Oklahoma Health Care Authority
MEDICAL ADVISORY COMMITTEE

AGENDA

May 16th, 2019
1:00 PM – 3:30 PM

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 March 14th, 2019: **Medical Advisory Committee Meeting**

III. Public Comments (2 minute limit)

IV. MAC Member Comments/Discussion

V. Financial Report: **Tasha Black, Director of Fiscal Planning**

VI. SoonerCare Operations Update: **Burl Beasley, Senior Director of Pharmacy Service**

VII. Legislative Update: **MaryAnn Martin, Senior Director of Communications**

VIII. Proposed Rule Changes: Presentation, Discussion, and Vote: **Sandra Puebla, Director of Federal & State Authorities**

   A. 19-02 Certified Community Behavioral Health Clinics (CCBHC) Project
   B. 19-03 Applied Behavior Analysis (ABA) Services

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

X. Future Meeting:
July 18th
September 19th
November 21st

XI. Adjourn

Oklahoma Health Care Authority
MEDICAL ADVISORY COMMITTEE
MINUTES of the March 14, 2019 Meeting
4345 N. Lincoln Blvd., Oklahoma City, OK 73105

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

Chairman Steven Crawford called the meeting to order at 1:00 PM.

***Delegates present were*:** Ms. Debra Billingsly, Dr. Erin Balzer, Dr. Joe Catalano, Mr. Victor Clay, Mr. Brett Coble, Dr. Steve Crawford, Ms. Wanda Felty, Dr. Don Flinn, Dr. Arlen Foulks, Ms. Terrie Fritz, Mr. Mark Jones, Ms. Annette Mays, Ms. Toni Pratt-Reid, Dr. Edd Rhoades, Dr. Jason Rhynes, Mr. Rick Snyder, and Dr. Paul Wright.

Alternates present were: Ms. Sarah Baker, Mr. Traylor Rains-Sims, and Dr. Kanwal Obhrai, providing a quorum.

***Delegates absent without an alternate were*:** Ms. Mary Brinkley, Mr. Steve Goforth, Dr. Lori Holmquist-Day, Ms. Alyssa Lee, Dr. Ashley Orynich, Dr. James Patterson, Dr. J. Daniel Post, Dr. Raymond Smith, and Mr. Jeff Tallent, and Mr. William Whited.

II. Approval of the January 17th, 2019 Minutes

Medical Advisory Committee
The motion to approve the minutes was by Dr. Joe Catalano and seconded by Ms. Toni Pratt-Reid and passed unanimously.

III. Public Comments (2 minute limit):

Mr. Brent Wilborn, Director of public policy for the Oklahoma primary care association, spoke to members of the MAC regarding agenda item **IX. N – Federally Qualified Health Centers Revisions.** Community health centers serve well over 220,000 patients in the state of Oklahoma at 90 different locations. Mr. Wilborn gives his thanks for the support of the committee in making this rule change.

IV. MAC Member Comments/Discussion:

There were no MAC Member comments.

V. Financial Report:

Tasha Black, Director of Fiscal Planning

Ms. Black presented the financial report ending in December 2018. OHCA is 0.9% under budget in revenues and 0.9% under budget in expenditures with the result that our budget variance is a

positive 356,849 dollars. The budget variance is primarily attributed to the following: Medicaid Program Variance is a positive .7 million state dollars, and administration is a positive 3.2 million state dollars. Drug Rebate is 1.7 million state dollars under budget. Taxes and Fees, which also included tobacco tax is 3.2 million state dollars under budget, and Medical refunds is 1.3 million state dollars over budget. For more detailed information, see item 5 in the MAC agenda.

VI. SoonerCare Operations Update:

Melinda Thomason, Director of Health Care Systems Innovation

Ms. Thomason presented the SoonerCare Operations Update to the committee. She presented information based on data for December of 2018. Patient Centered Medical Home enrollment is at 529,789 which is 4,150 less than the previous month. Sooner Care Traditional has a current enrollment of 231,828 which is 720 less than November. SoonerPlan is down by 917, giving a total number of 29,115. Insure Oklahoma has a total enrollment of 18,654, of which 13,632 are in the Employee Sponsored Plan, and 5,022 are in the individual plan. In total, SoonerCare enrollment is at 809,386 for December, which is a decrease of 6,005. Finally, In-state providers is up by 146 giving a total of 33,604 contracted providers.

A. Pharmacy Updates:

Burl Beasley, Senior Director of Pharmacy Service

Mr. Burl Beasley presented an informational update from the Drug Utilization Board Meeting conducted February 19, 2019. For certain drugs that, OHCA does not require a prior authorization. These are considered Narrow Therapeutic Index Drugs (NTI). For more detailed information, see item 6A in the MAC agenda.

VII. Legislative Update:

MaryAnn Martin, Senior Director of Communications

Ms. Martin gave an update on the legislation activities of interest to OHCA. Today is the second deadline. Bills must be passed from committees and out of the house of origin. When the legislative session began, the agency started monitoring 193 bills and now are currently tracking 75 or fewer bills. A few of our interests include, a pair of bills from the Senate that would increase reimbursement rates for nursing facilities, step therapy bills, and SB456, which was passed and signed into law yesterday allowing the Governor to appointment our administrator.

VIII. 1115(a) Waiver Amendment Update:

Sandra Puebla, Director of Federal & State Authorities

Pursuant to 42 CFR §431.408, the Oklahoma Health Care Authority (OHCA) is providing notice of its plan to submit an amendment to the 1115(a) demonstration waiver. The OHCA currently has an approved 1115(a) waiver for the 2018-2023 demonstration period. With this amendment request, the OHCA seeks approval of the following modifications to the 1115(a) demonstration for the current extension period that will be in effect through December 31, 2023:

Effective October 1, 2019, the waiver special terms and conditions will be updated for the Health Access Networks (HANs), contingent upon CMS approval. HANs are non-profit administrative entities that work with providers to coordinate and improve the quality of care for SoonerCare members. The OHCA proposes to remove three paragraphs that are either duplicative or no longer applicable to HAN duties from the approved Special Terms and Conditions (STC) at STC 40. The paragraphs identified for removal are in relation to 1) ensuring access to all levels of care, 2) submitting a development plan, and 3) offering core components of electronic medical records, improved access to specialty care, telemedicine, and expanded quality improvement strategies.

OHCA proposes to continue the currently approved monitoring and evaluation components identified in the STCs. The hypotheses and measures provided in the current evaluation design remain applicable with the following corrections to STC 84, Evaluation of the HANs. One correction will be to remove the word “pilot” from the reference to the program in the first paragraph. In addition, the subsequent paragraphs will be revised to reflect the evaluation design that the state has submitted to Centers for Medicare and Medicaid Services (CMS) as follows:

a. Impact on costs: The implementation and expansion of the HANs will reduce costs associated with the provision of health care services to SoonerCare beneficiaries served by the HANs;

b. Impact on access to care: The implementation and expansion of the HANs will improve access to and the availability of health care services to SoonerCare beneficiaries served by the HANs;

c. Impact on quality and coordination: The implementation and expansion of the HANs will improve the quality and coordination of health care services to SoonerCare beneficiaries served by the HANs, with specific focus on the populations at greatest risk, including those with multiple chronic illnesses; and

d. Impact on the patient-centered medical home (PCMH) program: The implementation and expansion of the HANs will enhance the State’s PCMH program through an evaluation of primary

care physician (PCP) profiles that incorporate a review of utilization, disease guideline compliance, and cost.

Amending the language will not have any effect on budget neutrality for the 1115(a) demonstration waiver.

IX. Proposed Rule Changes: Presentation, Discussion, and Vote:

Sandra Puebla, Director of Federal & State Authorities

Face-to-face tribal consultations regarding the following proposed changes were held on Tuesday, November 6, 2018 and Tuesday, January 8, 2019 in the Charles Ed McFall Boardroom of the Oklahoma Health Care Authority (OHCA).

APA work folders 18-07A, 18-07B, 18-09, 18-13, 18-14, 18-15A, 18-15B, 18-15C, 18-16, 18-17, 18-23, 18-24, 18-25, 18-26, 18-27, 18-28 and 18-30 were posted for a comment period from January 16, 2019 through February 15, 2019.

18-07A&B Preadmission Screening and Resident Review Program Revisions — The proposed revisions will incorporate new language to clarify that the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) will be used for diagnostic purposes of a mental illness and/or intellectual disability in Medicaid certified nursing facility admissions. Revisions will also involve limited rewriting aimed at clarifying text, eliminating redundancies, and updating outdated terminology.

Budget Impact: Budget neutral

The rule change motion to approve was by Ms. Toni Pratt-Reid and seconded by Mr. Traylor Rains-Sims and passed unanimously.

18-09 Suspended Claims Review and/or Prepayment Review — The proposed revisions will align policies with state and federal laws that require the OHCA to safeguard against unnecessary utilization of medical supplies and services. Additionally, the revisions will help to ensure that payments are consistent, efficient, economical, and provide good quality of care. Please refer to 42 United States Code § 1396a(a)(30)(A); 42 Code of Federal Regulations § 447.45(f); and 56 Oklahoma Statutes § 1010.4(B)(5). These revisions will help ensure that reimbursements are for medically necessary, correctly and/or appropriately billed, medical supplies and services. The changes define and explain the various reviews that may be performed by the OHCA or its contractor before the OHCA pays a claim for medical supplies or services rendered.

Budget Impact: It is expected that these types of reviews will achieve significant savings, the exact amount of which cannot be quantified.

The rule change motion to approve was by Dr. Joe Catalano and seconded by Mr. Rick Snyder and passed unanimously.

18-13 Application Fees and Provider Screening — The proposed revisions will establish application fees required by federal law for providers enrolling or re-enrolling in Medicaid. The revisions will define providers who are exempted from the application fee as individual physician on non-physician practitioners, providers who enrolled with and paid the fee to Medicare, and providers who enrolled with and paid the fee to another state Medicaid agency. Additional revisions will outline provider screening and enrollment requirements designed to help defend against Medicaid provider fraud, waste, or abuse. Provider screening requirements are outlined according to three (3) categorical screening levels: limited-risk, moderate-risk, and high-risk. Examples of screening requirements are licensure verification, on-site visits, and fingerprinting-based background checks.
Budget Impact: Agency staff estimates that the proposed rule change will generate revenue due to the application/screening fees. Per federal law, the collected fees shall be used for the cost of conducting screenings.
The rule change motion to approve was by Mr. Taylor Rains-Sims and seconded by Ms. Terrie Fritz and passed unanimously.

18-14 Countable Income and Resources — The proposed revisions will amend policy on resources that are disregarded by federal law due to Oklahoma transitioning from a 209(b) state to a Supplemental Security Income (SSI) criteria state for determination of eligibility for SSI related eligibility groups such as the Aged, Blind, and Disabled (ABD).
Budget Impact: Budget neutral
The rule change motion to approve was by Dr. Paul Wright and seconded by Dr. Joe Catalano and passed unanimously.

18-15A, B, & C Change Timeframes for Appeals — The proposed revisions will change all of the agency's appeals rules, to extend the length of time that appeals can be submitted from twenty (20) days to thirty (30) days from the date of an adverse agency action. Additionally, the revisions will add Supplemental Hospital Offset Payment Program (SHOPP) appeals to the list of other grievance procedures and processes.
Budget Impact: Budget neutral
The rule change motion to approve was by Ms. Toni Pratt-Reid and seconded by Ms. Terrie Fritz and passed unanimously.

18-16 Non-Emergency Transportation Parity Compliance — The proposed revisions will amend policy to provide non-emergency transportation (NET) to pregnant women covered under the Title XXI State Plan (Soon-to-be-Sooners and Soon-to-be-Sooners Maintenance of Effort populations). Under federal parity law requirements, children covered by the Children's Health Insurance Program (CHIP), including those in the unborn child category, must have the same access to Secretary-approved coverage of all Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefits including health care, diagnostic services, treatment, and other measures to correct or ameliorate defects and physical and mental illness and conditions as per the approved State Plan. The proposed revisions are

needed to comply with these parity federal regulations which instruct the State to provide equivalent services including NET to all children covered under the Plan.
Budget Impact: The agency anticipates that the proposed changes would potentially result in a budget impact of approximately $15,094 total, with $5,266 in state share for SFY 2020.
The rule change motion to approve was by Ms. Terrie Fritz and seconded by Ms. Toni Pratt-Reid and passed unanimously.

