MIKE FOGARTY
CHIEF EXECUTIVE OFFICER

MARY FALLIN
GOVERNOR

STATE OF OKLAHOMA

OKLAHOMA HEALTH CARE AUTHORITY

MEDICAL ADVISORY COMMITTEE MEETING
AGENDA
November 14, 2012
1:00 p.m. – Ponca Conference Room
2401 NW 23rd St., Suite 1A
Oklahoma City, OK 73107

I. Welcome, Roll Call, and Public Comment Instructions

II. Approval of minutes of the September 20, 2012 Medical Advisory Committee Meeting

III. MAC Member Comments/Discussion

IV. Financial Report: Gloria Hudson, Director of General Accounting

A. August Financial Summary
B. August Financial Detail Report

V. SoonerCare Operations Update: Jennifer King

A. SoonerCare Programs Report
B. Behavioral Health Report

VI. Dental Update – Dr. Leon Bragg

VII. MAC Meeting Dates for 2013

VIII. Care Management - Hemophilia: Marlene Asmussen

IX. Action Items: Tywanda Cox

OHCA Initiated

12-07 Therapy Referral Requirements— Agency policy on therapy services is revised to comply with federal law, which requires a prescription or referral from a physician or practitioner of the healing arts before therapy services are rendered. Policy is also revised to require a prior authorization for speech therapy services.
Budget Impact: Total Budget Savings of $25,000; State Savings of $8,750

12-08 Parental Consent Policy— Policy is amended to match state law and current agency operational requirements that parental or legal guardian consent must be given prior to rendering services to a minor child.
Budget Impact: Budget neutral

12-09 Long Term Care Crossover Payments— Policy will be amended to allow 100% payment of Medicare Crossover deductibles and coinsurance at skilled nursing facilities. Current policy allows

payment at the Medicaid rate, which was previously adjusted to 0%. The rationale behind current policy is based on a federal policy that allowed federal reimbursement/write-offs for bad debts. That federal policy is no longer in effect and has prompted the policy amendment request.
Budget Impact: Budget Cost of $24 million, $8.6 million state share

ODMHSAS Initiated

12-19 Behavioral Health Rehabilitation Services – Outpatient Behavioral Health rules are revised to: (1) Clarify that rehabilitative services are adjunct (enhancing) interventions designed to complement more intensive behavioral health therapies and interventions; (2) Limit BHRS services to age appropriate target populations for children and eliminate coverage to children under the age of 6 unless medical necessity requires an exception pursuant to EPSDT requirements; and (3) Impose limits on BHRS services which will be based on the individual's level of need as determined by standardized assessment tools recognized by ODMHSAS and OHCA.
Budget Impact: SFY 2013 $7,823,775 Total Savings ($2,814,994 State Savings); SFY 2014 $18,777,062 Total Savings ($6,755,986 State Savings)

X. New Business

XI. Adjourn

Next Meeting: Wednesday, November 14, 2012.

MEDICAL ADVISORY COMMITTEE MEETING
Draft Meeting Minutes
September 20, 2012

Members Present: Ms. Bierig, Dr. Bourdeau, Ms. Brinkley, Ms. Case, Dr. Cavallaro, Dr. Crawford, Mr. Rick Snyder for Ms. Patti Davis, Ms. Felty, Ms. Fritz, Mr. Goforth, Dr. Grogg, Ms. Holiman-James, Mr. Jones, Mr. McAdoo, Ms. Mayes, Dr. McNeill, Mr. Pilgrim, Dr. Post, Dr. Rhoades, Dr. Rhynes, Ms. Russell, Dr. Simon, Mr. Larry Brose for Ms. Slatton-Hodges, Dr. Wells, Ms. Wheaton, Dr. Jay Kinnard for Dr. Woodward, Dr. Wright

Ms. Bates, Ms. Bellah, Dr. Ogle, Mr. Patterson, Mr. Tallent

I. Welcome, Roll Call, and Public Comment Instructions

Roll call determined the establishment of a quorum. Dr. Crawford welcomed and introduced Dr. Sylvia Lopez M.D. as the new Chief Medical Officer as of July 1, 2012. Dr. Crawford announced that Mike Fogarty, CEO will retire on his birthday in March 2013. Mr. Fogarty thanked the MAC for their voluntary service.

Public comment by Mr. Lee Holmes addressing the Medicaid Income Pension Trust limit and qualifications, and requesting to do away with it. Mr. Holmes discussed the Spousal Impoverishment Law, the purpose is to prevent the at-home spouse from going broke paying for nursing home costs of their spouse. Mr. Holmes explained that if a member cannot qualify for the Trust, then they don't have enough money to provide any money for their spouse at home. If they do have the Trust, all the money goes into the Trust, and they have to leave in the trust an amount that exceeds $2,094. Mr. Holmes gave an example, if someone had $3,985. a month, they would be leaving about $1,800 in the Trust until they died. In the meantime, they can only take out the $2,094 a month, and out of that they have to pay their health insurance premiums, Medicare premiums, etc., that leaves the spouse at home $1,600 or $1,700 a month. In the rest of the country, every spouse keeps up to about $2841 a month income to live on, and is Federal and Oklahoma law, where we provide for spouses at home up to $2,800. Unfortunately when we have the Trust involved it limits how much can be pulled out of the Trust for the spouse. The amount pulled out of the Trust pays for the medical premiums, and the spouse gets $1,600 or $1,700 a month, which is not enough money, and there is about $2,094 that stays in the trust until the recipient dies, then that money gets paid to the state. All the time the person is in the nursing home with the Trust, with a spouse at home, Medicaid is paying 100% of the nursing home cost, but the spouse is not getting their minimum monthly maintenance needs allowance, and Medicaid is paying out 100% instead of using some of that money in the Trust. Mr. Holmes asked - Why do we use the Trust?, and said it takes time, effort, cost, and that he cannot see the benefit.

Explanation was provided by Dr. Splinter and Mr. Fogarty.

II. Approval of minutes of the May 17, 2012 Medical Advisory Committee Meeting

Motion to approve by Ms. Holiman-James, seconded by Ms. Fritz. Approved.

III. MAC Member Comments/Discussion

Dr. Wells commented on stainless steel vs. aesthetic crowns coding and renumeration. Request to reconsider code D2934, restoration of anterior teeth on children. Aesthetic crowns take 30 minutes extra anesthesia time and are more difficult to produce, and about 6 times more expensive just for the hardware.

Dr. Wells requested advance notice of code changes and to be given time until the next meeting so it can be taken to the dental community.

A question was asked by Dr. Wright if the reimbursement was changed with the new crown. Dr. Wells replied no. Dr. Wright asked if they're restricted to only using the new crowns, or can they still use the stainless steel. Dr. Wells said he can still use it, but if requested, and if he's doing it for private patients that are not SoonerCare patients, he has to offer the same service. Dr. Wright said in Dr. Wells's dental expertise, he could say the changing of the tooth and all the things mentioned as negative, could be reasons where he could steer the patient towards his dental opinion would be to use stainless steel. Dr. Wright expressed concern of the 30 minutes extra anesthesia time, extra risk.

A question was asked about the changing of codes and Ms. Tywanda Cox explained codes are done annually. For this dental code, this was an addition, not a restriction to the code.

Explanation is that no code was taken away, a code was added. Dr. Crawford said the agency isn't saying they dentists have to do that. Dr. Wells said if the parent says they need to do it, Dr. Wells said then they're in violation if doing it on their private patients and discriminating against SoonerCare patients.

Dr. Splinter commented that this is an added service that we did not cover before. Usually we are not as concerned about problems when we add covered services. It was being offered to patients, and because it was not a covered service, it could be balance billed, so the patients would pay out of pocket. Dr. Splinter and Dr. Bragg discussed and are looking at the code to see if patients are being hurt by this.

There is a question of the rate at the level it needs to be, now at the same rate, since there is additional cost. Dr. Splinter reminded the MAC of the problems with budget and with cosmetic services, and assured the MAC that we are looking at it. Mr. Rains and Ms. Anthony said the medical division can make a recommendation to review a code and temporarily turn a code off while reviewing. Dr. Splinter explained that turning off a code means it is not a covered Medicaid service, and we will not pay anything for that service, and the patients that do receive that are paying for it through balance billing out of pocket, and we would only cover the stainless steel anterior crowns at that point.

MAC members voiced concern of patients who had the appointment scheduled before the code was turned off. The providers and public would be notified.

Discussion continued about the pricing and the pain involved with more work on the crown, and Dr. Wells said he could solve it with a stainless steel crown in half the time, and stainless steel is twice as good as aesthetic. Mr. Fogarty asked if there was justification for this, and if medically a good thing to do.

Ms. Fritz suggested referring to the Dental Focus Group for discussion with Dr. Wells attending, and a report back to the MAC at the November meeting.

Dr. Splinter said we are looking at the number of kids involved, costs, budget. This issue has been looked at with our medical staff.

IV. Financial Report: Gloria Hudson, Director of General Accounting

A. June Financial Summary
B. June Financial Detail Report

There were no questions.

V. SoonerCare Operations Update:

A. SoonerCare Programs Report – Kevin Rupe
B. Productivity Report – Kevin Rupe
C. Motion Charts - A New Way to Visualize Healthcare Data – Alison Martinez
D. Medical Home 2013 - Possible Changes in Requirements – Melody Anthony

Reports were presented and reviewed. There was favorable response to Ms. Martinez's Motion Chart, with the breakout of the categories from the Annual Report. The motion charts are interactive and allow various types of graphs and charts to be used, i.e., bubble graphs, pie charts, bar charts. The chart reviewed was for demonstration only. The program is Google Viz. The chart is not difficult once all the information is pulled, but it is the pulling of the data that is time consuming.

