AGENDA

November 17, 2016
1:00 p.m. – 3:30pm

Charles Ed McFall Board Room

I. Welcome, Roll Call, and Public Comment Instructions: **Chairman, Steven Crawford, M.D.**

II. Action Item: Approval of Minutes of the September 15, 2016: **Medical Advisory Committee Meeting**

III. Public Comments (2 minute limit)

IV. MAC Member Comments/Discussion

V. Financial Report: **Gloria Hudson, Director of General Accounting**

VI. Fiscal Year 2018 Budget Appropriations: **Vickie Kersey, Director of Fiscal Planning and Procurement**

VII. SoonerCare Operations Update: **Marlene Asmussen, Director of Population Care Management**

   A. HMP Annual Evaluation: **Della Gregg, Supervisor of Health Management Program**

VIII. Proposed Rule Changes: Presentation, Discussion, and Vote: **Demetria Bennett, Policy Development Coordinator**

IX. Action Item: Vote on Proposed Rule Changes: **Chairman, Steven Crawford, M.D.**

   A. APA WF #16-13 Pharmacy Reimbursement
   B. APA WF 16-16 A&B Nursing Facility Supplemental Payment Program
   C. APA WF #16-18 Telemedicine Consent

X. New Business: **Chairman, Steven Crawford, M.D**

   A. Election of Officers

XI. Future Meetings

XII. Adjourn

Agenda

MAC Minutes for September 15, 2016

Welcome and Roll Call

Chairman Crawford called the meeting to order at 1:00 PM. ***Delegates present were*:** Ms. Teresa Bierig, Ms. Debra Billingsley, Dr. Joe Catalano, Dr. Steve Crawford, Ms. Wanda Felty, Ms. Melissa Gastorf, Mr. Steven Goforth, Mr. Mark Jones, Dr. Ashley Orynich, Ms. Annette Mays, Mr. Victor Clay, Dr. J. Daniel Post, Ms. Toni Pratt-Reid, Dr. Jason Rhynes, Dr. Kanwal Obhrai, Mr. Rick Snyder and Mr. Jeff Tallent, Dr. Gail Poyner.

Alternates present were: Ms. Lois Baer, Ms. Tandie Hastings, Mr. Traylor Rains-Sims, and Dr. Mike Talley providing a quorum.

***Delegates absent without an alternate were*:** Ms. Renee Banks**,** Dr. David Cavallaro, Ms. Terri Fritz, Dr. Stanley Grogg, Mr. James Patterson, and Dr. Edd Rhoades.

Introduction of new delegates

Dr. Crawford introduced Dr. Gail Poyner of the Oklahoma Psychological Association.

Public Comments

There were no public comments made at this meeting. Mr. Nico Gomez, departing CEO of the Oklahoma Health Care Authority then came up to address the committee. Mr. Gomez expressed his thanks to members of the committee for their time. He thanked them for their desire to do what is best for all the members and reaffirmed his thanks to the committee for their support. Mr. Gomez then congratulated Dr. Steven Crawford on receiving the TJ Brickner award.

Approval of July 21, 2016 Minutes

Chairman Crawford did a call to vote to approve the meeting minutes for July 21, 2016.
It was accepted by Mr. Traylor Rains-Sims and Ms. Lois Baer gave the second for the motion. All members voted to approve the minutes.

MAC Member Comments

Dr. Crawford asked if any member of the MAC had any comments. Dr. Jason Rhynes stated that he has an update regarding the billing for eye glasses that was discussed at the last meeting. He requested that the Oklahoma Health Care Authority please evaluate the codes that were turned on September 1. He stated he has multiple emails that claims are being denied. Dr. Rhynes stated he could provide specific examples on what codes are being denied. He stated that most common reason providers are receiving is that the rendering provider not eligible to perform services. He stated that this is a statewide issue. When the codes were turned on for whatever reason they are not paying providers. Dr. Crawford expressed his appreciation of Dr. Rhynes and his association for their continued diligence on this issue and his wish to get this resolved. Mr. Rick Snyder then stated there is some concern regarding non-contracted providers and a provider letter 2016-25 on the policy change floor with comments open right now. He stated one code turned recently is affecting some

emergency claims. He gave the example that a trauma case that comes into ER and the hospital has orthopedic staff on a rotating basis and not all those are contracted with Sooner Care. The responsibility of the provider is to take care and stabilize the patient. The non-contracted provider on call then takes the patient into surgery with no expectation of being paid. The hospital claims are now being denied because the provider was not contracted. Mr. Rick Snyder stated he just wanted to bring that to agency's attention. He understands there are new federal requirements that have gone in to affect. Dr. Crawford then asked comments from agency. Ms. Melody Anthony stated she will have Provider Services will follow up on this issue with Mr. Snyder. Dr. Crawford expressed the importance of patients being able to get care needed through whatever hospital they end up in so this needs to be looked into.

Financial Update

Gloria Hudson, Director of General Accounting, reported on the state's Fiscal Year 2016 financial transactions through the month of June 30, 2016. She reported that the state budget variance is a positive $15.2 million dollars. On the expenditure side, we were over budget with the Medicaid Program by 0.1% for negative $1 million state dollars and on the administration side under budget 13.6% for positive $6.6 million state dollars. On the revenue side, we were over budget on Drug Rebates and Collections by 11.8% for $12 million state dollars and under budget in Overpayments/Settlements by 4.1% for $ .7 million state dollars and under budget in Tobacco Tax Collections and Fees by 1.3% for negative $3.1 million state dollars. With preliminary data in through the month of August it looks like our agency will begin the new state fiscal year under budget. Ms. Hudson asked for questions, but there were no questions.

Soonercare Operations Update

Marlene Asmussen, Director of Population Care Management, presented the SoonerCare Operations Update to the committee regarding July 2016. She stated this information is based on the report given by newly appointed CEO Becky Ikard at last weeks' Board meeting. Patient Centered Medical Home enrollment is at 531,903 which is a slight increase from the previous month of 1,986. Sooner Care Traditional has a current enrollment of 227,955 which is 2,248 more than the previous month. Insure Oklahoma has a total enrollment of 18,883 of which 4,367 are in the Individual Plan and 14,516 are in the Employee Sponsored Plan which is an increase of 707 from the previous month. In total SoonerCare enrollment is at 811,270 for July which is a slight increase from about 5,000 previously reported. Ms. Asmussen stated that the two tables of in state providers show 33,218 contracted providers for July which is an increase of 403 additional providers. Our Medical Home Program SoonerCare Choice represents our largest health care delivery care program with 2,600 primary care providers in that network. Ms. Asmussen stated at the last MAC meeting, Casey Dunham, Director of Provider Services, at the request of the MAC gave an over of the contracted providers. We have added an additional table of Therapy Providers to include OT, PT and Speech who are contracted with SoonerCare. In-state contracted physician providers July totals reflect a slight, but continual increase from the beginning of this calendar year. Physician groups have been separated into major specialty groups and that network remains stable. In the last table reviewed, non-physician types are displayed according to provider category. Ms. Asmussen noted the temporary drop in Physician Assistant enrollment was due to the contract renewal period as examined at the last meeting. Enrollment for July was 1,150 indicating an increase from the previous month reported. The Extended Care Facility enrollment is 232 for July with Nursing Care Facility enrollment which is a subset of that group at 144. Ms. Asmussen then asked for questions, but there were none. Mr. Crawford then added that Becky Pasternik-

Ikard was appointed the new CEO of the Oklahoma Health Care Authority. Ms. Asmussen then presented information regarding the OB care coordination projects conducted by the Population Care Management department. Ms. Asmussen stated anyone currently enrolled in SoonerCare or Insure Oklahoma can receive care coordination through these projects. She added that all Oklahoma constituents even those not enrolled can get brief care coordination through the Population Care Management Department. PCM is comprised of three individual units. The Health Management Program or HMP provides practiced based chronic disease focused support to both members and to primary care providers. Nurses also known as Health Coaches work with members at selected primary care sites to improve health outcomes. They are trained in Motivational Interviewing, are experienced in Case Management and work directly with the patient. Specially trained Practice Facilitators work to improve the quality of practiced based process related to caring for persons with chronic disease. The Chronic Care unit provides telephonic Case Management to high risk and at risk members with certain chronic conditions. The Chronic Care unit or CCU works to address and assess health status, health literacy, and behavioral health and prescription drug utilization of identified members through care coordination, self-management principles and behavioral modification. The Case Management or CMU provides care coordination for members identified through specific programs, episodes or events. Examples of Case Management members would be high risk and at risk OB, at risk newborns, private duty nursing for children, women identified with breast and cervical cancer, and catastrophic natural disasters. This unit is staffed with Registered Nurses and Social Service Coordinators. Referrals for this unit are generated in a variety of ways, such as, self-referral, provider referrals, legislative, data mining and inter/intra agency referrals. The HMP program has been evaluated on an ongoing basis since 2008 and those findings have been previously highlighted for members of the MAC. Other Population Care Management projects under went formal evaluation in 2015. Ms. Asmussen stated today she would address two obstetrical programs with the committee. The High-Risk OB program provides case management for women approved for the High-Risk OB benefit set. Our case management nurses follow the women through the end of their pregnancy. This benefit includes extra ultra sounds, biophysical profiles and non-stress testing. When the evaluation methodology was developed the most recent full year of data available was fiscal year 2013 thus the independent evaluator Pacific Health Policy Group looked at data from fiscal year 2010 through 2013 to evaluate these programs. Data shows that during the time evaluated the early gestation low birth weights decreased deliveries decreased from 21.6% in state fiscal year 2010 to 16.2% in state fiscal year 2013. NICU admissions decreased slightly by almost one percent during this time. Both thirty day and sixty day readmission rates as well as thirty day and sixty day emergency room visits also decreased during this time. The At-Risk OB Program provides case management for women determined through a brief screening to be at risk for pregnancy related complications. All women who gain Medicaid eligibility through pregnancy are mailed a letter from Pat Brown asking that they call the SoonerCare Helpline to gain more information about their benefits from SoonerCare. When the pregnant member calls to speak with Pat Brown they are directed to Member Services to go through the screening process. A positive response to either of the two screening questions prompts a referral to Case Management for clinical assessment. Another way that newly eligible pregnant woman may be referred to CMU is through the Online Health Assessment that is available to all members who enroll through the web based portal. A positive response to the same two question s offered by the Pat Brown letter also prompts a referral to Case Management Unit. All pregnant women who are determined to be at risk for a poor birth outcomes are enrolled in Case Management through the remainder of their pregnancy. When surveyed 97% of the women who were actively case managed state they would recommend this program to someone else. The rate of readmissions for the first thirty days after

delivery decreased from 4.7% to 1.4% percent. The decrease in readmission rates continued at the sixty day mark going from 6.4% to 1.4%. Likewise, ER visits during the first post-partum decreased from 16.9% to 11% for this same group. Diminished ER utilization continued to decrease at the sixty day mark from 23.3% to 13%. The full evaluation report on PCM is posted on the web. In Conclusion, Ms. Asmussen stated that with SoonerCare as a predominant payer of deliveries in Oklahoma the Population Care Management Department is currently looking at options for the next steps in the Obstetrical Programs. Ms. Asmussen then asked for questions. Dr. Crawford asked about the significance of using the name Pat Brown in the letter? Ms. Asmussen stated it is a signal for the call center to send the member to Member Services for the screening. There were no other questions.