18-17 Maternal Depression Screening Revisions — The proposed revisions will add coverage and reimbursement language for maternal depression screenings at Early and Periodic Screening, Diagnostic and Treatment (EPSDT) well-child visits. Providers will be reimbursed for conducting a maternal depression screening at the child's well-child visit. The policy will also reiterate how the OHCA adopts and utilizes the American Academy of Pediatrics' Bright Futures periodicity schedule including for the maternal depression screenings. Additionally, the proposed revisions will update the child abuse section to provide a more thorough explanation of how to report child abuse including clarifying text, and updating outdated citations.
Budget Impact: The agency anticipates that the proposed changes would potentially result in a budget impact of approximately $128,748 total with $43,749 in state share savings for SFY2020.
The rule change motion to approve was by Ms. Terrie Fritz and seconded by Mr. Rick Snyder and passed unanimously.

18-23 Psychiatric Services in Nursing Facilities Revisions — The proposed behavioral health revisions will clarify that when rendering a direct physician service visit in a nursing facility, a psychiatrist or a physician with appropriate behavioral health training is required to perform such service. Additionally, revisions will clarify that other than the two (2) allowable direct physician services visit in a nursing facility, reimbursement for psychiatric services to members residing in a nursing facility is not allowed. Further revisions will involve limited rewriting aimed at clarifying text, eliminating redundancies, and updating outdated terminology.
Budget Impact: The proposed rule will result in a small savings to the agency as it will place limits on the overutilization of services.
The rule change motion to approve was by Dr. Joe Catalano and seconded by Dr. Paul Wright and passed unanimously.

18-24 Out-of-State Services — The proposed revisions will define and clarify coverage and reimbursement for services rendered by providers that are physically located outside of Oklahoma. Additionally, revisions will delineate out-of-state services, provider participation requirements, prior authorizations, and documentation/medical records requirements. The "payment for lodging and meals" section will be moved under the new Part 6 for "Out-of-State Services" in policy. Further revisions will strike out old out-of-state policy then replace with references directing to the new out-of-state policy. Lastly, revisions will outline reimbursement criteria for out-of-state providers who do not accept the payment rate established through the State Plan.
Budget Impact: Budget neutral

The rule change motion to approve was by Dr. Paul Wright and seconded by Ms. Toni Pratt-Reid and passed unanimously.

18-25 General Policy Language Cleanup — The proposed revisions will eliminate references to other policy sections that have been revoked. Outdated section references were revoked in past rulemaking sessions; however, language in other parts of the Chapter, referring to these sections, were inadvertently missed. Further revisions will update acronyms and grammatical mistakes for better flow and understanding.
Budget Impact: Budget neutral
The rule change motion to approve was by Dr. Don Flinn and seconded by Dr. Paul Wright and passed unanimously.

18-26 Residential Behavioral Management Services (RBMS) Group Homes Revisions — The proposed revisions will streamline group home coverage and reimbursement policy language and develop consistency with current practice. The proposed revisions will outline and clarify provider requirements and remove references to any services provided in wilderness camps and Diagnostic and Evaluation (D&E) centers. Additional revisions will involve limited rewriting aimed at updating outdated terminology.
Budget Impact: The proposed changes would potentially result in a combined federal and state spending of $7,048,848 total with $2,663,063 in state share for SFY2020. The state share will be paid by the Oklahoma Department of Human Services.
The rule change motion to approve was by Mr. Traylor Rains-Sims and seconded by Dr. Joe Catalano and passed unanimously.

18-27 Updates to Medicare Crossover Policy — The proposed revisions will streamline crossover payments of Medicare/Medicaid dual eligible individuals for Part A and B services. Further revisions will update outdated terminology.
Budget Impact: Budget neutral
The rule change motion to approve was by Dr. Don Flinn and seconded by Mr. Traylor Rains-Sims and passed unanimously.

18-28 Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services in Inpatient Psychiatric Settings — The proposed revisions will comply with federal regulations by assuring that members under twenty-one (21) years of age, who are residing in qualified inpatient psychiatric settings, have access to a full range of medically necessary EPSDT services. Revisions will also emphasize that EPSDT services are accessible, regardless of whether such services are listed on the individual plan of care.
Budget Impact: Budget neutral
The rule change motion to approve was by Dr. Arlen Foulks and seconded by Dr. Joe Catalano and passed unanimously.

18-30 Federally Qualified Health Centers (FQHCs) — The proposed revisions will amend the FQHC policy to reinstate administrative rules to allow and better define multiple encounters at FQHCs. Additional revisions will also define and establish guidelines for multiple encounters. Finally, revisions will update/remove outdated language in order to reflect current business practices and to provide consistency throughout policy.
Budget Impact: Budget neutral
The rule change motion to approve was by Dr. Joe Catalano and seconded by Ms. Terrie Fritz and passed unanimously.

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

XI. Future Meeting

May 16th, 2019
July 18th, 2019
September 19th, 2019
November 21st, 2019

XII. Adjournment

There was no dissent and the meeting was adjourned at 2:05p.m.

FINANCIAL REPORT

For the Seven Months Ended January 31, 2019
Submitted to the CEO & Board

- Revenues for OHCA through January, accounting for receivables, were **$2,561,724,206** or **1.1% under** budget.
- Expenditures for OHCA, accounting for encumbrances, were **$2,591,010,686** or **1.5% under** budget.
- The state dollar budget variance through January is a positive **$10,668,863.**
- The budget variance is primarily attributable to the following (in millions):

Expenditures:		
Medicaid Program Variance		7.5
Administration		3.3
Revenues:		
Drug Rebate		2.5
Medical Refunds		.4
Taxes and Fees		(3.1)
Total FY 19 Variance	**$**	**10.6**

ATTACHMENTS

OKLAHOMA HEALTH CARE AUTHORITY
Summary of Revenues & Expenditures: OHCA
SFY 2019, For the Seven Month Period Ending January 31, 2019

REVENUES	FY19 Budget YTD	FY19 Actual YTD	Variance	% Over/ (Under)
State Appropriations	$ 598,074,416	$ 598,074,416	$ -	0.0%
State Appropriations - GME Appropriated Funds	$ 64,192,520	$ 64,192,520	$ -	0.0%
Federal Funds	1,466,551,950	1,432,435,123	(34,116,827)	(2.3)%
Tobacco Tax Collections	29,293,219	26,687,088	(2,606,131)	(8.9)%
Quality of Care Collections	46,405,112	45,572,236	(832,876)	(1.8)%
Prior Year Carryover	11,000,000	11,000,000	-	0.0%
Federal Deferral - Interest	165,785	165,785	-	0.0%
Drug Rebates	185,871,739	192,545,010	6,673,271	3.6%
Medical Refunds	22,180,996	23,145,265	964,269	4.3%
Supplemental Hospital Offset Payment Program	159,797,063	159,797,063	-	0.0%
Other Revenues	7,829,626	8,109,699	280,073	3.6%
TOTAL REVENUES	**$ 2,591,362,426**	**$ 2,561,724,206**	**$ (29,638,221)**	**(1.1)%**

EXPENDITURES	FY19 Budget YTD	FY19 Actual YTD	Variance	% (Over)/ Under
ADMINISTRATION - OPERATING	**$ 34,282,525**	**$ 27,645,618**	**$ 6,636,907**	**19.4%**
ADMINISTRATION - CONTRACTS	**$ 63,244,220**	**$ 59,114,446**	**$ 4,129,774**	**6.5%**
MEDICAID PROGRAMS				
Managed Care:				
SoonerCare Choice	23,275,230	23,216,605	58,625	0.3%
Acute Fee for Service Payments:				
Hospital Services	559,583,404	555,724,783	3,858,621	0.7%
Behavioral Health	11,637,783	10,471,348	1,166,435	10.0%
Physicians	244,531,974	227,120,121	17,411,853	7.1%
Dentists	76,801,840	76,590,257	211,582	0.3%
Other Practitioners	32,339,719	31,554,019	785,699	2.4%
Home Health Care	12,771,711	14,108,350	(1,336,639)	(10.5)%
Lab & Radiology	16,173,881	15,228,774	945,107	5.8%
Medical Supplies	31,368,904	31,575,952	(207,047)	(0.7)%
Ambulatory/Clinics	138,045,540	140,739,627	(2,694,087)	(2.0)%
Prescription Drugs	381,268,037	366,789,503	14,478,534	3.8%
OHCA Therapeutic Foster Care	99,217	527	98,690	0.0%
Other Payments:				
Nursing Facilities	329,947,820	337,266,975	(7,319,155)	(2.2)%
Intermediate Care Facilities for Individuals with Intellectual Disabilities Private	37,079,146	37,759,421	(680,275)	(1.8)%
Medicare Buy-In	102,549,096	101,705,691	843,405	0.8%
Transportation	41,953,880	40,579,258	1,374,623	3.3%
Money Follows the Person-OHCA	206,863	227,051	(20,188)	0.0%
Electonic Health Records-Incentive Payments	1,706,942	1,706,942	-	0.0%
Part D Phase-In Contribution	64,314,952	63,794,721	520,231	0.8%
Supplemental Hospital Offset Payment Program	357,504,710	357,504,710	-	0.0%
Telligen	6,385,715	6,358,493	27,222	0.4%
Total OHCA Medical Programs	**2,469,546,365**	**2,440,023,129**	**29,523,236**	**1.2%**
OHCA Non-Title XIX Medical Payments	52,140	34,974	17,166	0.0%
OHCA Non-Title XIX - GME	64,192,520	64,192,519	1	0.0%
TOTAL OHCA	**$ 2,631,317,769**	**$ 2,591,010,686**	**$ 40,307,083**	**1.5%**
REVENUES OVER/(UNDER) EXPENDITURES	**$ (39,955,343)**	**$ (29,286,480)**	**$ 10,668,863**	

OKLAHOMA HEALTH CARE AUTHORITY
Total Medicaid Program Expenditures
by Source of State Funds
SFY 2019, For the Seven Month Period Ending January 31, 2019

Category of Service	Total	Health Care Authority	Quality of Care Fund	HEEIA	SHOPP Fund	BCC Revolving Fund	Other State Agencies
SoonerCare Choice	$ 23,269,063	$ 23,210,659	$ -	$ 52,458	$ -	$ 5,946	$ -
Inpatient Acute Care	779,738,885	357,773,237	283,901	1,759,335	266,940,917	463,287	152,518,209
Outpatient Acute Care	277,501,242	193,950,492	24,269	2,687,813	77,609,072	3,229,597	-
Behavioral Health - Inpatient	27,610,590	5,684,844	-	247,092	11,684,610	-	9,994,044
Behavioral Health - Psychiatrist	6,056,615	4,786,504	-	-	1,270,111	-	-
Behavioral Health - Outpatient	9,095,053	-	-	-	-	-	9,095,053
Behaviorial Health-Health Home	25,943,412	-	-	-	-	-	25,943,412
Behavioral Health Facility- Rehab	136,107,711	-	-	-	-	62,720	136,107,711
Behavioral Health - Case Management	1,573,786	-	-	-	-	-	1,573,786
Behavioral Health - PRTF	35,295,265	-	-	-	-	-	35,295,265
Behavioral Health - CCBHC	32,248,443	-					32,248,443
Residential Behavioral Management	6,564,594	-	-	-	-	-	6,564,594
Targeted Case Management	40,801,104	-	-	-	-	-	40,801,104
Therapeutic Foster Care	527	527	-	-	-	-	-
Physicians	266,902,944	224,532,640	33,892	3,008,914	-	2,553,589	36,773,908
Dentists	76,614,437	76,584,722	-	24,180	-	5,535	-
Mid Level Practitioners	1,236,646	1,231,598	-	4,764	-	284	-
Other Practitioners	30,616,444	29,999,810	260,379	294,306	-	61,949	-
Home Health Care	14,116,999	14,104,569	-	8,649	-	3,781	-
Lab & Radiology	15,674,446	15,118,813	-	445,672	-	109,961	-
Medical Supplies	31,711,296	29,972,954	1,581,727	135,345	-	21,270	-
Clinic Services	142,308,095	137,071,062	-	981,703	-	147,668	4,107,662
Ambulatory Surgery Centers	3,616,323	3,514,053	-	95,425	-	6,844	-
Personal Care Services	6,185,704	-	-	-	-	-	6,185,704
Nursing Facilities	337,266,975	206,114,715	131,152,260	-	-	-	-
Transportation	40,556,503	38,937,527	1,472,670	64,503	-	81,803	-
IME/DME	36,678,762	-	-	-	-	-	36,678,762
ICF/IID Private	37,759,421	30,875,220	6,884,200	-	-	-	-
ICF/IID Public	9,714,381	-	-	-	-	-	9,714,381
CMS Payments	165,500,412	165,234,940	265,472	-	-	-	-
Prescription Drugs	375,262,429	365,263,985	-	8,472,925	-	1,525,518	-
Miscellaneous Medical Payments	87,258	82,316	-	-	-	4,943	-
Home and Community Based Waiver	123,280,535	-	-	-	-	-	123,280,535
Homeward Bound Waiver	47,207,905	-	-	-	-	-	47,207,905
Money Follows the Person	227,051	227,051	-	-	-	-	-
In-Home Support Waiver	14,424,625	-	-	-	-	-	14,424,625
ADvantage Waiver	83,182,568	-	-	-	-	-	83,182,568
Family Planning/Family Planning Waiver	2,499,116	-	-	-	-	-	2,499,116
Premium Assistance*	33,481,053	-	-	33,481,053.18	-	-	-
Telligen	6,358,493	6,358,493	-	-	-	-	-
Electronic Health Records Incentive Payments	1,706,942	1,706,942	-	-	-	-	-
Total Medicaid Expenditures	**$ 3,305,984,055**	**$ -**	**$ 1,932,337,674**	**$ 141,958,770**	**$ 51,764,138**	**$ 357,504,710**	**$ 8,284,695**	**$ 814,196,788**