Medical Home 2013 was discussed. Behavioral Health screening in the Medical Home, currently mandatory in Tier 3, optional in Tier 2, not in Tier 1. We decided to leave Tier 1 alone this year for the screening, give notice for ACA requirements, make it mandatory in Tier 2 and keep it mandatory in Tier 3.

For after hours care, Ms. Anthony mentioned that providers said they would love to be a specific tier, but they have a life. The agency talked about taking it from 4 hours to 6 for after hours. We asked if providers could only do 4, if it would be the weekend, and if 6, possibly Monday through Friday. We are trying to increase access to care for members at the Medical Home. Ms. Anthony suggested providers collaborate with other providers in the community to have after hours. The MAC mentioned increased hours can result in decreased ER visits; lessen cost and improve care.

Dr. McNeill asked if we have evidence to support the change. Ms. Anthony replied we do not at this time, but we looked at providers who have 4 hours, utilizing OU-Tulsa, a Tier 3 and after hours responsibility, and they are looking at data to see if they are seeing more patients after hours than 8:00-5:00. We are also looking internally, and researching literature. Dr. Crawford explained the PCMH principle was to increase access to providers.

Ms. Anthony referred to the Annals of Family Medicine, an article stating there is an impact on the health of the member and the utilization of services at the practice if there are additional hours available at the practice.

A question was asked how this works with small provider offices and solo practitioners. Ms. Anthony replied that we had several practitioners respond they could not do the extra hours, and we requested they collaborate with a peer in the community, and as long as we know, and the members know who to call, and after hours coverage is collaborated, and to communicate if the member is not their member but a peer's in the after hours setting. We have an after hours code for Medical Home providers.

MAC members requested more study.

VI. Presentation on SoonerCare Choice Waiver Amendment for 2014 Compliance: Tywanda Cox

The information was reviewed and discussed. Mr. Gomez informed the MAC members they can make public comment through our website.

VII. Action Items:

OHCA Initiated

12-06 Medicaid Income Pension Trust— Emergency rule revisions are proposed to increase the income cap for the Medicaid Income Pension Trust (or Miller Trust) to the average monthly cost of nursing home care. The income cap in current rules is $3,000 per month. As of September 1, 2012, the average cost of nursing home care increases to $4,235 per month (as published in OKDHS Appendix C-1 Schedule VIII.B). Increasing the cap to the cost of care will help to eliminate the gap in coverage for people who have more than $3,000 in income per month but not enough to afford the full out-of-pocket cost of long term care services. This change affects financial eligibility rules for all long term care programs, including the waiver programs for Home and Community Based Services.
Budget Impact: SFY 2013 $6 million total; $2.15 million State share

Motion to approve by Dr. Wright. Seconded by Dr. Rhynes. Approved.

VIII. New Business

IX. Adjourn

Next Meeting: Wednesday, November 14, 2012.

OKLAHOMA HEALTH CARE AUTHORITY
Summary of Revenues & Expenditures: OHCA
Fiscal Year 2013, For the Two Months Ended August 31, 2012

REVENUES	FY13 Budget YTD	FY13 Actual YTD	Variance	% Over/ (Under)
State Appropriations	$ 193,955,502	$ 193,955,502	$ -	0.0%
Federal Funds	313,485,935	305,021,696	(8,464,239)	(2.7)%
Tobacco Tax Collections	10,663,036	10,181,242	(481,794)	(4.5)%
Quality of Care Collections	8,462,482	8,462,482	-	0.0%
Prior Year Carryover	43,075,735	43,075,735	-	0.0%
Federal Deferral - Interest	27,451	27,451	-	0.0%
Drug Rebates	39,452,556	38,661,161	(791,395)	(2.0)%
Medical Refunds	8,071,823	7,479,190	(592,633)	(7.3)%
SHOPP	93,513,235	93,513,235	-	0.0%
Other Revenues	3,838,770	3,867,766	28,996	0.8%
TOTAL REVENUES	**$ 714,546,525**	**$ 704,245,460**	**$ (10,301,065)**	**(1.4)%**

EXPENDITURES	FY13 Budget YTD	FY13 Actual YTD	Variance	% (Over)/ Under
ADMINISTRATION - OPERATING	**$ 7,761,512**	**$ 6,601,209**	**$ 1,160,303**	**14.9%**
ADMINISTRATION - CONTRACTS	**$ 20,326,770**	**$ 18,618,070**	**$ 1,708,700**	**8.4%**
MEDICAID PROGRAMS				
Managed Care:				
SoonerCare Choice	5,811,525	5,749,713	61,812	1.1%
Acute Fee for Service Payments:				
Hospital Services	145,615,830	137,437,839	8,177,991	5.6%
Behavioral Health	3,541,945	3,350,823	191,122	5.4%
Physicians	78,008,600	77,988,764	19,835	0.0%
Dentists	25,424,655	25,600,731	(176,076)	(0.7)%
Other Practitioners	11,426,318	11,232,519	193,799	1.7%
Home Health Care	3,963,007	3,839,247	123,760	3.1%
Lab & Radiology	10,309,615	9,968,742	340,872	3.3%
Medical Supplies	8,347,791	8,439,238	(91,447)	(1.1)%
Ambulatory/Clinics	20,599,949	20,355,294	244,655	1.2%
Prescription Drugs	64,501,955	62,063,033	2,438,922	3.8%
OHCA TFC	539,124	481,677	57,448	0.0%
Other Payments:				
Nursing Facilities	85,043,846	84,691,304	352,542	0.4%
ICF-MR Private	9,893,300	9,929,113	(35,813)	(0.4)%
Medicare Buy-In	21,571,464	21,425,739	145,725	0.7%
Transportation	10,999,466	10,940,720	58,746	0.5%
EHR-Incentive Payments	3,437,298	3,437,298	-	0.0%
Part D Phase-In Contribution	12,978,565	12,863,819	114,746	0.9%
SHOPP payments	85,960,153	85,960,153	-	0.0%
Total OHCA Medical Programs	**607,974,404**	**595,755,765**	**12,218,639**	**2.0%**
OHCA Non-Title XIX Medical Payments	89,382	-	89,382	0.0%
TOTAL OHCA	**$ 636,152,068**	**$ 620,975,044**	**$ 15,177,024**	**2.4%**
REVENUES OVER/(UNDER) EXPENDITURES	**$ 78,394,457**	**$ 83,270,416**	**$ 4,875,959**	

OKLAHOMA HEALTH CARE AUTHORITY
Total Medicaid Program Expenditures
by Source of State Funds
Fiscal Year 2013, For the Two Months Ended August 31, 2012

Category of Service	Total	Health Care Authority	Quality of Care Fund	HEEIA	Medicaid Program Fund	BCC Revolving Fund	Other State Agencies
SoonerCare Choice	$ 5,822,766	$ 5,746,309	$ -	$ 73,053	$ -	$ 3,403	$ -
Inpatient Acute Care	103,509,858	83,329,715	81,114	1,521,889	8,620,744	279,242	9,677,153
Outpatient Acute Care	46,896,653	44,473,078	6,934	1,769,631	-	647,010	-
Behavioral Health - Inpatient	3,359,043	2,158,063	-	-	-		1,200,980
Behavioral Health - Psychiatrist	1,192,760	1,192,760	-	-	-	-	-
Behavioral Health - Outpatient	4,075,565	-	-	-	-	-	4,075,565
Behavioral Health Facility- Rehab	40,426,250	(22,127)	-	114,812	-	22,127	40,311,439
Behavioral Health - Case Management	1,284,319	-	-	-	-	-	1,284,319
Behavioral Health - PRTF	15,934,596	-	-	-	-	-	15,934,596
Residential Behavioral Management	3,613,660	-	-	-	-	-	3,613,660
Targeted Case Management	6,609,410	-	-	-	-	-	6,609,410
Therapeutic Foster Care	481,677	481,677	-	-	-	-	-
Physicians	86,918,732	66,152,835	9,683	2,403,691	10,547,017	1,279,229	6,526,277
Dentists	25,611,237	24,168,651	-	10,505	1,425,777	6,303	-
Mid Level Practitioners	674,537	655,572	-	17,704	-	1,261	-
Other Practitioners	10,606,743	10,330,032	74,394	31,057	169,415	1,845	-
Home Health Care	3,839,247	3,836,851	-	-	-	2,397	-
Lab & Radiology	10,544,048	9,844,955	-	575,305	-	123,787	-
Medical Supplies	8,591,199	8,000,232	430,402	151,961	-	8,603	-
Clinic Services	19,707,881	18,452,333	-	258,287	-	52,089	945,172
Ambulatory Surgery Centers	1,949,709	1,848,291	-	98,837	-	2,580	-
Personal Care Services	2,184,238	-	-	-	-	-	2,184,238
Nursing Facilities	84,691,304	54,311,390	23,403,517	-	6,974,055	2,342	-
Transportation	10,878,961	9,914,623	427,534	-	523,868	12,936	-
GME/IME/DME	34,687,799	-	-	-	-	-	34,687,799
ICF/MR Private	9,929,113	8,196,184	1,594,560	-	138,369	-	-
ICF/MR Public	9,129,723	-	-	-	-	-	9,129,723
CMS Payments	34,289,558	33,838,395	451,162	-	-	-	-
Prescription Drugs	65,466,063	54,184,095	-	3,403,030	7,621,337	257,601	-
Miscellaneous Medical Payments	61,758	61,758	-	-	-	-	-
Home and Community Based Waiver	27,708,136	-	-	-	-	-	27,708,136
Homeward Bound Waiver	14,767,809	-	-	-	-	-	14,767,809
Money Follows the Person	643,892	-	-	-	-	-	643,892
In-Home Support Waiver	3,981,449	-	-	-	-	-	3,981,449
ADvantage Waiver	30,334,117	-	-	-	-	-	30,334,117
Family Planning/Family Planning Waiver	1,562,378	-	-	-	-	-	1,562,378
Premium Assistance*	8,547,962	-	-	8,547,962		-	-
EHR Incentive Payments	3,437,298	3,437,298	-	-	-	-	-
SHOPP Payments**	85,960,153	85,960,153	-	-	-	-	-
Total Medicaid Expenditures	**$ 829,911,600**	**$ 444,592,972**	**$ 26,479,302**	**$ 18,977,723**	**$ 36,020,583**	**$ 2,702,756**	**$ 215,178,111**