Proposed Rule Changes

Dr. Crawford invited Demetria Bennett, Policy Development Coordinator to discuss three proposed rule changes. Demetria noted that all three rules were presented at various Tribal Consultations and they are listed in the agenda. APA 16-08 posted for public comment from August 15 through September 15. We received a total of three comments regarding this rule change. Ms. Bennett stated that they decided after these comments to revise the rule. The rule will now be posted through October 12 for public comment. APA 16-12 received no comments by the public. APA 16-15 A and B received a total of four comments all of which were in support of the changes. Dr. Steven Crawford expressed his thanks to the agency for going back to the old way of reimbursement for OB reimbursement. Ms. Bennett stated that 16-08 is a screening procedure and fitness plan policy and these revisions are needed to comply with federal regulations and guidance. The language simply outlines screening procedures for providers who pose an increased risk of fraud, waste or abuse to the SoonerCare program. The rule also outlines guidelines and procedures for applicants who are seeking new or renewed contract enrollment as being subject to finger based criminal background checks if they are designated as high-risk in accordance with the federal regulation or state law. The rule also specifies the types of criminal convictions for applicants in regards to felonies being denied enrollment. Ms. Bennett noted that this rule is budget natural. Ms. Bennett then asked for questions. The question was asked regarding if these background checks are they nationwide? The answer is yes they are done nationwide. Mr. Traylor Rains-Sims then stated that the Department of Mental Health and Substance Abuse Services has some concerns with the wording in this rule. Within the area of mental health and substance abuse treatment system we rely on evidenced based practice for support which utilizes individuals who have involvement in the criminal justice system due alcohol and substance abuse related issues. These individuals are certified and screened through the Department of Mental Health and Substance Abuse Services. They are reviewed knowing that they are in recovery and it is taken into consideration that the previous criminal history could be because of a substance abuse issue. Mr. Rains-Sims noted he has spoken to the legal department and was informed the intent is to only refer to those deemed high-risk. Mr. Rains-Sims stated the way it is currently written that it could be construed as pertaining to any provider. The Department would respectfully propose for some additional language to be added to further ensure the rule is specifically referring those who are high-risk. Dr. Crawford then asked for thoughts. Ms. Bennett sated the agency will take the proposal into consideration. Dr. Crawford reiterated that is probably fairly common for counselors in this treatment area to have prior substance issues themselves. There were no other comments on this rule. Ms. Bennett then presented rule 16-12 which is a rule regarding medical residents licensure and policy cleanup around this rule. The general coverage policy revisions are being made to include licensing provisions for medical residents as required by their appropriate regulatory Medical Licensing Board.

Rules also add contracting requirements and these revisions are necessary to comply with federal regulations that require all ordering or referring physicians be enrolled as participating providers. Additional revisions remove language related to non-physicians because it is not needed and the rule also clarifies the visit limits for members. Ms. Bennett stated this rule is budget neutral. There were no questions regarding this rule. Dr. Crawford noted this rule would fix issues that were happening without these revisions. Dr. Crawford then did a call to vote regarding rule 16-08. The motion was accepted by Dr. Joe Catalano then Ms. Toni Pratt-Reid and Mr. Traylor Rains-Sims gave the seconds for the motion. There was no further discussion regarding this rule. There were was no opposition the passing of this rule change. Dr. Crawford then did a call to vote for rule 16-12. The motion was accepted by Mr. Traylor Rains-Sims and Dr. Mike Talley gave the second for the motion. There was no further discussion and no members opposed to the rule change. Ms. Bennett then presented the next item as the OB rule change 16-15. This revision simply reverts the language back to the previous bundled language. Dr. Crawford then did a call to vote for this rule. The motion was accepted by Mr. Jeff Tallent and Mr. Traylor Rains-Sims gave the second. There was no further discussion and no opposition.

New Business / Member Comments

Dr. Crawford then invited newly named Becky Pasternik-Ikard to address the committee. She expressed her thanks to the committee and reiterated the value we place on providers in the agency and will continue to work hard to not only retain providers, but also improve circumstances for them. She thanked the committee for their time and efforts in helping us move forward. There was no other new business.

Future Meetings

Dr. Crawford stated the next meeting will be held on November 17, 2016.

Adjournment

Dr. Crawford asked for a motion to adjourn. It was provided by Dr. Jeff Tallent and seconded by Mr. Dr. Crawford. There was no dissent and the meeting was adjourned.

Agenda

FINANCIAL REPORT

For the Two Months Ended August 31, 2016
Submitted to the CEO & Board

- Revenues for OHCA through August, accounting for receivables, were **$746,252,506** or **.6% under** budget.
- Expenditures for OHCA, accounting for encumbrances, were **$727,151,240 or .9% under** budget.
- The state dollar budget variance through August is a **positive $1,505,236.**
- The budget variance is primarily attributable to the following (in millions):

Expenditures:	
Medicaid Program Variance	1.9
Administration	.4
Revenues:	
Drug Rebate	.7
Taxes and Fees	(.9)
Overpayments/Settlements	(.6)
Total FY 17 Variance	**$ 1.5**

ATTACHMENTS

Summary of Revenue and Expenditures: OHCA 1
Medicaid Program Expenditures by Source of Funds 2
Other State Agencies Medicaid Payments 3
Fund 205: Supplemental Hospital Offset Payment Program Fund 4
Fund 230: Quality of Care Fund Summary 5
Fund 245: Health Employee and Economy Act Revolving Fund 6
Fund 250: Belle Maxine Hilliard Breast and Cervical Cancer Treatment Revolving Fund 7

OKLAHOMA HEALTH CARE AUTHORITY
Summary of Revenues & Expenditures: OHCA
SFY 2017, For the Two Month Period Ending August 31, 2016

REVENUES	FY17 Budget YTD	FY17 Actual YTD	Variance	% Over/ (Under)
State Appropriations	$ 192,478,309	$ 192,478,309	$ -	0.0%
Federal Funds	440,954,159	437,527,438	(3,426,721)	(0.8)%
Tobacco Tax Collections	8,589,782	8,221,543	(368,239)	(4.3)%
Quality of Care Collections	13,078,471	12,780,292	(298,179)	(2.3)%
Prior Year Carryover	17,518,798	17,518,798	-	0.0%
Federal Deferral - Interest	11,484	11,484	-	0.0%
Drug Rebates	14,121,606	15,916,307	1,794,701	12.7%
Medical Refunds	7,958,975	5,633,024	(2,325,951)	(29.2)%
Supplemental Hospital Offset Payment Program	48,841,494	48,841,494	-	0.0%
Other Revenues	7,534,558	7,323,818	(210,740)	(2.8)%
TOTAL REVENUES	**$ 751,087,635**	**$ 746,252,506**	**$ (4,835,129)**	**(0.6)%**

EXPENDITURES	FY17 Budget YTD	FY17 Actual YTD	Variance	% (Over)/ Under
ADMINISTRATION - OPERATING	**$ 8,766,535**	**$ 8,441,691**	**$ 324,845**	**3.7%**
ADMINISTRATION - CONTRACTS	**$ 11,721,529**	**$ 11,054,371**	**$ 667,158**	**5.7%**
MEDICAID PROGRAMS				
Managed Care:				
SoonerCare Choice	7,131,179	6,560,920	570,259	8.0%
Acute Fee for Service Payments:				
Hospital Services	158,655,061	157,363,759	1,291,302	0.8%
Behavioral Health	3,339,193	3,312,021	27,172	0.8%
Physicians	75,817,115	75,418,191	398,924	0.5%
Dentists	24,781,214	24,106,482	674,731	2.7%
Other Practitioners	9,615,350	9,369,380	245,970	2.6%
Home Health Care	3,554,397	3,288,187	266,210	7.5%
Lab & Radiology	7,139,294	6,852,002	287,292	4.0%
Medical Supplies	8,620,314	8,076,758	543,556	6.3%
Ambulatory/Clinics	28,733,550	28,723,712	9,838	0.0%
Prescription Drugs	94,267,476	93,611,186	656,290	0.7%
OHCA Therapeutic Foster Care	(0)	(27,133)	27,133	0.0%
Other Payments:				
Nursing Facilities	104,776,574	104,441,208	335,366	0.3%
Intermediate Care Facilities for Individuals with Intellectual Disabilities Private	11,798,927	11,194,577	604,349	5.1%
Medicare Buy-In	31,328,877	31,431,051	(102,173)	(0.3)%
Transportation	11,581,224	11,529,119	52,104	0.4%
Money Follows the Person-OHCA	61,160	17,405	43,755	0.0%
Electonic Health Records-Incentive Payments	4,203,071	4,203,071	-	0.0%
Part D Phase-In Contribution	15,413,857	15,386,403	27,454	0.2%
Supplemental Hospital Offset Payment Program	110,383,405	110,383,405	-	0.0%
Telligen	1,712,920	2,413,474	(700,554)	(40.9)%
Total OHCA Medical Programs	**712,914,159**	**707,655,179**	**5,258,980**	**0.7%**
OHCA Non-Title XIX Medical Payments	89,382	-	89,382	0.0%
TOTAL OHCA	**$ 733,491,605**	**$ 727,151,240**	**$ 6,340,365**	**0.9%**
REVENUES OVER/(UNDER) EXPENDITURES	**$ 17,596,030**	**$ 19,101,266**	**$ 1,505,236**	