* Includes $33,229,791.18 paid out of Fund 245

OKLAHOMA HEALTH CARE AUTHORITY
Summary of Revenues & Expenditures:
Other State Agencies
SFY 2019, For the Seven Month Period Ending January 31, 2019

		FY19 Actual YTD
REVENUE		
Revenues from Other State Agencies	$	355,324,584
Federal Funds		509,897,475
TOTAL REVENUES	**$**	**865,222,059**
EXPENDITURES		**Actual YTD**
Department of Human Services		
Home and Community Based Waiver	$	123,280,535
Money Follows the Person		-
Homeward Bound Waiver		47,207,905
In-Home Support Waivers		14,424,625
ADvantage Waiver		83,182,568
Intermediate Care Facilities for Individuals with Intellectual Disabilities Public		9,714,381
Personal Care		6,185,704
Residential Behavioral Management		4,013,732
Targeted Case Management		35,826,885
Total Department of Human Services		**323,836,335**
State Employees Physician Payment		
Physician Payments		36,773,908
Total State Employees Physician Payment		**36,773,908**
Education Payments		
Indirect Medical Education		34,965,572
Direct Medical Education		1,713,190
Total Education Payments		**36,678,762**
Office of Juvenile Affairs		
Targeted Case Management		1,301,366
Residential Behavioral Management		2,550,862
Total Office of Juvenile Affairs		**3,852,228**
Department of Mental Health		
Case Management		1,573,786
Inpatient Psychiatric Free-standing		9,994,044
Outpatient		9,095,053
Health Homes		25,943,412
Psychiatric Residential Treatment Facility		35,295,265
Certified Community Behavioral Health Clinics		32,248,443
Rehabilitation Centers		136,107,711
Total Department of Mental Health		**250,257,715**
State Department of Health		
Children's First		405,947
Sooner Start		1,236,350
Early Intervention		2,372,920
Early and Periodic Screening, Diagnosis, and Treatment Clinic		1,052,936
Family Planning		197,879
Family Planning Waiver		2,294,748
Maternity Clinic		964
Total Department of Health		**7,561,744**
County Health Departments		
EPSDT Clinic		368,063
Family Planning Waiver		6,489
Total County Health Departments		**374,552**
State Department of Education		**92,836**
Public Schools		**801,150**
Medicare DRG Limit		**144,535,167**
Native American Tribal Agreements		**1,449,349**
Department of Corrections		**1,154,687**
JD McCarty		**6,828,355**
Total OSA Medicaid Programs	**$**	**814,196,788**
OSA Non-Medicaid Programs	**$**	**46,963,771**
Accounts Receivable from OSA	**$**	**(4,061,500)**

OKLAHOMA HEALTH CARE AUTHORITY

SUMMARY OF REVENUES & EXPENDITURES:

Fund 205: Supplemental Hospital Offset Payment Program Fund

SFY 2019, For the Seven Month Period Ending January 31, 2019

REVENUES		FY 19 Revenue
SHOPP Assessment Fee		159,701,738
Federal Draws	$	218,652,500
Interest		93,042
Penalties		2,283
State Appropriations		(22,650,000)
TOTAL REVENUES	$	355,799,563

EXPENDITURES	Quarter	Quarter	Quarter	Quarter		FY 19 Expenditures
Program Costs:	7/1/18 - 9/30/18	10/1/18 - 12/31/18	1/1/19 - 3/31/19	4/1/19 - 6/30/19		
Hospital - Inpatient Care	84,988,728	181,952,189			$	266,940,917
Hospital -Outpatient Care	25,649,937	51,959,135				77,609,072
Psychiatric Facilities-Inpatient	3,352,856	8,331,754				11,684,610
Rehabilitation Facilities-Inpatient	416,290	853,821				1,270,111
Total OHCA Program Costs	114,407,810	243,096,899	-	-	$	357,504,710
Total Expenditures					$	357,504,710

CASH BALANCE		
	$	(1,705,146)

*** Expenditures and Federal Revenue processed through Fund 340

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OKLAHOMA HEALTH CARE AUTHORITY

SUMMARY OF REVENUES & EXPENDITURES:

Fund 230: Nursing Facility Quality of Care Fund

SFY 2019, For the Seven Month Period Ending January 31, 2019

REVENUES	Total Revenue	State Share
Quality of Care Assessment	**$ 45,547,990**	**$ 45,547,990**
Interest Earned	**24,246**	**24,246**
TOTAL REVENUES	**$ 45,572,236**	**$ 45,572,236**

EXPENDITURES	FY 19 Total $ YTD	FY 19 State $ YTD	Total State $ Cost
Program Costs			
Nursing Facility Rate Adjustment	$ 129,006,469	$ 50,574,748	
Eyeglasses and Dentures	162,051	63,545	
Personal Allowance Increase	1,983,740	778,429	
Coverage for Durable Medical Equipment and Supplies	1,581,727	620,873	
Coverage of Qualified Medicare Beneficiary	602,441	236,475	
Part D Phase-In	265,472	265,472	
ICF/IID Rate Adjustment	3,175,457	1,245,254	
Acute Services ICF/IID	3,708,744	1,453,400	
Non-emergency Transportation - Soonerride	1,472,670	577,959	
Total Program Costs	**$ 141,958,770**	**$ 55,816,155**	**$ 55,816,155**
Administration			
OHCA Administration Costs	$ 314,217	$ 157,109	
DHS-Ombudsmen	109,330	109,330	
OSDH-Nursing Facility Inspectors	35,001	35,001	
Mike Fine, CPA	-	-	
Total Administration Costs	**$ 458,548**	**$ 301,440**	**$ 301,440**
Total Quality of Care Fee Costs	**$ 142,417,318**	**$ 56,117,595**	
TOTAL STATE SHARE OF COSTS			**$ 56,117,595**

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

SFY 2019, For the Seven Month Period Ending January 31, 2019

REVENUES	FY 18 Carryover	FY 19 Revenue	Total Revenue
Prior Year Balance	$ 12,902,064	$ -	$ 6,997,587
State Appropriations	(6,000,000)	-	-
Tobacco Tax Collections	-	21,949,084	21,949,084
Interest Income	-	138,103	138,103
Federal Draws	208,931	21,055,321	21,055,321
TOTAL REVENUES	**$ 7,110,995**	**$ 43,142,507**	**$ 50,140,094**

EXPENDITURES		FY 18 Expenditures	FY 19 Expenditures	Total State $ YTD
Program Costs:				
	Employer Sponsored Insurance		$ 33,229,791	$ 33,229,791
	College Students/ESI Dental		251,262	98,925
Individual Plan				
	SoonerCare Choice		$ 50,997	$ 20,026
	Inpatient Hospital		1,756,113	693,042
	Outpatient Hospital		2,613,304	1,033,230
	BH - Inpatient Services-DRG		235,062	91,890
	BH -Psychiatrist		-	-
	Physicians		2,968,559	1,168,846
	Dentists		23,720	9,224
	Mid Level Practitioner		4,569	1,798
	Other Practitioners		291,588	114,630
	Home Health		8,649	3,446
	Lab and Radiology		438,081	171,769
	Medical Supplies		134,789	53,063
	Clinic Services		947,707	371,699
	Ambulatory Surgery Center		95,126	37,679
	Prescription Drugs		8,291,289	3,235,362
	Transportation		63,798	24,905
	Premiums Collected		-	(319,126)
Total Individual Plan			**$ 17,923,352**	**$ 6,711,482**
	College Students-Service Costs		**$ 359,733**	**$ 140,648**
Total OHCA Program Costs			**$ 51,764,138**	**$ 40,180,845**
Administrative Costs				
	Salaries	$ 24,543	$ 1,341,302	$ 1,365,845
	Operating Costs	9,662	73,588	83,250
	Health Dept-Postponing	-	-	-
	Contract - HP	79,204	491,423	570,627
Total Administrative Costs		**$ 113,409**	**$ 1,906,313**	**$ 2,019,722**
Total Expenditures				**$ 42,200,567**
NET CASH BALANCE		**$ 6,997,587**		**$ 7,939,527**

OKLAHOMA HEALTH CARE AUTHORITY

SUMMARY OF REVENUES & EXPENDITURES:

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

SFY 2019, For the Seven Month Period Ending January 31, 2019

REVENUES	FY 19 Revenue	State Share
Tobacco Tax Collections	$ 438,074	$ 438,074
TOTAL REVENUES	**$ 438,074**	**$ 438,074**

EXPENDITURES	FY 19 Total $ YTD	FY 19 State $ YTD	Total State $ Cost
Program Costs			
SoonerCare Choice	$ 5,946	$ 1,630	
Inpatient Hospital	463,287	125,493	
Outpatient Hospital	3,229,597	884,556	
Inpatient Services-DRG	-	-	
Psychiatrist	-	-	
TFC-OHCA	-	-	
Nursing Facility	-	-	
Physicians	2,553,589	707,488	
Dentists	5,535	1,515	
Mid-level Practitioner	284	78	
Other Practitioners	61,949	16,926	
Home Health	3,781	1,032	
Lab & Radiology	109,961	30,185	
Medical Supplies	21,270	5,760	
Clinic Services	147,668	40,663	
Ambulatory Surgery Center	6,844	1,836	
Prescription Drugs	1,525,518	418,483	
Transportation	81,803	22,505	
Miscellaneous Medical	4,943	1,313	
Total OHCA Program Costs	**$ 8,221,975**	**$ 2,259,463**	
OSA DMHSAS Rehab	$ 62,720	17,153	
Total Medicaid Program Costs	**$ 8,284,695**	**$ 2,276,616**	
TOTAL STATE SHARE OF COSTS			**$ 2,276,616**

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.