* Includes $8,492,758.81 paid out of Fund 245 and **$85,960,152.56 paid out of Fund 205

OKLAHOMA HEALTH CARE AUTHORITY
Summary of Revenues & Expenditures:
Other State Agencies
Fiscal Year 2013, For the Two Months Ended August 31, 2012

		FY13
REVENUE		**Actual YTD**
Revenues from Other State Agencies	$	91,389,395
Federal Funds		137,977,420
TOTAL REVENUES	**$**	**229,366,815**
EXPENDITURES		**Actual YTD**
Department of Human Services		
Home and Community Based Waiver	$	27,708,136
Money Follows the Person		643,892
Homeward Bound Waiver		14,767,809
In-Home Support Waivers		3,981,449
ADvantage Waiver		30,334,117
ICF/MR Public		9,129,723
Personal Care		2,184,238
Residential Behavioral Management		2,693,758
Targeted Case Management		4,508,474
Total Department of Human Services		**95,951,595**
State Employees Physician Payment		
Physician Payments		6,526,277
Total State Employees Physician Payment		**6,526,277**
Education Payments		
Graduate Medical Education		-
Graduate Medical Education - PMTC		193,168
Indirect Medical Education		30,449,271
Direct Medical Education		4,045,360
Total Education Payments		**34,687,799**
Office of Juvenile Affairs		
Targeted Case Management		574,026
Residential Behavioral Management - Foster Care		-
Residential Behavioral Management		919,902
Total Office of Juvenile Affairs		**1,493,929**
Department of Mental Health		
Case Management		1,284,319
Inpatient Psych FS		1,200,980
Outpatient		4,075,565
PRTF		15,934,596
Rehab		40,311,439
Total Department of Mental Health		**62,806,899**
State Department of Health		
Children's First		392,528
Sooner Start		348,416
Early Intervention		603,022
EPSDT Clinic		424,144
Family Planning		10,480
Family Planning Waiver		1,544,805
Maternity Clinic		6,199
Total Department of Health		**3,329,593**
County Health Departments		
EPSDT Clinic		122,301
Family Planning Waiver		7,094
Total County Health Departments		**129,395**
State Department of Education		**6,200**
Public Schools		**569,271**
Medicare DRG Limit		**9,000,000**
Native American Tribal Agreements		**-**
Department of Corrections		**-**
JD McCarty		**677,153**
Total OSA Medicaid Programs	**$**	**215,178,111**
OSA Non-Medicaid Programs	**$**	**12,739,889**
Accounts Receivable from OSA	**$**	**(1,448,815)**

OKLAHOMA HEALTH CARE AUTHORITY

SUMMARY OF REVENUES & EXPENDITURES:

Fund 205: Supplemental Hospital Offset Payment Program Fund

Fiscal Year 2013, For the Two Months Ended August 31, 2012

REVENUES		FY 13 Revenue
SHOPP Assessment Fee	**$**	**38,601,890**
Federal Draws		**54,911,345**
Penalties		**-**
State Appropriations		**(7,500,000)**
TOTAL REVENUES	**$**	**86,013,235**

EXPENDITURES	Quarter		FY 13 Expenditures
Program Costs:	**7/1/12 - 9/30/12**		
Hospital - Inpatient Care	76,857,805	**$**	**76,857,805**
Hospital -Outpatient Care	3,224,900	**$**	**3,224,900**
Psychiatric Facilities-Inpatient	5,660,381	**$**	**5,660,381**
Rehabilitation Facilities-Inpatient	217,066	**$**	**217,066**
Total OHCA Program Costs	**85,960,153**	**$**	**85,960,153**
Total Expenditures		**$**	**85,960,153**

CASH BALANCE		
	$	**53,083**

OKLAHOMA HEALTH CARE AUTHORITY
SUMMARY OF REVENUES & EXPENDITURES:
Fund 230: Nursing Facility Quality of Care Fund
Fiscal Year 2013, For the Two Months Ended August 31, 2012

REVENUES	Total Revenue	State Share
Quality of Care Assessment	$ 8,595,248	$ 8,595,248
Interest Earned	5,235	5,235
TOTAL REVENUES	**$ 8,600,483**	**$ 8,600,483**

EXPENDITURES	FY 13 Total $ YTD	FY 13 State $ YTD	Total State $ Cost
Program Costs			
NF Rate Adjustment	$ 22,739,198	$ 8,192,933	
Eyeglasses and Dentures	49,579	17,863	
Personal Allowance Increase	614,740	221,491	
Coverage for DME and supplies	430,402	155,074	
Coverage of QMB's	172,126	62,017	
Part D Phase-In	451,162	451,162	
ICF/MR Rate Adjustment	770,700	277,683	
Acute/MR Adjustments	823,861	296,837	
NET - Soonerride	427,534	154,041	
Total Program Costs	**$ 26,479,302**	**$ 9,829,101**	**$ 9,829,101**
Administration			
OHCA Administration Costs	$ 88,223	$ 44,112	
DHS - 10 Regional Ombudsman	-	-	
OSDH-NF Inspectors	-	-	
Mike Fine, CPA	-	-	
Total Administration Costs	**$ 88,223**	**$ 44,112**	**$ 44,112**
Total Quality of Care Fee Costs	**$ 26,567,525**	**$ 9,873,213**	
TOTAL STATE SHARE OF COSTS			**$ 9,873,213**

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

OKLAHOMA HEALTH CARE AUTHORITY
SUMMARY OF REVENUES & EXPENDITURES:
Fund 245: Health Employee and Economy Improvement Act Revolving Fund
Fiscal Year 2013, For the Two Months Ended August 31, 2012

REVENUES	FY 12 Carryover	FY 13 Revenue	Total Revenue
Prior Year Balance	$ 27,390,790	$ -	$ 19,048,779
State Appropriations			
Tobacco Tax Collections	-	8,373,763	8,373,763
Interest Income	-	121,948	121,948
Federal Draws	108,222	5,425,174	5,425,174
All Kids Act	(7,238,067)	44,454	44,454
TOTAL REVENUES	$ 20,260,945	$ 13,965,339	$ 32,969,664

EXPENDITURES		FY 12 Expenditures	FY 13 Expenditures	Total $ YTD
Program Costs:				
	Employer Sponsored Insurance		$ 8,390,433	$ 8,390,433
	College Students		55,203	55,203
	All Kids Act		102,326	102,326
Individual Plan				
	SoonerCare Choice		$ 70,593	$ 25,435
	Inpatient Hospital		1,517,414	546,724
	Outpatient Hospital		1,750,902	630,850
	BH - Inpatient Services-DRG		-	-
	BH -Psychiatrist		-	-
	Physicians		2,376,486	856,248
	Dentists		6,608	2,381
	Mid Level Practitioner		17,422	6,277
	Other Practitioners		30,264	10,904
	Home Health		-	-
	Lab and Radiology		568,992	205,008
	Medical Supplies		146,271	52,702
	Clinic Services		253,029	91,166
	Ambulatory Surgery Center		98,539	35,504
	Prescription Drugs		3,348,868	1,206,597
	Miscellaneous Medical		-	-
	Premiums Collected		-	(405,497)
Total Individual Plan			$ 10,185,389	$ 3,264,298
	College Students-Service Costs		$ 108,507	$ 39,095
	All Kids Act- Service Costs		$ 21,053	$ 7,585
Total OHCA Program Costs			$ 18,862,912	$ 11,858,941
OSA-DMHSAS Rehab			$ 114,812	$ -
Total Medicaid Program Costs			$ 18,977,723	$ 11,858,941
Administrative Costs				
	Salaries	$ 30,135	$ 253,348	$ 283,483
	Operating Costs	28,814	42,743	71,557
	Health Dept-Postponing	-	-	-
	Contract - HP	1,153,217	-	1,153,217
Total Administrative Costs		$ 1,212,166	$ 296,091	$ 1,508,257
Total Expenditures				$ 13,367,198
NET CASH BALANCE		$ 19,048,779		$ 19,602,466

OKLAHOMA HEALTH CARE AUTHORITY

SUMMARY OF REVENUES & EXPENDITURES:

Fund 250: Belle Maxine Hilliard Breast and Cervical Cancer Treatment Revolving Fund

Fiscal Year 2013, For the Two Months Ended August 31, 2012

REVENUES	FY 13 Revenue	State Share
Tobacco Tax Collections	$ 167,113	$ 167,113
TOTAL REVENUES	**$ 167,113**	**$ 167,113**

EXPENDITURES	FY 13 Total $ YTD	FY 13 State $ YTD	Total State $ Cost
Program Costs			
SoonerCare Choice	$ 3,403	$ 858	
Inpatient Hospital	279,242	70,425	
Outpatient Hospital	647,010	163,176	
Inpatient Services-DRG	-	-	
Psychiatrist	0	-	
TFC-OHCA	0	-	
Nursing Facility	2,342	591	
Physicians	1,279,229	322,621	
Dentists	6,303	1,590	
Mid-level Practitioner	1,261	318	
Other Practitioners	1,845	465	
Home Health	2,397	604	
Lab & Radiology	123,787	31,219	
Medical Supplies	8,603	2,170	
Clinic Services	52,089	13,137	
Amulatory Surgery Center	2,580	651	
Prescription Drugs	257,601	64,967	
Transportation	12,936	3,262	
Miscellaneous Medical	0	-	
Total OHCA Program Costs	$ 2,680,629	$ 676,055	
OSA-DMHSAS Rehab	$ 22,127	$ 5,581	
Total Medicaid Program Costs	$ 2,702,756	$ 681,635	
TOTAL STATE SHARE OF COSTS			**$ 681,635**

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.