OKLAHOMA HEALTH CARE AUTHORITY
SFY 2018
Budget Request Detail

Description of Priority	# FTE	State	Total
1 Annualizations			
FFP Match Rate from 59.94% to 58.57%		41,402,874	-
Medicare A & B Premiums - 01/01/17		1,214,576	2,956,073
CHIP- Enhanced FMAP to Regular FMAP >10/01/2017		49,613,547	-
(If Congress does not extend CHIP funding - 9 months impact)			
		$92,230,997	**$2,956,073**
2 Maintenance			
FY'18 Growth/Utilization increases (1.6%)		16,704,517	49,290,549
Medicare A & B premiums - 01/01/2018		933,269	2,252,640
Medicare Part D (clawback) - 100% State		6,894,599	6,894,599
Medicaid Inflationary Contract Increases:			
Pediatric Diabetes Management		20,000	40,000
MMIS (HPE)		54,982	210,346
Care Management		331,250	6,125,000
FTE required to maintain Medicaid Program	11.0	312,326	782,317
	11.0	**$25,250,943**	**$65,595,452**
3 Mandates			
Security Governance Director	1.0	14,423	144,227
Provider Enrollment Staffing	4.0	118,425	236,849
	5.0	**$132,847**	**$381,076**
4 One-Time Funding			
FY-16 Carryover & Replace		39,042,831	-
FY-16 General Revenue Reconciliation (State Surplus)		(23,524,033)	-
State Funding for delayed payment cycle from FY'16 to FY'17		(21,796,674)	-
		($6,277,876)	**$0**
5 SoonerHealth+ ABD Care Coordination Program			
Claim Bubble (Overlap of Fee-for-Svc & Capitation Pymts)		45,890,914	110,767,351
Behavioral Health Assessments to Determine System of Care		1,411,856	3,407,811
Changes to Medicaid Claims Payment System (MMIS)		2,130,000	21,300,000
License for Business Objects for MCO contracted staff		5,000	10,000
Contracts:			
Development		250,000	500,000
Evaluation		125,000	250,000
Actuary		250,000	500,000
Enrollment Counselor		2,500,000	5,000,000
Encounter data evaluator (April - June 2018)		62,500	125,000
Less FY-17 base (currently budgeted for contracts)		(372,543)	(745,086)
FTE required for SoonerHealth+ Program	13.0	671,277	1,342,554
	13.0	**$52,924,003**	**$142,457,630**
6 Remove certain medications from monthly rx limit		**$2,292,683**	**$5,580,000**
7 Provider Rate Maintenance - restore to pre-SFY-10 level			
Inpatient Hospitals DRG / Per diem		28,375,126	69,060,240
Outpatient Hospitals		13,166,645	32,045,378
SoonerCare Choice Care Management		419,147	1,020,133
Behavioral Health (OHCA)		1,086,366	2,644,032
Nursing Facilities (100% of Allowable Costs)		38,059,499	92,630,359
ICF/MR's (100% of Allowable Costs)		1,496,009	3,641,031
Physicians (Increase to 100% of Medicare)		23,805,563	57,938,700
Dental		6,770,057	16,477,170
Mid-Level Practioners		141,361	344,048
Other Practitioner		2,147,643	5,226,997
Home Health		1,027,853	2,501,619
Lab & Radiology		2,976,397	7,244,045
Clinic Services		1,888,093	4,595,298
Emergency Transportation		511,454	1,244,791
Ambulatory Surgery Center (ASC)		350,802	853,793
Durable Medical Equipment (DME)		2,220,174	5,403,525
Pharmacy Dispensing Fees		1,209,761	2,944,353
Crossovers (To pay 100% of coinsurance and deductibles)		12,056,321	29,343,040
		$137,708,271	**$335,158,554**
FY-2018 Budget Request Totals	**29.0**	**$ 304,261,869**	**$ 552,128,784**

Notes:

#1 - If Congress extends CHIP funding thru FFY-2019, the state dollar request will decrease by $50 million.

#5 - Up to $53 million depending on the responses to the RFP.

Draft

Agenda

Agenda

Soonercare Operations Update (August 2016 Data)

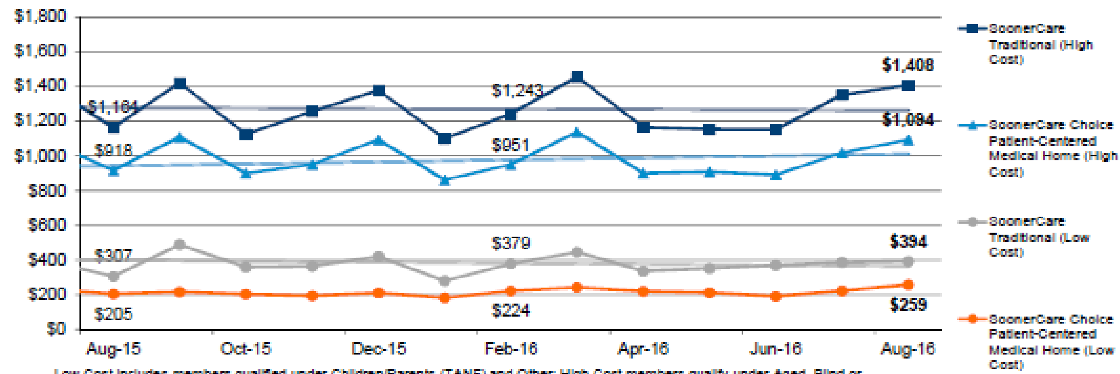
SOONERCARE ENROLLMENT/EXPENDITURES

Delivery System		Enrollment August 2016	Children August 2016	Adults August 2016	Enrollment Change	Total Expenditures August 2016	PMPM August 2016	Forecasted August 2016 Trend PMPM
SoonerCare Choice Patient-Centered Medical Home		**538,128**	**442,970**	**95,158**	**6,225**	**$175,398,999**		
Lower Cost	(Children/Parents; Other)	494,823	429,333	65,490	6,332	$128,031,419	$259	$229
Higher Cost	(Aged, Blind or Disabled; TEFRA; BCC)	43,305	13,637	29,668	-107	$47,367,579	$1,094	$991
SoonerCare Traditional		**229,876**	**84,902**	**144,974**	**1,921**	**$204,424,924**		
Lower Cost	(Children/Parents; Other)	117,548	79,799	37,749	1,630	$46,267,981	$394	$376
Higher Cost	(Aged, Blind or Disabled; TEFRA; BCC & HCBS Waiver)	112,328	5,103	107,225	291	$158,156,943	$1,408	$1,288
SoonerPlan		**33,951**	**2,811**	**31,140**	**1,422**	**$323,406**	$10	$8
Insure Oklahoma		**19,102**	**569**	**18,533**	**219**	**$6,736,816**		
Employer-Sponsored Insurance		14,616	370	14,246	100	$4,468,104	$306	$302
Individual Plan		4,486	199	4,287	119	$2,268,712	$506	$446
TOTAL		**821,057**	**531,252**	**289,805**	**9,787**	**$386,884,145**		

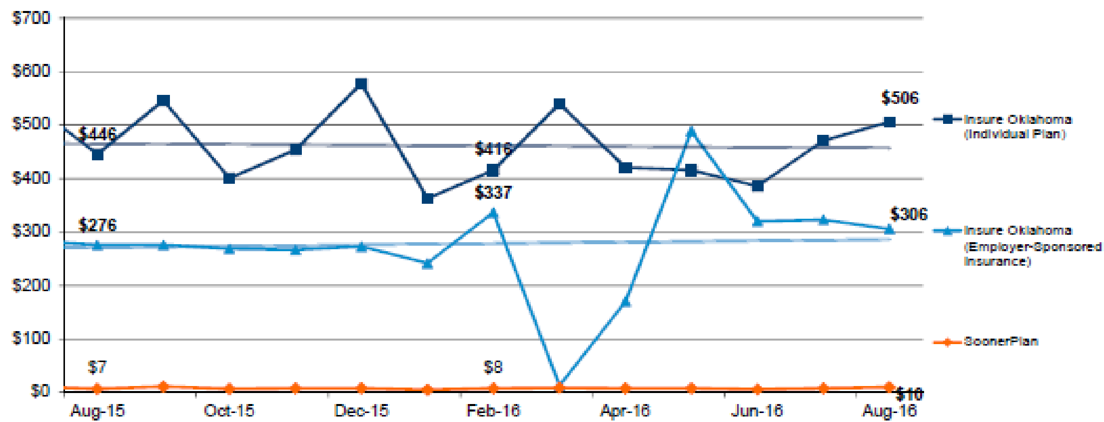
Enrollment totals include all members enrolled during the report month. Members may not have expenditure data. Children are members aged 0 - 20 or for Insure Oklahoma enrolled as Students or Dependents.

Total In-State Providers: 33,803 (+585)	(In-State Providers counted multiple times due to multiple locations, programs, types, and specialties)							
Physician	Pharmacy	Dentist	Hospital	Mental Health	Optometrist	Extended Care	Total PCPs	PCMH
10,274	960	1,263	199	5,923	666	232	6,840	2,630

PER MEMBER PER MONTH COST BY GROUP



Low Cost includes members qualified under Children/Parents (TANF) and Other; High Cost members qualify under Aged, Blind or Disabled, Oklahoma Cares, TEFRA or a Home and Community-Based Services waiver.



The changes in Insure Oklahoma from February to May were due to eligibility changes.

Data Set 3 of 9/26/2016

GREAT 100 NURSES FOUNDATION

It is a great honor in the life of a nurse...

The Great 100 Nurses Foundation was founded in New Orleans, Louisiana thirty years ago and since then has honored thousands of Nurses across Louisiana, North Carolina, Texas, Oklahoma and beginning in the spring of 2017, honoring the Great Nurses in Arkansas. These exemplary Nurses are selected based on their concern for humanity, their contributions to the profession of Nursing, and their mentoring of others. It is a great honor in the life of the Nurse. Our Foundation helps each RN recognize themselves as Nurse Heroes.

We are very proud of our program. Each year, community, civic, health care and government leaders, family, friends and peers join together to honor these Great 100 Nurses.

The funds we raise through our Celebration are used not only to honor the Nurses you will meet at our annual Celebrations, but to also support nursing advocacy, nursing scholarships, and research for the betterment of lives, publication of nursing discoveries and the implementation of those discoveries.

The Great 100 Nurses Celebration belongs to everyone who has met and been touched by an exceptional Nurse.