MAC Meeting
(January 2019 Data)

SOONERCARE ENROLLMENT/EXPENDITURES

Delivery System			Enrollment January 2019	Children January 2019	Adults January 2019	Enrollment Change	Total Expenditures January 2019	PMPM January 2019
SoonerCare Choice Patient-Centered Medical Home			**525,486**	**436,396**	**89,090**	**-4,303**	**$179,687,745**	
	Lower Cost	*(Children/Parents; Other)*	482,692	423,198	59,494	-4,490	$128,820,837	$267
	Higher Cost	*(Aged, Blind or Disabled; TEFRA; BCC)*	42,794	13,198	29,596	187	$50,866,907	$1,189
SoonerCare Traditional			**231,784**	**84,305**	**147,479**	**-44**	**$204,887,103**	
	Lower Cost	*(Children/Parents; Other; Q1; SLMB)*	116,459	79,597	36,862	101	$48,485,640	$416
	Higher Cost	*(Aged, Blind or Disabled; LTC; TEFRA; BCC & HCBS Waiver)*	115,325	4,708	110,617	-145	$156,401,463	$1,356
Insure Oklahoma			**18,754**	**532**	**18,222**	**100**	**$7,732,014**	
	Employer-Sponsored Insurance		13,647	332	13,315	15	$4,754,271	$348
	Individual Plan		5,107	200	4,907	85	$2,977,744	$583
SoonerPlan			**28,322**	**2,265**	**26,057**	**-793**	**$274,975**	$10
TOTAL			**804,346**	**523,498**	**280,848**	**-5,040**	**$392,581,837**	

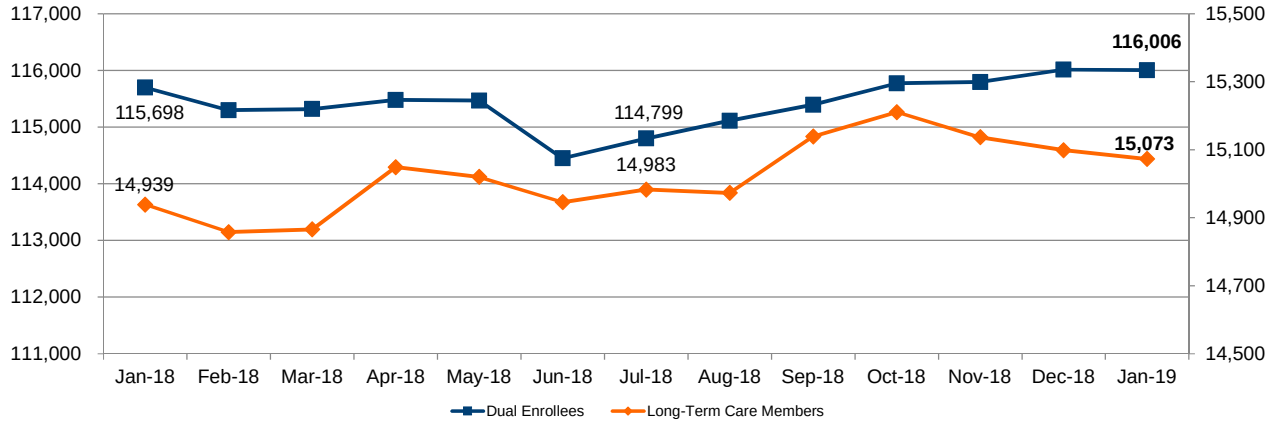
Enrollment totals include all members enrolled during the report month. Members may not have expenditure data. Children are members aged 0 - 20 or for Insure Oklahoma enrolled as Students or Dependents.
Dual Eligibles (Medicare & Medicaid) are in the Traditional delivery system in both the Low Cost (Q1 & SLMB) and High Cost (ABD) groups. OTHER includes DDSD, PKU, Q1, Refugee, SLMB, STBS and TB.

Total In-State Providers: 33,892 (+288) **(In-State Providers counted multiple times due to multiple locations, programs, types, and specialties)**

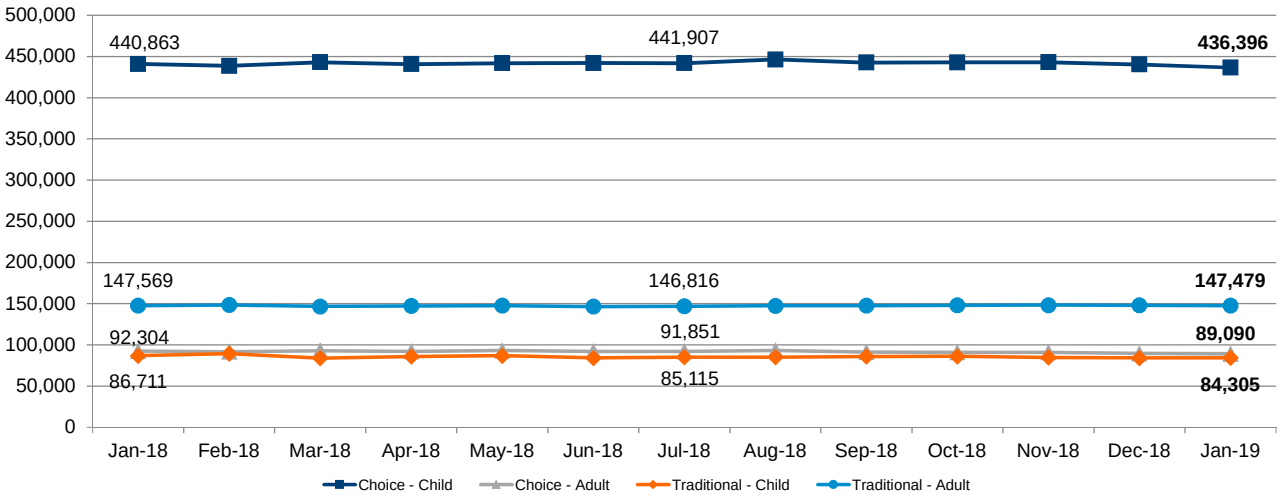
Physician	Pharmacy	Dentist	Hospital	Mental Health	Optometrist	Extended Care	Total PCPs*	PCMH
9,901	892	1,132	161	4,787	641	413	7,162	2,602

*PCPs consist of all providers contracted as a Certified Registered Nurse Practitioner, Family Practitioner, General Pediatrician, General Practitioner, Internist, General Internist, and Physician Assistant.

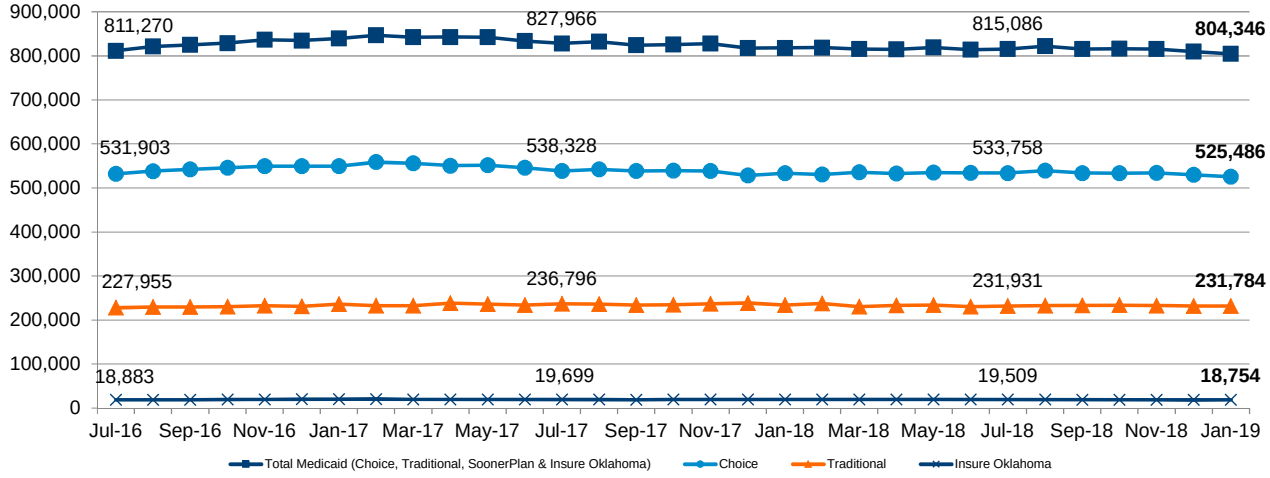
DUAL ENROLLEES & LONG-TERM CARE MEMBERS

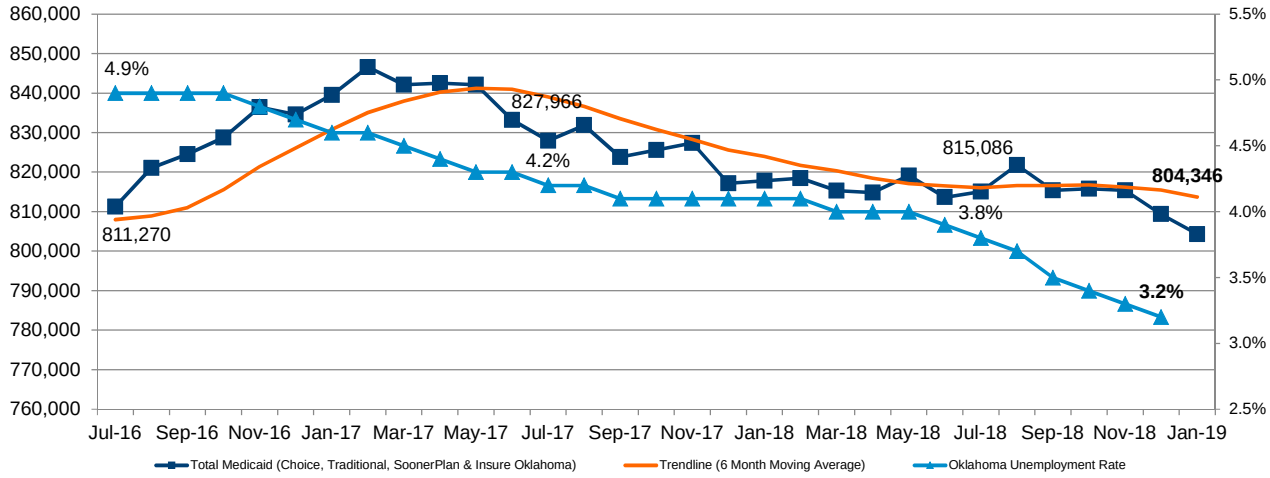


CHILDREN & ADULTS ENROLLMENT



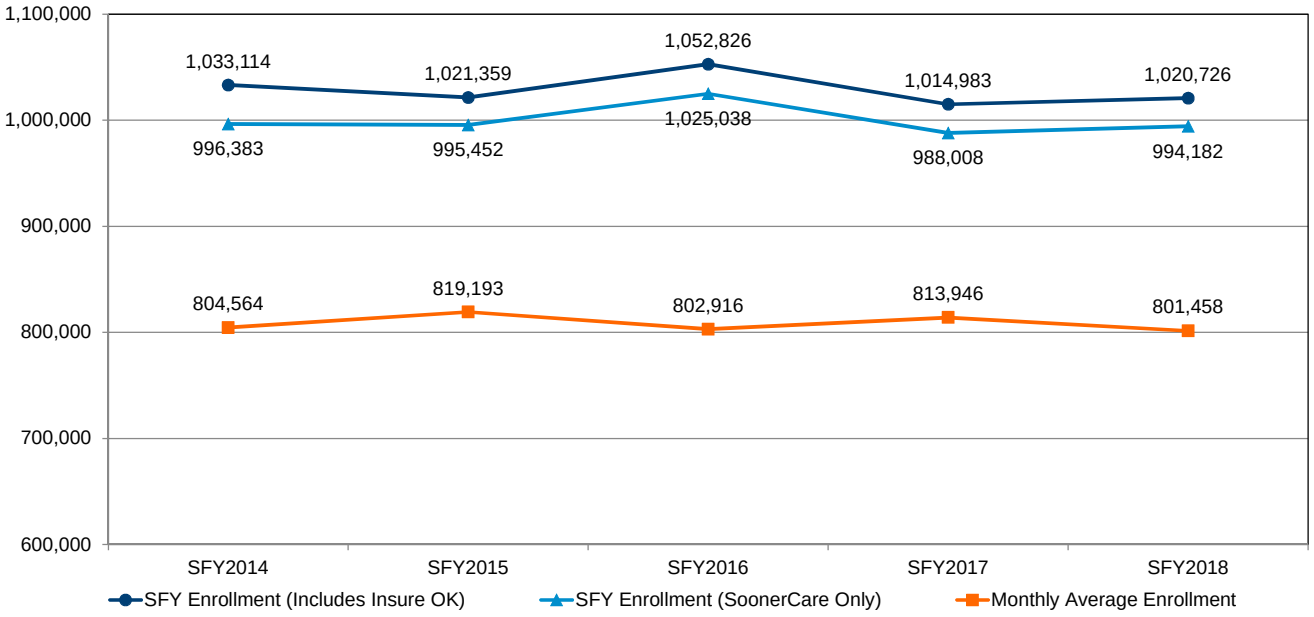
ENROLLMENT BY MONTH





Oklahoma Unemployment Rate is from the Bureau of Labor Statistics 'Local Area Unemployment Statistics' (https://www.bls.gov/lau/) and is seasonally adjusted. Data was extracted on 9/26/2018.
In June 2017 there were changes to the passive renewal system criteria that reduced the number of passively renewed members by 2/3rds.

ENROLLMENT BY STATE FISCAL YEAR



State Fiscal Year (SFY) is July - June. Enrollment is unduplicated. Monthly Average Enrollment excludes Insure OK.

May MAC
Proposed Rule Amendment Summaries

A face-to-face tribal consultation regarding the following proposed changes was held on Tuesday, January 8, 2019 in the Charles Ed McFall Boardroom of the Oklahoma Health Care Authority (OHCA).

APA work folders 19-02 and 19-03 will be posted for a comment period through May 17, 2019.

