OKLAHOMA HEALTH CARE AUTHORITY
REGULARLY SCHEDULED BOARD MEETING
June 25, 2015 at 1:00 P.M.
Oklahoma Health Care Authority
Charles Ed McFall Boardroom
4345 N. Lincoln Blvd.
Oklahoma City, OK

A G E N D A

Items to be presented by Ed McFall, Chairman

1. Call to Order / Determination of Quorum

2. Action Item – Approval of the March 30, 2015 and May 14, 2015 OHCA Board Meeting Minutes

Item to be presented by Nico Gomez, Chief Executive Officer

3. Discussion Item – Chief Executive Officer's Report

   a) All-Star Introduction

   - March 2015 All-Star – Theo Hensley, Accountant, Finance (Carrie Evans)
   - April 2015 All-Star – Brenda Turner, Exceptional Needs Coordinator, Care Management (Garth Splinter)

   b) Financial Update – Carrie Evans, Chief Financial Officer

   c) Medicaid Director's Update – Garth Splinter, State Medicaid Director

Item to be presented by Nicole Nantois, Chief of Legal Services

4. Discussion Item – Public Comment on this meeting's agenda items by attendees who gave 24 hour prior written notice

Item to be presented by Nicole Nantois, Chief of Legal Services

5. Announcements of Conflicts of Interest Panel Recommendations for All Action Items Regarding This Board Meeting.

Item to be presented by Tywanda Cox, Chief of Federal and State Policy

6. a) Action Item – Consideration and Vote upon declaration of a Compelling Public Interest for the promulgation of **all Emergency Rules** in action item six of this agenda in accordance with 75 Okla. Stat. § 253.

   b) Action Item – Consideration and Vote of Agency Recommended Rulemaking Pursuant to Article I of the Administrative Procedures Act. The Agency Requests the Adoption of the Following Emergency Rules:

   The following emergency rules HAVE NOT previously been approved by the Board.

A. AMENDING Agency rules at OAC 317:30-5-41 and 317:30-5-47 to clarify the reimbursement methodology for DRG hospitals. Proposed policy revisions clarify that compensable inpatient services provided to SoonerCare eligible members admitted to acute care and critical access hospitals will be reimbursed the lesser of the billed charges **OR** the DRG amount. The effective date of this emergency rule will be July 1, 2015 or immediately upon governor's signature.
Budget Impact: The agency will observe a total savings of $11,181,897; state savings of $3,964,760.

(Reference APA WF # 15-03)

B. 1) AMENDING Agency rules at OAC 317:30-3-59, 317:30-5-2, and 317:30-5-42.17 to eliminate coverage for the removal of benign skin lesions for adults. The effective date of this emergency rule will be July 1, 2015 or immediately upon governor's signature. **Budget Impact: The agency estimates that the savings from eliminating coverage for the removal of benign skin lesions for adults will be $106,832 total dollars; state savings of $37,879.**

(Reference APA WF # 15-04)

2) AMENDING Agency rules at OAC 317:30-3-59, 317:30-5-2, and 317:30-5-42.17 to eliminate coverage for adult sleep studies. The effective date of this emergency rule will be July 1, 2015 or immediately upon governor's signature.
Budget Impact: The agency estimates that the savings from eliminating adult sleep studies will be $1,459,302 total dollars; state savings of $517,420.

(Reference APA WF # 15-04)

C. AMENDING Agency High Risk Obstetrical (HROB) program rules at OAC 317:30-5-22 and 317:30-5-22.1 to update provider qualifications to allow certain Board Eligible or Board Certified obstetrical providers to refer and render services for members eligible for the HROB program; revisions also include amendments to the number of units allowed for ultrasounds. The change will decrease the allowed units for ultrasounds from six to three. Additionally, ultrasounds to assist in the diagnosis of a high risk condition are revised to one from six. Further, revisions include decreasing the number of units from 12 for a singleton fetus for biophysical profiles/non-stress tests or any combination thereof to a total of five, with one test per week beginning at 34 weeks gestation and continuing to 38 weeks. These changes align with the current standards of care and reflect the current number of ultrasounds and biophysical profiles that are being utilized by SoonerCare pregnant women. The effective date of this emergency rule will be July 1, 2015 or immediately upon Governor's signature. The emergency rule will be superseded by the 2014 permanent rule (APA WF# 14-28) August 27, 2015.
Budget Impact: The proposed rule change is projected to save $292,433 total dollars; state savings of $103,687.

(Reference APA WF # 15-05)

D. AMENDING Agency rules regarding coverage for durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) at OAC 317:30-5-210.2 to restrict coverage for continuous positive airway pressure devices (CPAP) to children only. The effective date of this emergency rule will be July 1, 2015 or immediately upon governor's signature.
Budget Impact: The proposed rule change is projected to save $506,630 total dollars; state savings of $179,634.

(Reference APA WF # 15-06)

E. AMENDING Agency rules at OAC 317:30-5-20 and ADDING Agency rules at OAC 317:30-5-20.1 to establish policy for the appropriate administration of urine drug screening and testing to align with

recommended allowances based on clinical evidence and standards of care. Criteria include: purpose for urine testing, coverage requirements, non-covered testing, provider qualifications, and medical record documentation requirements necessary to support medical necessity. Additionally, revisions include clean-up to reimbursement language from general laboratory services policy. The effective date of this emergency rule will be July 1, 2015 or immediately upon governor's signature.
Budget Impact: The proposed rule change is projected to save $11,703,400 total dollars; state savings of $4,149,635.

(Reference APA WF # 15-08)

F. ADDING Agency rules at OAC 317:30-3-11, 317:30-3-11.1, 317:30-5-44, 317:30-5-744, 317:30-5-893, 317:30-5-973, 317:30-5-993, and 317:30-5-1045 to restrict the timely filing of claims for reimbursement from 12 months to six months. In addition, policy regarding resubmission is revised to update the deadline from 24 months to 12 months. Changes to the timely filing restrictions are in accordance with federal authority. Timely filing for crossover claims will remain one year. In addition, language corrections are included at 317:30-5-44 to reflect current practice. The effective date of this emergency rule will be July 1, 2015 or immediately upon governor's signature.
Budget Impact: The proposed rule change is projected to save $3,330,000 total dollars; state savings of $1,288,044.

(Reference APA WF # 15-09)

The following emergency rules HAVE previously been approved by the Board. These rules have been REVISED for emergency rulemaking.

G. AMENDING Agency High Risk Obstetrical (HROB) program rules at OAC 317:30-5-22 and 317:30-5-22.1 to update provider qualifications to allow certain Board Eligible or Board Certified obstetrical providers to refer and render services for members eligible for the HROB program; revisions also include amendments to the number of units allowed for ultrasounds. The change will decrease the allowed units for ultrasounds from six to three. Additionally, ultrasounds to assist in the diagnosis of a high risk condition are revised to one from six. Further, revisions include decreasing the number of units from 12 for a singleton fetus for biophysical profiles/non-stress tests or any combination thereof to a total of five, with one test per week beginning at 34 weeks gestation and continuing to 38 weeks. These changes align with the current standards of care and reflect the current number of ultrasounds and biophysical profiles that are being utilized by SoonerCare pregnant women. The effective date of this emergency rule will be August 27, 2015 or immediately upon governor's signature, whichever is later.
Budget Impact: This rule will not result in any additional costs or savings to the agency.

(Reference APA WF # 15-07)

Item to be presented by Carrie Evans, Chairperson of State Plan Amendment Rate Committee

7. Action Item – Consideration and Vote Upon the Recommendations of the State Plan Amendment Rate Committee.

   A. Consideration and Vote to reduce Diagnosis-Related Group Outlier payments by increasing the DRG threshold to $50,000. This change has an estimated total dollar savings of $18,881,600, of which $6,694,786 is state savings.

   B. Consideration and Vote to pay the lesser of billed charges or the Diagnosis-Related Group amount. This change has an estimated total dollar savings of $11,914,717, of which $4,224,561 is state savings.

C. Consideration and Vote to pay the lesser of the transfer fee or the Diagnosis-Related Group. This change has an estimated total dollar savings of $2,774,924, of which $983,896 is state savings.

D. Consideration and Vote to revise the methodology and reimbursement structure for physician/practitioner Resource Based Relative Value Scale reimbursement by assigning Relative Value Units based on Facility or Non-Facility Place of Service. This change has an estimated total dollar savings of $7,376,605, of which $2,615,498 is state savings.

E. Consideration and Vote to reduce the reimbursement for deductibles and co-insurance for nursing facility Medicare Crossover claims to 75 percent. This change has an estimated total dollar savings of $6,179,930, of which $2,191,197 is state savings.

F. Consideration and Vote to reduce the reimbursement rate for polycarbonate lens to $10.00 per unit, or $20 per pair of glasses. This change has an estimated total dollar savings of $4,150,150, of which $1,471,505 is state savings.

G. Consideration and Vote to increase the base rate to $156.19 for Acute (16 Beds or Less) Intermediate Care Facilities for Individuals with Intellectual Disabilities. This change will increase the annual budget by an estimated $61,297, comprised of $37,587 in federal matching funds and $28,710 in state matching funds coming from the increased Quality of Care Fee, which is paid by the facilities.