SOONERCARE HEALTH MANAGEMENT PROGRAM AND CHRONIC CARE UNIT

Agenda

Population Care Management

- Case Management Unit (CMU)
- Health Management Program (HMP)
- Chronic Care Unit (CCU)

HMP Overview

- Medicaid Reform Act of 2006 (HB2842)
- Health coaching
  - Registered nurses
  - SoonerCare Choice members with/at risk for chronic conditions
  - In 2013, transitioned from field-based and telephonic coaching to embedding coaches in select PCMH practices
- Practice facilitation and education for patient centered medical home providers
- Currently administered by Telligen, a national quality improvement and medical management firm

CCU Overview

- In 2013, legislature awarded 6 FTE to expand reach
- Telephonic nurse case management to high risk members not aligned with a practice with an embedded health coach
- Not limited to SoonerCare Choice members
- Special populations such as members with hemophilia, sickle cell, hepatitis C, bariatric surgery candidates, etc.
- Internal unit

Program Objectives

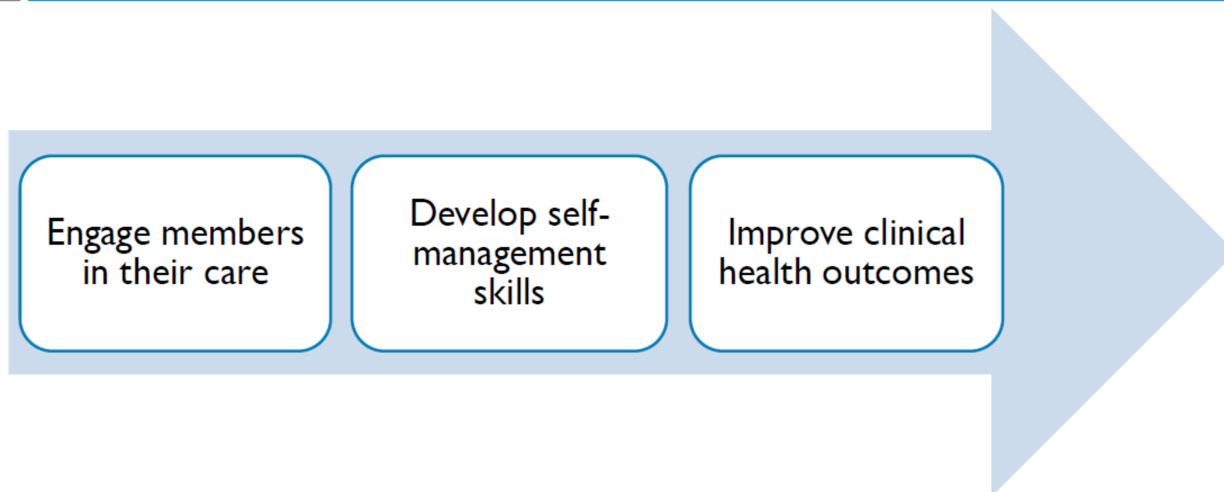
Address physical and behavioral health needs of chronically ill members

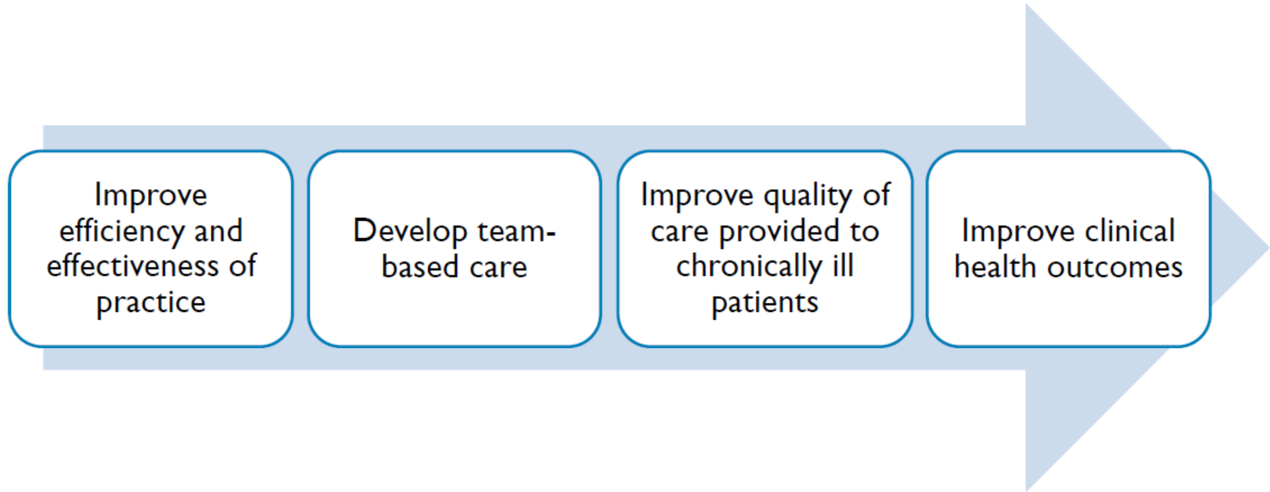
Improve member self-management skills

Reduce avoidable acute care services and costs

Improve provider management of patients with chronic conditions

Member Goals

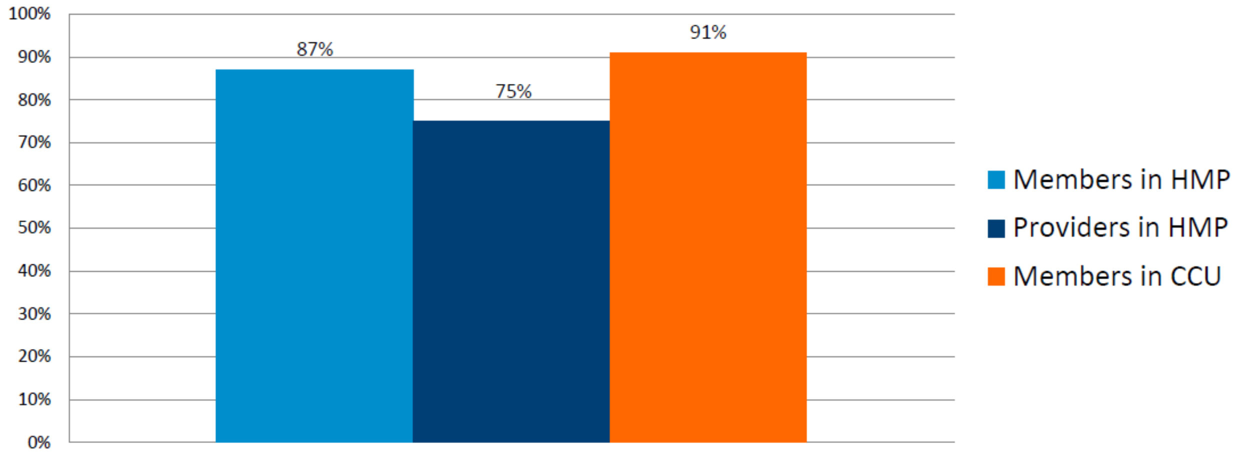



HMP Practice Facilitation
Improve efficiency and effectiveness of practice
Develop team-based care
Improve quality of care provided to chronically ill patients
Improve clinical health outcomes

HMP/CCU Outcomes

- Annual external evaluation
- Pacific Health Policy Group (PHPG)
  - Satisfaction
  - Quality of care
  - Utilization
  - Cost-effectiveness

SFY2015 Satisfaction

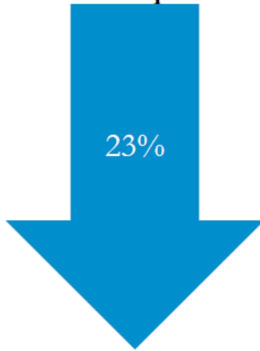


SFY2015 Quality of Care

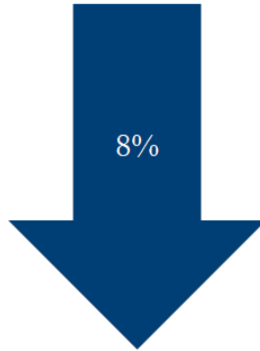
- Participants exceeded comparison group on 17 disease specific HEDIS measures
  - HMP health coached members – 12 measures
  - Members assigned to a PCMH with a practice facilitator – 8 measures
  - CCU members – 10 measures

ER Utilization

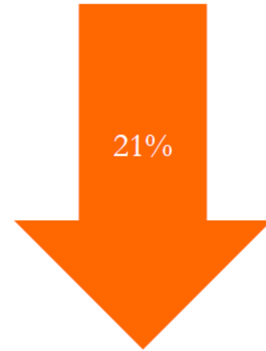
Health Coaching Participants



Members in PCMH with PF

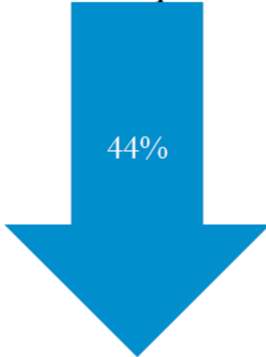


CCU Participants

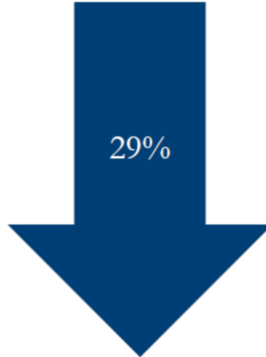


Inpatient Utilization

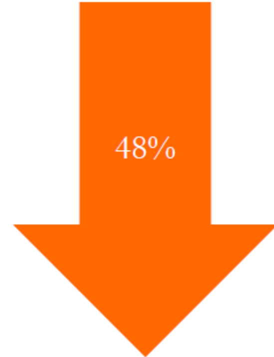
Health Coaching Participants



Members in PCMH with PF



CCU Participants



SFY2015 HMP Cost-effectiveness

Component	Medical Savings	Administrative Costs	Net Savings	Return on Investment
Health Coaching	$22,861,281	($10,101,726)	$12,759,555	126.3%
Practice Facilitation	$34,893,323	($6,454,160)	$28,439,163	440.6%
TOTAL	$57,754,604	($16,555,886)	$41,198,718	248.8%

SFY2015 CCU Cost-effectiveness

Medical Savings	Administrative Costs	Net Savings	Return on Investment
$4,078,393	($1,380,489)	$2,697,904	**195.4%**

Contact:

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For more information and full report:

www.okhca.org/studies

www.okhca.org/PCM

Agenda

November MAC
Proposed Rule Amendment Summaries

Face to face tribal consultation regarding the following proposed changes were held Tuesday, November 3, 2015, Tuesday, September 6, 2016, and Tuesday, November 1, 2016 in the Board Room of the OHCA.

APA WF# 16-18 will be posted for comments through December 1, 2016. APA WF# 16-13 and APA WF# 16-16 A&B will be posted for comments through December 7, 2016.

16-13 Pharmacy Reimbursement — The proposed Pharmacy revisions amend the reimbursement structure for I/T/U and non I/T/U pharmacies. The I/T/U pharmacies will be reimbursed at the federal Office of Management and Budget (OMB) encounter rate. The pharmacies will receive one rate per member per facility per day regardless of the number of prescriptions dispensed to the member on that day. Revisions also revise ingredient cost methodology. The revision will align reimbursement for covered outpatient drugs with the Actual Acquisition Cost (AAC) and create a new pricing term for specialty pharmaceutical products. In addition, rules are amended to modify the current dispensing fee to a professional dispensing fee. Further, policy is revised to remove the limitations for smoking cessation benefits, and to update references to outdated policy.
Budget Impact: Budget neutral

16-16 A&B Nursing Facility Supplemental Payment Program — The proposed policy adds a supplemental payment program for nursing facilities owned and as applicable operated by non-state government owned (NSGO) entities. The policy adds requirements and criteria for supplemental payments to be made to participating NSGOs up to the allowable Medicare upper payment limit (UPL). In addition, proposed revisions define terms related to the program and set forth criteria and eligibility requirements. Rules are also added to outline cost reporting, change in ownership, disbursement of payment, and appeal requirements.
Budget Impact: There is no cost to the OHCA as the state share will be financed by the NSGO and will be transferred to the state by way of an intergovernmental transfer for claiming of federal financial participation.