19-02 Certified Community Behavioral Health Clinics (CCBHC) Project — The proposed revisions will incorporate new rules to sustain the CCBHC project beyond its demonstration period in Oklahoma. The services provided include nine types of behavioral health treatment services, with an emphasis on the provision of 24-hour crisis care, utilization of evidence based practices, care coordination, and integration with physical health. The proposed rules will outline CCBHC member eligibility, provider participation requirements, and program scope.

Budget Impact: As these rules represent the sustainability plan for a current demonstration project, there are no new immediate costs to the Oklahoma Health Care Authority (OHCA) or the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) for implementation and enforcement of the proposed rule. However, ODMHSAS estimates a FFY 2020 net fiscal impact for CCBHCs, as $35.6M ($23.5M Federal / 12.1M State).

19-03 Applied Behavior Analysis (ABA) Services — The proposed revisions will add new language establishing coverage and reimbursement for ABA services as an Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit. The proposed language will define scope of service, provider criteria and credentialing requirements, medical necessity, intervention criteria, and extension requests for continued services. Other revisions will involve limited rewriting aimed at clarifying text and updating outdated policy sections.

Budget Impact: The proposed changes would potentially result in a combined federal and state spending of $11,455,015 total with $4,969,759 in state share for FFY19 and FFY20.

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

SUBCHAPTER 5 INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 24 CERTIFIED COMMUNITY BEHAVIORAL HEALTH CLINICS

317:30-5-263. Definitions

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

"Advanced practice registered nurse (APRN)" means a registered nurse in good standing with the Oklahoma Board of Nursing, who has acquired knowledge and clinical skills through the completion of a formal program of study approved by the Oklahoma Board of Nursing and has obtained professional certification through the appropriate national board recognized by the Oklahoma Board of Nursing. APRN services are limited to the scope of their practice as defined in Title 59 of the Oklahoma Statutes (O.S.) § 567.3a and corresponding rules and regulations at Oklahoma Administrative Code (OAC) 485:10.

"Behavioral health rehabilitation (BHR) services" means 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.

"Centers for Medicare and Medicaid Services (CMS)" means the federal agency within the United States Department of Health and Human Services (HHS) that administers the Medicare program and works in partnership with state governments to administer Medicaid.

"Certified alcohol and drug counselor (CADC)" means an individual with an Oklahoma certification as an alcohol and drug counselor.

"Certified behavioral health case manager (CM)" means an individual who is certified by the ODMHSAS as a behavioral health case manager pursuant to OAC, Title 450, Chapter 50.

"Certified community behavioral health clinics (CCBHC)" means a service delivery model designed to provide a comprehensive range of mental health and/or substance abuse rehabilitative services. Services are furnished by an interdisciplinary and mobile mental health team that functions interchangeably.

"CFR" means the Code of Federal Regulations.

"Facility-based crisis stabilization (FBCS)" means emergency psychiatric and substance abuse services aimed at resolving crisis situations. The services provided are emergency stabilization,

which includes a protected environment, chemotherapy, detoxification, individual and group treatment, and medical assessment.

"Family support and training provider (FSP)" means an individual who provides a system of care that is child-centered with the needs of the child and family dictating the types and mix of services provided, to assist in keeping the family together and preventing an out-of-home placement. FSP providers must:

(A) Have a high school diploma or equivalent;

(B) Be twenty-one (21) years of age and have a successful experience as a family member of a child or youth with serious emotional disturbance, or have lived experience as the primary caregiver of a child or youth who has received services for substance use disorder and/or co-occurring substance use and mental health, or have lived experience being the caregiver for a child with Child Welfare/Child Protective Services involvement;

(C) Successfully complete family support training according to a curriculum approved by the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) and pass the examination with a score of eighty (80) percent or better;

(D) Pass Oklahoma State Bureau of Investigation (OSBI) background check;

(E) Have treatment plans be overseen and approved by a licensed behavioral health professional (LBHP) or licensure candidate; and

(F) Function under the general direction of an LBHP, licensure candidate or systems of care team, with an LBHP or licensure candidate available at all times to provide back up, support, and/or consultation.

"Illness/wellness management and recovery (IMR/WMR)" means evidence-based practice models designed to help people who have experienced psychiatric symptoms. Elements include: developing personalized strategies for managing their mental illness and moving forward with their lives; setting and pursuing personal goals; learning information and skills to develop a sense of mastery over their psychiatric illness; and helping clients put strategies into action in their everyday lives.

"Institution for mental disease (IMD)" means a hospital, nursing facility, or other institution of more than sixteen (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, as defined by 42 CFR § 435.1010.

"Intermediate care facility for individuals with intellectual disabilities (ICF/IID)" means a facility which primarily provides health-related care and services above the level of custodial care

to intellectually disabled individuals but does not provide the level of care available in a hospital or skilled nursing facility.

"Licensed behavioral health professional (LBHP)" means any of the following practitioners:

(A) An allopathic or osteopathic physician with a current license and board certification in psychiatry or board eligible in the state in which services are provided, or a current medical resident in psychiatry;

(B) A practitioner with a current license to practice in the state in which services are provided, within one (1) of the following areas of practice:

(i) Psychology;

(ii) Social work (clinical specialty only);

(iii) Professional counselor;

(iv) Marriage and family therapist;

(v) Behavioral practitioner; or

(vi) Alcohol and drug counselor.

(C) An advanced practice registered nurse, certified in a psychiatric mental health specialty, and licensed as a registered nurse with a current certification of recognition from the board of nursing in the state in which services are provided; or

(D) A physician assistant with a current license to practice and in good standing in the state in which services are provided and has received specific training for and is experienced in performing mental health therapeutic, diagnostic, or counseling functions.

"Licensure candidate" means a practitioner who is actively and regularly receiving board approved supervision, and extended supervision by a fully licensed clinician if the board's supervision requirement is met but the individual is not yet licensed, to become licensed in a specific area of practice as outlined in (B)(i) through (vi) above. The supervising LBHP responsible for the member's care must:

(A) Staff the member's case with the candidate;

(B) Be personally available, or ensure the availability of an LBHP to the candidate for consultation while they are providing services;

(C) Agree with the current plan for the member;

(D) Confirm that the service provided by the candidate was appropriate; and

(E) Show that the member's medical record meet the requirements for reimbursement and the LBHP responsible for the member's care has reviewed, countersigned, and dated the service plan and any updates thereto so that it is documented that the licensed professional is responsible for the member's care.

"OAC" means Oklahoma Administrative Code, the publication authorized by 75 Oklahoma Statutes (O.S.), Sec. 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.

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

"OHCA" means the Oklahoma Health Care Authority.

"O.S." means Oklahoma Statutes.

"Peer recovery support specialist (PRSS)" means an individual certified by ODMHSAS as a peer recovery support specialist pursuant to requirements found in OAC 450:53.

"Program of All-Inclusive Care for the Elderly (PACE)" means a home and community based acute and long-term care services program for eligible individuals who meet the medical requirements for nursing facility care and can be served safely and appropriately in the community.

"Psychiatric residential treatment facility (PRTF)" means a non-hospital facility contracted with the OHCA to provide inpatient psychiatric services to SoonerCare-eligible members under the age of twenty-one (21), as defined by 42 C.F.R. § 483.352.

"Psychosocial rehabilitation services (PSR)" means 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 independently in the community, improve self-care and social skills, and promote lifestyle change and recovery practices.

"Qualified behavioral health aide (QBHA)" means a behavioral health aide who must meet requirements described in OAC 317:30-5-240.3.

"Registered nurse (RN)" means an individual who is a graduate of an approved school of nursing and is appropriately licensed in the state in which he or she practices.

"Serious emotional disturbance (SED)" means a condition experienced by persons from birth to eighteen (18) who have a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria outlined in OAC 317:30-5-240.1.

"Serious mental illness (SMI)" means a condition experienced by persons age eighteen (18) and over that have a diagnosable mental, behavior, or emotional disorder that causes serious functional impairment that substantially interferes with or limits one or more major life activities. Specific diagnostic criteria is outlined in OAC 317:30-5-240.1.

"System of care values" means a philosophy, which embraces a family-driven, child-centered model of care that integrates and

coordinates the efforts of different agencies and providers to individualize care in the least restrictive setting that is clinically appropriate.

"Wellness recovery action plans (WRAP)" means a self-management and recovery system designed to:

(A) Decrease intrusive or troubling feelings and behaviors;

(B) Increase personal empowerment;

(C) Improve quality of life; and

(D) Assist people in achieving their own life goals and dreams.

"Wraparound approach" means a team-based planning and implementation process to improve the lives of children with complex needs and their families by developing individualized plans of care. The key characteristics of the process are that the plan is developed by a family centered team, is individualized based on the strengths and culture of the child and his or her family, and is driven by needs rather than services.

317:30-5-264. Purpose

Certified community behavioral health clinic is a service delivery model designed to provide a comprehensive range of mental health and substance use disorder services. Services are furnished by an interdisciplinary and mobile mental health team that functions interchangeably to provide the rehabilitation and treatment designed to enable the member to live successfully in the community.

317:30-5-265. Eligible providers

(a) **Agency requirements.** Certified community behavioral health clinics are responsible for providing services to qualifying individuals within the provider's specified service area. Qualifying providers must:

(1) Be certified by the ODMHSAS as a community mental health center under OAC 450:17 and have provider specific credentials from ODMHSAS for CCBHCs (OAC 450:17-5-170 et seq.);

(2) Be under the direction of a licensed physician;

(3) Provide mobile crisis care twenty-four (24) hours, seven

(7) days a week and have a twenty-four (24) hours, seven (7) days a week walk-in crisis clinic or a psychiatric urgent care, or have an agreement in place with a State-sanctioned alternative;

(4) Actively use an Office of National Coordinator (ONC) certified Electronic Health Record (EHR) as demonstrated on the ONC Certified Health IT Product List;

(5) Have a contract with a Health Information Exchange (HIE) and demonstrate staff use of obtaining and sending data through the HIE as well as policy stating frequency of use and security

protocols; and

(6) Report on encounter, clinical outcomes, and quality improvement. This includes meeting all federal and State specifications of the required CMS quality measure reporting, as well as performance improvement reports outlining activities taken to improve outcomes.

(b) **Interdisciplinary team.** CCBHCs will utilize an interdisciplinary team of professionals and paraprofessionals to identify an individual's strengths and needs, create a unified plan to empower a person toward self-management, and coordinate the individual's varied healthcare needs. CCBHC teams will vary in size depending on the size of the member panel and acuity of the member. The treatment team includes the member, the family/caregiver of child members, the adult member's family to the extent the member does not object, and any other person the member chooses. Each CCBHC shall maintain a core staff comprised of employed and, as needed, contracted staff, as appropriate to the needs of the member as stated in the member's individual service plan.

(1) Teams shall at a minimum, include the following positions:

(A) Licensed psychiatrist;

(B) Licensed nurse care manager (registered nurse or licensed practical nurse);

(C) Consulting primary care physician, advanced practice registered nurse, or physician assistant;

(D) At least one (1) licensed behavioral health professional and may include additional LBHPs and licensure candidates [see OAC 317:30-5-240.3(a) and (b)];

(E) Certified peer recovery support specialist [see OAC 317:30-5-240.3(e)];

(F) Family support provider for child members [see OAC 317:30-5-240.3(f)]; and

(G) Certified behavioral health case manager II or certified alcohol and drug counselor [see OAC 317:30-5-240.3(c) and (h)].

(2) Optional team members may include the following:

(A) Certified behavioral health case manager I [see OAC 317:30-5-240.3(h)];

(B) Licensed nutritionist;

(C) Occupational therapist; and/or

(D) Occupational therapist assistant.

317:30-5-266. Covered services

Certified community behavioral health clinics provide a comprehensive array of services that create access, stabilize people in crisis, and provide the needed treatment and recovery support services for those with the most serious and complex mental

health and substance use disorders. CCBHCs integrate additional services to ensure an approach to health care that emphasizes recovery, wellness, trauma-informed care, and physical-behavioral health integration. Initial screening, assessment, and diagnosis must be completed in order to receive a covered service. Services must be medically necessary and recommended by an LBHP or licensure candidate (refer to OAC 317:30-5-240.3). Services are covered when provided in accordance with a person-centered and family-centered service plan. Coverage includes the following services:

(1) **Crisis assessment and intervention services.**

(A) **Service requirements.** This service is an immediately available service designed to meet the psychological, physiological, and environmental needs of individuals who are experiencing mental health and/or substance use disorder crises. Services include the following:

(i) Twenty-four (24) hours mobile crisis teams [see OAC 317:30-5-241.4(a) for service definition]. This service is provided by either a team consisting of an LBHP/licensure candidate and a CM II or CADC, or just an LBHP/licensure candidate. Reimbursement is triggered by the LBHP/licensure candidate crisis assessment;

(ii) Emergency crisis intervention service [see OAC 317:30-5-241.4(a) for service definition]. This service is provided by an LBHP/licensure candidate; and

(iii) Facility-based crisis stabilization [see OAC 317:30-5-241.4(b) for service definition], provided directly by the CCBHC or by a State-sanctioned alternative. This service is provided by a team, directed by a physician, and consisting of an LBHP/licensure candidate, licensed nurses, CM II or CADC, and PRSS staff.