H. Consideration and Vote to increase the base rate component to $198.22 for the Acquired Immune Deficiency Syndrome rate for Nursing Facilities. This change will increase the annual budget by an estimated $1,769, comprised of $1,085 in federal matching funds and $684 in state matching funds coming from the increased Quality of Care Fee, which is paid by the facilities.

I. Consideration and Vote to increase the base rate component to $107.29 for Regular Nursing Facilities and decrease the pool amount for these facilities in the state plan for the “Other” and “Direct Care” components to $155,145,293. This change will increase the annual budget by an estimated $833,616, comprised of $511,173 in federal matching funds and $322,443 in state matching funds coming from the increased Quality of Care Fee, which is paid by the facilities.

J. Consideration and Vote to increase the base rate to $121.96 for Regular Intermediate Care Facilities for Individuals with Intellectual Disabilities. This change will increase the annual budget by an estimated $28,291, comprised of $17,348 in federal matching funds and $10,943 in state matching funds coming from the increased Quality of Care Fee, which is paid by the facilities.

K. Consideration and Vote to approve the method change and rate of $65.25 per day for Agency Companion (Contractor) Intermittent and Respite Service. The estimated total annualized savings is $4,654, of which $1,754 is state savings.

Item to be presented by Vickie Kersey, Director, Fiscal Planning and Procurement

8. a) Action Item – Consideration and Vote of the State Fiscal Year 2016 Budget Work Program

Item to be presented by Vickie Kersey, Director, Fiscal Planning and Procurement

9. a) Action Item – Consideration and Vote of Authority for Expenditure of Funds for Incontinence Supplies

b) Action Item – Consideration and Vote of Authority for Expenditure of Funds for Voxiva Health Services

Item to be presented by Nancy Nesser, Pharmacy Director

10. Action Item - Consideration and Vote Regarding Recommendations Made by the Drug Utilization Review Board Under 63 Okla. Stat. ¶5030.3.

    a) Consideration and vote to add **Ruconest® (C1 Esterase Inhibitor), Hemangeol™ (Propranolol Oral Solution), and Sotylize™ (Sotalol Oral Solution)** to the utilization and scope prior authorization program under OAC 317:30-5-77.2(e).

Item to be presented by Ed McFall, Chairman

11. New Business

12. ADJOURNMENT

NEXT BOARD MEETING
August 12, 2015
STRATEGIC PLANNING CONFERENCE
August 12, 13 & 14, 2015
Location - TBD

MINUTES OF A REGULARLY SCHEDULED BOARD MEETING
OF THE HEALTH CARE AUTHORITY BOARD
March 30, 2015
Held at the Oklahoma Health Care Authority
Oklahoma City, Oklahoma

Manner and Time of Notice of Meeting: A statutorily required public meeting notice was placed on the front door of the Oklahoma Health Care Authority on March 27, 2015 at 12:30 p.m. Advance public meeting notice was provided to the Oklahoma Secretary of State. In addition to the posting of the statutory public notice, the agency placed its agenda on its website on March 27, 2015 at 9:30 a.m.

Pursuant to a roll call of the members, a quorum was declared to be present, and Vice-Chairman Armstrong called the meeting to order at 1:00 p.m.

BOARD MEMBERS PRESENT: Vice-Chairman Armstrong, Member Bryant, Member Robison, Member Case

BOARD MEMBERS ABSENT: Chairman McFall, Member McVay, Member Nuttle

OTHERS PRESENT:
David Dude, American Cancer Society
Traylor Rains, ODMHSAS
Jaclyn Cosgrove, The Oklahoman
Melissa Gower, Chickasaw Nation
Ray Hester, OKDHS/DDS
Reginald Mason, OHCA
Doug, Fellrath, Choices for Life Foster Care
Becky Ikard, OHCA
Sherris Harris Ososanya, OHCA

OTHERS PRESENT:
Rebecca Williamson, Oklahoma Ambulance Association
Debbie Spaeth, Quest MHSA, LLC
Marty Wafford, Chickasaw Nation
Becky Moore, OAHCP
Mike Fogarty
Brent Wilborn, OKPCA
Garth Splinter, OHCA
Terry Cothran, COP
Tewanna Edwards, OHCA

DISCUSSION AND POSSIBLE VOTE ON APPROVAL OF BOARD MINUTES OF THE REGULARY SCHEDULED BOARD MEETING HELD FEBRUARY 12, 2015.

The Board routinely reviews and approves a synopsis of all its meetings. The full-length recordings of the meetings of the Board are retained at the Board Offices and may be reviewed upon written request.

MOTION: Member Case moved for approval of the February 12, 2015 board meeting minutes as published. The motion was seconded by Member Bryant.

FOR THE MOTION: Vice-Chairman Armstrong, Member Robison

ABSENT: Chairman McFall, Member McVay, Member Nuttle

ITEM 3a / ALL STARS INTRODUCTION
Nico Gomez, Chief Executive Officer

The OHCA All-Star for January 2015 was recognized.

- Sirian DeLeon, Member Services Coordinator (Kevin Rupe presented)

ITEM 3b / FINANCIAL UPDATE
Carrie Evans, Chief Financial Officer

Ms. Evans reported on the financial transactions through the month of January and noted that we are under budget with a $11.5 million positive state variance and the agency is under budget in program spending and in administration spending. She stated that the agency is running over budget in the revenue categories. Ms. Evans predicted that OHCA will have a positive variance for March. For more detailed information, see Item 3b in the board packet.

ITEM 3c / MEDICAID DIRECTOR'S UPDATE
Garth Splinter, State Medicaid Director

Dr. Splinter provided an update for January that included a report on the number of enrollees in the Medicaid program. He also reported on dual enrollees, long term care members and SoonerCare contracted provider information. He briefly discussed the Oklahoma Electronic Prescribing Controlled Substance (EPCS) provider and pharmacy status through February 2015. For more detailed information, see Item 3c in the board packet.

ITEM 3d / LEGISLATIVE UPDATE
Carter Kimble, Director of Governmental Relations

Mr. Kimble reported that OHCA is currently tracking 53 bills, of which we have one OHCA request bill remaining, 20 direct impact bills, 6 agency interest, 7 miscellaneous and 19 employee interest bills. He discussed senate bill 704 which allows OHCA to recover funds put in a trust for, but not spent on, burial/funeral expenses. Recovery amount not to exceed cost of services provided. This passed unanimously out of the full Senate and received Do Pass 8-0 in (H) A&B, Health subcommittee on March 23, 2015. For more detailed information, see Item 3d in the board packet.

ITEM 3e / RECOGNITION OF CINDY ROBERTS
Nico Gomez, Vice-Chairman Armstrong, Member Bryant, Member Robison and Member Case

Nico Gomez presented Cindy Roberts, retired Deputy Chief Executive Officer of OHCA. He gave a brief background history for Mrs. Roberts and the board thanked her for her service. Mr. Gomez and the board members presented Mrs. Roberts with an Oklahoma flag that was previously flown at the Capitol along with a framed description of the flag, a plaque honoring her state service, as well as a citation from State Senator Brian Bingman.

ITEM 4 / ANNOUNCEMENTS OF CONFLICTS OF INTEREST PANEL RECOMMENDATIONS FOR ALL ACTIONITEMS
Nicole Nantois, Chief of Legal Services

There were no recommendations regarding conflicts.

ITEM 5a / CONSIDERATION AND VOTE FOR THE OHCA/ODMHSAS HEALTH HOME DISEASE REGISTRY REQUEST FOR PROPOSAL
Vickie Kersey, Director of Fiscal Planning and Procurement

MOTION:	Member Case moved for Item 5a as published. The motion was seconded by Member Robison.
FOR THE MOTION:	Vice-Chairman Armstrong, Member Bryant
ABSENT:	Chairman McFall, Member McVay, Member Nuttle

ITEM 5b / CONSIDERATION AND VOTE FOR THE INSURE OKLAHOMA MULTIMEDIA MARKETING REQUEST FOR PROPOSAL
Vickie Kersey, Director of Fiscal Planning and Procurement

MOTION:	Member Case moved for Item 5b as published. The motion was seconded by Member Bryant.
FOR THE MOTION:	Vice-Chairman Armstrong, Member Robison
ABSENT:	Chairman McFall, Member McVay, Member Nuttle

ITEM 6 / CONSIDERATION AND VOTE OF AGENCY RECOMMENDED RULEMAKING PURSUANT TO ARTICLE I OF THE ADMINISTRATIVE PROCEDURES ACT. THE AGENCY REQUESTS THE ADOPTION OF THE FOLLOWING PERMANENT RULES
Tywanda Cox, Chief of Federal and State Policy

A. AMENDING Agency rules at OAC 317:30-5-355.1, 317:30-5-356, 317:30-5-357, 317:30-5-361, 317:30-5-664.3, and 317:30-5-664.12 and REVOKING Agency rules at OAC 317:30-5-664.4 to limit encounters within Federally Qualified

Health Centers (FQHC) and Rural Health Clinics (RHC) to one encounter per member per day as well as limit encounters to a total of four visits per member per month for adults.
Budget Impact: Savings approved during promulgation of the emergency rule, the rule change will not result in any additional costs and/or savings to the agency.