16-18 Telemedicine Consent — Proposed revisions amend language in Chapter 30 to reflect the repeal of 36 O.S. Section 6804, of The Oklahoma Telemedicine Act, which eliminates the informed consent requirement from Oklahoma Statutes.
Budget Impact: Budget neutral

Agenda

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 5. PHARMACIES

317:30-5-72.1. Drug benefit

OHCA administers and maintains an Open Formulary subject to the provisions of Title 42, United States Code (U.S.C.), Section 1396r-8. The OHCA covers a drug that has been approved by the Food and Drug Administration (FDA) and whose manufacturers have entered into a drug rebate agreement with the Centers for Medicare and Medicaid Services (CMS), subject to the following exclusions and limitations.

(1) The following drugs, classes of drugs, or their medical uses are excluded from coverage:

(A) Agents used to promote fertility.

(B) Agents primarily used to promote hair growth.

(C) Agents used for cosmetic purposes.

(D) Agents used primarily for the treatment of anorexia or weight gain. Drugs used primarily for the treatment of obesity, such as appetite suppressants are not covered. Drugs used primarily to increase weight are not covered unless otherwise specified.

(E) Agents that are investigational, experimental or whose side effects make usage controversial.

(F) Covered outpatient drugs which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or designee.

(G) Agents when used for the treatment of sexual or erectile dysfunction, unless such agents are used to treat a condition, other than sexual or erectile dysfunction, for which the agents have been approved by the Food and Drug Administration.

(2) The drug categories listed in (A) through ~~(E)~~(D) of this paragraph are covered at the option of the state and are subject to restrictions and limitations. An updated list of products in each of these drug categories is included on the OHCA's public website.

(A) Agents used for the systematic relief of cough and colds. Antihistamines for allergies or antihistamine use associated with asthmatic conditions may be covered when medically necessary and prior authorized.

(B) Vitamins and Minerals. Vitamins and minerals are not covered except under the following conditions:

(i) prenatal vitamins are covered for pregnant women up to age 50;

(ii) fluoride preparations are covered for persons under 16 years of age or pregnant;

(iii) vitamin D, metabolites, and analogs when used to treat end stage renal disease are covered;

(iv) iron supplements may be covered for pregnant women if determined to be medically necessary;
(v) vitamin preparations may be covered for children less than 21 years of age when medically necessary and furnished pursuant to EPSDT protocol; and
(vi) some vitamins are covered for a specific diagnosis when the FDA has approved the use of that vitamin for a specific indication.

~~(C) Agents used for smoking cessation. A limited smoking cessation benefit is available.~~

~~(D)~~(C) Coverage of non-prescription or over the counter drugs is limited to:

(i) Insulin, PKU formula and amino acid bars, other certain nutritional formulas and bars for children diagnosed with certain rare metabolic conditions;
(ii) certain smoking cessation products;
(iii) family planning products;
(iv) OTC products may be covered if the particular product is both cost-effective and clinically appropriate; and
(v) prescription and non-prescription products which do not meet the definition of outpatient covered drugs, but are determined to be medically necessary.

~~(E)~~(D) Coverage of food supplements is limited to PKU formula and amino acid bars for members diagnosed with PKU, other certain nutritional formulas and bars for children diagnosed with certain rare metabolic conditions when medically necessary and prior authorized.

(3) All covered outpatient drugs are subject to prior authorization as provided in OAC 317-30-5-77.2 and 317:30-5-77.3.

(4) All covered drugs may be excluded or coverage limited if:

(A) the prescribed use is not for a medically accepted indication as provided under 42 U.S.C. § 1396r-8; or
(B) the drug is subject to such restriction pursuant to the rebate agreement between the manufacturer and CMS.

317:30-5-78. Reimbursement

~~(a) **Reimbursement**. Reimbursement for pharmacy claims is based on the sum of an estimate of the ingredient cost, plus a dispensing fee.~~

~~(b) **Ingredient Cost.** Ingredient cost is estimated by one of the following methods:~~

~~(1) **Maximum Allowable Cost.**~~

~~(A) The State Maximum Allowable Cost (SMAC) is established for certain products which have a Food and Drug Administration (FDA) approved generic equivalent. The SMAC will be calculated using prices from pharmaceutical wholesalers who supply these products to pharmacy providers in Oklahoma. Pharmacies may challenge a specific product's SMAC price by providing invoices~~

~~that reflect a net cost higher than the calculated SMAC price and by certifying that there is not another product available to them which is generically equivalent to the higher priced product.~~

~~(B) The Federal Upper Limit (FUL) is established by CMS in accordance with applicable federal laws and regulations.~~

~~(C) Injectable drugs which are dispensed by a retail pharmacy through the Vendor Drug Program shall be priced based on a formula equivalent to the Medicare allowed charge whether they are furnished through the pharmacy program or through the medical program.~~

~~(2) **The Estimated Acquisition Cost.** The Estimated Acquisition Cost (EAC) means the agency's best estimate of the price generally and currently paid by providers for a drug marketed or sold by a particular manufacturer or labeler. EAC is typically based on a benchmark published price plus or minus a percentage. The current benchmark price is the Average Wholesale Price (AWP) as provided by the OHCA's pricing resource. EAC is calculated as AWP minus 12%. The Wholesale Acquisition Cost (WAC) means the price paid by the wholesaler for drugs purchased from the wholesaler's supplier, typically the manufacturer of the drug. Should the AWP no longer be published by the agency's pricing vendor then the agency will use WAC as the benchmark price whereas the EAC will be calculated as WAC + 5.6%.~~

(a) **Reimbursement.** Reimbursement for pharmacy claims is based on the sum of the ingredient cost plus a professional dispensing fee for brand and generic drugs dispensed by a retail community pharmacy or for a member residing in a long term care facility.

(b) **Ingredient Cost.** Ingredient cost is determined by one of the following methods:

(1) **Maximum Allowable Cost.** The State Maximum Allowable Cost (SMAC) is established for certain products which have a Food and Drug Administration (FDA) approved generic equivalent. The SMAC will be calculated using prices from pharmaceutical wholesalers who supply these products to pharmacy providers in Oklahoma. Pharmacies may challenge a specific product's SMAC price by providing information from at least two wholesalers to certify a net cost higher than the calculated SMAC price and that there is not another product available to them which are generically equivalent to the higher priced product.

(2) **Actual Acquisition Cost.** The Actual Acquisition Cost (AAC) means the cost of a particular drug product to the pharmacy based on a review of invoices or the Wholesale Acquisition Cost (WAC), whichever is lower. The National Average Drug Acquisition Cost (NADAC) is based on a review of invoices and published by Centers for Medicare and Medicaid Services (CMS) and will be used in the determination of AAC.

(3) **Specialty Pharmaceutical Allowable Cost.** Reimbursement for specialty drugs not typically dispensed by a retail community pharmacy and dispensed primarily by delivery, including clotting factor for hemophilia, shall be set as a Specialty Pharmaceutical Allowable Cost (SPAC). The Medicare Part B allowed charge, defined as Average Sales Price (ASP) plus 6%, WAC, and NADAC when available, will be considered in setting the SPAC rate. For the purpose of this section, a specialty drug is defined as having one or more of the following characteristics:

(A) Covered by Medicare Part B;

(B) "5i drug" - Injected, infused, instilled, inhaled, or implanted;

(C) Cost greater than $1,000.00 per claim;

(D) Licensed by the FDA under a Biological License Application;

(E) Special storage, shipping, or handling requirements;

(F) Available only through a limited distribution network; and/or

(G) Does not have a NADAC price from CMS.

(4) **Exceptions.**

(A) Physician administered drugs shall be priced based on a formula equivalent to the Medicare Part B allowed charge, defined as ASP plus 6%. If a price equivalent to the Medicare Part B allowed charge cannot be determined, a purchase invoice may be supplied by the provider and will be considered in setting the reimbursement.

(B) I/T/U pharmacies shall be reimbursed at the OMB encounter rate as a per member per facility per day fee regardless of the number of prescriptions filled on that day. I/T/U pharmacies should not split prescriptions into quantities less than a one month supply for maintenance medications. For this purpose a maintenance medication is one that the member uses consistently month to month.

(C) Pharmacies other than I/T/U facilities that acquire drugs via the Federal Supply Schedule (FSS) or at nominal price outside the 340B program or FSS shall notify OHCA and submit claims at their actual invoice price plus a professional dispensing fee.

(c) **~~Maximum allowable~~ Professional dispensing fee.** The ~~maximum allowable~~ professional dispensing fee for prescribed medication is established by review of surveys. A recommendation is made by the State Plan Amendment Rate Committee and presented to the Oklahoma Health Care Authority Board for their approval. There may be more than one level or type of dispensing fee if approved by the OHCA Board and CMS. A contracted pharmacy agrees to participate in any survey conducted by the OHCA with regard to dispensing fees. The pharmacy shall furnish all necessary information to determine the cost of dispensing drug products. Failure to participate may result

in administrative sanctions by the OHCA which may include but are not limited to a reduction in the dispensing fee.

(d) **Reimbursement for prescription claims.** Prescription claims will be reimbursed using the lower of the following calculation methods:

~~(1) the lower of estimated acquisition cost, Federal Upper Limit (FUL), or State Maximum Allowable Cost (SMAC) plus a dispensing fee, or~~

(1) the lower of Actual Acquisition Cost (AAC), State Maximum Allowable Cost (SMAC), or Specialty Pharmaceutical Allowable Cost (SPAC) plus a professional dispensing fee, or

(2) usual and customary charge to the general public. The pharmacy is responsible to determine its usual and customary charge to the general public and submit it to OHCA on each pharmacy claim. The OHCA may conduct periodic reviews within its audit guidelines to verify the pharmacy's usual and customary charge to the general public and the pharmacy agrees to make available to the OHCA's reviewers prescription and pricing records deemed necessary by the reviewers. The OHCA defines general public as the patient group accounting for the largest number of non-SoonerCare prescriptions from the individual pharmacy, but does not include patients who purchase or receive their prescriptions through other third-party payers. If a pharmacy offers discount prices to a portion of its customers (i.e. -10% discount to senior citizens), these lower prices would be excluded from the usual and customary calculations unless the patients receiving the favorable prices represent more than 50% of the pharmacy's prescription volume. The usual and customary charge will be a single price which includes both the product price and the dispensing fee. For routine usual and customary reviews, the pharmacy may provide prescription records for non-SoonerCare customers in a manner which does not identify the customer by name so long as the customer's identity may be determined later if a subsequent audit is initiated. The OHCA will provide the pharmacy notice of its intent to conduct a review of usual and customary charges at least ten days in advance of its planned date of review.

