REQUIREMENTS

317:35-5-28. Community engagement

(a) General requirements. Beginning January 1, 2027, an applicable individual, as defined in 42 C.F.R. § 435.551, must demonstrate community engagement or be deemed to have demonstrated community engagement as a condition of eligibility.

(1) At application, an applicable individual must demonstrate or be deemed to have demonstrated community engagement for one (1) month immediately preceding the month in which the individual applies.

(2) At renewal, an applicable individual must demonstrate or be deemed to have demonstrated community engagement for one (1) month during the period between the effective date of the individual's most recent eligibility determination or redetermination at renewal and the date the individual's next renewal is due.

(b) Demonstration of community engagement, exclusions, and exceptions.

(1) An applicable individual demonstrates community engagement in accordance with 42 C.F.R. § 435.552.

(2) A specified excluded individual described in 42 C.F.R. § 435.554 is not subject to the community engagement requirement.

(3) An applicable individual is deemed to have demonstrated community engagement for a month in which a mandatory exception under 42 C.F.R. § 435.553 applies for part or all of the month.

(4) OHCA elects all short-term hardship exceptions described in 42 C.F.R. § 435.555. An applicable individual is deemed to have demonstrated community engagement for a month in which a short-term hardship exception applies for part or all of the month.

(c) Verification.

(1) OHCA first attempts to verify that an individual is a specified excluded individual or that an applicable individual demonstrated or is deemed to have demonstrated community engagement using reliable information available to the agency in accordance with 42 C.F.R. § 435.557.

(2) OHCA requests documentation or other additional information from the individual only when the information needed by the agency cannot be verified using reliable information available to the agency or when information provided by or on behalf of the individual is not reasonably compatible with reliable information available to the agency.

(d) Noncompliance.

(1) When OHCA is unable to verify that an individual is a specified excluded individual or that an applicable individual demonstrated or is deemed to have demonstrated community engagement for the required month, the agency provides notice in accordance with 42 C.F.R. § 435.558.

(2) The individual has thirty (30) calendar days from receipt of the notice to make a satisfactory showing that:

(A) the individual demonstrated community engagement;

(B) the individual is deemed to have demonstrated community engagement under an applicable exception; or

(C) the community engagement requirement does not apply to the individual.

(3) Medical assistance continues for an enrolled individual during the response period and until the individual is determined ineligible.

(4) Before denying eligibility or disenrolling an individual for failure to meet the community engagement requirement, the agency determines whether the individual is eligible for medical assistance on another basis.

(5) An individual who does not make a satisfactory showing and is not eligible on another basis is denied eligibility or disenrolled in accordance with 42 C.F.R. § 435.558 and applicable notice and fair hearing requirements.

(6) An individual denied eligibility or disenrolled for failure to meet the community engagement requirement may reapply for medical assistance at any time.

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 1. PHYSICIANS

317:30-5-22. Obstetrical care

(a) **Covered services for adults.** Payment is made for obstetrical care that is reasonable and necessary. Obstetrical care should be billed using the appropriate CPT codes for maternity care or delivery. The following limitations apply:

(1) **Assessments**. The completion of an American College of Obstetricians and Gynecologist (ACOG) assessment form or form covering same elements as ACOG, and the most recent version of the Oklahoma Health Care Authority's (OHCA) Prenatal Psychosocial Assessment are reimbursable when both documents are included in the prenatal record. SoonerCare allows one (1) assessment per provider and no more than two (2) per pregnancy.

(2) **Ultrasounds**. To be eligible for payment, all ultrasound reports must meet the guideline standards published by the American Institute of Ultrasound Medicine (AIUM).

(A) One (1) ultrasound will be covered in the first trimester of an uncomplicated pregnancy. Both an abdominal and vaginal ultrasound may be allowed when clinically appropriate and medically necessary. The ultrasound must be performed by a board eligible/board certified obstetrician-gynecologist (OB-GYN), radiologist, or a board eligible/board certified maternal-fetal medicine specialist. In addition, this ultrasound may be performed by a certified nurse midwife (CNM), family practice physician or advanced practice nurse practitioner (APRN) in obstetrics with a certification in OB ultrasonography.

(B) One (1) ultrasound after the first trimester will be covered. This ultrasound must be performed by a board eligible/board certified OB-GYN, radiologist, or a board eligible/board certified maternal-fetal medicine specialist. In addition, this ultrasound may be performed by a CNM, family practice physician, or APRN with certification in OB ultrasonography.

