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

317:30-3-28. Electronic Health Records Incentive Program.

(a) **Program.** The Oklahoma Electronic Health Records Incentive Program is authorized by the American Recovery and Reinvestment Act of 2009. Under this program, SoonerCare providers may qualify for incentive payments if they meet the eligibility guidelines in this section and demonstrate they are engaged in efforts to adopt, implement, upgrade, or meaningfully use certified electronic health records (EHR) technology. The EHR incentive program is governed by the policy in this section and the Electronic Health Records Program Final Rule issued by CMS in CMS-0033-F and 45 CFR 170. Providers should also use the EHR program manual as a reference for additional program details.

(b) **Eligible providers.** To qualify for incentive payments, a provider must be an "eligible professional" or an "eligible hospital." Providers who receive incentive payments must have an existing Provider Agreement with OHCA and at least one of their facilities must be located within the State of Oklahoma.

(1) **Eligible professionals.** An eligible professional is defined as a physician, a physician assistant practicing in a Federally Qualified Health Center or Rural Health Center led by a physician assistant, a board certified pediatrician, a nurse practitioner, a certified nurse midwife, or a dentist. OHCA will determine eligibility based on the provider type, specialty associated with the provider in the MMIS system, and documentation.

(A) Eligible professionals may not be hospital-based, unless they practice predominantly at an FQHC or RHC as defined by the CMS Final Rule. A "hospital-based" professional furnishes ninety percent (90%) or more of their SoonerCare-covered professional services during the relevant EHR reporting period in a hospital setting, whether inpatient or Emergency Room, through the use of the facilities and equipment of the hospital.

(B) Eligible professionals may not participate in both the Medicaid and Medicare EHR incentive payment program during the same payment year.

(2) **Eligible hospitals.** Eligible hospitals are Children's Hospitals or Acute Care Hospitals, including Critical Access Hospitals and cancer hospitals. An Acute Care Hospital is defined as a health care facility where the average length of patient stay is twenty-five (25) days or fewer and that has a CMS certification number that has the last four digits in the series 0001-0879 and 1300-1399. A Children's Hospital is defined as a separately certified children's hospital, either freestanding or hospital-within-hospital, that predominantly treats individuals under 21 years of age and has a CMS certification number with the last 4 digits in the series 3300-3399. Hospitals that do not meet either of the preceding definitions are not eligible for incentive payments.

(c) **Patient Volume.** Eligible professionals and eligible hospitals must meet SoonerCare patient volume criteria to qualify for incentive payments. Patient volume criteria compliance will be verified by the OHCA through claims data and provider audits. When calculating SoonerCare patient volume, all SoonerCare populations may be counted. To calculate patient volume, the provider's total SoonerCare patient encounters in the specified reporting period must be divided by the provider's total patient encounters in the same reporting period.

(1) **Eligible professionals**. Eligible professionals must meet a 30% SoonerCare patient volume threshold over a continuous 90-day period in the preceding calendar year. The only exception is for pediatricians, as discussed in OAC 317:30-3-28(c)(5).

(2) **Eligible hospitals.** With the exception of children's hospitals, which have no patient volume requirement, eligible hospitals must meet a 10% SoonerCare patient volume threshold over a continuous 90-day period in the preceding calendar year.

(3) **FQHC or RHC patient volume.** Eligible professionals practicing predominantly in an FQHC or RHC may be evaluated according to their "needy individual" patient volume. To qualify as a "needy individual," patients must meet one of the following criteria: (i) Received medical assistance from SoonerCare; (ii) Were furnished uncompensated care by the provider; or (iii) Were furnished services at either no cost or reduced cost based on a sliding scale determined by the individual's ability to pay.

(4) **Clinics and Group Practices.** Clinics or group practices may calculate patient volume using the

clinic's or group's SoonerCare patient volume under the following conditions: (i) The clinic or group practice's patient volume is appropriate as a patient volume methodology calculation for the eligible professional; (ii) There is an auditable data source to support the patient volume determination; (iii) All eligible professionals in the clinic or group practice use the same methodology for the payment year; (iv) The clinic or group practice uses the entire practice's patient volume and does not limit patient volume in any way; and (v) If an eligible professional works inside and outside of the clinic or practice, the patient volume calculation includes only those encounters associated with the clinic or group practice, and not the eligible professional's outside encounters.

(5) **Pediatricians.** Pediatricians may qualify for 2/3 incentive payments if their SoonerCare patient volume is 20-29%. A pediatrician is defined as a medical doctor who diagnoses, treats, examines, and prevents diseases and injuries in children and possesses a valid, unrestricted medical license and board certification in Pediatrics through either the American Board of Pediatrics (ABP) or the American Osteopathic Board of Pediatrics (AOPB). To qualify as a pediatrician for the purpose of receiving a 2/3 payment under the incentive program, the provider must provide OHCA with a copy of their pediatric licenses and board certification.

(6) **Out of State Patients.** For eligible professionals and eligible hospitals using out of state Medicaid recipients for patient volume requirement purposes, the provider must retain proof of the encounter for the out of state patient.

(d) **Attestation.** Eligible professionals and eligible hospitals must execute an amendment to their Provider Agreement to attest to meeting program criteria through the Electronic Provider Enrollment (EPE) system in order to qualify for incentive payments. Registration in the CMS EHR Incentive Payment Registration and Attestation system is a pre-requisite to EPE attestation.