(e) **Payment of Claims.** In order for an eligible provider to be paid for filling a prescription drug, the pharmacy must complete all of the following:

(1) have an existing provider agreement with OHCA,

(2) submit the claim in a format acceptable to OHCA,

(3) have a prior authorization before filling the prescription, if a prior authorization is necessary,

(4) have a proper brand name certification for the drug, if necessary, and

(5) include the usual and customary charges to the general public as well as the ~~estimated~~ actual acquisition cost and professional dispensing fee.

(f) **Claims.** Prescription reimbursement may be made only for individuals who are eligible for coverage at the time a prescription is filled. Member eligibility information may be accessed by swiping a SoonerCare identification card through a commercial card swipe machine which is connected to the eligibility database or via the Point of Sale (POS) system when a prescription claim is submitted for payment. Persons who do not contract with commercial vendors can use the Member Eligibility Verification System (EVS) at no additional cost.

317:30-5-87. 340B Drug Discount Program

(a) The purpose of this Section is to provide special provisions for providers participating in the 340B Drug Discount program. The 340B Drug Discount program special provisions apply to a provider that has asserted it is a "covered entity" or a contract pharmacy for a covered entity under the provisions of 42 U.S.C. § 256b of the United States Code (otherwise known as the 340B Drug Discount Program).

(b) Covered Entities.

(1) The covered entity must notify OHCA in writing within 30 days of any changes in 340B participation, as well as any changes in name, address, NPI number, etc.

(2) The covered entity must maintain their status on the HRSA Medicaid exclusion file and report any changes to OHCA within 30 days.

(3) The covered entity must execute a contract addendum with OHCA in addition to their provider contract.

(4) To prevent a duplicate discount, quarterly adjustments will be made to all pharmacy or medical claims for drugs submitted by the covered entity. OHCA will adjust each claim by subtracting the ~~Unit Rebate Amount~~340B Ceiling Price from the amount reimbursed and ~~multiplied~~ multiplying the difference by the quantity submitted. All drugs shall be adjusted by the ~~URA~~ 340B Ceiling Price whether purchased through the 340B program or otherwise when billed using the registered SoonerCare NPI number on the HRSA Medicaid Exclusion File. OHCA will use the ~~Unit Rebate Amount~~ 340B Ceiling Price applicable to the quarter in which the claim is ~~submitted to OHCA for payment~~ paid.

(c) Contract pharmacies for covered entities may be permitted to bill drug products purchased under the 340B Drug Discount Program to the Oklahoma Medicaid Program when certain conditions are met and an agreement is in place between OHCA, the contract pharmacy and the covered entity. These pharmacies will be subject to the recovery process stated above.

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

317:30-5-1090. Provision of other health services outside of the

I/T/U encounter

(a) Medically necessary SoonerCare covered services that are not included in the I/T/U outpatient encounter rate may be billed outside the encounter rate within the scope of the SoonerCare fee-for-service contract. The services will be reimbursed at the fee-for-service rate, and will be subject to any limitations, restrictions or prior authorization requirements. Examples of these services include but are not limited to:

~~(1) pharmaceuticals/drugs;~~

~~(2)~~(1) durable medical equipment;

~~(3)~~(2) glasses;

~~(4)~~(3) ambulance;

~~(5)~~(4) home health;

~~(6)~~(5) inpatient practitioner services;

~~(7)~~(6) non-emergency transportation [refer to OAC 317:35-3-2];

~~(8)~~(7) behavioral health case management ~~[refer to OAC 317:30-5-240 through 317:30-5-249];~~ [refer to OAC 317:30-5-241.6];

~~(9)~~(8) psychosocial rehabilitative services ~~[refer to OAC 317:30-5-240 through 317:30-5-249];~~ [refer to OAC 317:30-5-241.3]; and

~~(10)~~(9) psychiatric residential treatment facility services ~~[refer to OAC 317:30-5-96.3].~~ [refer to OAC 317:30-5, Part 6, Inpatient Psychiatric Hospitals].

(b) If the I/T/U facility chooses to provide other SoonerCare State Plan covered health services which are not included in the I/T/U encounter definition, those service providers must be contracted with OHCA and bill for those services under their assigned provider number consistent with program coverage limitations and billing procedures described by the OHCA.

317:30-5-1098. I/T/U outpatient encounters

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

(b) The following words and terms have the following meaning unless the context clearly indicates otherwise:

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

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

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

(1) Medical;
(2) Diagnostic;
(3) Behavioral Health services [refer to OAC 317:30-5-1094];
(4) Dental, Medical and Mental Health Screenings;
(5) Vision;
(6) Physical Therapy;
(7) Occupational Therapy;
(8) Podiatry;
(9) Speech;
(10) Hearing;
(11) Visiting Nurse Service [refer to OAC 317:30-5-1093];
(12) Smoking and Tobacco Use Cessation Counseling
(13) Other Title XIX or XXI services as allowed under OHCA's SoonerCare State Plan and OHCA Administrative Rules;
(14) Drugs or medication treatments provided during a clinic visit are part of the encounter rate. For example, a member has come into the clinic with high blood pressure and is treated at the clinic with a hypertensive drug or drug sample. Drug samples are included in the encounter rate. ~~Prescriptions are not included in the encounter rate and must be billed through the pharmacy program by a qualified enrolled pharmacy;~~ Prescriptions are reimbursed pursuant to OAC 317:30-5-78(b)(4)(B).
(15) Encounters with a registered professional nurse or a licensed practical nurse and related medical supplies (other than drugs and biologicals) furnished on a part-time or intermittent basis to home-bound members; and
(16) I/T/U Multiple Outpatient Encounters.
(A) OHCA will cover one medically necessary outpatient medical encounter per member per day unless if due to an emergency, the same member returns on the same day for a second visit with a different diagnosis. Then, a second encounter is allowed.
(B) OHCA will cover one dental encounter per member per day regardless of how many procedures are done or how many providers are seen unless if due to an emergency, the same member returns on the same day for a second visit and has a different diagnosis. Then, a second encounter is allowed.
(C) OHCA will cover one behavioral health professional outpatient encounter per member per day unless if due to an emergency, the same member returns on the same day for a second visit and has a different diagnosis. Then, a second encounter is allowed.
(D) Each service must have distinctly different diagnoses in order to meet the criteria for multiple I/T/U outpatient encounters.

(d) More than one outpatient visit with a medical professional within a 24-hour period for distinctly different diagnoses may be reported as two encounters. This does not imply that if a member is seen at a single office visit with multiple problems that multiple encounters can be billed. For example, a member comes to the clinic in the morning for an immunization, and in the afternoon, the member falls and breaks an arm. This would be considered multiple medical encounters and can be billed as two encounters. However, a member who comes to the I/T/U facility for a diabetic wellness screening and is then referred to a podiatrist within the clinic for diabetes-related follow-up on the same date of service would not be considered a distinctly different diagnosis and can only be billed as a single encounter.
(e) The following services may be considered as separate or multiple encounters when two or more services are provided on the same date of service with distinctly different diagnoses:
(1) Medical Services;
(2) Dental Services;
(3) Mental Health and addiction services with similar diagnoses can only be billed as one encounter. In addition, if the member is also seen for a medical office visit with a mental health or addiction diagnosis, then it is considered a single encounter;
(4) Physical or occupational therapy (PT/OT). If this service is also performed on the same date of service as the medical encounter that determined the need for PT/OT (initial referral), then it is considered a single encounter;
(5) Administration of immunizations. If no other medical office visit occurs on the same date of services; and
(6) Tobacco cessation limited to state plan services. If no other medical or addiction encounter occurs on the same date of service.
(f) I/T/U outpatient encounters for IHS eligible SoonerCare members whether medical, dental, or behavioral health, are not subject to prior authorization. Other State Plan covered services that the I/T/U facility chooses to provide but which are not part of the I/T/U encounter are subject to all applicable SoonerCare regulations which govern the provision and coverage for that service.

Agenda

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY

CHAPTER 2. GRIEVANCE PROCEDURES AND PROCESS

317:2-1-2. Appeals
(a) **Member Process Overview**
(1) The appeals process allows a member to appeal a decision which

adversely affects their rights. Examples are decisions involving medical services, prior authorizations for medical services, or discrimination complaints.

(2) In order to file an appeal, the member files a LD-1 form within 20 days of the triggering event. The triggering event occurs at the time when the Appellant (Appellant is the person who files a grievance) knew or should have known of such condition or circumstance for appeal.

(3) If the LD-1 form is not received within 20 days of the triggering event, OHCA sends the Appellant a letter stating the appeal will not be heard because it is untimely. In the case of tax warrant intercept appeals, if the LD-1 form is not received by OHCA within the timeframe pursuant to Title 68 O.S. ' 205.2, OHCA sends the Appellant a letter stating the appeal will not be heard because it is untimely.

(4) If the LD-1 form is not completely filled out or if necessary documentation is not included, then the appeal will not be heard.

(5) The staff advises the Appellant that if there is a need for assistance in reading or completing the grievance form that arrangements will be made.

(6) Upon receipt of the member's appeal, a fair hearing before the Administrative Law Judge (ALJ) will be scheduled. The member will be notified in writing of the date and time for this procedure. The member must appear at this hearing and it is conducted according to 317:2-1-5. The ALJ's decision may be appealed to the Chief Executive Officer of the OHCA, which is a record review at which the parties do not appear (317:2-1-13).

(7) Member appeals are ordinarily decided within 90 days from the date OHCA receives the member's timely request for a fair hearing unless the member waives this requirement. [Title 42 CFR 431.244(f)]

(8) Tax warrant intercept appeals will be heard directly by the ALJ. A decision is normally rendered by the ALJ within 20 days of the hearing before the ALJ.

(b) **Provider Process Overview.**

(1) The proceedings as described in this subsection contain the hearing process for those appeals filed by providers. These appeals encompass all subject matter cases contained in 317:2-1-2(c)(2).

(2) All provider appeals are initially heard by the OHCA Administrative Law Judge under 317:2-1-2(c)(2).

(A) The Appellant (Appellant is the provider who files an appeal) files an LD form requesting an appeal hearing within 20 days of the triggering event. The triggering event occurs at the time when the Appellant knew or should have known of such condition or circumstance for appeal. (LD-2 forms are for provider appeals and LD-3 forms are for nursing home wage enhancement grievances.)

(B) If the LD form is not received within 20 days of the triggering event, OHCA sends the Appellant a letter stating the appeal will not be heard because it is untimely.
(C) A decision will be rendered by the ALJ ordinarily within 45 days of the close of all evidence in the case.
(D) Unless an exception is provided in 317:2-1-13, the Administrative Law Judge's decision is appealable to OHCA's CEO under 317:2-1-13.