(Reference APA WF # 14-02)

B. AMENDING Agency rules at OAC 317:30-5-56 to reduce/deny payment for preventable readmissions that occur within 30 days from discharge. The current policy reviews readmissions occurring within 15 days of prior acute care admissions or a related condition to determine medical necessity and appropriateness of care. If it is determined either or both admissions may be inappropriate, payment for either or both admissions may be denied.
Budget Impact: Savings approved during promulgation of the emergency rule, the rule change will not result in any additional costs and/or savings to the agency.

(Reference APA WF # 14-04)

C. AMENDING Agency cost-sharing rules at OAC 317:30-3-5 to permit an increase of copays to the federal maximum. Additionally, policy is amended to add diabetic supplies and smoking cessation counseling and products to the service copayment exemption list in order to ensure member have access to necessary services that improve member health outcomes.
Budget Impact: Savings approved during promulgation of the emergency rule, the rule change will not result in any additional costs and/or savings to the agency.

(Reference APA WF # 14-05)

D. AMENDING Agency oxygen and oxygen equipment rules at OAC 317:30-5-211.11 and 317:30-5-211.12 to require a prior authorization after the initial three months. In addition, rules are revised to clarify arterial blood gas analysis (ABG) and pulse oximetry testing and Certificate of Medical Necessity requirements. Rules for rental oxygen are amended to clarify that reimbursement for rented oxygen concentrators includes both stationary and portable oxygen systems.
Budget Impact: Savings approved during promulgation of the emergency rule, the rule change will not result in any additional costs and/or savings to the agency.

(Reference APA WF # 14-07)

E. AMENDING Agency rules at OAC 317:50-1-14 and 317:35-17-14 to ensure all 1915(c) waiver programs comply with federal regulation regarding conflict of interest provisions for case management services. The regulation states providers of HCBS for the individual, or those who have an interest in or are employed by a provider of HCBS for the individual, must not provide case management or develop the person centered service plan.
Budget Impact: Savings approved during promulgation of the emergency rule, the proposed rule change is budget neutral.

(Reference APA WF # 14-14.a & b)

F. ADDING Agency rules at OAC 317:30-5-250, 317:30-5-251, 317:30-5-252, 317:30-5-253, and 317:30-5-254 to create coverage guidelines for Health Homes. Health Homes are created to promote enhanced integration and coordination of primary, acute, behavioral health, and long-term services and supports for persons across the lifespan with chronic illness. The purpose of the Health Home is to improve the health status of SoonerCare members with Serious Mental Illness or Serious Emotional Disturbance by promoting wellness and prevention and to improve access and continuity in healthcare for these members by supporting coordination and integration of primary care services in specialty behavioral healthcare settings. Additionally, rules are added to create a distinction between LBHPs and Licensure Candidates.
Budget Impact: Savings approved during promulgation of the emergency rule, the rule change will not result in any additional costs and/or savings to the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS).

(Reference APA WF # 14-16)

G. AMENDING Agency eligibility determinations for Aged, Blind, and Disabled (ABD) individuals applying for Medicaid services rules at OAC 317:35-5-41.2, 317:35-5-41.3, and 317:35-5-42 in order to come into compliance with federal

regulations. Policy changes include adding new language regarding the Asset Verification System to check the income or resources of ABD applicants held at financial institutions, updating how resources are counted towards the maximum resource limit, exempting the value of one automobile regardless of its value from the maximum resource limit, expanding the income disregards list, and disregarding $20 of unearned income. Rules regarding income received from capital resources and rental property are amended to deduct the severance tax from the gross income for ABD applicants. Rules regarding infrequent or irregular income are amended to better match the Social Security Administration rules for determining Supplemental Security Income.
Budget Impact: Budget impact approved during promulgation of the emergency rule, the rule change will not result in any additional costs and/or savings to the agency.

(Reference APA WF # 14-17)

H. AMENDING Agency Developmental Disabilities Services (DDS) rules at OAC 317:40-1-1 to implement policy changes recommended during the Oklahoma Department of Human Services (DHS) Developmental Disabilities Services (DDS) annual policy review process. The recommended policy revisions will position DDS to utilize best practice in the administration of the statewide Request for Waiver Services list.
Budget Impact: Budget neutrality determined and approved during promulgation of the emergency rule, the rule change will not result in any additional costs and/or savings to the agency.

(Reference APA WF # 14-34)

The following permanent rules HAVE previously been approved by the Board and the Governor under Emergency rulemaking. These rules have been REVISED for Permanent Rulemaking.

I. AMENDING Agency rules at OAC 317:30-5-241.2 and 317:30-5-241.3 to add eligibility criteria required in order to receive psychosocial rehabilitation (PSR) services. Adult PSR services will be limited to members with a history of psychiatric hospitalization or admissions to crisis centers; have been determined disabled by the Social Security Administration for mental health reasons; or who are residing in residential care facilities. Children's PSR services will be limited to members with a history of psychiatric hospitalization or admissions to crisis centers; have been determined disabled by the Social Security Administration for mental health reasons; or have a current Individual Education Plan (IEP) for emotional disturbance. The aforementioned changes were approved during promulgation of the emergency rule. The following are proposed changes not previously reviewed: revisions to outpatient behavioral health rules are also made to clarify that daily or weekly summary notes and related requirements are for rehab day programs only and that all other rehab should follow general progress note requirements, to create a distinction in terminology between Licensed Behavioral Health Professionals (LBHPs) who are fully licensed by their respective licensing board and those individuals who are under supervision for licensure from an approved licensing board (Licensure Candidates). Additionally, rules are amended to clarify that group psychotherapy is not reimbursable for children younger than three years of age. The aforementioned clarification was an oversight in last year's rule promulgation cycle. Revisions also include minor clean-up.
Budget Impact: Budget neutral

(Reference APA WF # 14-13)

J. AMENDING Agency rules at OAC 317:30-5-241, 317:30-5-276, and 317:30-5-281 to limit the number of hours that outpatient behavioral health rendering providers can be reimbursed to 35 hours per week. The aforementioned change was approved during promulgation of the emergency rule. The following are proposed changes not previously reviewed: rules are revised to correct scrivener's errors made during the 2014 permanent rulemaking session. The 2014 permanent rules clarified that individual and group psychotherapy services as well as testing cannot be provided to children ages 0-3.
Budget Impact: Budget neutral

(Reference APA WF # 14-15)

K. AMENDING Agency rules at OAC 317:40-5-3, 317:40-5-5, 317:40-5-6 317:40-5-11, 317:40-5-13, and 317:40-5-40 and REVOKING Agency rules at OAC 317:40-5-4, 317:40-5-9, and 317:40-5-10 to implement policy changes recommended during the annual Developmental Disabilities Services (DDS) policy review process. The policy changes recommended will assist DDS in becoming compliant with the new regulations of the Fair Labor Standards Act (FLSA) for "domestic service" employees, who provide "companionship services" to members. The Department of Labor has issued a new final ruling that precludes third party employers from claiming the companion exemption.
Budget Impact: Budget neutral

(Reference APA WF # 14-23)

The following permanent rules HAVE NOT previously been approved by the Board.

L. AMENDING Agency State Plan Personal Care rules at OAC 317:35-15-1, 317:35-15-2, 317:35-15-3, 317:35-15-4, 317:35-15-7, 317:35-15-8, 317:35-15-8.1, 317:35-15-9, 317:35-15-10, 317:35-15-13.1, 317:35-15-13.2, 317:35-15-14, and 317:35-15-15 to align with current procedures that are in place at OKDHS. Changes include policy clean up to remove unnecessary language regarding personal care service settings and criteria for persons eligible to serve as Personal Care Assistants. Rules also clarify the service eligibility criteria to match the terms and standards of the Uniform Comprehensive Assessment Tool (UCAT), and minor changes to language regarding the administration of State Plan Personal Care services are made to match current processes and protocol currently in place at OKDHS.
Budget Impact: Budget neutral

(Reference APA WF # 14-18)

M. AMENDING Agency rules at OAC 317:30-3-39 and 317:30-3-41 and REVOKING Agency rules at OAC 317:50-3-1 through 317:50-3-16 and 317:50-5-1 through 317:50-5-16 to transition the operational functions of two of OHCA's internal 1915c Waiver services and responsibilities as the waiver are set to expire. The two (2) internal waivers include: (a) My Life My Choice and (b) Sooner Seniors. Members will be served in the ADvantage waiver in the future.
Budget Impact: Budget neutral

(Reference APA WF # 14-19.a & b)

N. ADDING Agency rules at OAC 317:35-6-38 to implement Hospital Presumptive Eligibility (HPE) per federal regulation. HPE allows participating hospitals to make presumptive eligibility (PE) determinations, on behalf of the agency, for applicants who are deemed eligible for Medicaid services based on preliminary information provided by the applicant. Hospitals may then provide services under HPE and bill OHCA. Hospitals are guaranteed payment for HPE services, regardless of whether or not the applicant is later found eligible for SoonerCare. The rules will delineate the parameters of the HPE program, eligibility guidelines, and hospital participation rules.
Budget Impact: Federal Mandate: The proposed rule change to implement the Hospital Presumptive Eligibility program has an estimated budget impact of $5,607,000; this cost has a federal share of $3,493,161 and a state share of $2,113,839.