FINANCIAL REPORT

For the Two Months Ended August 31, 2012
Submitted to the CEO & Board
October 24, 2012

- Revenues for OHCA through August, accounting for receivables, were **$704,245,460** or **(1.4%) under** budget.
- Expenditures for OHCA, accounting for encumbrances, were **$620,975,044** or **2.4% under** budget.
- The state dollar budget variance through August is **$4,875,959 positive.**
- The budget variance is primarily attributable to the following (in millions):

Expenditures:		
Medicaid Program Variance		4.9
Administration		1.0
Revenues:		
Taxes and Fees		(.5)
Drug Rebate		(.3)
Overpayments/Settlements		(.2)
Total FY 13 Variance	**$**	**4.9**

ATTACHMENTS

SoonerCare Programs

September 2012 Data for November 2012 Board Meeting

SOONERCARE ENROLLMENT/EXPENDITURES

Delivery System			Monthly Enrollment Average SFY2012	Enrollment September 2012	Total Expenditures September 2012	Average Dollars Per Member Per Month September 2012
SoonerCare Choice Patient-Centered Medical Home			468,268	**478,690**	**$121,739,149**	
	Lower Cost	*(Children/Parents; Other)*		434,030	$85,914,205	$198
	Higher Cost	*(Aged, Blind or Disabled; TEFRA; BCC)*		44,660	$35,824,943	$802
SoonerCare Traditional			241,278	**249,896**	**$171,664,723**	
	Lower Cost	*(Children/Parents; Other)*		141,245	$45,560,486	$323
	Higher Cost	*(Aged, Blind or Disabled; TEFRA; BCC & HCBS Waiver)*		108,651	$126,104,237	$1,161
SoonerPlan			41,378	**46,198**	**$958,796**	$21
Insure Oklahoma			31,502	**30,219**	**$9,151,848**	
	Employer-Sponsored Insurance		17,728	16,525	$4,158,910	$252
	Individual Plan		13,773	13,694	$4,992,938	$365
TOTAL			**782,425**	**805,003**	**$303,514,516**	

The enrollment totals above include all members enrolled during the report month; therefore, some members may not have expenditure data.
Custody expenditures are excluded. Non-member specific expenditures of $56,227,020 are excluded.

Net Enrollee Count Change from Previous Month Total	5,586

New Enrollees	21,004

Opportunities for Living Life (OLL) (subset of data above)

Qualifying Group	Age Group	Enrollment
Aged/Blind/Disabled	*Child*	19,574
Aged/Blind/Disabled	*Adult*	132,366
Other	*Child*	176
Other	*Adult*	20,736
PACE	*Adult*	110
TEFRA	*Child*	440
Living Choice	*Adult*	97
OLL Enrollment		**173,499**

The "Other" category includes DDSD State, PKU, Q1, Q2, Refugee, SLMB, Soon-to-be-Sooners (STBS) and TB members.

Medicare and SoonerCare	Monthly Average SFY2012	Enrolled September 2012
Dual Enrollees	**107,504**	**108,415**

		Monthly Average SFY2012	Enrolled September 2012
Long-Term Care Members		**15,770**	**15,866**
	Child	87	69
	Adult	15,683	15,797

FACILITY PER MEMBER PER MONTH

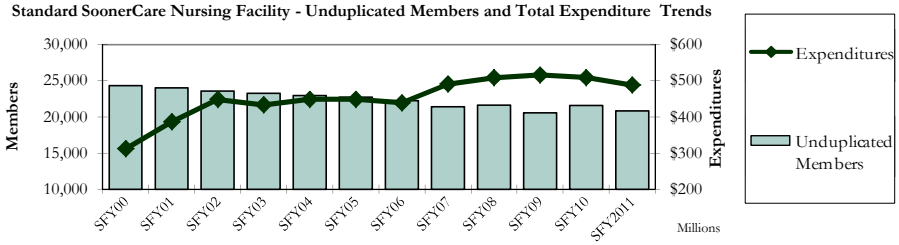
$3,348

SFY2011 Long-Term Care

Statewide LTC Occupancy Rate - 71.0%
SoonerCare funded LTC Bed Days 68.2%

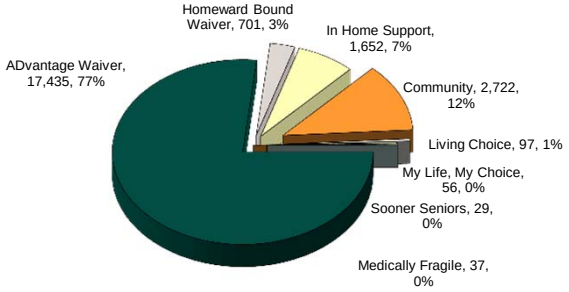
Data as of October 2011

Standard SoonerCare Nursing Facility - Unduplicated Members and Total Expenditure Trends



Data as of Aug. 8, 2011. Figures do not include intermediate care facilities for the intellectually disabled (ICF/ID).

Waiver Enrollment Breakdown Percent



ADvantage Waiver - Serves frail elderly individuals age 65 or older and adults age 21 and older with physical disabilities who would otherwise require placement in a nursing facility.
Community - serves individuals 3 years of age and older who have intellectual disabilities and certain persons with related conditions who would otherwise require placement in an intermediate care facility for the intellectually disabled (ICF/ID).
Homeward Bound Waiver - Designed to serve the needs of individuals with intellectual disabilities or "related conditions" who are also members of the Plaintiff Class in Homeward Bound et al. v. The Hissom Memorial Center, et al, who would otherwise qualify for placement in an ICF/ID.
In Home Support - Serves the needs of individuals 3 years of age and older with intellectual disabilities who would otherwise require placement in an ICF/ID.
Living Choice - Promotes community living for people of all ages who have disabilities or long-term illnesses.
Medically Fragile - This program serves qualifying individuals who meet hospital or skilled nursing facility level of care.
My Life, My Choice - This program is for adults with physical disabilities who transitioned to the community under the Living Choice program.
Sooner Seniors - This program is for adults 65 and older with long term illnesses who transitioned to community-based services in the Living Choice program.

SoonerCare Programs

SOONERCARE CONTRACTED PROVIDER INFORMATION

Provider Counts		Monthly Average SFY2012	Enrolled September 2012*
Total Providers		**29,723**	**39,314**
	In-State	20,881	28,798
	Out-of-State	8,842	10,516

*Effective July 2012, the methodology for counting providers has changed to count provider network. Previous counts include group practice and its members; the current count will include members only. Provider Network is providers who are contracted to provide health care services by locations, programs, types, and specialties. Providers are being counted multiple times if they have multiple locations, programs, types,

Program	% of Capacity Used
SoonerCare Choice	42%
SoonerCare Choice I/T/U	14%
Insure Oklahoma IP	3%

Select Provider Type Counts	*In-State*		*Totals*	
	Monthly Average SFY2012	*Enrolled September 2012**	Monthly Average SFY2012	Enrolled September 2012
Physician	*7,497*	*8,818*	*13,790*	15,639
Pharmacy	*874*	*894*	*1,153*	1,197
Mental Health Provider**	*3,395*	*5,373*	*3,449*	5,440
Dentist	*986*	*1,183*	*1,124*	1,351
Hospital	*194*	*200*	*934*	1,068
Optometrist	*550*	*597*	*587*	634
Extended Care Facility	*375*	*365*	375	365

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

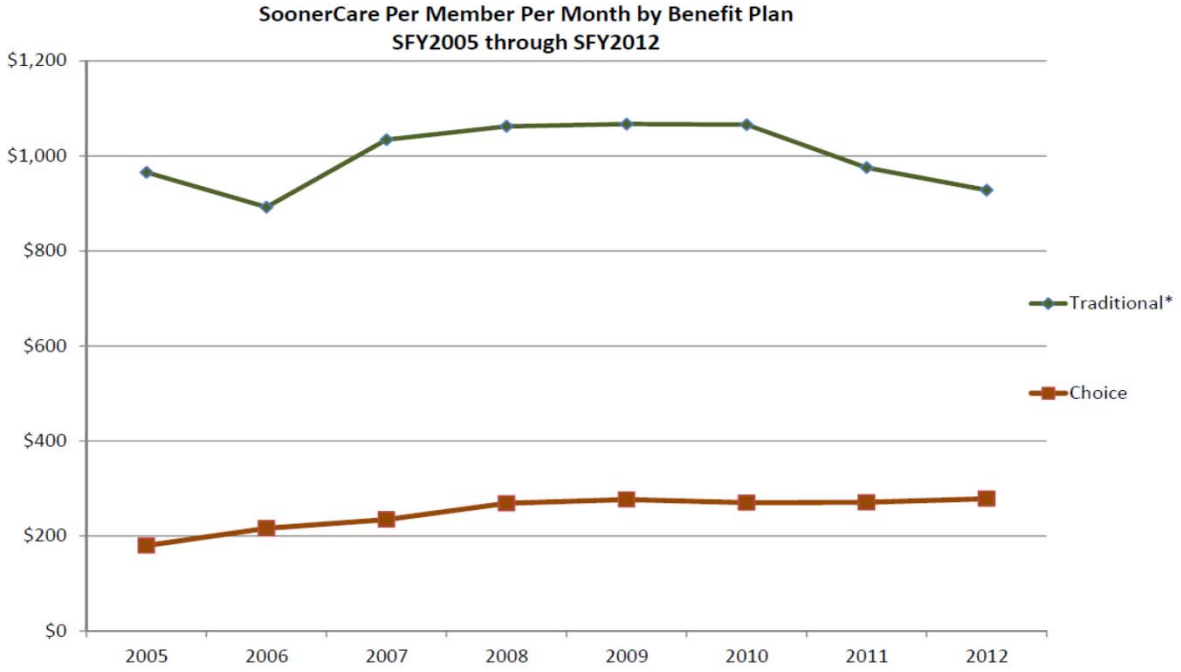
Total Primary Care Providers	*4,915*	*5,321*	6,955	7,366
Patient-Centered Medical Home	*1,711*	*1,953*	1,739	1,991

Including Physicians, Physician Assistants and Advance Nurse Practitioners.