(2) **Behavorial health integrated (BHI) services.**

(A) **Service requirements.** This service includes activities provided that have the purpose of coordinating and managing the care and services furnished to each member, assuring a fixed point of responsibility for providing treatment, rehabilitation, and support services. This service includes, but is not limited to:

(i) Care coordination for primary health care, specialty health care, and transitional care from emergency departments, hospitals, and PRTFs;

(ii) Ensuring integration and compatibility of mental health and physical health activities;

(iii) Providing on-going service coordination and linking members to resources;

(iv) Tracking completion of mental and physical health goals in member's comprehensive care plan;

(v) Coordinating with all team members to ensure all

objectives of the comprehensive care plan are progressing;
(vi) Appointment scheduling;
(vii) Conducting referrals and follow-up monitoring;
(viii) Participating in hospital discharge processes; and
(ix) Communicating with other providers and members/family.

(B) **Qualified professionals.** This service is performed by an LBHP/licensure candidate, nurse, CM II or CADC, and/or PRSS staff.

(3) **Person-centered and family-centered treatment planning.**

(A) **Service requirements.** This service is a process in which the information obtained in the initial screenings and assessments are used to develop a treatment plan that has individualized goals, objectives, activities, and services that will enable the member to improve. For children assessed as SED with significant behavioral needs, treatment planning is a wraparound process consistent with System of Care values. A wraparound planning process supports children and youth in returning to or remaining in the community.

(B) **Qualified professionals.** This service is conducted by LBHPs/licensure candidates, nurses, CM II or CADC, and/or PRSS staff. Treatment planning must include the member and involved practitioners.

(4) **Psychotherapy (individual / group / family).**

(A) **Service requirements.** See OAC 317:30-5-241.2 for service definitions and requirements. Fee for service billing limitations do not apply.

(B) **Qualified professionals.** This service is conducted by an LBHP/licensure candidate.

(5) **Medication training and support.**

(A) **Service requirements.** This service includes:
(i) A review and educational session focused on the member's response to medication and compliance with the medication regimen and/or medication administration;
(ii) Prescription administration and ordering of medication by appropriate medical staff;
(iii) Assisting the member in accessing medications;
(iv) Carefully monitoring medication response and side effects; and
(v) Assisting members with developing the ability to take medications with greater independence.

(B) **Qualified professionals.** This service is performed by a registered nurse, APRN, or a physician assistant (PA) as a direct service under the supervision of a physician.

(6) **Psychosocial rehabilitation services (PSR).**

(A) **Service requirements.** PSR services are face-to-face

behavioral health rehabilitation (BHR) 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 independently in the community, improve self-care and social skills, and promote lifestyle change and recovery practices. Rehabilitation services may be provided individually or in group sessions, and they take the format of curriculum-based education and skills training. This service is generally performed with only the member and the qualified provider, but may include a member and the member's family/support system when providing educational services from a curriculum that focuses on the member's diagnosis, symptom management, and recovery. 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. Family involvement is allowed for support of the member and education regarding his/her recovery but does not constitute family therapy, which requires a licensed provider. Eligibility requirements and billing limits found in OAC 317:30-5-241.3 do not apply.

(B) **Qualified professionals.** This service is solely restorative in nature and may be performed by a behavioral health CM II, CADC, LBHP, or licensure candidate, following development of a service plan and treatment curriculum approved by an LBHP or licensure candidate. The behavioral health CM II and CADC must have immediate access to an LBHP who can provide clinical oversight and collaborate with the qualified PSR provider in the provision of services.

(7) **Psychoeducation and counseling.**

(A) **Service requirements.** This service is designed to restore, rehabilitate, and support the individual's overall health and wellness. Services are intended for members to provide purposeful and ongoing psychoeducation and counseling that are specified in the individual's person-centered, individualized plan of care. Components include:

(i) Delivery of manualized wellness management interventions via group and individual work such as WRAP or IMR/WMR; and

(ii) Emotional support, education, resources during periods of crisis, and problem-solving skills.

(B) **Qualified professionals.** This service is provided by a licensed nurse, licensed nutritionist, or CM II or CADC within the scope of their licensure, certification, and/or training.

(8) **Peer recovery support services.**

(A) **Service requirements.** See OAC 317:30-5-241.5(d) for

service requirements

(B) **Qualified professionals.** PRSS must be certified through ODMHSAS pursuant to OAC 450:53.

(9) **Family support and training.**

(A) **Service requirements.** See OAC 317:30-5-241.5(c) for service requirements.

(B) **Qualified professionals.** Family support providers must be trained/credentialed through ODMHSAS.

(10) **Screening, assessment, and service planning.**

(A) **Service requirements.** See OAC 317:30-5-241.1 for service requirements. Service billing limitations found in OAC 317:30-5-241.1 do not apply.

(B) **Qualified professionals.** Screenings can be performed by any qualified team member as listed in OAC 317:30-5-265(b). Assessment and service planning can only be performed by an LBHP or licensure candidate.

(11) **Occupational therapy.**

(A) **Service requirements.** This service includes the therapeutic use of everyday life activities (occupations) with an individual or groups for the purpose of participation in roles and situations in home, school, workplace, community, and other settings for the purpose of promoting health and wellness. Occupational therapy services are provided to those who have developed an illness, injury, disease, disorder, condition, impairment, disability, activity limitation, or participation restrictions. Occupational therapy addresses the physical, cognitive, psychosocial, sensory, and other aspects of performance in a variety of contexts to support engagement in everyday life activities that affect health, well-being, and quality of life.

(B) **Qualified professionals.** This service is solely restorative in nature and provided by a qualified occupational therapist or occupational therapist assistant who is contracted with the OHCA and appropriately licensed for the service to be provided (see OAC 317:30-5-295).

(C) **Coverage limitations.** In order to be eligible for SoonerCare reimbursement, occupational therapy services must be prior authorized and/or prescribed by a physician or other licensed practitioner of the healing arts, in accordance with State and federal law, including, but not limited to, OAC 317:30-5-296, OAC 317:30-5-1020, and 42 CFR § 440.110.

317:30-5-267. Reimbursement

(a) In order to be eligible for payment, CCBHCs must have an approved provider agreement on file with the OHCA. Through this agreement, the CCBHC assures that OHCA's requirements are met and

assures compliance with all applicable federal and State Medicaid law, including, but not limited to, OHCA administrative rules, ODMHSAS administrative rules, the Code of Federal regulations, and the Oklahoma State Medicaid Plan. These agreements are renewed annually with each provider.

(b) Reimbursement is made using a provider-specific PPS rate developed based on provider-specific cost report data. The PPS rate varies by category and level of service intensity and is paid when a CCBH program delivers at least one (1) CCBHC covered service, and when a valid individual procedure code is reported for the calendar month. Care coordination services do not trigger a PPS payment when billed alone in a calendar month. For reimbursement purposes, members are categorized as follows, and are assigned to special populations by the State:

(1) Standard population;

(2) Special population 1. This population includes individuals eighteen (18) years of age and over with SMI and complex needs including those with co-occurring substance use disorder (SUD). Individuals between eighteen (18) and twenty-one (21) years of age can be served in either special population 1 or 2 depending on the member's individualized needs; and

(3) Special population 2. This population includes children and youth [ages six (6) through twenty-one (21)] with SED and complex needs, including those with co-occurring mental health and SUD;

(c) Payments for services provided to non-established clients will be separately billable. Non-established CCBH clients are those who receive crisis services directly from the CCBHC without receiving a preliminary screening and risk assessment by the CCBHC and those referred to the CCBHC directly from other outpatient behavioral health agencies for pharmacologic management.

(d) Additional reimbursement may be made to the CCBHC once in the same calendar month as the PPS payment for care coordination provided by CCBHC staff to members who are involved in a drug court or other specialty court program. Physician services provided to these members by the CCBHC are reimbursable using the SoonerCare fee schedule.

(e) Reimbursement rates will be reviewed bi-annually and updated as necessary by the Medicare Economic Index (MEI).

317:30-5-268. Limitations

(a) The following are non-billable opportunities for CCBHCs serving eligible members:

(1) Employment services;

(2) Personal care services;

(3) Childcare and respite services; and

(4) Care coordination.

(b) The following SoonerCare members are not eligible for CCBHC services:

(1) Members receiving care in an Institution for Mental Disease (IMD);

(2) Members residing in a nursing facility or ICF/IID;

(3) Inmates of a public correctional institution; and

(4) SoonerCare members being served by a PACE provider.

(c) SoonerCare members receiving services from a CCBHC are not eligible for enrollment in a SoonerCare behavioral health home.

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

SUBCHAPTER 3. GENERAL PROVIDER POLICIES

PART 4. EARLY AND PERIODIC SCREENING, ~~DIAGNOSIS~~DIAGNOSTIC AND TREATMENT (EPSDT) PROGRAM/CHILD-HEALTH SERVICES

317:30-3-65.12 Applied Behavior Analysis (ABA) services

(a) **Purpose and general provisions.** The purpose of this Section is to establish guidelines for the provision of ABA services under the EPSDT benefit.

(1) ABA focuses on the analysis, design, implementation, and evaluation of instructional and other environmental modifications to produce meaningful changes in human behavior. ABA services include the use of direct observation, measurement, and functional analysis of the relations between the environment and behavior. Common ABA-based techniques include, but are not limited to: discrete trial training; pivotal response training; and verbal behavioral intervention.

(2) ABA may be provided in a variety of settings, including home, community, or a clinical setting. It involves development of an individualized treatment plan that includes transition and aftercare planning, and significant family involvement.

(3) At an initial assessment, target symptoms are identified. A treatment plan is developed that identifies the core deficits and aberrant behaviors, and includes designated interventions intended to address these deficits and behaviors and achieve individualized goals.

(4) Functional behavioral assessment (FBA) may also be a part of any assessment. An FBA consists of:

(A) Description of the problematic behavior (topography, onset/offset, cycle, intensity, severity);

(B) History of the problematic behavior (long-term and recent);

(C) Antecedent analysis (setting, people, time of day, events);

(D) Consequence analysis; and

(E) Impression and analysis of the function of the problematic behavior.

(5) ABA services require prior authorization [refer to Oklahoma Administrative Code (OAC) 317:30-3-31]. These services are designed to accomplish medically necessary management of severe and complex clinical conditions in which there is a realistic expectation that within a finite and reasonable period of time, the caregiver will be able to demonstrate knowledge and ability

to independently and safely carry out the established plan of care.

(b) **Eligible providers.** Eligible ABA provider types include:

(1) Board Certified Assistant Behavior Analyst (BCaBA) – A bachelor's level practitioner who is certified by the nationally accredited Behavior Analyst Certification Board (BACB) and certified by the Oklahoma Department of Human Services' (DHS) Developmental Disabilities Services Division (DDS) to provide behavior analysis services under the supervision of a BCBA;

(2) Board Certified Behavior Analyst (BCBA) – A master's or doctoral level independent practitioner who is certified by the nationally accredited BACB and licensed by DHS DDS to provide behavior analysis services. A BCBA may supervise the work of BCaBA's implementing behavior analytic interventions; or

(3) Human services professional – A practitioner who is licensed or certified by the State of Oklahoma and by the nationally accredited BACB, and who is working within the scope of his or her practice, to include:

(A) A licensed physical therapist or physical therapy assistant;

(B) An occupational therapist, occupational therapy assistant, or occupational therapy aide;

(C) A licensed clinical social worker, licensed masters social worker, or licensed social work associate;

(D) A psychologist or health service psychologist;

(E) A speech-language pathologist or audiologist;

(F) A licensed professional counselor or licensed professional counselor candidate;

(G) A licensed marital and family therapist or licensed marital and family therapist candidate; or

(H) A licensed behavioral practitioner or licensed behavioral practitioner candidate.

(c) **Provider criteria.** To direct, supervise, and/or render ABA services, the following conditions shall be met.