(Reference APA WF # 14-20)

O. AMENDING Agency rules at OAC 317:30-5-211.1, 317:30-5-211.3, 317:30-5-211.4, 317:30-5-211.5, 317:30-5-211.9, 317:30-5-211.10, 317:30-5-211.17, 317:30-5-217, and 317:30-5-218 to clarify rules for durable medical equipment (DME) services. Changes include: updating billing and PA requirements for DME items, updating the list of DME items that require a certificate of medical necessity, clarifying that repairs for rental DME items are not covered, and revising the definition of invoice.
Budget Impact: Nominal impact, potentially budget neutral

(Reference APA WF # 14-22)

P. AMENDING Agency dental rules at OAC 317:30-5-696, 317:30-5-698, 317:30-5-699, 317:30-5-700, and 317:30-5-700.1 to align practice with the Code on Dental Procedures and Nomenclature (CDT) and to ensure the delivery of dental services meets the standard of care. Proposed revisions include guidelines for x-rays, comprehensive and periodic oral evaluations, and dental sealants.

Revisions also include clean-up to remove language regarding composite and amalgam restorations as it is referenced in a different section. Proposed revisions outline guidelines for stainless steel crowns to clarify that placement is allowed once for a minimum period of 24 months as well as other clean-up for clarity.

In addition, policy is revised to ensure root canal therapy is performed only when medically necessary. Proposed revisions clarify utilization parameters for restorations, observation time prior to making a referral for an orthodontic consultation, and the start of the treatment year for orthodontic services.

Policy is revised to clarify the treatment year for orthodontic services begin on the date of the placement of the bands. Orthodontic policy is also revised to increase observation time prior to allowing a child to be referred for a consultation.
Budget Impact: Savings were approved during promulgation of the emergency rule, the additional proposed changes will result in an additional nominal savings to the agency.

(Reference APA WF # 14-25)

Q. AMENDING Agency rules at OAC 317:30-5-14 and ADDING Agency rules at OAC 317:30-5-14.1 to establish policy for the appropriate administration of allergy testing and immunotherapy services. Criteria include: definition of allergy testing and immunotherapy, coverage requirements, non-covered services, reimbursement conditions, appropriate delivery sites, provider qualifications, and documentation requirements for home administration of immunotherapy. Additionally, revisions include clean-up to remove allergy reimbursement language from injection policy as it is referenced in the new section.
Budget Impact: Budget savings of $5,180,000; total state savings are projected as $3,200,000.

(Reference APA WF # 14-28)

R. AMENDING Agency rules at OAC 317:35-1-2, 317:35-5-4, and 317:35-5-4.1, 317:35-7-61.1 and 317:35-9-48.1 and ADDING Agency rules at OAC 317:35-5-4.2 and 317:35-5-4.3 to change the TEFRA program eligibility rules to match federal guidelines for level of care (LOC). Changes include replacing all TEFRA language regarding mental retardation or ICF/MR to individuals with intellectual disabilities or ICF/IID. Rules regarding ICF/IID LOC eligibility will change to match current DSM-5 and SSA guidelines regarding intellectual disabilities. Specific LOC criteria for determining both hospital and nursing facility will be added to coincide with the ICF/IID criteria. TEFRA rules will also allow one additional psychological evaluation after the age of six, as medically needed. Finally, the "Definitions" section is updated to include the term "Ineligible Spouse".
Budget Impact: Nominal impact, potentially budget neutral

(Reference APA WF # 14-33)

S. AMENDING Agency long-term care eligibility rules at OAC 317:35-5-41.8 to align with federal policy. Proposed revisions include increasing home equity maximum amount to $500,000 plus the increase by the annual percentage increase in the urban component of the consumer price index and allowing the individual to decrease this equity interest through the use of a reverse mortgage or home equity loan. The term "relative" is removed from the home exemption rules for members who fail to return back home from a long-term care institution. The term "annuity" is changed to also include annuities purchased by, or on behalf of, an annuitant seeking long-term care services.
Budget Impact: Budget neutral

(Reference APA WF # 14-36)

T. AMENDING Agency inpatient psychiatric hospital rules at OAC 317:30-5-95.4, 317:30-5-95.14, and 317:30-5-95.33 to clarify that the member's signature on the Individual Plan of Care is required at the time of completion. However, if the member was too physically ill or their acuity level precluded them from signing the plan of care and/or the plan of care review at the time of completion, the member must sign the plan when their condition improves but before discharge. Rules are also revised to indicate that the individual plan of care must adhere to the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM).
Budget Impact: Budget neutral

(Reference APA WF # 14-38)

U. AMENDING Agency rules at OAC 317:30-5-742.2 to indicate a 1.5 hours daily limit on services billed by the Treatment Parent Specialist (TPS) within the Therapeutic Foster Care (TFC) setting. This change in policy aligns with limitations delineated within the State Plan for this particular provider and setting. Additionally, rules are revised to make a distinction between LBHPs and Licensure Candidates.
Budget Impact: Budget neutral

(Reference APA WF # 14-39)

V. AMENDING Agency rules at OAC 317:30-5-95.6, 317:30-5-95.16, 317:30-5-95.37, and 317:30-5-95.42 to reflect that the History and Physical (H&P) should be completed within 24 hours after admission into an inpatient psychiatric

hospital. Rules are also amended to clarify that the psychiatric evaluation is performed by a psychiatrist. Further, rules are amended to clarify that the psychiatric evaluation is completed within 60 hours of admission. Rules are amended to clarify recoupment methodology when documentation is not in the member's file. Additionally, rules are amended to reflect a distinction between LBHPs and Licensure Candidates.
Budget Impact: Budget neutral

(Reference APA WF # 14-42)

W. ADDING Agency rules at OAC 317:35-6-62.1 to allow electronic notices to be sent to SoonerCare members' designated email addresses. Members may actively select that they wish to receive electronic communications from the agency through the SoonerCare application. The agency will confirm that the member is informed of their right to change this election at any time, ensure that members receive mailed notice of this election, and that all notices are posted on the SoonerCare application for member viewing within one business day. In instances of failed electronic communications, the agency will notify the member, through the mail, of this failed correspondence and that action is necessary.
Budget Impact: Budget neutral

(Reference APA WF # 14-44)

X. AMENDING Agency inpatient psychiatric hospital rules at OAC 317:30-5-95.24 to indicate that non-specialty Psychiatric Residential Treatment Facilities (PRTF) should have a staff to member ratio of 1:6 during routine awake hours and 1:8 during sleeping hours. Additionally, changes are made to clarify that staffing ratios should always be present for each individual unit not by facility or program. Other minor grammatical changes were made to the rule.
Budget Impact: Budget neutral

(Reference APA WF # 14-45)

Y. AMENDING Agency rules at OAC 317:30-5-412, 317:30-5-422, 317:30-5-482, 317:40-5-100, 317:40-5-103, 317:40-5-152 and 317:40-7-15 and ADDING Agency rules at OAC 317:40-1-3 to implement policy changes recommended during the Oklahoma Department of Human Services (OKDHS) Developmental Disabilities Services (DDS) annual policy review process.
Budget Impact: OKDHS Budget: The rule change has total projected budget cost of $111,430. The federal share is $71,315.20 and the state share is $40,114.80.

(Reference APA WF # 14-46.a & b)

Z. AMENDING Agency rules at OAC 317:30-5-95.34 to indicate that when the History and Physical (H&P) or a combined H&P and psychiatric evaluation are completed by an allopathic or osteopathic physician with a current license and a board certification/eligible in psychiatry, the assessment(s) may count as the first visit by the physician in active treatment. Additionally, rules are revised to include a distinction between LBHPs and Licensure Candidates.
Budget Impact: Budget neutral

(Reference APA WF # 14-47)

AA. AMENDING Agency behavioral health case management rules at OAC 317:30-5-595 and 317:30-5-596 to add the State Plan authorized billing limits of 25 units per month for regular TCM and 54 units for intensive TCM. Rules are also amended to create a distinction between LBHPs and licensure candidates. Additionally, rules are revised to include CM II certification requirements; this change in rules is to correct scrivener's errors made during the 2014 permanent rulemaking session.
Budget Impact: Budget neutral

(Reference APA WF # 14-48)

BB. AMENDING Agency rules at OAC 317:35-5-25, 317:45-1-3, 317:45-9-1, 317:45-11-20, and 317:45-11-21 to change the methodology for determining Insure Oklahoma (IO) eligibility, for both IP and ESI, to the Modified Gross Adjustment Income (MAGI) methodology. The MAGI methodology will supersede previous IO eligibility criteria. The new rules will reference the MAGI methodology rules already established at OAC 317:35-6-39 through 317:35-6-54. Additional changes include amending the requirement that members notify the agency of changes in household circumstances from within 30 calendar days to 10 days. Rules will be added to indicate changes in the member's household circumstances may require an eligibility redetermination for IO. References to IO's various FPLs will be

removed; IO's income standards will now be published online using standard IO Income forms. Additionally, the reasonable opportunity for SoonerCare members to obtain citizenship or alienage documentation is changed from 60 days to 90 days.
Budget Impact: Budget neutral for program costs. $10,000,000 for system changes; the federal share is $9,000,000; state share is $1,000,000 and is provided by non-appropriated tobacco tax dollars.