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

**Due to federal regulations, OHCA must have an approved agreement on file for all providers providing care to our members. To meet this requirement OHCA is directly contracting with providers that had previously billed through a group or agency. This contributed to the increase in the provider counts for Mental Health Providers.

SOONERCARE PER MEMBER PER MONTH SFY 2005 - SFY 2012



Source: Member months from monthly Fast Facts reports. Total expenditures from SFY 2007-SFY2012 OHCA Annual Reports; SFY2005-SFY2006 extracted August 2012.
*Traditional includes Home and Community-Based Services waiver and SoonerCare Supplemental. Choice and Traditional include supplemental payments. To maintain comparability SHOPP payments ($342,365,712) were removed from SFY2012 Traditional.

ELECTRONIC HEALTH RECORDS (EHR) INCENTIVE STATISTICS

The Electronic Health Records Incentive Program is a federal program that offers major financial support to assist certain providers to adopt (acquire and install), implement (train staff, deploy tools, exchange data), upgrade (expand functionality or interoperability) or meaningfully use certified EHR technology.

As Of 10/24/2012	October 2012		Since Inception	
	Number of Payments	Payment Amount	Total Number of Payments	Total Payment Amount
Eligible Professionals	71	$1,139,000	1,446	$31,383,417
Eligible Hospitals	1*	$300,000	82	$55,191,968
Totals	72	$1,439,000	1,528	$86,575,385

*Current Eligible Hospitals Paid
HARMON MEM HSP

MIKE FOGARTY
CHIEF EXECUTIVE OFFICER

MARY FALLIN
GOVERNOR

STATE OF OKLAHOMA

OKLAHOMA HEALTH CARE AUTHORITY

2013 MAC DATES (PROPOSED)

January 17, 2013	July 18, 2013
March 13, 2013*	September 19, 2013
May 16, 2013	November 21, 2013

*** Changed to Wednesday, March 13th, due to OHCA Board Meeting.**

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 27. INDEPENDENT LICENSED PHYSICAL THERAPISTS

317:30-5-291. Coverage by category

Payment is made to registered physical therapists as set forth in this Section.

(1) **Children.** Initial therapy evaluations do not require prior authorization. All therapy services following the initial evaluation must be prior authorized for continuation of service. Prior to the initial evaluation, the therapist must have on file a signed and dated prescription or referral for the therapy services from the member's physician or other licensed practitioner of the healing arts. The prescribing or referring provider must be able to provide, if requested, clinical documentation from the member's medical record that supports the medical necessity for the evaluation and referral.

(2) **Adults.** There is no coverage for adults for services rendered by individually contracted providers. Coverage for adults is permitted in an outpatient hospital setting as described in 30-5-42.1.

(3) **Individuals eligible for Part B of Medicare.** Services provided to Medicare eligible recipients are filed directly with the fiscal agent.

PART 28. OCCUPATIONAL THERAPY SERVICES

317:30-5-296. Coverage by category

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

(1) **Children.** Initial therapy evaluations do not require prior authorization. All therapy services following the initial evaluation must be prior authorized for continuation of service. Prior to the initial evaluation, the therapist must have on file a signed and dated prescription or referral for the therapy services from the member's physician or other licensed practitioner of the healing arts. The prescribing or referring provider must be able to provide, if requested, clinical documentation from the member's medical record that supports the medical necessity for the evaluation and referral.

(2) **Adults.** There is no coverage for adults for services rendered by individually contracted providers. Coverage for adults is permitted in an outpatient hospital setting as

described in 30-5-42.1.

(3) **Individuals eligible for Part B of Medicare.** Services provided to Medicare eligible recipients are filed directly with the fiscal agent.

PART 77. SPEECH AND HEARING SERVICES

317:30-5-676. Coverage by category

Payment is made for speech and hearing services as set forth in this Section.

(1) **Children.** Coverage for children is as follows:

(A) **Preauthorization required.** ~~Initial therapy evaluations and the first three therapy visits do not require prior authorization. All therapy services following the initial evaluation and first three visits must be preauthorized prior to continuation of service.~~ All therapy services, including the initial evaluation, must be prior authorized. Prior to the initial evaluation, the therapist must have on file a signed and dated prescription or referral for the therapy services from the member's physician or other licensed practitioner of the healing arts. The prescribing or referring provider must be able to provide, if requested, clinical documentation from the member's medical record that supports the medical necessity for the evaluation and referral.

(B) **Speech/Language Services.** Speech/language therapy services may include speech/language evaluations, individual and group therapy services provided by a state licensed speech/language pathologist.

(C) **Hearing aids.** Hearing and hearing aid evaluations include pure tone air, bone and speech audiometry by a state licensed audiologist. Payment is made for a hearing aid following a recommendation by a Medical or Osteopathic physician and a hearing aid evaluation by a state licensed audiologist.

(2) **Adults.** There is no coverage for adults for services rendered by individually contracted providers. Coverage for adults is permitted in an outpatient hospital setting as described in 30-5-42.1.

(3) **Individuals eligible for Part B of Medicare.** Services provided to Medicare eligible recipients are filed directly with the fiscal agent.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 1. PHYSICIANS

317:30-5-2. General coverage by category

(a) **Adults.** Payment for adults is made to physicians for medical and surgical services within the scope of the Oklahoma Health Care Authority's (OHCA's) SoonerCare program, provided the services are reasonable and necessary for the diagnosis and treatment of illness or injury, or to improve the functioning of a malformed body member. Coverage of certain services must be based on a determination made by the OHCA's medical consultant in individual circumstances.

(1) Coverage includes the following medically necessary services:

(A) Inpatient hospital visits for all SoonerCare covered stays. All inpatient services are subject to post-payment review by the OHCA, or its designated agent.

(B) Inpatient psychotherapy by a physician.

(C) Inpatient psychological testing by a physician.

(D) One inpatient visit per day, per physician.

(E) Certain surgical procedures performed in a Medicare certified free-standing ambulatory surgery center (ASC) or a Medicare certified hospital that offers outpatient surgical services.

(F) Therapeutic radiology or chemotherapy on an outpatient basis without limitation to the number of treatments per month for members with proven malignancies or opportunistic infections.

(G) Direct physician services on an outpatient basis. A maximum of four visits are allowed per month per member in office or home regardless of the number of physicians providing treatment. Additional visits per month are allowed for those services related to emergency medical conditions and for services in connection with Family Planning.

(H) Direct physician services in a nursing facility for those members residing in a long-term care facility. A maximum of two nursing facility visits per month are allowed. To receive payment for a second nursing facility visit in a month denied by Medicare for a Medicare/SoonerCare member, attach the EOMB from Medicare showing denial and mark "carrier denied coverage".

(I) Diagnostic x-ray and laboratory services.

(J) Mammography screening and additional follow-up mammograms.
(K) Obstetrical care.
(L) Pacemakers and prostheses inserted during the course of a surgical procedure.
(M) Prior authorized examinations for the purpose of determining medical eligibility for programs administered by OHCA. A copy of the authorization, OKDHS form 08MA016E, Authorization for Examination and Billing, must accompany the claim.
(N) If a physician renders direct care to a member on the same day as a dialysis treatment, payment is allowed for a separately identifiable service unrelated to the dialysis.
(O) Family planning includes sterilization procedures for legally competent members 21 years of age and over who voluntarily request such a procedure and execute the federally mandated consent form with his/her physician. A copy of the consent form must be attached to the claim form. Separate payment is allowed for the insertion and/or implantation of contraceptive devices during an office visit. Certain family planning products may be obtained through the Vendor Drug Program. Reversal of sterilization procedures for the purposes of conception is not allowed. Reversal of sterilization procedures are allowed when medically indicated and substantiating documentation is attached to the claim.
(P) Genetic counseling.
(Q) Laboratory testing (such as complete blood count (CBC), platelet count, or urinalysis) for monitoring members receiving chemotherapy, radiation therapy, or medications that require monitoring during treatment.
(R) Payment for ultrasounds for pregnant women as specified in OAC 317:30-5-22.
(S) Payment to the attending physician in a teaching medical facility for compensable services when the physician signs as claimant and renders personal and identifiable services to the member in conformity with federal regulations.
(T) Payment to clinical fellow or chief resident in an outpatient academic setting when the following conditions are met:

(i) Recognition as clinical faculty with participation in such activities as faculty call, faculty meetings, and having hospital privileges;

(ii) Board certification or completion of an accredited residency program in the fellowship specialty area;
(iii) Hold unrestricted license to practice medicine in Oklahoma;
(iv) If Clinical Fellow, practicing during second or subsequent year of fellowship;
(v) Seeing members without supervision;
(vi) Services provided not for primary purpose of medical education for the clinical fellow or chief resident;
(vii) Submit billing in own name with appropriate Oklahoma SoonerCare provider number.
(viii) Additionally if a clinical fellow practicing during the first year of fellowship, the clinical fellow must be practicing within their area of primary training. The services must be performed within the context of their primary specialty and only to the extent as allowed by their accrediting body.

(U) Payment to the attending physician for the services of a currently Oklahoma licensed physician in training when the following conditions are met.

(i) Attending physician performs chart review and signs off on the billed encounter;
(ii) Attending physician is present in the clinic/or hospital setting and available for consultation;
(iii) Documentation of written policy and applicable training of physicians in the training program regarding when to seek the consultation of the attending physician.

(V) Payment to the attending physician for the outpatient services of an unlicensed physician in a training program when the following conditions are met:

(i) The member must be at least minimally examined by the attending physician or a licensed physician under the supervision of the attending physician;
(ii) The contact must be documented in the medical record.