(C) One (1) additional detailed ultrasound is allowed by a board eligible/board certified maternal fetal specialist or general obstetrician with documented specialty training in performing detailed ultrasounds. This additional ultrasound is allowed to identify or confirm a suspected fetal/maternal anomaly. This additional ultrasound does not require prior authorization. Any subsequent ultrasounds will require prior authorization.

(D) Limited obstetrical ultrasounds are covered in an emergency room (ER) setting when medically necessary.

(3) **Standby at cesarean section**. Standby attendance at cesarean section is compensable when billed by a physician or qualified health care provider not participating in the delivery. Payment will not be made to the same provider for both standby and assistant services at a cesarean section.

(4) **Multiple gestations**.

(A) If multiple fetuses are delivered vaginally, the appropriate delivery code should be billed for each fetus.

(B) If multiple fetuses are delivered via cesarean section, the appropriate delivery code be billed only once.

(C) If multiple fetuses are delivered vaginally and via cesarean section, the appropriate vaginal delivery code should be billed for each fetus that is delivered vaginally and the appropriate cesarean section delivery code should be billed once.

(5) **Noncovered services**. There is no coverage for the following services:

(A) Double set up examinations;

(B) Fetal stress tests for normal pregnancies (see OAC 317:30-5-22.1 for high-risk pregnancy

coverage);
(C) Fetal scalp blood sampling; and
(D) Pudendal anesthetic.

(b) **Covered services for children**. Covered services for children are the same as for adults. Additional procedures may be covered under Early and Periodic Screening, Diagnostic and Treatment (EPSDT) provisions if determined to be medically necessary.

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

(2) Federal Medicaid regulations also require the State to make the determination as to whether the service is medically necessary and do not require the provision of any items or services that the State determines are not safe and effective or which are considered experimental. For more information regarding experimental or investigational and clinical trials see OAC 317:30-3-57.1.

~~(a) Obstetrical (OB) care is billed using the appropriate CPT codes for maternity care and delivery. The date of delivery is used as the date of service for charges for total OB care. Inclusive dates of care should be indicated on the claim form as part of the description. Payment for total OB care includes all routine care, and any ultrasounds performed by the attending physician provided during the maternity cycle unless otherwise specified in this Section. For payment of total OB care, a physician must have provided care for more than one (1) trimester. To bill for prenatal care only, the claim is filed after the member leaves the provider's care. Payment for routine or minor medical problems will not be made separately to the OB physician outside of the antepartum visits. The antepartum care during the prenatal care period includes all care by the OB attending physician except major illness distinctly unrelated to the pregnancy.~~

~~(b) Procedures paid separately from total OB care are listed in (1) – (8) of this subsection.~~

~~(1) The completion of an American College of Obstetricians and Gynecologist (ACOG) assessment form or form covering same elements as ACOG, and the most recent version of the Oklahoma Health Care Authority's (OHCA) Prenatal Psychosocial Assessment are reimbursable when both documents are included in the prenatal record. SoonerCare allows one (1) assessment per provider and no more than two (2) per pregnancy.~~

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

~~(A) One (1) ultrasound will be covered in the first trimester of an uncomplicated pregnancy. Both an abdominal and vaginal ultrasound may be allowed when clinically appropriate and medically necessary. The ultrasound must be performed by a board eligible/board certified obstetrician-gynecologist (OB-GYN), radiologist, or a board eligible/board certified maternal-fetal medicine specialist. In addition, this ultrasound may be performed by a certified nurse-midwife (CNM), family practice physician or advanced practice nurse practitioner (APRN) in obstetrics with a certification in OB ultrasonography.~~

~~(B) One (1) ultrasound after the first trimester will be covered. This ultrasound must be performed by a board eligible/board certified OB-GYN, radiologist, or a board eligible/board certified maternal-fetal medicine specialist. In addition, this ultrasound may be performed by a CNM, family practice physician, or APRN with certification in OB ultrasonography.~~

~~(C) One (1) additional detailed ultrasound is allowed by a board eligible/board certified maternal fetal specialist or general obstetrician with documented specialty training in performing detailed ultrasounds. This additional ultrasound is allowed to identify or confirm a suspected fetal/maternal anomaly. This additional ultrasound does not require prior authorization. Any subsequent ultrasounds will require prior authorization.~~