(Reference APA WF # 14-49.a & b)

CC. AMENDING Agency telemedicine rules at OAC 317:30-3-27 to clarify the definition for telemedicine, and to remove the definitions sections for consistency. Proposed changes also remove coverage guidelines to expand the scope of the telemedicine delivery method. Revisions remove requirements for a presenter at the originating site to align with the Oklahoma Medical Licensure rules, and guidelines regarding the required use of OHCA-approved telemedicine networks. Proposed revisions also eliminate the originating site fee payment. Additional clean-up ensures no restrictions on services rendered using the telemedicine delivery model.
Budget Impact: The anticipated savings tied to the removal of the originating site fee payment will result in approximately $650,000 total dollars; $245,050 state dollars. Nominal impact, potentially budget neutral due to anticipated savings.

(Reference APA WF # 14-50)

DD. AMENDING Agency SoonerRide rules at OAC 317:30-3-64, 317:30-5-327, 317:30-5-327.1, 317:30-5-327.3, and 317:35-3-2 to remove coverage for transport to state Veterans Affair hospitals as these facilities are not contracted with the Oklahoma Health Care Authority. Rules also clarify coverage guidelines for escorts, and rules remove mention of the My Life, My Choice and Sooner Senior groups as the waivers are set to expire. Additional cleanup is made to the rule to align policy with current practice.
Budget Impact: Budget neutral

(Reference APA WF # 14-52.a & b)

EE. AMENDING Agency outpatient behavioral health rules at OAC 317:30-5-241.1 to add service coverage for mental health/substance use disorder screening for SoonerCare adult and child members within an outpatient behavioral health agency setting. Additionally, rules are revised to create a distinction between LBHPs and Licensure Candidates.
Budget Impact: ODMHSAS Budget: 120,000 clients were provided mental health services through SoonerCare in SFY2015. Assuming 10% uptake in utilization of the new screening code in SFY2016, estimated budget impact would be $303,840 total dollars; $114,547 state share, $189,290 federal share.

(Reference APA WF # 14-53)

FF. AMENDING Agency outpatient behavioral health rules at OAC 317:30-5-95.9, 317:30-5-95.19, 317:30-5-95.36, 317:30-5-95.39, 317:30-5-95.41, 317:30-5-240.2, 317:30-5-240.3, 317:30-5-241.4, 317:30-5-241.5, 317:30-5-740.1, and 317:30-5-741 to create distinction between licensed behavioral health professionals and licensure candidates. Additionally, other minor grammatical errors were corrected and outdated references were removed.
Budget Impact: Budget neutral

(Reference APA WF # 14-55)

GG. AMENDING Agency high risk obstetrical (HROB) services rules at OAC 317:30-5-22 and 317:30-5-22.1 to increase access in rural areas. Currently high risk obstetrical services are allowed only after an evaluation with Maternal Fetal Medicine (MFM) doctor and the member is deemed high risk; enhanced services are allowed only after a prior authorization request and treatment plan are initiated and submitted by the MFM. The initial intent of the HROB program was to promote the establishment of a relationship between the MFMs in urban areas with mothers located in rural communities. However, it appears that pregnant women in rural communities rarely travel to the urban areas to receive services. Allowing the general OB to request the HROB services/package for pregnant women will ensure pregnant women with high risk conditions receive HROB services.
Budget Impact: This change has an impact of $258,000 total dollars, state dollars $99,801.

(Reference APA WF # 14-58)

HH. AMENDING Agency rules at OAC 317:30-5-660.1 to allow Federally Qualified Health Centers (FQHC) to be reimbursed at the PPS rate immediately upon receiving their Health Resources and Services Administration (HRSA) grant award letter. Currently, OHCA requires the facility to submit the award letter and their Medicare certification number. In the interim, facilities contract as a clinic and are paid the fee for service (FFS) rate.
Budget Impact: Budget neutral

(Reference APA WF # 14-60)

MOTION: Member Robison moved for the approval of Item 6A-HH as published. The motion was seconded by Member Bryant.

FOR THE MOTION: Vice-Chairman Armstrong, Member Case

ABSENT: Chairman McFall, Member McVay, Member Nuttle

ITEM 7 / CONSIDERATION AND VOTE REGARDING RECOMMENDATIONS MADE BY THE DRUG UTILIZATION REVIEW BOARD UNDER 63 OKLAHOMA STATUTES 5030.3.
Nancy Nesser, Pharmacy Director

a) Consideration and vote to add **Viekira Pak™ (Ombitasvir/Paritaprevir/ Ritonavir/Dasabuvir), Northera™ (Droxidopa), Akynzeo® (Netupitant/ Palonosetron), Lemtrada™ (Alemtuzumab), Plegridy™ (Peginterferon β-1a), Brisdelle® (Paroxetine Mesylate), Orenitram™ (Treprostinil) Revatio® (Sildenafil Oral Suspension), and Myalept™ (Metreleptin)** to the utilization and scope prior authorization program under OAC 317:30-5-77.2(e).

MOTION: Member Case moved for approval of Item 7a as published. The motion was seconded by Member Bryant.

FOR THE MOTION: Vice-Chairman Armstrong, Member Robison

ABSENT: Chairman McFall, Member McVay, Member Nuttle

ITEM 8 / PROPOSED EXECUTIVE SESSION AS RECOMMENDED BY THE CHIEF OF LEGAL SERVICES AND AUTHORIZED BY THE OPEN MEETINGS ACT, 25 OKLAHOMA STATUTES §307(B) (1), (4), (7) AND (9).
Nicole Nantois, Chief of Legal Services

Vice-Chairman Armstrong entertained a motion to go into Executive Session at this time.

MOTION: Member Case moved for approval to go into Executive Session. The motion was seconded by Member Robison.

FOR THE MOTION: Vice-Chairman Armstrong, Member Bryant

ABSENT: Chairman McFall, Member McVay, Member Nuttle

8. Discussion Item – Proposed Executive Session as Recommended by the Chief of Legal Services and Authorized by the Open Meetings Act, 25 Oklahoma Statutes § 307(B) (1), (4), (7) and (9).

a) Discussion of Pending Litigation, Investigations and Claims
Daniels v. OHCA
Choices v. OHCA

ITEM 9 / NEW BUSINESS

There was no new business.

ITEM 10 / ADJOURNMENT

MOTION:	Member Robison moved for approval for adjournment. The motion was seconded by Member Case.
FOR THE MOTION:	Vice-Chairman Armstrong, Member Bryant
ABSENT:	Chairman McFall, Member McVay, Member Nuttle

Meeting adjourned at 2:36 p.m., 3/30/2015

NEXT BOARD MEETING
May 14, 2015
Oklahoma Health Care Authority
Charles Ed McFall Boardroom
4345 N. Lincoln Blvd.
OKC, OK

Lindsey Bateman
Board Secretary

Minutes Approved: _____

*Initials:*_____

MINUTES OF A REGULARLY SCHEDULED BOARD MEETING
OF THE HEALTH CARE AUTHORITY BOARD
May 14, 2015
Held at the Oklahoma Health Care Authority
Oklahoma City, Oklahoma

Manner and Time of Notice of Meeting: A statutorily required public meeting notice was placed on the front door of the Oklahoma Health Care Authority on May 13, 2015 at 11:30 a.m. Advance public meeting notice was provided to the Oklahoma Secretary of State. In addition to the posting of the statutory public notice, the agency placed its agenda on its website on May 9, 2015 at 5:30 p.m.

Pursuant to a roll call of the members, a quorum was declared to be present, and Vice-Chairman Armstrong called the meeting to order at 1:02 p.m.

BOARD MEMBERS PRESENT: Chairman McFall, Vice-Chairman Armstrong, Member Nuttle, Member McVay

BOARD MEMBERS ABSENT: Member Bryant, Member Robison, Member Case

OTHERS PRESENT:
Tyler Talley, eCapitol
David Dude, American Cancer Society
Lisa Macias, OU Nursing Care Mgmt
Tony Russell, OHCA
Becky Ikard, OHCA
Rebecca Moore, OAHCP
Mary Brinkley, LeadingAge OK
Glenda Blanton, OHCA
Will Widman, HP
Nichole Burland, OHCA
Sherris H Ososanya, OHCA

OTHERS PRESENT:
Teri Round, OU College of Nursing Care Mgmt.
JT Petherick, BCBSOK
Melissa Pratt, OHCA
Kimrey McGinnis, OHCA
Lisa Moses, OHCA
Lisa Spain, HP
Alan Danielson, College of Pharmacy
Nicole Warren, OHCA
Jennifer King, OHCA
Shelly Patterson, OHCA

DISCUSSION AND POSSIBLE VOTE ON APPROVAL OF BOARD MINUTES OF THE REGULARY SCHEDULED BOARD MEETING HELD MARCH 26, 2015.