(W) The payment to a physician for medically directing the services of a CRNA or for the direct supervision of the services of an Anesthesiologist Assistant (AA) is limited. The maximum allowable fee for the services of both providers combined is limited to the maximum allowable had the service been performed solely by the anesthesiologist.

(X) One pap smear per year for women of child bearing age. Two follow-up pap smears are covered when medically indicated.

(Y) Medically necessary solid organ and bone marrow/stem cell transplantation services for children and adults are covered services based upon the conditions listed in (i)-(iv) of this subparagraph:

(i) Transplant procedures, except kidney and cornea, must be prior authorized to be compensable.

(ii) To be prior authorized all procedures are reviewed based on appropriate medical criteria.

(iii) To be compensable under the SoonerCare program, all organ transplants must be performed at a facility which meets the requirements contained in Section 1138 of the Social Security Act.

(iv) Procedures considered experimental or investigational are not covered.

(Z) Donor search and procurement services are covered for transplants consistent with the methods used by the Medicare program for organ acquisition costs.

(i) Donor expenses incurred for complications are covered only if they are directly and immediately attributable to the donation procedure.

(ii) Donor expenses that occur after the 90 day global reimbursement period must be submitted to the OHCA for review.

(AA) Total parenteral nutritional therapy (TPN) for identified diagnoses and when prior authorized.

(BB) Ventilator equipment.

(CC) Home dialysis equipment and supplies.

(DD) Ambulatory services for treatment of members with tuberculosis (TB). This includes, but is not limited to, physician visits, outpatient hospital services, rural health clinic visits and prescriptions. Drugs prescribed for the treatment of TB beyond the prescriptions covered under SoonerCare require prior authorization by the University of Oklahoma College of Pharmacy Help Desk using form "Petition for TB Related Therapy". Ambulatory services to members infected with TB are not limited to the scope of the SoonerCare program, but require prior authorization when the scope is exceeded.

(EE) Smoking and Tobacco Use Cessation Counseling for treatment of individuals using tobacco.

(i) Smoking and Tobacco Use Cessation Counseling consists of the 5As:

(I) Asking the member to describe their smoking use;
(II) Advising the member to quit;
(III) Assessing the willingness of the member to quit;
(IV) Assisting the member with referrals and plans to quit; and
(V) Arranging for follow-up.

(ii) Up to eight sessions are covered per year per individual.

(iii) Smoking and Tobacco Use Cessation Counseling is a covered service when performed by physicians, physician assistants, advanced registered nurse practitioners, certified nurse midwives, dentists, and Oklahoma State Health Department and FQHC nursing staff. It is reimbursed in addition to any other appropriate global payments for obstetrical care, PCP care coordination payments, evaluation and management codes, or other appropriate services rendered. It must be a significant, separately identifiable service, unique from any other service provided on the same day.

(iv) Chart documentation must include a separate note and signature along with the member specific information addressed in the five steps and the time spent by the practitioner performing the counseling. Anything under three minutes is considered part of a routine visit.

(FF) Immunizations as specified by the Advisory Committee on Immunization Practices (ACIP) guidelines.

(2) General coverage exclusions include the following:

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

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

(C) Services of two physicians for the same type of service to the same member on the same day, except when supplemental skills are required and different specialties are involved.

(D) Refractions and visual aids.

(E) Pre-operative care within 24 hours of the day of admission for surgery and routine post-operative care as defined under the global surgery guidelines promulgated by Current Procedural Terminology (CPT) and the Centers for Medicare and Medicaid Services (CMS).

(F) Payment to the same physician for both an outpatient visit and admission to hospital on the same date.

(G) Sterilization of members who are under 21 years of age, mentally incompetent, or institutionalized or reversal of sterilization procedures for the purposes of conception.
(H) Non-therapeutic hysterectomies.
(I) Medical services considered experimental or investigational.
(J) Payment for more than four outpatient visits per month (home or office) per member, except those visits in connection with family planning or related to emergency medical conditions.
(K) Payment for more than two nursing facility visits per month.
(L) More than one inpatient visit per day per physician.
(M) Physician services which are administrative in nature and not a direct service to the member including such items as quality assurance, utilization review, treatment staffing, tumor board review or multidisciplinary opinion, dictation, and similar functions.
(N) Charges for completion of insurance forms, abstracts, narrative reports or telephone calls.
(O) Payment for the services of social workers, licensed family counselors, registered nurses or other ancillary staff, except as specifically set out in OHCA rules.
(P) Induced abortions, except when certified in writing by a physician that the abortion was necessary due to a physical disorder, injury or illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would place the woman in danger of death unless an abortion is performed, or that the pregnancy is the result of an act of rape or incest. (Refer to OAC 317:30-5-6 or 317:30-5-50.)
(Q) Speech and Hearing services.
(R) Mileage.
(S) A routine hospital visit on the date of discharge unless the member expired.
(T) Direct payment to perfusionist as this is considered part of the hospital reimbursement.
(U) Inpatient chemical dependency treatment.
(V) Fertility treatment.
(W) Payment for removal of benign skin lesions unless medically necessary.

(b) **Children.** Payment is made to physicians for medical and surgical services for members under the age of 21 within the scope of the Authority's SoonerCare program, provided the

services are medically necessary for the diagnosis and treatment of illness or injury, or to improve the functioning of a malformed body member. Medical and surgical services for children are comparable to those listed for adults. For services rendered to a minor child, the child's parent or court-appointed legal guardian must provide written authorization prior to the service being rendered. In addition to those services listed for adults, the following services are covered for children.

(1) **Pre-authorization of inpatient psychiatric services.** All inpatient psychiatric services for members under 21 years of age must be prior authorized by an agency designated by the Oklahoma Health Care Authority. All psychiatric services are prior authorized for an approved length of stay. Non-authorized inpatient psychiatric services are not SoonerCare compensable.

(A) All residential and acute psychiatric services are authorized based on the medical necessity criteria as described in OAC 317:30-5-95.25,317:30-5-95.27 and 317:30-5-95.29.

(B) Out of state placements are not authorized unless it is determined that the needed medical services are more readily available in another state or it is a general practice for members in a particular border locality to use resources in another state. If a medical emergency occurs while a member is out of the State, treatment for medical services is covered as if provided within the State. A prime consideration for placements is proximity to the family or guardian in order to involve the family or guardian in discharge and reintegration planning.

(2) **General acute care inpatient service limitations.** All general acute care inpatient hospital services for members under the age of 21 are not limited. All inpatient care must be medically necessary.

(3) **Procedures for requesting extensions for inpatient services.** The physician and/or facility must provide necessary justification to enable OHCA, or its designated agent, to make a determination of medical necessity and appropriateness of treatment options. Extension requests for psychiatric admissions must be submitted to the OHCA or its designated agent. Extension requests must contain the appropriate documentation validating the need for continued treatment in accordance with the medical necessity criteria described in OAC 317:30-5-95.26, 317:30-5-95.28 and 317:30-5-95.30. Requests must be made prior to the expiration of the

approved inpatient stay. All decisions of OHCA or its designated agent are final.

(4) **Utilization control requirements for psychiatric beds.** Utilization control requirements for inpatient psychiatric services for members under 21 years of age apply to all hospitals and residential psychiatric treatment facilities.

(5) **Early and periodic screening diagnosis and treatment program.** Payment is made to eligible providers for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) of members under age 21. These services include medical, dental, vision, hearing and other necessary health care. Refer to OAC 317:30-3-65.2 through 317:30-3-65.11 for specific guidelines.

(6) **Child abuse/neglect findings.** Instances of child abuse and/or neglect discovered through screenings and regular exams are to be reported in accordance with State Law. Section 7103 of Title 10 of the Oklahoma Statutes mandates reporting suspected abuse or neglect to the Oklahoma Department of Human Services. Section 7104 of Title 10 of the Oklahoma Statutes further requires reporting of criminally injurious conduct to the nearest law enforcement agency.

(7) **General exclusions.** The following are excluded from coverage for members under the age of 21:

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

(B) Services or any expense incurred for cosmetic surgery unless the physician certifies the procedure emotionally necessary.

(C) Services of two physicians for the same type of service to the same member on the same day, except when supplemental skills are required and different specialties are involved.

(D) Pre-operative care within 24 hours of the day of admission for surgery and routine post-operative care as defined under the global surgery guidelines promulgated by Current Procedural Terminology (CPT) and the Centers for Medicare and Medicaid Services (CMS).

(E) Payment to the same physician for both an outpatient visit and admission to hospital on the same date.

(F) Sterilization of members who are under 21 years of age, mentally incompetent, or institutionalized or reversal of sterilization procedures for the purposes of conception.

(G) Non-therapeutic hysterectomies.

(H) Medical Services considered experimental or investigational.

(I) More than one inpatient visit per day per physician.

(J) Induced abortions, except when certified in writing by a physician that the abortion was necessary due to a physical disorder, injury or illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would place the woman in danger of death unless an abortion is performed, or that the pregnancy is the result of an act of rape or incest. (Refer to OAC 317:30-5-6 or 317:30-5-50.)

(K) Physician services which are administrative in nature and not a direct service to the member including such items as quality assurance, utilization review, treatment staffing, tumor board review or multidisciplinary opinion, dictation, and similar functions.

(L) Payment for the services of social workers, licensed family counselors, registered nurses or other ancillary staff, except as specifically set out in OHCA rules.

(M) Direct payment to perfusionist as this is considered part of the hospital reimbursement.

(N) Charges for completion of insurance forms, abstracts, narrative reports or telephone calls.

(O) Mileage.

(P) A routine hospital visit on date of discharge unless the member expired.