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

~~delivery.~~

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

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

~~(6) Additional payment is not made for the delivery of multiple gestations. If one (1) fetus is delivered vaginally and additional fetus(es) are delivered by C-section by the same physician, the higher-level procedure is paid. If one (1) fetus is delivered vaginally and additional fetus(es) are delivered by C-section, by different physicians, each should bill the appropriate procedure codes without a modifier. Payment is not made to the same physician for both standby and assistant at C-section.~~

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

~~(8) Limited OB ultrasounds are covered in an emergency room (ER) setting when medically necessary.~~

~~(c) Assistant surgeons are paid for C-sections which include only in-hospital post-operative care. Family practitioners who provide prenatal care and assist at C-section bill separately for the prenatal and the six (6) weeks postpartum office visit.~~

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

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

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

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

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

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

~~(e) OB coverage for children is the same as for adults. Additional procedures may be covered under Early and Periodic Screening, Diagnostic and Treatment (EPSDT) provisions if determined to be medically necessary.~~

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

~~(2) Federal Medicaid regulations also require the State to make the determination as to whether the service is medically necessary and do not require the provision of any items or services that the State determines are not safe and effective or which are considered experimental. For more information regarding experimental or investigational and clinical trials see OAC 317:30-3-57.1.~~

317:30-5-22.1. Enhanced services for medically high risk pregnancies

(a) **Enhanced services.** Enhanced services are available for pregnant women eligible for SoonerCare and are in addition to services for uncomplicated maternity cases. Women deemed high risk based on criteria established by the Oklahoma Health Care Authority (OHCA) must receive prior authorization for medically necessary enhanced benefits which include:

(1) Prenatal at risk antepartum management;

(2) A combined maximum of five (5) fetal non stress test(s) and biophysical profiles (additional units can be prior authorized for multiple fetuses)with one (1) test per week beginning at thirty-two (32) weeks gestation and continuing to thirty-eight (38) weeks; and

(3) A maximum of three (3) follow-up ultrasounds not covered under Oklahoma ~~Adminisrative~~Administrative Code (OAC) ~~317:30-5-22(b)(2)~~317:30-5-22.

(b) **Prior authorization**. To receive enhanced services, the following documentation must be received by the OHCA Medical Authorization Unit for review and approval:

(1) A comprehensive prenatal assessment from the American College of Obstetricians and Gynecologist (ACOG) or other comparable comprehensive prenatal assessment; and

(2) Appropriate documentation supporting medical necessity from a board eligible/board certified Maternal Fetal Medicine (MFM) specialist, a board eligible/board certified Obstetrician-Gynecologist (OB-GYN), or a board eligible/board certified Family Practice Physician who has completed an Accreditation Council for Graduate Medical Education (ACGME) approved residency. The medical residency program must include appropriate obstetric training, and the physician must be credentialed by the hospital at which they provide obstetrical services in order to perform such services. The documentation must include information identifying and detailing the qualifying high risk condition. Non-MFM obstetrical providers requesting enhanced services are limited to a specific set of diagnoses as outlined on the OHCA website (www.okhca.org).

(c) **Reimbursement**. When prior authorized, enhanced benefits will be reimbursed as follows:

(1) Antepartum management for high risk is reimbursed to the primary obstetrical provider. If the primary provider of obstetrical care is not the MFM and wishes to request authorization of the antepartum management fee, the treatment plan must be signed by the primary provider of OB care. Additionally, reimbursement for enhanced at risk antepartum management is not made during an in-patient hospital stay.

(2) Non stress tests, biophysical profiles and ultrasounds [in addition to those covered under OAC ~~317:30-5-22 (b)(2) (A) through (C)~~317:30-5-22] are reimbursed when prior authorized.

(3) Reimbursement for enhanced at risk antepartum management is not available to physicians who already qualify for enhanced reimbursement as state employed physicians.

PART 19. CERTIFIED NURSE MIDWIVES

317:30-5-226. Coverage by category

(a) **Adults.** Payment is made for certified nurse midwife services within the scope of practice as defined by state law including obstetrical care such as antepartum care, delivery, postpartum care, and care of the normal newborn during the first 28 days of life. Services are subject to the limitations described in OAC 317:30-5-22. Obstetrical care should be billed using the appropriate CPT codes for maternity care or delivery.

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

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

(b) **Newborn.** Payment to certified nurse midwives for services to newborn is the same as for adults. A newborn is an infant during the first 28 days following birth.

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

(2) Charges billed on the mother's person code for services rendered to the child will be denied.