The Board routinely reviews and approves a synopsis of all its meetings. The full-length recordings of the meetings of the Board are retained at the Board Offices and may be reviewed upon written request.

Chairman McFall stated that the March 26, 2015 board meeting minutes will be currently tabled and presented at the June 25, 2015 board meeting for possible vote on approval.

ITEM 3a / ALL STARS INTRODUCTION
Nico Gomez, Chief Executive Officer

The following OHCA All-Stars were recognized:

- 2014 Supervisor of the 4th Quarter – Shelly Patterson, Director of Health Promotions and Community Relations (Ed Long presented)
- February – Melissa Boyle, Claims Resolution Supervisor (Carrie Evans presented)

ITEM 3b / FINANCIAL UPDATE
Carrie Evans, Chief Financial Officer

Ms. Evans reported on the financial transactions through the month of March and noted that we are under budget with a $14.6 million positive state variance and the agency is under budget in program spending and $4.4 million in administration spending. She stated that the agency is running over budget in the revenue categories. Ms. Evans predicted that OHCA will be slightly under budget for April and May. For more detailed information, see Item 3b in the board packet.

ITEM 3c / MEDICAID DIRECTOR'S UPDATE
Kevin Rupe, Chief Operating Officer

Mr. Rupe provided an update for February and March data that included a report on the number of enrollees in the Medicaid program. He stated that things have relatively stayed the same. Mr. Rupe reviewed a SoonerCare monthly enrollment chart for April 2013 through March 2015. For more detailed information, see Item 3c in the board packet.

ITEM 3d / LEGISLATIVE UPDATE
Carter Kimble, Director of Governmental Relations

Mr. Kimble reported that OHCA is currently tracking 37 bills. The Governor has signed 19 of our tracked bills, vetoed 2 bills, 5 bills have been sent to her for signature and we have 11 remaining on our tracking list awaiting action.

- SB704 – OHCA Request Bill - Sen. A.J. Griffin and Rep. Dr. Doug Cox - Allows OHCA to recover funds put in a trust for, but not spent on, burial/funeral expenses. Recovery amount not to exceed cost of services provided. Governor Signed 5-6-15.
- HB1566 – Sen. Kim David and Rep. Glen Mulready - OHCA to initiate RFP's for care coordination models for the aged, blind and disabled persons. Care coordination models for members receiving institutional care shall be phased in two (2) years after the initial enrollment period of a care coordination program. Governor Signed 5-4-15.
- HB1628 – Rep. David Derby and Sen. A.J. Griffin – New market drugs that do not fall into a class that is already prior authorized (PA) shall be automatically PA'd, but the PA will be removed if the DUR does not review within 100 days of market availability. Sent to the Governor 5-6-15.

For more detailed information, see Item 3d in the board packet.

ITEM 3e / BUDGET UPDATE
Nico Gomez

Mr. Gomez currently does not have any new information regarding the budget. He mentioned that there are copies available for review of the budget reduction list. Mr. Gomez added this discussion to the board agenda in case the legislature reached a budget agreement. then he would be able to discuss it.

Mr. Gomez noted there is a significant shortfall in the state in terms of their revenue and being able to appropriate. He said that the agency proactively met with the provider groups about a proposed budget reductions. The agency needs about $78.5 million in addition to what we received last year in order to run the same program July 1st that we run today at the current rate structure. Our best case scenario would be what the Governor proposed in her budget which is $20 million above what we had last year. The agency does not know what the Governor and legislature is going to appropriate so we had to start planning to give us an opportunity to react by July 1st. Last Monday the agency publicly distributed a difficult cut list to our providers of about $40.4 state dollars which is a total impact of $111 million total dollars to the program. This will not come before the board members for any consideration before the OHCA June 25th board meeting. The agency is starting a process of public dialogue and feedback and what this could mean to our provider partners, health care economy, etc. The majority of the providers we are hearing from are nurse practitioners and physician assistants, rightfully so, because of the proposed 15% cut to their fee schedule. Mr. Gomez noted that all items on the cut list were difficult decisions but we are also dealing with the reality that there is not enough revenue for us to run the program as it is today. He stated that we are trying to put on the table what we believe we could do to balance the budget and maintain a responsible program, which is getting more difficult.

Mr. Gomez stated that as soon as we get a budget agreement, we will have a better idea of what the details are and will be communicating that to the board.

Chairman McFall asked that we look at an urban rural differential reimbursement for nurse practitioners and physician assistants. Mr. Gomez stated that we can certainly look at that.

ITEM 4 / LEVERAGING DIGITAL COMMUNICATION STRATEGIES TO IMPROVE HEALTH OUTCOMES IN OKLAHOMA
Ed Long, Chief Communications Officer & Kendall Brown, Digital Communications Coordinator

Ms. Brown discussed the impact of digital strategy, promoted posts on social media, targeting custom audiences, digital communication analytics and conversion tracking. For more detailed information, see Item 4 in the board packet.

ITEM 5 / ANNUAL EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT (EPSDT) UPDATE
Shelly Patterson, Director of Health Promotion & Community Relations

Ms. Patterson gave the annual EPSDT participation report for Oklahoma, which included: CMS state requirements, CMS 416 report, participation rate, screening rate, utilization and percentages. For more detailed information, see Item 5 in the board packet.

ITEM 6 / ANNOUNCEMENTS OF CONFLICTS OF INTEREST PANEL RECOMMENDATIONS FOR ALL ACTION ITEMS
Nicole Nantois, Chief of Legal Services

There were no recommendations regarding conflicts.

ITEM 7a / CONSIDERATION AND VOTE OF AUTHORITY FOR EXPENDITURE OF FUNDS FOR THE THIRD PARTY COLLECTION SERVICES REQUEST FOR PROPOSAL
Vickie Kersey, Director of Fiscal Planning and Procurement

MOTION:	Member Nuttle moved for Item 7a as published. The motion was seconded by Vice-Chairman Armstrong.
FOR THE MOTION:	Chairman McFall, Member McVay
ABSENT:	Member Bryant, Member Robison, Member Case

ITEM 8a / CONSIDERATION AND VOTE REGARDING RECOMMENDATIONS MADE BY THE DRUG UTILIZATION REVIEW BOARD UNDER 63 OKLAHOMA STATUTES 5030.3.
Nancy Nesser, Pharmacy Director

a) Consideration and vote to add **Sylvant™ (Siltuximab)** to the utilization and scope prior authorization program under OAC 317:30-5-77.2(e).

MOTION:	Member McVay moved for approval of Item 8a as published. The motion was seconded by Member Nuttle.
FOR THE MOTION:	Chairman McFall, Vice-Chairman Armstrong
ABSENT:	Member Bryant, Member Robison, Member Case

ITEM 9 / NEW BUSINESS

There was no new business.

ITEM 10 / ADJOURNMENT

MOTION:	Vice-Chairman Armstrong moved for approval for adjournment. The motion was seconded by Member Nuttle.
FOR THE MOTION:	Chairman McFall, Member McVay
ABSENT:	Member Bryant, Member Robison, Member Case

Meeting adjourned at 2:00 p.m., 5/14/2015

NEXT BOARD MEETING
June 25, 2015
Oklahoma Health Care Authority
Charles Ed McFall Boardroom
4345 N. Lincoln Blvd.
OKC, OK

Lindsey Bateman
Board Secretary

Minutes Approved: _____

*Initials:*_____

FINANCIAL REPORT

For the Ten Months Ended April 30, 2015
Submitted to the CEO & Board

- Revenues for OHCA through April, accounting for receivables, were **$3,381,611,546** or **.8% under** budget.
- Expenditures for OHCA, accounting for encumbrances, were **$3,366,734,316 or 1.4% under** budget.
- The state dollar budget variance through April is a **positive $20,125,538.**
- The budget variance is primarily attributable to the following (in millions):

Expenditures:		
Medicaid Program Variance		18.8
Administration		3.4
Revenues:		
Drug Rebate		.4
Taxes and Fees		3.1
Overpayments/Settlements		8.4
FY15 Carryover Committed to FY16		(14.0)
Total FY 15 Variance	**$**	**20.1**

ATTACHMENTS

OKLAHOMA HEALTH CARE AUTHORITY
Summary of Revenues & Expenditures: OHCA
Fiscal Year 2015, For the Ten Months Ended April 30, 2015