(c) **ALJ jurisdiction.** The Administrative Law Judge has jurisdiction of the following matters:
(1) Member Appeals:
(A) Discrimination complaints regarding the SoonerCare program;
(B) Appeals which relate to the scope of services, covered services, complaints regarding service or care, enrollment, disenrollment, and reenrollment in the SoonerCare Program;
(C) Fee for Service appeals regarding the furnishing of services, including prior authorizations;
(D) Appeals which relate to the tax warrant intercept system through the Oklahoma Health Care Authority. Tax warrant intercept appeals will be heard directly by the ALJ. A decision will be rendered by the Administrative Law Judge within 20 days of the hearing before the ALJ;
(E) Proposed administrative sanction appeals pursuant to 317:35-13-7. Proposed administrative sanction appeals will be heard directly by the ALJ. A decision by the ALJ will ordinarily be rendered within 20 days of the hearing before the ALJ. This is the final and only appeals process for proposed administrative sanctions;
(F) Appeals which relate to eligibility determinations made by OHCA;
(G) Appeals of insureds participating in Insure Oklahoma which are authorized by 317:45-9-8(a); and
(2) Provider Appeals:
(A) Whether Pre-admission Screening and Resident Review (PASRR) was completed as required by law;
(B) Denial of request to disenroll member from provider's SoonerCare Choice panel;
(C) Appeals by Long Term Care facilities for nonpayment of wage enhancements, determinations of overpayment or underpayment of wage enhancements, and administrative penalty determinations as a result of findings made under 317:30-5-131.2(b)(5), (e)(8), and (e)(12);
(D) Appeals of Professional Service Contract awards and other matters related to the Central Purchasing Act pursuant to Title 74 O. S. ' 85.1;
(E) Drug rebate appeals;
(F) Proposed administrative sanction appeals pursuant to 317:30-3-19. Proposed administrative sanction appeals will be

heard directly by the ALJ. A decision will normally be rendered by the ALJ within 20 days of the hearing before the ALJ. This is the final and only appeals process for proposed administrative sanctions;

(G) Provider appeals of OHCA audit findings pursuant to 317:2-1-7. This is the final and only appeals process for appeals of OHCA audits; and

(H) Oklahoma Electronic Health Records Incentive program appeals related only to incentive payments, incentive payment amounts, provider eligibility determinations, and demonstration of adopting, implementing, upgrading, and meaningful use eligibility for incentives.

(I) Supplemental Hospital Offset Payment Program (SHOPP) annual assessment, Supplemental Payment, fees or penalties as specifically provided in OAC 317:2-1-15.

(J) Nursing Facility Supplemental Payment Program (NFSPP) eligibility determinations, the assessed amount for each component of the Intergovernmental transfer, Upper Payment Limit payments, calculation of the per patient per Medicaid day participation fee and penalties specifically provided in OAC 317:30-5-136. This is the final and only process for appeals regarding NFSPP.

317:2-1-16. Nursing Facility Supplemental Payment Program Appeals

(a) In accordance with OAC 317:30-5-136, OHCA is authorized to promulgate rules for appeals of the Nursing Facility Supplemental Payment Program (NFSPP). The rules in this Section describe those appeal rights.

(1) The following are appealable issues of the program: program eligibility determination, the assessed amount for each component of the Intergovernmental transfer, the Upper Payment Limit (UPL) payment, the Upper Payment Limit Gap payment, calculation of the per patient per Medicaid (PPMD) and penalties for the providers. This is the final and only process for appeals regarding NFSPP. Suspensions or terminations from the program are not appealable in the administrative process.

(2) Appeals are heard by the OHCA Administrative Law Judge (ALJ).

(3) To file an appeal, the provider (Appellant is the provider who files an appeal) shall file an LD-2 form within twenty (20) days from the date of the OHCA letter which advises the provider of the program eligibility determination, component of intergovernmental transfer (IGT), calculation of Medicaid PPMD, UPL payment and/or a penalty. The IGT shall be deducted from the provider's UPL payment if the IGT is unpaid at the time the appeal is filed. Any applicable penalties must also be deducted from the UPL payment regardless of any appeal action requested by the facility. Any change in the payment amount resulting from an appeals decision in

which a recoupment or additional allocation is necessary will be adjusted in the future from any Medicaid payments.

(4) Consistent with Oklahoma rules of practice, all NSGO providers must be represented by an attorney licensed to practice within the State of Oklahoma. Attorneys not licensed to practice in Oklahoma must comply with 5 O.S. Art II, Sec. 5, and rules of the Oklahoma Bar Association.

(5) The hearing will be conducted in an informal manner, without formal rules of evidence or procedure. However parties who fail to appear at a hearing, after notification of said hearing date, will have their cases dismissed for failure to prosecute.

(6) The provider has the burden of proof by the preponderance of the evidence standard as defined by the Oklahoma Supreme Court.

(7) The docket clerk will send the Appellant and any other necessary party a notice which states the hearing location, date, and time.

(8) The ALJ may:

(A)Identify and rule on issues being appealed which will be determined at the administrative hearing;

(B) Require the parties to state their positions concerning appeal issue(s);

(C)Require the parties to produce for examination those relevant witnesses and documents under their control;

(D) Rule on whether witnesses have knowledge of the facts at issue;

(E) Establish time limits for the submission of motions or memoranda;

(F) Rule on relevant motions, requests and other procedural items, limiting all decisions to procedure matters and issues directly related to the contested determination resulting from OAC 317:30-5-136;

(G) Rule on whether discovery requests are relevant;

(H) Strike or deny witnesses, documents, exhibits, discovery requests, another requests or motions which are cumulative, not relevant, not material, used as a means of harassment, unduly burdensome, or not timely filed;

(I) Schedule pre-hearing conferences to settle, simplify, or identify issues in a proceeding or to consider other matters that may end the appeal;

(J) Impose appropriate sanctions against any party failing to obey an order of the ALJ;

(K) Rule on any requests for extension of time;

(L) Dismiss an issue or appeal if:

(i) it is not timely filed or is not within the OHCA's jurisdiction or authority;

(ii) it is moot or there is insufficient evidence to support the allegations;

(iii) the appellant fails or refuses to appear for a scheduled meeting;
(iv) or the appellant refuses to accept a settlement offer which affords the relief the party could reasonably expect if the party prevailed in the appeal;
(M) Set and/or limit the time frame for the hearing.
(9) After the hearing:
(A) The ALJ should attempt to make the final hearing decision within ninety (90) days from the date of the hearing and send a copy of the ALJ's decision to both parties outlining their rights to appeal the decision. Any appeal of the final order pursuant to 12 O.S. § 951 must be filed with the District Court of Oklahoma County within 30 days.
(B) It shall be the duty of the Appellant in any District Court appeal to order a written transcript of proceedings to be used on appeal. The transcript must be ordered within thirty (30) days of the filing of an appeal in the District Court and any costs associated with the preparation of the transcript shall be borne by the Appellant.
(10) All orders and settlements are non-precedential decisions.
(11) The hearing shall be digitally recorded and closed to the public.
(12) The case file and any audio recordings shall remain confidential.

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 9. LONG TERM CARE FACILITIES

317:30-5-136. Nursing Facility Supplemental Payment Program
(a) **Purpose.** The nursing facility supplemental payment program is a supplemental payment, up to the Medicare upper payment limit, made to non-state government owned entities that own and as applicable have operating responsibility for nursing facilities.
(b) **Definitions.** The following words and terms, when used in this Section have the following meaning, unless the context clearly indicates otherwise:
(1) **"Intergovernmental transfer (IGT)"** means a transfer of state share funds from a non-state government owned facility to the Oklahoma Health Care Authority.
(2) **"Non-state government-owned (NSGO)"** means an institution owned and as applicable operated by a unit of government other than the state and approved by OHCA as a qualified NSGO.
(3) **"Public funds"** means funds, as outlined in 42 Code of Federal

Regulations 433.51, appropriated directly to the State or local Medicaid agency, or funds that are transferred from other public agencies (including Indian tribes) to the State or local agency and under its administrative control, or funds certified by the contributing public agency as representing expenditures eligible for Federal Financial Participation (FFP).

(4) **"Resource Utilization Groups (RUGs)"** means the system used to set Medicare per diem payments for skilled nursing facilities, as the basis to demonstrate a Medicare payment estimate for use in the upper payment limit calculation.

(5) **"Supplemental payment calculation period"** means the calendar quarter for which supplemental payment amounts are calculated based on adjudicated claims for days of service provided in the qualifying quarter. Note, in the event there are no paid days in the quarter as a result of the time in which the claims are adjudicated, the supplemental payment will be calculated on days billed in a subsequent quarter.

(6) **"Upper payment limit (UPL)"** refers to a reasonable estimate of the amount that would be paid for the services furnished by a facility under Medicare payment principles.

(c) **Eligible nursing facilities.** A nursing facility that is owned and under the operational responsibility of an NSGO is eligible for participation when the following conditions are met:

(1) the NSGO has executed an agreement of participation with the OHCA;

(2) the nursing facility is licensed and certified by the Oklahoma State Department of Health;

(3) the participating NSGO has provided proof that it holds the facility's license and has complete operational responsibility for the facility;

(4) the participating NSGO has filed the certification of eligibility application for the UPL program participation and received approval from OHCA for participation;

(5) the NSGO has signed an attestation that a plan towards the reduction and mitigation of unnecessary Return to Acute Admissions (RTA) will be implemented within six months of program participation;

(6) the facility is an active participant in the Focus on Excellence program; and

(7) the facility and NSGO comply with Care Criteria requirements.

(d) **NSGO participation requirements.** The following conditions are required of the NSGO:

(1) must execute a nursing facility provider contract as well as an agreement of participation with the OHCA;

(2) must provide and identify the source of the IGT;

(3) must pay the calculated IGT to OHCA by the required deadline;

(4) must provide proof of ownership, if applicable (i.e. Change of Ownership) as Licensed Operator of the nursing facility;

(5) must provide OHCA with an executed Management Agreement between the NSGO and the facility Manager;
(6) must provide proof of district authority for nursing facility participants which include proximity requirements of no greater than 150 miles of NSGO. Exceptions may be made at the sole discretion of OHCA; and
(7) must provide per facility, the per patient per Medicaid day (PPMD) participation fee assessment upon enrollment in the program as indicated below:
(A) For the first year-$6.50 PPMD.
(B) For the second year-$7.50 PPMD.
(C) For the third year-$8.50 PPMD, or the equivalent of 10% of nursing facility budget of the current fiscal year, whichever is less.
(i) This amount excludes any administration fees assessed by the OHCA for actual administration cost associated with the nursing home UPL supplemental program.
(ii) Any remaining funds after administration cost will be distributed through the rate setting methodology process.
(iii) Distribution will occur once escrowed funds reaches an amount sufficient to distribute as determined by OHCA.