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

317:30-5-229. Reimbursement

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

(1)Providers must use the NODOS/NB1 form (found on the OHCA website at https://oklahoma.gov/ohca/providers/forms.html) for a newborn child delivered by a SoonerCare member. A claim may then be filed for charges for the newborn under the case number and the newborn's name and assigned person code. Newborn charges billed on the mother's person code will be denied.

(2) Obstetrical care should be billed using the appropriate CPT codes for Maternity Care and Delivery. Reimbursement will made for services within scope of practice according to the methodology described in the Oklahoma State Plan. ~~The date of delivery should be used as the date of service for charges for total obstetrical care. Inclusive dates of care should be indicated on the claim form as part of the description. The date the patient was first seen must be on the claim form. Payment for total obstetrical care includes all routine care performed by the attending provider. For payment of total OB care, the provider must have provided care for more than one trimester. To bill for prenatal care only, the claim is filed after the member leaves the provider's care. Payment for routine or minor medical problems will not be made separately to the OB provider outside of antepartum visits. The antepartum care during the prenatal care period includes all care by the OB provider except major illness distinctly unrelated to the pregnancy.~~

PART 35. RURAL HEALTH CLINICS

317:30-5-356. Coverage for adults

Payment is made to RHCs for adult services as set forth in this Section.

(1) **RHC services.** Payment is made for one (1) encounter per member per day. Payment is also limited to four (4) visits per member per month. This limit may be exceeded if the SoonerCare Choice member has elected the RHC as his/her/their Patient Centered Medical Home/Primary Care Provider. Preventive service exceptions include:

(A) **Obstetrical care.** An RHC should have a written contract with its physician, PA, APRN, or CNM that specifically identifies how obstetrical care will be billed to SoonerCare, in order to avoid duplicative billing situations. The agreement should also specifically identify the physician's compensation for RHC and other ambulatory services.

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

(ii) If the clinic does not compensate its practitioners to provide obstetrical care, then the independent practitioner must bill the OHCA for prenatal care according to the ~~global~~ method described in the SoonerCare provider specific rules for physicians, PAs, APRNs and CNMs (refer to OAC 317:30-5-22).

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

(B) **Family planning services.** Family planning services are available only to members with reproductive capability. Family planning visits do not count as one (1) of the four (4) RHC visits per month.

(2) **Other ambulatory services.** These services are not considered a part of an RHC visit; therefore, these may be billed to the SoonerCare program by the RHC or service provider on the

appropriate claim form. Refer to OAC 317:30-1, General Provisions, and OAC 317:30-3-57, 317:30-5-59, and 317:30-3-60 for general coverage and exclusions under the SoonerCare program. Some specific limitations are applicable to other ambulatory services as set forth in specific provider rules and excerpted as follows: There is no coverage for eye exams for the purpose of prescribing eyeglasses, contact lenses or other visual aids. (See OAC 317:30-5-431.)

317:30-5-361. Billing

(a) **Encounters.** Payment is made for one (1) encounter per member per day. Encounters with more than one (1) health professional and multiple encounters with the same health professional that takes place on the same day and a single location, constitute a single visit except when the member, after the first encounter, suffers illness or injury requiring additional diagnosis or treatment. Medical review will be required for additional visits. RHCs must bill the combined fees of all "core" services provided during an encounter on the appropriate claim form. Claims must include reasonable and customary charges.

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

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

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

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

(5) **EPSDT screening.** EPSDT screenings must be billed by the attending provider using the appropriate Preventative Medicine procedure code from the CPT Manual. Payment is made directly to the RHC on an encounter basis for on-site dental services by a licensed dentist for members under the age of twenty-one (21).

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

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

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

(7) **Visual analysis.** Visual analysis services for a child with glasses, or a child who needs glasses, or a medical eye exam. This includes the refraction and medical eye health evaluation. Visual analysis services are billed using the appropriate revenue code and a HCPCS code. Payment is made directly to the RHC on an encounter basis for on-site optometric services by a licensed optometrist for members under the age of twenty-one (21).

(b) **Services billed separately from encounters.**

(1) Other ambulatory services and preventive services itemized separately from encounters must be billed using the appropriate revenue, HCPC and/or CPT codes. Claims must include reasonable and customary charges from the physical location where services were rendered/performed.

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

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

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

(D) **Contraceptives.** Contraceptives are billed independently from the family planning encounter. A revenue code and the appropriate CPT or HCPC codes are required.