REVENUES	FY15 Budget YTD	FY15 Actual YTD	Variance	% Over/ (Under)
State Appropriations	$ 813,346,029	$ 813,346,029	$ -	0.0%
Federal Funds	1,986,626,916	1,957,258,473	(29,368,442)	(1.5)%
Tobacco Tax Collections	37,409,682	40,442,800	3,033,118	8.1%
Quality of Care Collections	64,020,318	63,466,681	(553,637)	(0.9)%
SFY 15 Carryover Committed to SFY16	14,000,000	-	(14,000,000)	100.0%
Prior Year Carryover	61,029,661	61,029,661	-	0.0%
Federal Deferral - Interest	218,233	218,233	-	0.0%
Drug Rebates	185,828,146	187,014,631	1,186,485	0.6%
Medical Refunds	37,688,414	48,463,956	10,775,542	28.6%
Supplemental Hospital Offset Payment Program	197,421,201	197,421,201	-	0.0%
Other Revenues	12,825,175	12,949,880	124,705	1.0%
TOTAL REVENUES	**$ 3,410,413,775**	**$ 3,381,611,546**	**$ (28,802,229)**	**(0.8)%**

EXPENDITURES	FY15 Budget YTD	FY15 Actual YTD	Variance	% (Over)/ Under
ADMINISTRATION - OPERATING	**$ 48,116,815**	**$ 42,504,496**	**$ 5,612,319**	**11.7%**
ADMINISTRATION - CONTRACTS	**$ 103,707,264**	**$ 101,207,787**	**$ 2,499,477**	**2.4%**
MEDICAID PROGRAMS				
Managed Care:				
SoonerCare Choice	33,757,527	30,147,655	3,609,872	10.7%
Acute Fee for Service Payments:				
Hospital Services	764,729,527	766,492,636	(1,763,109)	(0.2)%
Behavioral Health	16,859,489	16,446,341	413,148	2.5%
Physicians	416,519,412	409,383,689	7,135,723	1.7%
Dentists	115,349,697	108,201,429	7,148,268	6.2%
Other Practitioners	35,077,606	31,476,650	3,600,957	10.3%
Home Health Care	17,699,799	16,824,422	875,377	4.9%
Lab & Radiology	64,207,499	63,497,042	710,458	1.1%
Medical Supplies	33,557,233	33,665,649	(108,416)	(0.3)%
Ambulatory/Clinics	105,718,048	104,118,100	1,599,947	1.5%
Prescription Drugs	402,878,932	404,907,431	(2,028,499)	(0.5)%
OHCA Therapeutic Foster Care	1,701,405	1,413,070	288,336	16.9%
Other Payments:				
Nursing Facilities	488,413,542	475,252,389	13,161,153	2.7%
Intermediate Care Facilities for Individuals with Intellectual Disabilities Private	51,260,416	49,726,688	1,533,728	3.0%
Medicare Buy-In	113,832,198	111,545,372	2,286,826	2.0%
Transportation	59,156,977	57,827,264	1,329,713	2.2%
Money Follows the Person-OHCA	865,357	542,328	323,030	0.0%
Electonic Health Records-Incentive Payments	27,615,297	27,615,297	-	0.0%
Part D Phase-In Contribution	64,693,785	64,083,708	610,078	0.9%
Supplemental Hospital Offset Payment Program	449,854,873	449,854,873	-	0.0%
Total OHCA Medical Programs	**3,263,748,621**	**3,223,022,033**	**40,726,588**	**1.2%**
OHCA Non-Title XIX Medical Payments	89,382	-	89,382	0.0%
TOTAL OHCA	**$ 3,415,662,082**	**$ 3,366,734,316**	**$ 48,927,767**	**1.4%**
REVENUES OVER/(UNDER) EXPENDITURES	**$ (5,248,308)**	**$ 14,877,230**	**$ 20,125,538**	

OKLAHOMA HEALTH CARE AUTHORITY
Total Medicaid Program Expenditures
by Source of State Funds
Fiscal Year 2015, For the Ten Months Ended April 30, 2015

Category of Service	Total	Health Care Authority	Quality of Care Fund	HEEIA	SHOPP Fund	BCC Revolving Fund	Other State Agencies
SoonerCare Choice	$ 30,270,340	$ 30,135,162	$ -	$ 122,685	$ -	$ 12,493	$ -
Inpatient Acute Care	962,930,884	526,021,680	405,572	2,957,682	347,449,538	1,193,804	84,902,608
Outpatient Acute Care	316,824,070	235,265,616	34,670	3,286,503	74,665,987	3,571,294	
Behavioral Health - Inpatient	47,339,514	9,956,334	-	225,272	26,415,674	-	10,742,234
Behavioral Health - Psychiatrist	7,813,681	6,490,007	-	-	1,323,674	-	-
Behavioral Health - Outpatient	23,611,187	-	-	-	-	-	23,611,187
Behaviorial Health-Health Home	1,442,219	-	-	-	-	-	1,442,219
Behavioral Health Facility- Rehab	212,997,313	-	-	-	-	76,019	212,997,313
Behavioral Health - Case Management	17,538,051	-	-	-	-	-	17,538,051
Behavioral Health - PRTF	76,386,542	-	-	-	-	-	76,386,542
Residential Behavioral Management	19,528,861	-	-	-	-	-	19,528,861
Targeted Case Management	56,068,464	-	-	-	-	-	56,068,464
Therapeutic Foster Care	1,413,070	1,413,070	-	-	-	-	-
Physicians	461,400,271	404,349,249	48,417	4,634,514	-	4,986,023	47,382,067
Dentists	108,217,025	108,190,337	-	15,596	-	11,093	-
Mid Level Practitioners	2,528,421	2,511,793	-	14,977	-	1,651	-
Other Practitioners	29,037,491	28,584,582	371,970	74,285	-	6,654	-
Home Health Care	16,829,524	16,806,432	-	5,103	-	17,990	-
Lab & Radiology	64,878,923	63,067,308	-	1,381,881	-	429,734	-
Medical Supplies	33,897,466	31,335,362	2,259,613	231,817	-	70,675	-
Clinic Services	103,990,178	97,097,296	-	580,254	-	173,375	6,139,253
Ambulatory Surgery Centers	7,017,890	6,825,811	-	170,461	-	21,619	-
Personal Care Services	10,928,982	-	-	-	-	-	10,928,982
Nursing Facilities	475,252,389	299,391,089	175,859,318	-	-	1,982	-
Transportation	57,542,256	55,295,589	2,178,930	-	-	67,736	-
GME/IME/DME	112,531,140	-	-	-	-	-	112,531,140
ICF/IID Private	49,726,688	40,752,515	8,974,173	-	-	-	-
ICF/IID Public	35,480,065	-	-	-	-	-	35,480,065
CMS Payments	175,629,080	175,027,196	601,884	-	-	-	
Prescription Drugs	412,930,668	403,292,931	-	8,023,237	-	1,614,500	-
Miscellaneous Medical Payments	285,008	269,684	-	-	-	15,324	-
Home and Community Based Waiver	156,331,836	-	-	-	-	-	156,331,836
Homeward Bound Waiver	74,825,193	-	-	-	-	-	74,825,193
Money Follows the Person	10,832,625	542,328	-	-	-	-	10,290,297
In-Home Support Waiver	21,105,940	-	-	-	-	-	21,105,940
ADvantage Waiver	143,909,403	-	-	-	-	-	143,909,403
Family Planning/Family Planning Waiver	6,590,469	-	-	-	-	-	6,590,469
Premium Assistance*	35,088,297	-	-	35,088,297	-	-	-
Electronic Health Records Incentive Payments	27,615,297	27,615,297	-	-	-	-	-
Total Medicaid Expenditures	**$ 4,408,566,722**	**$ 2,570,236,668**	**$ 190,734,547**	**$ 56,812,564**	**$ 449,854,873**	**$ 12,271,964**	**$1,128,732,125**

* Includes $34,832,340.23 paid out of Fund 245

OKLAHOMA HEALTH CARE AUTHORITY
Summary of Revenues & Expenditures:
Other State Agencies
Fiscal Year 2015, For the Ten Months Ended April 30, 2015

		FY15 Actual YTD
REVENUE		
Revenues from Other State Agencies	$	468,773,622
Federal Funds		712,150,327
TOTAL REVENUES	**$**	**1,180,923,949**
EXPENDITURES		**Actual YTD**
Department of Human Services		
Home and Community Based Waiver	$	156,331,836
Money Follows the Person		10,290,297
Homeward Bound Waiver		74,825,193
In-Home Support Waivers		21,105,940
ADvantage Waiver		143,909,403
Intermediate Care Facilities for Individuals with Intellectual Disabilities Public		35,480,065
Personal Care		10,928,982
Residential Behavioral Management		14,800,949
Targeted Case Management		43,923,568
Total Department of Human Services		**511,596,233**
State Employees Physician Payment		
Physician Payments		47,382,067
Total State Employees Physician Payment		**47,382,067**
Education Payments		
Graduate Medical Education		70,019,832
Graduate Medical Education - Physicians Manpower Training Commission		4,529,375
Indirect Medical Education		31,865,924
Direct Medical Education		6,116,009
Total Education Payments		**112,531,140**
Office of Juvenile Affairs		
Targeted Case Management		2,707,504
Residential Behavioral Management		4,717,166
Total Office of Juvenile Affairs		**7,424,669**
Department of Mental Health		
Case Management		17,538,051
Inpatient Psychiatric Free-standing		10,742,234
Outpatient		23,611,187
Health Homes		1,442,219
Psychiatric Residential Treatment Facility		76,386,542
Rehabilitation Centers		212,997,313
Total Department of Mental Health		**342,717,546**
State Department of Health		
Children's First		1,178,505
Sooner Start		2,269,253
Early Intervention		3,531,297
Early and Periodic Screening, Diagnosis, and Treatment Clinic		1,735,819
Family Planning		(47,871)
Family Planning Waiver		6,617,939
Maternity Clinic		26,550
Total Department of Health		**15,311,491**
County Health Departments		
EPSDT Clinic		643,806
Family Planning Waiver		20,402
Total County Health Departments		**664,208**
State Department of Education		**107,217**
Public Schools		**4,631,120**
Medicare DRG Limit		**77,041,622**
Native American Tribal Agreements		**1,463,825**
Department of Corrections		**1,451,481**
JD McCarty		**6,409,505**
Total OSA Medicaid Programs	**$**	**1,128,732,125**
OSA Non-Medicaid Programs	**$**	**62,839,588**
Accounts Receivable from OSA	**$**	**10,647,763**