(c) **Individuals eligible for Part B of Medicare.** Payment is made utilizing the OHCA allowable for comparable services. Claims filed with Medicare Part B should automatically cross over to OHCA. The explanation of Medicare Benefits (EOMB) reflects a message that the claim was referred to SoonerCare. If such a message is not present, a claim for coinsurance and deductible must be filed with the OHCA within 90 days of the date of Medicare payment or within one year of the date of service in order to be considered timely filed.

(1) In certain circumstances, some claims do not automatically "cross over". Providers must file a claim for coinsurance and/or deductible to SoonerCare within 90 days of the Medicare payment or within one year from the date of service.

(2) If payment was denied by Medicare Part B and the service is a SoonerCare covered service, mark the claim "denied by Medicare" and attach the Medicare EOMB showing the reason for the denial.

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

317:30-3-25. Crossovers (coinsurance and deductible)

(a) **Medicare Part B**. Payment is made for Medicare deductible and coinsurance on behalf of eligible individuals.

(b) **Medicare Part A**. Payment is made for Medicare deductible and coinsurance on behalf of eligible individuals. ~~limited to the Medicaid allowable reimbursement for services in a skilled nursing facility.~~

(c) **Medicare Advantage Plans.** Payment is made for Medicare HMO co-payments. For services offered by Medicare Advantage Plans that revert to traditional Medicare type benefits, payment is made for coinsurance and deductibles according to subsection (a) and (b) in this section.

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 9. LONG TERM CARE FACILITIES

317:30-5-122. Levels of care

(a) This rule sets forth the criteria used to determine whether an individual who is seeking SoonerCare payment for long term care services needs services at the level of Skilled Nursing Facility, or Intermediate Care Facility for People with Mental Retardation (ICF/MR). The criteria set forth in this Section must be used when determining level of care for individuals seeking SoonerCare coverage of either facility-based institutional long term care services or Home and Community Based Services (HCBS) Waivers.

(b) The level of care provided by a long term care facility or through a HCBS Waiver is based on the nature of the person's needs and the care, services, and treatment required from appropriately qualified personnel. The level of care review is a determination of an individual's physical, mental and social/emotional status to determine the appropriate level of care required. In addition to level of care requirements, other applicable eligibility criteria must be met.

(1) **Skilled Nursing facility.** ~~When total payments from all other payers are less than the Medicaid rate, payment~~ Payment is made for the Part A coinsurance and deductible for Medicare covered skilled nursing facility care for dually eligible, categorically needy individuals.

(2) **Nursing Facility.** Care provided by a nursing facility to patients who require professional nursing supervision and a maximum amount of nonprofessional nursing care due to physical

conditions or a combination of physical and mental conditions.

(3) **Intermediate Care Facility for the Mentally Retarded.** Care for persons with intellectual disabilities or related conditions to provide health and/or habilitative services in a protected residential setting. To qualify for ICF/MR level of care, persons must have substantial functional limitations in three or more of the following areas of major life activity:

(A) Self-care. The individual requires assistance, training or supervision to eat, dress, groom, bathe, or use the toilet.

(B) Understanding and use of language. The individual lacks functional communication skills, requires the use of assistive devices to communicate, does not demonstrate an understanding of request or is unable to follow two-step instructions.

(C) Learning. The individual has a valid diagnosis of intellectual disability as defined in the Diagnostic and Statistical Manual of Mental Disorders.

(D) Mobility. The individual requires the use of assistive devices to be mobile and cannot physically self-evacuate from a building during an emergency without assistive device.

(E) Self-direction. The individual is 7 years old or older and significantly at risk in making age appropriate decisions or an adult who is unable to provide informed consent for medical care, personal safety or for legal, financial, habilitative or residential issues and/or has been declared legally incompetent. The individual is a danger to himself or others without supervision.

(F) Capacity for independent living. The individual who is 7 years old or older and is unable to locate and use a telephone, cross the street safely or understand that it is unsafe to accept rides, food or money from strangers or an adult who lacks basic skills in the areas of shopping, preparing food, housekeeping or paying bills.

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

317:30-5-240.1. Definitions

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

"Accrediting body" means one of the following:

(A) Accreditation Association for Ambulatory Health Care (AAAHC);

(B) American Osteopathic Association (AOA);

(C) Commission on Accreditation of Rehabilitation Facilities (CARF);

(D) Council on Accreditation of Services for Families and Children, Inc. (COA);

(E) The Joint Commission (TJC) formerly known as Joint Commission on Accreditation of Healthcare Organizations; or

(F) other OHCA approved accreditation.

"Adult" means an individual 21 and over, unless otherwise specified.

"AOD" means Alcohol and Other Drug.

"AODTP" means Alcohol and Other Drug Treatment Professional.

"BH" means behavioral health, which relates to mental, substance abuse, addictions, gambling, and other diagnosis and treatment.

"BHAs" means Behavioral Health Aides.

"BHRS" means Behavioral Health Rehabilitation Specialist.

"Certifying Agency" means the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS).

"Child" means an individual younger than 21, unless otherwise specified.

"Client Assessment Record (CAR)" means the standardized tool recognized by OHCA and ODMHSAS to evaluate the functioning of the member.

"CM" means case management.

"CMHC's" means Community Mental Health Centers who are state operated or privately contracted providers of behavioral health services for adults with ~~severe~~serious mental illnesses, and youth with serious emotional disturbances.

"Cultural competency" means the ability to recognize, respect, and address the unique needs, worth, thoughts,

communications, actions, customs, beliefs and values that reflect an individual's racial, ethnic, age group, religious, sexual orientation, and/or social group.

"DSM" means the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association.

"EBP" means an Evidence Based Practice per the Substance Abuse & Mental Health Services Administration (SAMHSA).

"FBCS" means Facility Based Crisis Stabilization.

"FSPs" means Family Support Providers.

"ICF/MR" means Intermediate Care Facility for the Mentally Retarded.

"Institution" means an inpatient hospital facility or Institution for Mental Disease (IMD).

"IMD" means Institution for Mental Disease as per 42 CFR 435.1009 as a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care and related services. The regulations indicate that an institution is an IMD if its overall character is that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases. Title XIX of the Social Security Act provides that, except for individuals under age 21 receiving inpatient psychiatric care, Medicaid (Title XIX) does not cover services to IMD patients under 65 years of age [section 1905(a)(24)(B)].

"**Level of Functioning Rating"** means a standardized mechanism to determine the intensity or level of services needed based upon the severity of the member's condition. The CAR level of function rating scale is the tool that links the clinical assessment to the appropriate level of treatment. The CAR level of functioning rating scale is to be utilized in conjunction with the clinical judgment of the Licensed Behavioral Health Professional.

"LBHP" means a Licensed Behavioral Health Professional.

"MST" means the EBP Multi-Systemic Therapy.

"OAC" means Oklahoma Administrative Code, the publication authorized by 75 O.S. 256 known as The Oklahoma Administrative Code, or, prior to its publication, the compilation of codified rules authorized by 75 O.S. 256(A)(1)(a) and maintained in the Office of Administrative Rules.

"Objectives" means a specific statement of planned accomplishments or results that are specific, measurable, attainable, realistic, and time-limited.

"ODMHSAS" means the Oklahoma Department of Mental Health and Substance Abuse Services.

"ODMHSAS contracted facilities" means those providers that have a contract with the ODMHSAS to provide mental health or substance abuse treatment services, and also contract directly with the Oklahoma Health Care Authority to provide Outpatient Behavioral Health Services.

"OHCA" means the Oklahoma Health Care Authority.

"OJA" means the Office of Juvenile Affairs.

"Provider Manual" means the OHCA BH Provider Billing Manual.

"RBMS" means Residential Behavioral Management Services within a group home or therapeutic foster home.

"Recovery" means an ongoing process of discovery and/or rediscovery that must be self defined, individualized and may contain some, if not all, of the ten fundamental components of recovery as outlined by SAMHSA.

"RSS" means Recovery Support Specialist.

"SAMHSA" means the Substance Abuse and Mental Health Services Administration.

~~**"SED"** means Severe Emotional Disturbance.~~**"Serious Emotional Disturbance (SED)"** means a condition experienced by persons from birth to 18 that show evidence of points of (1), (2) and (3) below:

(1) The disability must have persisted for six months and be expected to persist for a year or longer.

(2) A condition or serious emotional disturbance as defined by the most recently published version of the DSM or the International Classification of Disease (ICD) equivalent with the exception of DSM "V" codes, substance abuse, and developmental disorders which are excluded, unless they co-occur with another diagnosable serious emotional disturbance.

(3) The child must exhibit either (A) or (B) below:

(A) Psychotic symptoms of a serious mental illness (e.g. Schizophrenia characterized by defective or lost contact with reality, often hallucinations or delusions); or

(B) Experience difficulties that substantially interfere with or limit a child or adolescent from achieving or maintaining one or more developmentally appropriate social, behavioral, cognitive, communicative, or adaptive skills. There is functional impairment in at least two of the following capacities (compared with expected developmental level):

(i) Impairment in self-care manifested by a person's consistent inability to take care of personal

grooming, hygiene, clothes and meeting of nutritional needs.

(ii) Impairment in community function manifested by a consistent lack of age appropriate behavioral controls, decision-making, judgment and value systems which result in potential involvement or involvement with the juvenile justice system.

(iii) Impairment of social relationships manifested by the consistent inability to develop and maintain satisfactory relationships with peers and adults.

(iv) Impairment in family function manifested by a pattern of disruptive behavior exemplified by repeated and/or unprovoked violence to siblings and/or parents, disregard for safety and welfare or self or others (e.g., fire setting, serious and chronic destructiveness, inability to conform to reasonable limitations and expectations which may result in removal from the family or its equivalent).

(v) Impairment in functioning at school manifested by the inability to pursue educational goals in a normal time frame (e.g., consistently failing grades, repeated truancy, expulsion, property damage or violence toward others).