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

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

PART 75. FEDERALLY QUALIFIED HEALTH CENTERS

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

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

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

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

(2) If the clinic does not compensate the provider for the provision of obstetrical care, then the provider must bill the OHCA for prenatal care according to the ~~global~~ method described in the SoonerCare Traditional provider specific rules for physicians, certified nurse midwives, physician assistants, and advanced practice nurses [refer to Oklahoma Administrative Code (OAC) 317:30-5-22].

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

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

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

317:30-5-1095. I/T/U services not compensable under outpatient encounters

I/T/U services that are not compensable under outpatient encounters include:

(1) group or mass information programs, health education classes, or group education activities, including media productions and publications;

(2) vaccines covered by the Vaccines for Children program [refer to Oklahoma Administrative Code 317:30-5-14(a)(1)];

(3) group or sports physicals and medical reports;

(4) drug samples or other prescription drugs provided to the clinic free of charge;

(5) administrative medical examinations and report services; and

(6) gauze, band-aids, or other disposable products used during an office visit.~~; and~~

~~(7) billing global obstetrical care when performing a cesarean or vaginal delivery only.~~

317:30-5-1099. I/T/U service limitations and requirements

Service limitations governing the provision of all Oklahoma SoonerCare services will apply pursuant to Chapter 30 of the OHCA rules. In addition, the following limitations and requirements apply to services provided by I/T/U facilities:

(1) **Multiple encounters.** An I/T/U facility may bill for more than one encounter per twenty-four (24) hour period under certain conditions.

(2) **Behavioral Health services.** Behavioral Health Services are limited to those services furnished to members at or on behalf of the I/T/U facility.

(3) **Laboratory procedures.** Laboratory procedures performed by an I/T/U outpatient facility (not an independently certified enrolled laboratory) on the same date of service are considered part of the health care practitioner's service and are included in the I/T/U encounter.

(4) **Obstetrical services**. For OB services provided to a member before, during, and/or after the same pregnancy, ~~ITUs may not bill for individual encounters and the package/bundled rate.~~ Providers may ~~only either:~~

~~(A)~~ bill for antepartum visits, postpartum visits, and/or a cesarean or vaginal delivery as individual encounter~~; or~~

~~(B) bill the packaged/bundled rate for total care obstetrics, (which includes antepartum and postpartum visits and delivery). Refer to Oklahoma Administrative Code 317:30-5-22 for more detailed obstetrical care policy.~~

PART 115. LICENSED MIDWIVES

317:30-5-1237. Reimbursement

(a) **Payment**. Payment for covered services (as described in OAC 317:30-5-1226) to eligible providers (as described in OAC 317:30-5-1225) shall be made when the same service would have been covered if ordered or performed by a physician. Payment to licensed midwives is made at 80% of the physician fee schedule for the rendered service. Payment for lab and imaging services ordered by licensed midwives is made at 100% of the physician fee schedule.

(b) **Billing**.

(1) **Adults and children**. Obstetrical care should be billed using the appropriate CPT codes for Maternity Care and Delivery. ~~The date of delivery should be used as the date of service for charges for total obstetrical care. Inclusive dates of care should be indicated on the claim form as part of the description. The date the patient was first seen must be on the claim form. Payment for total obstetrical care includes all routine care performed by the attending provider. For payment of total OB care, the provider must have provided care for more than one trimester. To bill for prenatal care only, the claim is filed after the member leaves the provider's care. Payment for routine or minor medical problems will not be made separately to the OB provider outside of antepartum visits. The antepartum care during the prenatal care period includes all care by the OB provider except major illness distinctly unrelated to the pregnancy.~~

(2) **Newborns**. Providers must complete the NODOS/NB1 form (found on the OHCA website at https://oklahoma.gov/ohca/providers/forms.html) for a newborn child delivered by a SoonerCare member. A claim may then be filed for charges for the newborn under the case number and the newborn's name and assigned person code. Charges billed on the mother's person code for services rendered to the child will be denied.