(1) A BCBA shall:

(A) Be currently licensed by DHS DDS as a BCBA;

(B) Have no sanctions or disciplinary actions by DHS DDS or the BACB;

(C) Have no current overpayment(s) due to SoonerCare, and no Medicare or Medicaid sanctions or exclusions from participation in federally funded programs; and

(D) Be fully contracted with SoonerCare as a provider.

(2) A BCaBA shall:

(A) Be currently certified by DHS DDS as a BCaBA;

(B) Work under the supervision of a BCBA with the supervisory relationship documented in writing;

(C) Have no current overpayment(s) due to SoonerCare, and no Medicare or Medicaid sanctions or exclusions from participation in federally funded programs; and

(D) Be fully contracted with SoonerCare as a provider.

(3) A human services professional shall:

(A) Be currently licensed or certified by the State of Oklahoma, in accordance with Title 59 of the Oklahoma Statutes (O.S.), § 1928;

(B) Be currently certified by the nationally accredited BACB;

(C) Have no sanctions or disciplinary actions by the applicable state licensing board or the BACB;

(D) If working under supervision within the scope of his or her practice, have the supervisory relationship documented in writing;

(E) Have no current overpayment(s) due to SoonerCare, and no Medicare or Medicaid sanctions or exclusions from participation in federally funded programs; and

(F) Be fully contracted with SoonerCare as a provider.

(d) **Medical necessity criteria for members under twenty-one (21) years of age.** ABA services are considered medically necessary when all of the following conditions are met:

(1) The member is under twenty-one (21) years of age with a definitive diagnosis of an Autism Spectrum Disorder (ASD) from the following providers:

(A) Pediatric neurologist or neurologist;

(B) Developmental pediatrician;

(C) Licensed psychologist;

(D) Psychiatrist; or

(E) Other licensed physician experienced in the diagnosis and treatment of autism.

(2) A comprehensive diagnostic evaluation completed by one (1) of the above identified professionals must:

(A) Include a complete pertinent medical and social history, including pre-and perinatal, medical, developmental, family, and social elements; and

(B) Be based on criteria outlined in the Diagnostic and Statistical Manual of Mental Disorders-V (DSM-V) for ASD and/or may also include scores from the use of formal diagnostic tests such as the Autism Diagnostic Interview-Revised (ADI-R), Autism Diagnostic Observation Schedule-2 (ADOS-2), Childhood Autism Rating Scale (CARS) or other tools with acceptable psychometric properties. Screening

scales are not sufficient to make a diagnosis and will not be accepted as the only formal scale.

(3) There must be a reasonable expectation that the member will benefit from ABA. The member must exhibit:

(A) The ability/capacity to learn and develop generalized skills to assist with his or her independence; and

(B) The ability to develop generalized skills to assist in addressing maladaptive behaviors associated with ASD.

(4) The member is medically stable and does not require twenty-four (24) hour medical/nursing monitoring or procedures provided in a hospital or intermediate care facility for individuals with intellectual disabilities (ICF/IID).

(5) The member exhibits atypical or disruptive behavior within the most recent thirty (30) calendar days that significantly interferes with daily functioning and activities that includes one (1) or more of the following (plus any additional atypical or disruptive behavior not identified on this list):

(A) Impulsive aggression toward others;

(B) Self-injury behaviors; or

(C) Intentional property destruction.

(6) The focus of treatment is not custodial in nature (which is defined as care provided when the member "has reached maximum level of physical or mental function and such person is not likely to make further significant improvement" or "any type of care where the primary purpose of the type of care provided is to attend to the member's daily living activities which do not entail or require the continuing attention of trained medical or paramedical personnel.")

(7) It has been determined that there is no less intensive or more appropriate level of services which can be safely and effectively provided.

(e) **Intervention criteria.** Eligible providers must submit an initial prior authorization request to the Oklahoma Health Care Authority (OHCA) or its designated agent and meet the following SoonerCare intervention criteria for ABA services.

(1) The intervention criteria includes a comprehensive behavioral and functional evaluation outlining the behaviors consistent with the diagnosis of ASD and its associated comorbidities. In addition to completing the initial request form, providers will be required to submit a written assessment that will consist of the following:

(A) Information about relevant medical status, prior assessment results, response to prior treatment, and other relevant information gathered from review of records and past assessments.

(B) Information gathered from interview of family and/or

caregivers, rating scales, and social validity measures to assess perceptions of the client's skill deficits and behavioral excesses, and the extent to which these deficits impede the life of the member and the family.

(C) Direct assessment and observation, including any data related to the identified problem behavior. The analysis of such data serves as the primary basis for identifying pretreatment levels of functioning, developing and adapting treatment protocols, and evaluating response to treatment and progress towards goals.

(D) Functional assessment of problem behavior that includes antecedent factors, skill deficits, and consequences contributing to the problem behavior. The treatment plan should address all three (3) areas, including antecedent interventions, teaching replacement skills, and modification of consequences.

(2) The ABA treatment will be time limited and must:

(A) Be child-centered and based upon individualized goals that are strengths-specific, family focused, and community based;

(B) Be culturally competent and the least intrusive as possible;

(C) Clearly define in measurable and objective terms the specific target behaviors that are linked to the function of (or reason for) the behavior;

(D) Record the frequency, rate, symptom intensity/duration, or other objective measures of baseline levels;

(E) Set quantifiable criteria for progress;

(F) Establish and record behavioral intervention techniques that are appropriate to target behaviors. The detailed behavior analytic treatment plan utilizes reinforcement and other behavioral principles and excludes the use of methods or techniques that lack consensus about their effectiveness based on evidence in peer-reviewed publications;

(G) Specify strategies for generalization of learned skills;

(H) Document planning for transition through the continuum of interventions, services, and settings, as well as discharge criteria;

(I) Include parent(s)/legal guardian(s) in behavioral training techniques so that they can practice additional hours of intervention on their own. The treatment plan is expected to achieve the parent(s)/legal guardian(s) ability to successfully reinforce the established plan of care. Frequency of parental involvement will be determined by the treatment provider and listed on the treatment plan;

(J) Document parent(s)/legal guardian(s) participation in

the training of behavioral techniques in the member's medical record. Parent(s)/legal guardian (s)' participation is critical to the generalization of treatment goals to the member's environment; and

(K) Ensure that recommended ABA services do not duplicate or replicate services received in a member's primary academic education setting, or provided within an Individualized Education Plan Education Plan (IEP) or Individualized Service Plan (ISP).

(f) **ABA extension requests.** Extension requests for ABA services must be submitted to the OHCA or its designated agent. Extension requests must contain the appropriate documentation validating the need for continued treatment and establish the following:

(1) Eligibility criteria in (d) 1-6;

(2) The frequency of the target behavior has diminished since last review, or if not, there has been modification of the treatment or additional assessments have been conducted;

(3) If progress has not been measurable after two (2) extension requests, a functional analysis will be completed which records the member's maladaptive serious target behavioral symptom(s), and precipitants, as well as makes a determination of the function a particular maladaptive behavior serves for the member in the environmental context;

(4) Appropriate consultations from other staff or experts have occurred (psychiatric consults, pediatric evaluation for other conditions) and interventions have been changed, including the number of hours per week of service or setting (higher level of care);

(5) Parent(s)/legal guardian(s) have received re-training on these changed approaches; and

(6) The treatment plan documents a gradual tapering of higher intensities of intervention and shifting to supports from other sources (i.e., schools) as progress occurs.

(g) **Reimbursement Methodology.** SoonerCare shall provide reimbursement for ABA services in accordance with the Medicaid State Plan.

(1) Payment shall be made to fully contracted BCBAs and human service professionals who are currently licensed and in good standing. Payment for ABA services rendered by any practitioner who is under supervision at the time the service is provided, shall be made to his or her licensed supervisor. If the rendering practitioner operates through an agency or corporate entity, payment may be made to that agency or entity.

(2) Reimbursement for ABA services is only made on a fee-for-services basis. The maximum allowable fee for a unit of service has been determined by OHCA to be a reasonable fee, consistent

with efficiency, economy, and quality of care. Payment for covered services is the lower of the provider's actual billed charges, consistent with the provider's usual and customary charge to the general public for the service, or the maximum allowable per unit of service.

(3) Reimbursement shall only be made for services that have been prior-authorized by OHCA or its designee.

(4) Reimbursement for ABA services shall not be made to or for services rendered by a parent, legal guardian, or other legally responsible person.

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 35. RURAL HEALTH CLINICS

317:30-5-355.1. Definition of services

The ~~RHC~~Rural Health Clinic (RHC) benefit package, as described in Title 42 of the Code of Federal Regulations (CFR), ~~part~~ § 440.20, consists of two (2) components: RHC ~~Services and Other Ambulatory Services~~services and other ambulatory services.

(1) **RHC services.** RHC services are covered when furnished to a member at the clinic or other location, including the member's place of residence. These services are described in this Section.

(A) **Core services.** As set out in ~~Federal Regulations at~~ 42 CFR § 440.20(b), RHC "core" services include, but are not limited to:

(i) Physician's services;

(ii) Services and supplies incident to a physician's services;

(iii) Services of advanced practice registered nurses ~~(APNs)~~(APRNs), physician assistants (PAs), certified nurse midwives (CNMs), or specialized advanced practice nurse practitioners;

(iv) Services and supplies incident to the services of ~~APNs~~APRNs and PAs (including services furnished by ~~certified nurse midwives~~CNMs);

(v) Visiting nurse services to the homebound;

(vi) Clinical psychologist (CP) and clinical social worker (CSW) services;

(vii) Services and supplies incident to the services of CPs and CSWs.

(B) **Physicians' services.** In addition to the professional services of a physician, and services provided by an ~~APN~~APRN, PA, and ~~NMW~~CNM which would be covered as RHC services under Medicare, certain primary preventive services are covered

under the SoonerCare RHC benefit. The services must be furnished by or under the direct supervision of ~~a~~an RHC practitioner who is a clinic employee:

(i) ~~prenatal~~Prenatal and postpartum care;

(ii) ~~screening~~Screening examination under the Early and Periodic Screening, ~~Diagnosis~~Diagnostic and Treatment (EPSDT) Program for members under ~~21~~twenty-one (21);

(iii) ~~family~~Family planning services;

(iv) ~~medically~~Medically necessary screening mammography and follow-up mammograms ~~when medically necessary~~.

(C) **Services and supplies "incident to".** Services and supplies incident to the service of a physician, ~~physician assistant, advanced practice nurse, clinical psychologist, or clinical social worker~~PA, APRN, CP, or CSW are covered if the service or supply is:

(i) ~~a~~A type commonly furnished in physicians' offices;

(ii) ~~a~~A type commonly rendered either without charge or included in the rural health clinic's bill;

(iii) ~~furnished~~Furnished as an incidental, although integral, part of a physician's professional services; or

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

(D) **Visiting nurse services.** Visiting nurse services are covered if:

(i) ~~the~~The RHC is located in an area in which the Centers for Medicare and Medicaid Services (CMS) has determined there is a shortage of home health agencies;

(ii) ~~the~~The services are rendered to members who are homebound;

(iii) ~~the~~The member is furnished nursing care on a part-time or intermittent basis by a registered nurse, licensed practical nurse, or licensed vocational nurse who is employed by or receives compensation for the services from the RHC; and

(iv) ~~the~~The services are furnished under a written plan of treatment.

(E) **RHC encounter.** RHC "core" services (including preventive services, i.e., prenatal, EPSDT, or family planning) are part of an all-inclusive visit. A "visit" means a face-to-face encounter between a clinic patient and ~~a~~an RHC health professional ~~(i.e., physicians, physician~~

~~assistants, advanced practice nurses, certified nurse midwives, clinical psychologists and clinical social workers)~~(physicians, PAs, APRNs, CNMs, CPs, and CSWs). Encounters with more than one (1) health professional and multiple encounters with the same health professional that takes place on the same day and a single location, constitute a single visit except when the member, after the first encounter, suffers illness or injury requiring additional diagnosis or treatment. Payment is made for one (1) encounter per member per day. Medical review will be required for additional visits for children. Payment is also limited to four (4) visits per member per month for adults.

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

(2) **Other ambulatory services.** ~~A Rural Health Clinic~~An RHC must provide other items and services which are not "RHC services" as described in ~~(a)~~(1) of this Section, and are separately billable ~~to the SoonerCare program~~within the scope of the SoonerCare fee-for-service (FFS) contract. Coverage of services are based upon the scope of coverage under the SoonerCare program.