"SMI" ~~means Severely Mentally Ill.~~**"Serious Mental Illness (SMI)"** means a condition experienced by persons age 18 and over that show evidence of points of (1), (2) and (3) below:

(1) The disability must have persisted for six months and be expected to persist for a year or longer.

(2) A condition or serious mental illness as defined by the most recently published version of the DSM or the International Classification of Disease (ICD) equivalent with the exception of DSM "V" codes, substance abuse, and developmental disorders which are excluded, unless they co-occur with another diagnosable serious mental illness.

(3) The adult must exhibit either (A) or (B) below:

(A) Psychotic symptoms of a serious mental illness (e.g. Schizophrenia characterized by defective or lost contact with reality, often hallucinations or delusions); or

(B) Experience difficulties that substantially interfere with or limit an adult from achieving or maintaining one or more developmentally appropriate social, behavioral, cognitive, communicative, or adaptive skills. There is functional impairment in at least two of the following capacities (compared with expected developmental level):

(i) Impairment in self-care manifested by a person's consistent inability to take care of personal grooming, hygiene, clothes and meeting of nutritional needs.
(ii) Impairment in community function manifested by a consistent lack of appropriate behavioral controls, decision-making, judgment and value systems which result in potential involvement or involvement with the criminal justice system.
(iii) Impairment of social relationships manifested by the consistent inability to develop and maintain satisfactory relationships with peers.
(iv) Impairment in family function manifested by a pattern of disruptive behavior exemplified by repeated and/or unprovoked violence, disregard for safety and welfare of self or others (e.g., fire setting, serious and chronic destructiveness, inability to conform to reasonable limitations and expectations..
(v) Impairment in functioning at school or work manifested by the inability to pursue educational or career goals.

"Trauma informed" means the recognition and responsiveness to the presence of the effects of past and current traumatic experiences in the lives of members.

317:30-5-241. Covered Services

(a) Outpatient behavioral health services are covered for adults and children as set forth in this Section unless specified otherwise, and when provided in accordance with a documented individualized service plan, developed to treat the identified behavioral health and/or substance abuse disorder(s).

(b) All services are to be for the goal of improvement of functioning, independence, or well-being of the member. The services and treatment plans are to be recovery focused, trauma and co-occurring specific. The member must be able to actively participate in the treatment. Active participation means that the member must have sufficient cognitive abilities, communication skills, and short-term memory to derive a reasonable benefit from the treatment.

(c) In order to be reimbursed for services, providers must submit a completed Customer Data Core (CDC) to OHCA or its designated agent. The CDC must be reviewed, updated and resubmitted by the provider every six months. Reimbursement is made only for services provided while a current CDC is on file

with OHCA or its designated agent. For further information and instructions regarding the CDC, refer to the Behavioral Health Provider Manual.
(d) Some outpatient behavioral health services may require authorization. For information regarding services requiring authorization and the process for obtaining them, refer to the Behavioral Health Provider Manual. Authorization of services is not a guarantee of payment. The provider is responsible for ensuring that the eligibility, medical necessity, procedural, coding, claims submission, and all other state and federal requirements are met. OHCA does retain the final administrative review over both authorization and review of services as required by 42 CFR 431.10.

317:30-5-241.3. Behavioral Health Rehabilitation (BHR) services
(a) **Definition**. ~~BHR are behavioral health rehabilitation services which are necessary to improve the member's ability to function in the community. They are performed to improve the skills and abilities of members to live interdependently in the community, improve self-care and social skills, and promote lifestyle change and recovery practices. This service may include the Evidence Based Practice of Illness, Management, and Recovery.~~Behavioral Health Rehabilitation (BHR) services are goal oriented outpatient interventions that target the maximum reduction of mental and/or behavioral health impairments and strive to restore the members to their best possible mental and/or behavioral health functioning. BHR services must be coordinated in a manner that is in the best interest of the member and may be provided in a variety of community and/or professional settings.
(b) **Psychosocial Rehabilitation (PSR).**
(1) **Definition.** PSR services are face-to-face Behavioral Health Rehabilitation services which are necessary to improve the member's ability to function in the community. They are performed to improve the skills and abilities of members to live interdependently in the community, improve self-care and social skills, and promote lifestyle change and recovery practices. For adults, this service may include the Evidence Based Practice of Illness Management and Recovery. For children, PSR services include two levels of intervention: Children's Psychosocial Rehabilitation - Intensive (CPSR-I) and Children's Psychosocial Rehabilitation - Remedial (CPSR-R).
(A) **CPSR-I.** CPSR-1 is a level of support designed to help

children with Serious Emotional Disturbance (SED) who are experiencing an acute psychiatric condition, alleviating or eliminating the need to admit them into a psychiatric inpatient or residential setting. It is a comprehensive, time-limited, community-based service delivered to children with SED who are exhibiting symptoms that interfere with their individual lives in a highly disabling or incapacitating manner.

(B) **CPSR-R.** CPSR-R is a level of support designed to help children/adolescents who have been diagnosed with serious social, behavioral and/or emotional issues that substantially interfere with functioning in the home, school or community. The service plan is focused toward age-appropriate rehabilitation. Primary emphasis is to develop stabilization in the community and home. CPSR-R services teach members a variety of life skills

~~(1)~~(2) **Clinical restrictions**. This service is generally performed with only the members and the ~~BHRS~~qualified provider, but may include a member and the member's family/support system group that focuses on the member's diagnosis, management, and recovery based curriculum. A member who at the time of service is not able to cognitively benefit from the treatment due to active hallucinations, substance abuse, or other impairments is not suitable for this service.

~~(2)~~(3) **Qualified providers**. A BHRS, CADC, or LBHP may perform ~~BHR~~PSR, following development of a service plan and treatment curriculum approved by a LBHP. Staff must be appropriately trained in a recognized behavioral/management intervention program such as MANDT or CAPE or trauma informed methodology.

~~(3)~~(4) **Group sizes**. The ~~minimum~~ maximum staffing ratio is fourteen members for each BHRS, CADC, or LBHP for adults and eight to one for children under the age of eighteen.

~~(4)~~(5) **Limitations.**

(A) **Transportation**. Travel time to and from ~~BHR~~PSR treatment is not compensable. Group ~~psychosocial rehabilitation~~PSR services do not qualify for the OHCA transportation program, but ~~they~~ OHCA will arrange for transportation for those who require specialized transportation equipment. ~~A member who at the time of service is not able to cognitively benefit from the treatment due to active hallucinations, substance use, or other impairments is not suitable for this service.~~

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

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

(D) **Eligibility for PSR services.** PSR services are intended for adults with Serious Mental Illness (SMI) and children with emotional or behavioral disorders. The following members are not eligible for BHR services:

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

(ii) children under age 6, unless a prior authorization has been granted by OHCA or its designated agent based on a finding of medical necessity;

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

(iv) inmates of public institutions;

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

(vi) members residing in nursing facilities.

~~(D)~~(E) **Billing limits**. ~~Residents of ICF/MR facilities and children receiving RBMS in a group home or therapeutic foster home are not eligible for this service, unless allowed by OHCA or its designated agent.~~BHR services are time-limited services designed to be provided over the briefest and most effective period possible. Service limits are based on the member's needs according to the CAR or other approved tool, the requested placement based on the level of functioning rating, medical necessity, and best practice. Service limitations are designed to help prevent rehabilitation diminishing return by remaining within reasonable age and developmentally appropriate daily limits. BHR services authorized under this Section should not duplicate the structured services required for children residing in group home or therapeutic foster care settings. BHR is billed in unit increments of 15 minutes with the following limits:

(i) **Group PSR**. The maximum is 24 units per day for

adults and 16 units per day for children.

(ii) **Individual PSR**. The maximum is six units per day. Children under an ODMHSAS Systems of Care program may be prior authorized additional units as part of an intensive transition period.

(iii) **Per-Member service levels and limits.** CPSR-I services are not authorized for Levels 1, 2 or 3. Group and/or individual CPSR-R services provided in combination may not exceed the following monthly limits depending upon which level for which the member has been approved:

(I) Level 1: 32 units.

(II) Level 2: 48 units.

(III) Level 3: 64 units.

(iv) **EPSDT.** Pursuant to OAC 317:30-3-65 et seq., billing limits may be exceeded or may not apply if documentation demonstrates that the requested services are medically necessary and are needed to correct or ameliorate defects, physical or behavioral illnesses or conditions discovered through a screening tool approved by OHCA or its designated agent.

~~(E)~~(F) **Documentation requirements.** In accordance with OAC 317:30-5-241.1, the individual rehabilitation plan developed by the LBHP must include the member's strengths, functional assets, weaknesses or liabilities, treatment goals, objectives and methodologies that are specific and time-limited, and defines the services to be performed by the practitioners and others who comprise the treatment team. The plan must address objectives that are specific, attainable, realistic, and time-limited. Progress notes for intensive and rehabilitative outpatient ~~mental~~behavioral health, substance abuse or integrated programs may be in the form of daily summary or weekly summary notes and must include the following:

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

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

(iii) Specific goal(s) and objectives addressed during the week;

(iv) Type of Skills Training provided each day and/or during the week including the specific curriculum used with member;

(v) Member satisfaction with staff intervention(s);

(vi) Progress, or barrier to, made towards goals, objectives;
(vii) New goal(s) or objective(s) identified;
(viii) Signature of the lead BHRS; and
(ix) Credentials of the lead BHRS.

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

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

~~(b)~~(c) **Medication training and support**.

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

(2) **Limitations**.

(A) Medication Training and Support may not be billed for SoonerCare members who reside in ICF/MR facilities.
(B) One unit is allowed per month per patient.
(C) Medication Training & Support is not allowed to be billed on the same day as pharmacological management.

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

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

(A) a member's response to medication;
(B) compliance with the medication regimen;
(C) medication benefits and side effects;
(D) vital signs, which include pulse, blood pressure and respiration; and
(E) documented within the progress notes/medication record.