MEDICAID DIRECTOR UPDATE

September 3, 2026

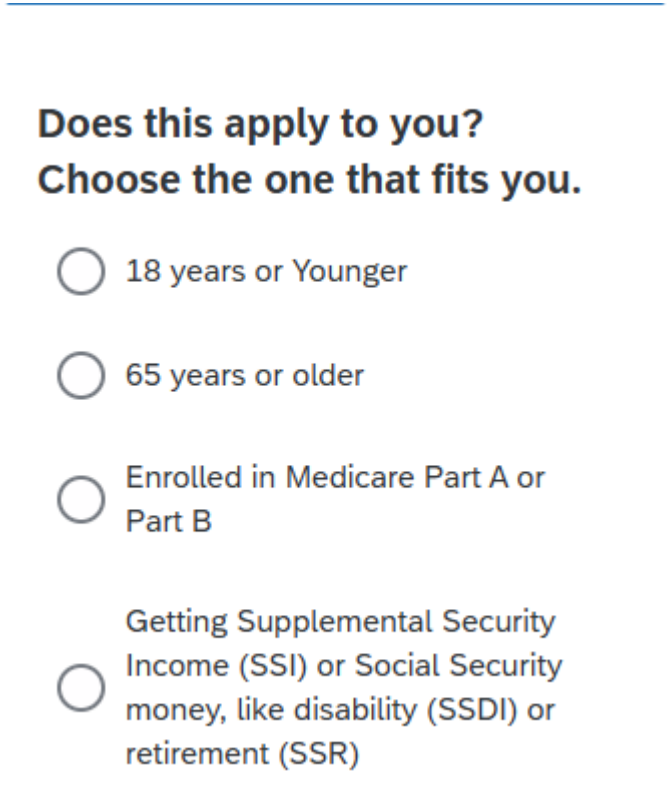
FEDERAL CHANGES IN H.R.1

WORK REQUIREMENTS

Communications

- Yellow letter – official notification letter sent to all members who COULD be affected
- OHCA webpage and screener
- Stakeholder toolkit

oklahoma.gov/ohca/workrequirements



WORK REQUIREMENTS

Member Experience

- **Late August:** Members within the **expansion** group were notified that they are *subject to* (but could be exempt from) work requirements.
- **Regular renewal date** (12 months from last renewal): Members complete their renewal process at their currently scheduled annual renewal date for CY 2027.
  - If OHCA can determine the individual is exempt using existing, available data resources, the process will remain very similar for members.
  - If not, the individual will need to supply additional documentation to obtain an exception or demonstrate compliance.
  - Members have 30 days to demonstrate compliance/exception after initial adverse action.
  - Failure to complete the required actions within 30 days will result in denial of coverage.

WORK REQUIREMENTS

Member Experience

- Self-attestation: Allowed for CY 2027 but only as a last resort.
- Medical frailty: CMS is wanting to make it as claims-based as possible but also needs to impact ability to meet requirements.
- Redetermination: Expansion adults (with the exception of tribal members) will begin to have 6 month renewals instead of annual. This will be reflected when the renewal is processed in CY 2027.
- Retroactive eligibility: Affects ALL members; 1 month for expansion and 2 months for everyone else.

WORK REQUIREMENTS

Member Experience

Demonstrating compliance: Working/Volunteering/Going to School

- Those individuals having to demonstrate compliance through documented work/volunteer/educational hours will have to re-verify compliance every 6 months.
- Compliance needs to be demonstrated for the 1 month prior for NEW applicants; 1 month out of the last 6 months for RENEWALS

WORK REQUIREMENTS

Member Impact: How Many Oklahomans will be Affected?

- Approx. 25% of the Medicaid population (or around **250,000** Oklahomans) are enrolled as expansion adults and *subject to* the work requirements.
- Of those, approx. 37% or **90,000** have verified income above the minimum to be excluded from work requirements.
- It is challenging to anticipate how many expansion adults will meet one of the exceptions. However, Oklahoma estimates about **30,000-90,000** will not be passively given an exception and will need to take additional action to verify compliance.

MEMBER OUTREACH

What should I do right now?

- **Update your information:** Make sure your phone number, address and email are up to date at MySoonerCare.org.
- **Watch your mail and email:** Check your mail and email for letters from SoonerCare or OHCA with more instructions.
- **Review resources:** If you need help finding a job or enrolling in school, view resources on the Work Requirements page at oklahoma.gov/ohca/workrequirements.

PROGRAMMATIC UPDATES

JUVENILE REENTRY INITIATIVE

- The Reconnect (JIY) program supports youth and young adults in safely returning to their communities with coordinated access to health care and support services.
- Phase 1 launched July 1, 2026, with DOC, OJA, and ODMHSAS implementing eligibility, enrollment, service delivery, and reentry coordination.
- OHCA and partner agencies continue to strengthen workflows for billing, care coordination, data sharing, reporting, and compliance.
- Phase 1 lessons learned are informing ongoing improvements and Phase 2 planning.

OKLAHOMA
Health Care Authority

GET IN TOUCH

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