(e) **Care Criteria.** Each facility must comply with the below care criteria quality metric:
(1) Facilities must adhere to performance measures outlined in the Focus on Excellence program. The resulting outcome is to improve the quality of care being delivered to members. A written action plan must be developed and must include the following:
(A) the satisfaction survey results;
(B) analysis of satisfaction survey with identification of areas for improvement; and
(C) plan of action towards identified areas of improvement.
(2) Facilities must develop and implement a written plan for the mitigation of unnecessary Return to Acute Admissions (RTA) within six months of participation. The resulting outcome is to improve the efficiency and care avoidance cost to the overall SoonerCare program. A written plan must be developed and must include the following:
(A) the RTA management tool which identifies those residents at high risk for the potential return to acute;
(B) the RTA management tools to support effective communications;
(C) advance directive planning and implementation; and
(D) application of Quality Assurance/Program Integrity (QA/PI) methodology in review of RTAs for the root cause analysis and teaching needs.
(3) Facilities are required to implement a pro-active Pneumonia/Flu Vaccination program which will result in improved vaccination scores above the facility specific baseline at or

above the national average, as measured using the CMS Quality Metrics. The resulting outcome is to improve efficiency and care avoidance costs to the overall SoonerCare program. A written plan must be developed and must include the following:

(A) the latest available three quarter average of CMS measure code 411 (% of long-stay residents assessed and appropriately given the seasonal influenza vaccine) and 415 (% of long-stay residents assessed and appropriately given the pneumococcal vaccine) to establish baseline;

(B) the current measure code 411 and 415 score; and

(C) the written plan for flu and pneumonia vaccination program to address new admissions and current residents.

(4) Facilities are required to participate in the Oklahoma Healthy Aging Initiative. The resulting outcome is to improve the quality of care and health of members. Facilities must attest to elevate healthy aging in Oklahoma by implementing a plan that accomplishes at least one of the following strategies:

(A) Preventing and reducing of falls;

(B) improving of nutrition;

(C) increasing physical activity; or

(D) reducing depression.

(5) Facilities are required to demonstrate improvement above the facility specific baseline in the 5-Star Quality Measures Composite scoring. Metrics will be determined based upon CMS Nursing Home Compare composite score over the trailing 12-month period. Facilities with Quality Measures star rating of three or better for the most recent quarter or showing improvement in composite scoring with no two quarters consistently below three, will be recognized as meeting the care criteria. The resulting outcome is to improve the quality of care being provided.

(A) Facilities must provide the most recent three quarter average of the CMS quality measure star rating to establish baseline.

(B) Facilities are required to have a star rating of three or better or must demonstrate improvement over previous quarter with no two quarters below three stars.

(f) **Supplemental Payments.**

(1) The nursing facility supplemental payments to a NSGO under this program shall not exceed Medicare payment principles pursuant to 42 CFR 447.272. Payments are made in accordance with the following criteria:

(A) The methodology utilized to calculate the upper payment limit is the RUGs.

(B) The eligible supplemental amount is the difference/gap between the SoonerCare payment and the Medicare upper payment limit as determined based on compliance with the Care Criteria metrics.

(2) The amount of the eligible supplemental payment is associated

with improvement of care of SoonerCare nursing facility residents as demonstrated through the care criteria. NSGO participants receive payment under the program based on earned percentages related to the care criteria. The NSGO must meet or exceed at least two of the five established care criteria metrics to be eligible for UPL payment for each quarter. After at least two of the five metrics have been met, the NSGO is eligible for 85% of the total eligible UPL amount for participating nursing facilities. The NSGO may qualify for the remaining 15% of the total UPL by attribution in 5% increments for each additional care criterion that is met resulting in the full 100% of the eligible UPL amount.

(g) **Change in ownership.**

(1) A nursing facility participating in the supplemental payment program must notify the OHCA of changes in ownership (CHOW) that may affect the nursing facility's continued eligibility within 30 days after such change.

(2) For a nursing facility that changes ownership on or after the first day of the SoonerCare supplemental payment limit calculation period, the data used for the calculations will include data from the facility for the entire upper payment limit calculation period relating to payments for days of service provided under the prior owner, pro-rated to reflect only the number of calendar days during the calculation period that the facility is owned by the new owner.

(h) **Disbursement of payment to facilities.** Facilities must secure allowable Intergovernmental Transfer funds (IGT) from a non-governmental entity to fund the non-federal share amount**.** The method is as follows:

(1) The OHCA or its designee will notify the NSGO of the non-federal share amount to be transferred by an IGT, via a designated portal and Notice of Program Reimbursement (NPR), for purposes of seeking federal financial participation (FFP) for the UPL supplemental payment, within 25 business days after the end of the quarter. This amount will take into account the percentage of metrics achieved under the Care Criteria requirement. The NSGO will have five (5) business days to sign the participant agreement and make payment of the state share in the form of an IGT either in person or via mail. In addition, the NSGO will be responsible to also remit the applicable per patient per Medicaid (PPMD) day participation fee at the same time of transfer of the IGT in full pursuant to d(7)above.

(2) If the total transfer and PPMD participation fee is received within five business days, the UPL payment will then be disbursed to the NSGO by OHCA within 10 business days in accordance with established payment cycles. An IGT or PPMD participation assessment fee that is not received by the date specified by OHCA or that is not the total assessed may be subject to penalty and

suspension from the program.

(i) **Penalties/Adjustments.** Failure by an NSGO to remit the full IGT and PPMD assessed by OHCA or its designee within the defined designated timeframes below indicates the NSGO has voluntarily elected to withdraw participation for that current quarter and may reapply for participation in the program in subsequent quarter(s).

(1) The IGT and PPMD must be received within five business days from assessment notification contained in the NSGO participation agreement uploaded by OHCA or its designee in the program portal.

(A) Receipt of the IGT and PPMD within five business days is not subject to penalty.

(B) The date the assessment is uploaded to the portal is the official date the clock starts to measure the five business days.

(2) IGT and PPMD assessments received after the fifth business day but with an OHCA date stamp or mailing postal mark on or prior to five business days from the official date of the uploaded assessment in the portal will not be subject to penalty however, payment will be disbursed during the next available payment cycle.

(3) IGT and PPMD assessments with an OHCA date stamp or mailing postal mark received with a date after five business days of receipt of the assessment but not exceeding eight business days of the assessment will be deemed late and subject to a penalty in accordance with (3) (B) below.

(A) Any NSGO that remits payment of the IGT and PPMD under the above circumstances will receive payment during the next available payment cycle including an assessed penalty as described below.

(B) A 5% penalty will be assessed for IGT and PPMD payments received after 5 business days but within 8 business days of notification of assessed amount. The 5% penalty will be assessed on the total eligible supplemental payment for the quarter in which the IGT and/or PPMD are late and assessed to the specific NSGO as applicable.

(C) The OHCA will notify the NSGO of the assessed penalty via invoice. If the provider fails to pay the OHCA the assessed penalty within the time frame noted on the invoice to the NSGO, the assessed penalty will be deducted from the nursing facility's Medicaid payment. The penalty must be paid regardless of any appeals action requested by the NSGO. Should an appeals decision result in a disallowance of a portion or the entire assessed penalty, reimbursement to the NSGO will be made to future nursing facility Medicaid payments.

(4) If nursing facility fails to achieve at a minimum, two of the care criteria metrics for two consecutive quarters, the facility will be suspended for two subsequent quarters and will not be eligible to participate in the program during suspended quarters. A facility that has been suspended for a total of four quarters

within a two year period due to non-compliance with the Care Criteria will be terminated from the program, and if the facility wishes to participate again, it will be required to reapply. Reentry into the program is at the sole discretion of the OHCA. If the facility is readmitted to the program, terms of participation may include a probationary period with defined requirements as it relates to care.

(j) **Appeals.** Participant appeals may be filed in accordance with grievance procedures found at OAC 317:2-1-2(b) and 317:2-1-16.

Agenda

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

SUBCHAPTER 3. GENERAL PROVIDER POLICIES

PART 1. GENERAL SCOPE AND ADMINISTRATION

317:30-3-27. Telemedicine

(a) **Applicability and scope.** The purpose of this Section is to implement telemedicine policy that improves access to health care services, while complying with all applicable federal and state statutes and regulations. Telemedicine services are not an expansion of SoonerCare covered services but an option for the delivery of certain covered services. However, if there are technological difficulties in performing an objective thorough medical assessment or problems in the member's understanding of telemedicine, hands-on-assessment and/or in person care must be provided for the member. Any service delivered using telehealth technology must be appropriate for telemedicine delivery and be of the same quality and otherwise on par with the same service delivered in person. A telemedicine encounter must comply with the Health Information Portability and Accountability Act (HIPAA). For purposes of SoonerCare reimbursement telemedicine is the use of interactive audio, video or other electronic media for the purpose of diagnosis, consultation or treatment that occur in real-time and when the member is actively participating during the transmission. Telemedicine does not include the use of audio only telephone, electronic mail, or facsimile transmission. Transfer of data from one site to another through the use of a camera or similar device that records (stores) an image that is sent (forwarded) via telecommunication to another site for consultation. Asynchronous or "store and forward" applications would not be considered telemedicine but may be utilized to deliver services.

(b) **Conditions.** The following conditions apply to all services

rendered via telemedicine.

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

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

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

(4) The provider must be contracted with SoonerCare and appropriately licensed for the service to be provided. If the provider is outside of Oklahoma, the provider must comply with all laws and regulations of the provider's location, including health care and telemedicine requirements.

~~(5) The health care practitioner must obtain written consent from the SoonerCare member that states he or she agrees to participate in the telemedicine-based office visit. The consent form must include a description of the risks, benefits and consequences of telemedicine and be included in the member's medical record.~~

~~(6)~~(5) If the member is a minor child, a parent/guardian must present the minor child for telemedicine services unless otherwise exempted by State or Federal law. The parent/guardian need not attend the telemedicine session unless attendance is therapeutically appropriate.

~~(7)~~(6) The member retains the right to withdraw at any time.

~~(8)~~(7) All telemedicine activities must comply with the HIPAA Security Standards, OHCA policy, and all other applicable state

and federal laws and regulations.

~~(9)~~(8) The member has access to all transmitted medical information, with the exception of live interactive video as there is often no stored data in such encounters.

~~(10)~~(9) There will be no dissemination of any member images or information to other entities without written consent from the member.

(c) **Reimbursement.**

(1) Services provided by telemedicine must be billed with the appropriate modifier.

(2) If the technical component of an X-ray, ultrasound or electrocardiogram is performed during a telemedicine transmission, the technical component can be billed by the provider that provided that service. The professional component of the procedure and the appropriate visit code should be billed by the provider that rendered that service.

(3) The cost of telemedicine equipment and transmission is not reimbursable by SoonerCare.

(d) **Documentation.**

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

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

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

(A) Chart notes;

(B) Start and stop times;

(C) Service provider's credentials; and

(D) Provider's signature.

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