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

(i) ~~dental~~Dental services for members under ~~age 21~~the age of twenty-one (21);

(ii) ~~optometric~~Optometric services;

(iii) ~~clinical~~Clinical lab tests performed in the RHC lab, including the lab tests required for RHC certification;

(iv) ~~technical~~Technical component of diagnostic tests such as x-rays and EKGs (interpretation of the test provided by the RHC physician is included in the encounter rate);

(v) ~~durable~~Durable medical equipment;

(vi) ~~emergency ambulance transportation~~Transportation by ambulance (refer to OAC 317:30-5-335);

(vii) ~~prescribed~~Prescribed drugs;

(viii) ~~prosthetic~~Prosthetic devices (other than dental) which replace all or part of an internal body organ (including colostomy bags) and supplies directly related to colostomy care and the replacement of such devices;

(ix) ~~specialized~~Specialized laboratory services furnished away from the clinic;

(x) ~~inpatient~~Inpatient services;

(xi) ~~outpatient~~Outpatient hospital services~~.~~; and

(xii) Applied behavior analysis (ABA) [refer to Oklahoma Administrative Code (OAC) 317:30-3-65.12].

(B) Payment is made directly to the RHC on an encounter basis for on-site dental services by a licensed dentist or optometric services by a licensed optometrist for members under ~~age 21~~the age of twenty-one (21). Encounters are billed as one (1) of the following:

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

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

(iii) **Visual analysis.** Visual analysis (initial or yearly) for a child with glasses, or a child who needs glasses, or a medical eye exam. This includes the refraction and medical eye health evaluation. Glasses must be billed separately. Payment is limited to two (2) glasses per year. Any glasses beyond this limit must be prior authorized and determined to be medically necessary.

(C) Services listed in ~~(a)~~(2)(A), (v)-(viii), of this Section, furnished on-site, require separate provider agreements with the ~~OHCA~~Oklahoma Health Care Authority (OHCA). Service item ~~(a)~~(2)(A)(iii) does not require a separate contract when furnished on-site, however, certain conditions of participation apply. (Refer to OAC 317:30-5-361 for conditions.)

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

current contract with the OHCA.

317:30-5-357. Coverage for children

Coverage for rural health clinic (RHC) services and other ambulatory services for children include the same services as for adults in addition to the following:

(1) ~~The receipt of an Early and Periodic Screening, Diagnosis and Treatment (EPSDT) examination by a Medicaid eligible individual under age 21 renders that individual child eligible for all necessary follow-up care, whether or not the medically necessary services are covered under the Medicaid.~~Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services are covered for eligible members under twenty-one (21) years of age in accordance with OAC 317:30-3-65. An EPSDT exam performed by ~~a~~an RHC must be billed on the appropriate claim form with the appropriate ~~Preventative Medicine~~preventive medicine procedure code from the Current Procedural Terminology ~~Manual~~ (CPT) manual. If an EPSDT screening is billed, ~~a~~an RHC encounter should not be billed on the same day. ~~Refer to OAC 317:30-3-47 through 317:30-3-54 for coverages under EPSDT).~~Refer to Oklahoma Administrative Code (OAC) 317:30-3-65 through 317:30-3-65.12.

(2) Under EPSDT, coverage is allowed for visual screenings and eyeglasses to correct visual defects. Payment is limited to two (2) glasses per year. Any glasses beyond this limit must be prior authorized and determined to be medically necessary.

(3) An EPSDT screening is considered a comprehensive examination. A provider billing the Medicaid program for an EPSDT ~~screen~~screening may not bill any other visits for that patient on that same day. It is expected that the screening provider will perform necessary treatment as part of the screening charge. Additional services such as tests, immunizations, etc., required at the time of screening may be billed independently from the screening.

(4) The administration fee for immunizations should be billed if provided at the same time as a scheduled EPSDT examination.

(5) Payment may be made directly to the RHC for the professional services of physician assistants performing EPSDT screenings within the certified RHC. The claim form must include the signature of the supervising physician.

PART 37. ADVANCED PRACTICE NURSE

317:30-5-376. Coverage by category

Payment is made to ~~Advanced Practice Nurse~~advanced practice nurses as set forth in this Section.

(1) **Adults.** Payment for adults is made for primary care health services, within the scope of practice of ~~Advanced Practice Nurse~~advanced practice nurse and within the scope of the Oklahoma Health Care Authority (OHCA) medical programs.

(2) **Children.** Payment for children is made for primary care health services, within the scope of practice of ~~Advanced Practice Nurse~~advanced practice nurse, to ~~children and adolescents under 21~~members under twenty-one (21) years of age, including ~~EPSDT~~Early and Periodic Screening, Diagnostic and Treatment (EPSDT) screening services~~ and within the scope of the Oklahoma Health Care Authority medical programs~~.

(A) Payment is made to eligible providers for ~~Early and Periodic Screening, Diagnosis and Treatment of individuals under age 21~~EPSDT services to members under twenty-one (21) years of age. Specific guidelines for the EPSDT program including the periodicity schedule are found in ~~OAC~~Oklahoma Administrative Code (OAC) 317:30-3-65 through ~~317:30-3-65.11~~317:30-3-65.12.

(B) Comprehensive screening examinations are to be performed by a provider qualified under State law to furnish primary health care services.

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

PART 75. FEDERALLY QUALIFIED HEALTH CENTERS

317:30-5-664.1. Provision of other health services outside of the Health Center core services

(a) If the Center chooses to provide other ~~SoonerCare~~Oklahoma Medicaid State Plan covered health services which are not included in the Health Center core service definition in ~~OAC~~Oklahoma Administrative Code (OAC) 317:30-5-661.1, the practitioners of those services are subject to the same program coverage limitations, enrollment, and billing procedures described by the OHCA, and these services (e.g., home health services) are not included in the PPS settlement methodology in OAC 317:30-5-664.12.

(b) Other medically necessary health services that will be reimbursed at the fee-for-service (FFS) rate include, but are not limited to:

(1) ~~dental~~Dental services (refer to OAC 317:30-5-696) except for primary preventive dental services;

(2) ~~eyeglasses (OAC 317:30-5-430 and OAC 317:30-5-450)~~Eyeglasses (refer to OAC 317:30-5-431, 317:30-5-432.1 and 317:30-5-451);

(3) ~~clinical~~Clinical lab tests performed in the Center lab (other than the specific laboratory tests set out for Health

Centers' certification and covered as Health Center services);
(4) ~~technical~~Technical component of diagnostic tests such as x-rays and EKGs (interpretation of the test provided by the Center physician is included as physician professional services);
(5) ~~durable~~Durable medical equipment (refer to OAC 317:30-5-210);
(6) ~~emergency ambulance transportation~~Transportation by ambulance (refer to OAC 317:30-5-335);
(7) ~~prescribed~~Prescribed drugs (refer to OAC 317:30-5-70);
(8) ~~prosthetic~~Prosthetic devices (other than dental) which replace all or part of an internal body organ (including colostomy bags) and supplies directly related to colostomy care and the replacement of such devices;
(9) ~~specialized~~Specialized laboratory services furnished away from the clinic;
(10) Psychosocial ~~Rehabilitation Services~~rehabilitation services ~~[refer to OAC 317:30-5-241.3]~~(refer to OAC 317:30-5-241.3); ~~and~~
(11) ~~behavioral~~Behavioral health related case management services (refer to OAC 317:30-5-241.6)~~.~~; and
(12) Applied behavior analysis (ABA) (refer to OAC 317:30-3-65.12).

PART 108. NUTRITION SERVICES

317:30-5-1076. Coverage by category

Payment is made for ~~Nutritional Services~~nutritional services as set forth in this ~~section~~Section.

(1) **Adults.** Payment is made for six (6) hours of medically necessary nutritional counseling per year by a licensed registered dietician. All services must be prescribed by a physician, physician assistant (PA), advanced practice registered nurse (APRN), or certified nurse midwife (CNW), and be ~~face to face~~face-to-face encounters between a licensed registered dietitian and the member. Services must be expressly for diagnosing, treating or preventing, or minimizing the effects of illness. Nutritional services for the treatment of obesity is not covered unless there is documentation that the obesity is a contributing factor in another illness.

(2) **Children.** Payment is made for medically necessary nutritional counseling as described above for adults. Nutritional services for the treatment of obesity may be covered for children as part of the ~~EPSDT~~Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit. Additional services which are deemed medically necessary and allowable under federal regulations may be covered by the EPSDT benefit found

at OAC 317:30-3-65 ~~and~~through ~~317:30-3-65.11~~317:30-3-65.12.

(3) **Home and ~~Community Based Waiver Services~~community-based services (HCBS) waiver for the ~~Intellectually Disabled~~intellectually disabled.** All providers participating in the ~~Home and Community Based Waiver Services~~HCBS waiver for the intellectually disabled program must have a separate contract with ~~OHCA~~the Oklahoma Health Care Authority (OHCA) to provide ~~Nutrition Services~~nutrition services under this program. All services are specified in the individual's plan of care.

(4) **Individuals eligible for Part B of Medicare.** Payment is made utilizing the Medicaid allowable for comparable services. Services which are not covered under Medicare should be billed directly to OHCA.

(5) **Obstetrical patients.** Payment is made for a maximum of six (6) hours of medically necessary nutritional counseling per year by a licensed registered dietitian for members at risk for or those who have been recently diagnosed with gestational diabetes. The initial consultation may be in a group setting for a maximum of two (2) hours of class time. Thereafter, four (4) hours of nutritional counseling by a licensed registered dietitian may be provided to the individual if deemed medically necessary, which may include a post-partum visit, typically done at ~~6~~six (6) weeks after delivery. All services must be prescribed by a physician, ~~physician assistant, advanced practice nurse or a certified nurse midwife~~PA, APRN, or CNM and be face-to-face between a licensed registered dietitian and the member(s). Services must be solely for the prevention, diagnosis, or treatment of gestational diabetes.

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 (FFS) contract. The services will be reimbursed at the ~~fee-for-service~~FFS rate, and will be subject to any limitations, restrictions, or prior authorization requirements. Examples of these services include, but are not limited to:

(1) ~~durable~~Durable medical equipment [refer to Oklahoma Administrative Code (OAC) 317:30-5-210];

(2) ~~glasses~~Eyeglasses (refer to OAC 317:30-5-431, 317:30-5-432.1 and 317:30-5-451);

(3) ~~ambulance~~Transportation by ambulance (refer to OAC 317:30-5-335);

(4) ~~home~~Home health ~~[refer to OAC 317:30-5-546]~~(refer to OAC 317:30-5-546);

(5) ~~inpatient~~Inpatient practitioner services (refer to OAC 317:30-5-1100);

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

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

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

(9) ~~psychiatric~~Psychiatric residential treatment facility services ~~[refer to OAC 317:30-5, Part 6, Inpatient Psychiatric Hospitals].~~(refer to OAC 317:30-5-95 through 317:30-5-98); and

(10) Applied behavior analysis (ABA) (refer to OAC 317:30-3-65.12).

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

PART 112. PUBLIC HEALTH CLINIC SERVICES

317:30-5-1154. ~~CHD/CCHD~~County health department (CHD)and city-county health department (CCHD) services/limitations

CHD/CCHD service limitations are:

(1) Child ~~Guidance~~-guidance services ~~(see OAC 317:30-3-65 through OAC 317:30-3-5-65.11 for specifics regarding program requirements).~~(refer to Oklahoma Administrative Code (OAC)317:30-5-1023).

(2) Dental services ~~[OAC 317:30-3-65.4(7)].~~(refer to OAC 317:30-3-65.4(7) for specific coverage).

(3) Early and Periodic Screening, ~~Diagnosis,~~Diagnostic and Treatment (EPSDT) services ~~(including blood lead testing and follow-up services)~~, including blood lead testing and follow-up services (~~see~~refer to OAC 317:30-3-65 through ~~OAC 30-3-65.11~~317:30-3-65.12 for specific coverage).

(4) Environmental investigations.

(5) Family ~~Planning~~planning and SoonerPlan ~~Family Planning~~family planning services (~~see~~refer to OAC 317:30-5-12 for specific coverage guidelines).

(6) Immunizations (adult and child).

(7) Blood lead testing (~~see~~refer to OAC 317:30-3-65.4 for specific coverage).
(8) Newborn hearing screening.
(9) Newborn metabolic screening.
(10) Maternity services (~~see~~refer to OAC 317:30-5-22 for specific coverage).
(11) Public health nursing services.
(12) Tuberculosis case management and directly observed therapy.
(13) Laboratory services.
(14) Targeted case management.