(e) **Adoption/ Implementation/ Upgrade (A/I/U).** Eligible professionals or eligible hospitals in their first participation year under the Oklahoma EHR Incentive Payment program may choose to attest to adopting, implementing, or upgrading certified EHR technology. Proof of A/I/U must be submitted to OHCA in order to receive payment.

(f) **Meaningful Use.** Eligible professionals in their second through sixth participation year and eligible hospitals in

their second through third participation year must attest to meaningful use of certified EHR technology. Eligible hospitals must attest to meaningful use if they are participating in both the Medicare and Oklahoma EHR Incentive programs in their first participation year. The definition of "meaningful use" is outlined in, and determined by, the Electronic Health Records Program Final Rule CMS-0033-F.

(g) **Payment.** Eligible professionals may receive a maximum of $63,750 in incentive payments over six years. Providers must begin their participation by 2016 to be eligible for payments. Payments will be made one time per year per provider and will be available through 2021. Eligible hospitals cannot initiate payments after 2016 and payment years must be consecutive after 2016.

(1) Eligible professionals and eligible hospitals must use a Taxpayer Identification Number (TIN) to assign a valid entity as the incentive payments recipient. Valid entities may be the individual provider or a group with which the provider is associated. The assigned payee must have a current Provider Agreement with OHCA.

(2) The provider is responsible for repayment of any identified overpayment. In the event OHCA determines monies have been paid inappropriately, OHCA will recoup the funds by reducing any future payments owed to the provider.

(h) **Administrative Appeals.** Administrative appeals of decisions related to the Oklahoma Electronic Health Records Incentive Program will be handled under the procedures described in OAC 317:2-1-2(b).

CHAPTER 2. GRIEVANCE PROCEDURES AND PROCESS

317:2-1-2. Appeals

(a) **Member Process Overview.**

(1) The appeals process allows a member to appeal a decision which adversely affects their rights. Examples are decisions involving medical services, prior authorizations for medical services, or discrimination complaints.

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

(3) If the LD-1 form is not received within 20 days of the triggering event, OHCA sends the Appellant a letter stating the appeal will not be heard because it is untimely. In the case of tax warrant intercept appeals, if the LD-1 form is not received within 30 days of written notice sent by OHCA according to Title 68 O.S. ' 205.2, OHCA sends the Appellant a letter stating the appeal will not be heard because it is untimely.

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

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

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

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

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

(b) **Provider Process Overview.**

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

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

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

(B) If the LD form is not received within 20 days of the triggering event, OHCA sends the Appellant a

letter stating the appeal will not be heard because it is untimely.

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

(D) A decision will be rendered by the ALJ ordinarily within 45 days of the close of all evidence in the case.

(E) The Administrative Law Judge's decision is appealable to OHCA's CEO under OAC 317:2-1-13.

(c) **ALJ jurisdiction.** The administrative law judge has jurisdiction of the following matters:

(1) Member Appeals:

(A) Discrimination complaints regarding the SoonerCare program;

(B) Appeals which relate to the scope of services, covered services, complaints regarding service or care, enrollment, disenrollment, and reenrollment in the SoonerCare Program;

(C) Fee for Service appeals regarding the furnishing of services, including prior authorizations;

(D) Appeals which relate to the tax warrant intercept system through the Oklahoma Health Care Authority. Tax warrant intercept appeals will be heard directly by the ALJ. A decision will be rendered by the Administrative Law Judge within 20 days of the hearing before the ALJ;

(E) Complaints regarding the possible violation of the Health Insurance Portability and Accountability Act of 1996 (HIPAA);

(F) Proposed administrative sanction appeals pursuant to OAC 317:35-13-7. Proposed administrative sanction appeals will be heard directly by the ALJ. A decision by the ALJ will ordinarily be rendered within 20 days of the hearing before the ALJ. This is the final and only appeals process for proposed administrative sanctions; and

(2) Provider Appeals:

(A) Whether Pre-admission Screening and Resident Review (PASRR) was completed as required by law;

(B) Denial of request to disenroll member from provider's SoonerCare Choice panel;

(C) Appeals by Long Term Care facilities for nonpayment of wage enhancements, determinations of overpayment or underpayment of wage enhancements, and administrative penalty determinations as a result of

findings made under OAC 317:30-5-131.2(b)(5), (e)(8), and (e)(12);
(D) Petitions for Rulemaking;
(E) Appeals of insureds participating in Insure Oklahoma/ O-EPIC which are authorized by OAC 317:45-9-8(a);
(F) Appeals to the decision made by the Contracts manager related to reports of supplier non-compliance to the Central Purchasing Division, Oklahoma Department of Central Services and other appeal rights granted by contract;
(G) Drug rebate appeals;
(H) Nursing home contracts which are terminated, denied, or non-renewed;
(I) Proposed administrative sanction appeals pursuant to OAC 317:30-3-19. Proposed administrative sanction appeals will be heard directly by the ALJ. A decision will normally be rendered by the ALJ within 20 days of the hearing before the ALJ. This is the final and only appeals process for proposed administrative sanctions; and
(J) Contract award appeals.
(K) Oklahoma Electronic Health Records Incentive program appeals related only to incentive payments, incentive payment amounts, provider eligibility determinations, and demonstration of adopting, implementing, and upgrading, and meaningful use eligibility for incentives.