OKLAHOMA HEALTH CARE AUTHORITY
SUMMARY OF REVENUES & EXPENDITURES:
Fund 205: Supplemental Hospital Offset Payment Program Fund
Fiscal Year 2015, For the Ten Months Ended April 30, 2015

REVENUES	FY 15 Revenue
SHOPP Assessment Fee	$ 197,156,731
Federal Draws	282,239,613
Interest	133,816
Penalties	130,354
State Appropriations	(30,200,000)
TOTAL REVENUES	$ 449,460,514

EXPENDITURES	Quarter	Quarter	Quarter	Quarter	FY 15 Expenditures
Program Costs:	7/1/14 - 9/30/14	10/1/14 - 12/31/14	1/1/15 - 3/31/15	4/1/15 - 6/30/15	
Hospital - Inpatient Care	92,872,986	92,764,153	78,587,045	83,225,354	$ 347,449,538
Hospital -Outpatient Care	15,052,817	15,729,600	21,418,128	22,465,442	$ 74,665,987
Psychiatric Facilities-Inpatient	6,919,304	7,316,146	5,914,677	6,265,547	$ 26,415,674
Rehabilitation Facilities-Inpatient	272,784	288,429	370,249	392,213	$ 1,323,674
Total OHCA Program Costs	115,117,891	116,098,329	106,290,098	112,348,555	$ 449,854,873
Total Expenditures					$ 449,854,873

CASH BALANCE	$ (394,358)

OKLAHOMA HEALTH CARE AUTHORITY
SUMMARY OF REVENUES & EXPENDITURES:
Fund 230: Nursing Facility Quality of Care Fund
Fiscal Year 2015, For the Ten Months Ended April 30, 2015

REVENUES	Total Revenue	State Share
Quality of Care Assessment	**$ 63,432,810**	**$ 63,432,810**
Interest Earned	**33,871**	**33,871**
TOTAL REVENUES	**$ 63,466,681**	**$ 63,466,681**

EXPENDITURES	FY 15 Total $ YTD	FY 15 State $ YTD	Total State $ Cost
Program Costs			
Nursing Facility Rate Adjustment	$ 172,832,785	$ 65,157,960	
Eyeglasses and Dentures	228,132	86,006	
Personal Allowance Increase	2,798,400	1,054,997	
Coverage for Durable Medical Equipment and Supplies	2,259,613	851,874	
Coverage of Qualified Medicare Beneficiary	860,630	324,457	
Part D Phase-In	601,884	601,884	
ICF/IID Rate Adjustment	4,325,754	1,630,809	
Acute Services ICF/IID	4,648,419	1,752,454	
Non-emergency Transportation - Soonerride	2,178,930	821,457	
Total Program Costs	**$ 190,734,547**	**$ 72,281,898**	**$ 72,281,898**
Administration			
OHCA Administration Costs	$ 416,688	$ 208,344	
DHS-Ombudsmen	177,158	177,158	
OSDH-Nursing Facility Inspectors	400,000	400,000	
Mike Fine, CPA	6,000	3,000	
Total Administration Costs	**$ 999,846**	**$ 788,502**	**$ 788,502**
Total Quality of Care Fee Costs	**$ 191,734,393**	**$ 73,070,399**	
TOTAL STATE SHARE OF COSTS			**$ 73,070,399**

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

OKLAHOMA HEALTH CARE AUTHORITY
SUMMARY OF REVENUES & EXPENDITURES:
Fund 245: Health Employee and Economy Improvement Act Revolving Fund
Fiscal Year 2015, For the Ten Months Ended April 30, 2015

REVENUES	FY 14 Carryover	FY 15 Revenue	Total Revenue
Prior Year Balance	$ 13,950,701	$ -	$ 7,221,671
State Appropriations	-	-	-
Tobacco Tax Collections	-	33,263,990	33,263,990
Interest Income	-	288,089	288,089
Federal Draws	160,262	23,093,755	23,093,755
All Kids Act	(6,636,667)	108,344	108,344
TOTAL REVENUES	**$ 7,474,296**	**$ 56,754,178**	**$ 63,867,504**

EXPENDITURES		FY 14 Expenditures	FY 15 Expenditures	Total $ YTD
Program Costs:				
	Employer Sponsored Insurance		$ 34,531,411	$ 34,531,411
	College Students		255,957	92,093
	All Kids Act		300,929	300,929
Individual Plan				
	SoonerCare Choice		$ 118,053	$ 42,475
	Inpatient Hospital		2,932,612	1,055,154
	Outpatient Hospital		3,235,649	1,164,187
	BH - Inpatient Services-DRG		222,368	80,008
	BH -Psychiatrist		-	-
	Physicians		4,620,173	1,662,338
	Dentists		14,876	5,352
	Mid Level Practitioner		14,240	5,124
	Other Practitioners		73,005	26,267
	Home Health		5,103	1,836
	Lab and Radiology		1,366,853	491,794
	Medical Supplies		220,168	79,217
	Clinic Services		573,252	206,256
	Ambulatory Surgery Center		163,427	58,801
	Prescription Drugs		7,905,193	2,844,288
	Miscellaneous Medical		-	-
	Premiums Collected		-	(456,609)
Total Individual Plan			**$ 21,464,972**	**$ 7,266,488**
	College Students-Service Costs		**$ 259,100**	**$ 93,224**
	All Kids Act- Service Costs		**$ 195**	**$ 70**
Total OHCA Program Costs			**$ 56,812,563**	**$ 42,284,215**
Administrative Costs				
	Salaries	$ 30,565	$ 1,123,928	$ 1,154,493
	Operating Costs	125,839	488,926	614,765
	Health Dept-Postponing	-	-	-
	Contract - HP	96,221	758,464	854,685
Total Administrative Costs		**$ 252,625**	**$ 2,371,318**	**$ 2,623,943**
Total Expenditures				**$ 44,908,159**
NET CASH BALANCE		**$ 7,221,671**		**$ 18,959,346**

OKLAHOMA HEALTH CARE AUTHORITY
SUMMARY OF REVENUES & EXPENDITURES:
Fund 250: Belle Maxine Hilliard Breast and Cervical Cancer Treatment Revolving Fund
Fiscal Year 2015, For the Ten Months Ended April 30, 2015

REVENUES	FY 15 Revenue	State Share
Tobacco Tax Collections	$ 663,658	$ 663,658
TOTAL REVENUES	**$ 663,658**	**$ 663,658**

EXPENDITURES	FY 15 Total $ YTD	FY 15 State $ YTD	Total State $ Cost
Program Costs			
SoonerCare Choice	$ 12,493	$ 3,297	
Inpatient Hospital	1,193,804	315,045	
Outpatient Hospital	3,571,294	942,465	
Inpatient Services-DRG	-	-	
Psychiatrist	-	-	
TFC-OHCA	-	-	
Nursing Facility	1,982	523	
Physicians	4,986,023	1,315,811	
Dentists	11,093	2,927	
Mid-level Practitioner	1,651	436	
Other Practitioners	6,654	1,756	
Home Health	17,990	4,748	
Lab & Radiology	429,734	113,407	
Medical Supplies	70,675	18,651	
Clinic Services	173,375	45,754	
Ambulatory Surgery Center	21,619	5,705	
Prescription Drugs	1,614,500	426,067	
Transportation	67,736	17,876	
Miscellaneous Medical	15,324	4,044	
Total OHCA Program Costs	$ 12,195,945	$ 3,218,510	
OSA DMHSAS Rehab	$ 76,019	$ 20,061	
Total Medicaid Program Costs	$ 12,271,964	$ 3,238,571	
TOTAL STATE SHARE OF COSTS			**$ 3,238,571**

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.

SoonerCare Programs

April 2015 Data for June 2015 Board Meeting

SOONERCARE ENROLLMENT/EXPENDITURES

Delivery System			Monthly Enrollment Average SFY2014	Enrollment April 2015	Total Expenditures April 2015	Average Dollars Per Member Per Month April 2015
SoonerCare Choice Patient-Centered Medical Home			559,363	**544,782**	**$182,246,829**	
	Lower Cost	*(Children/Parents; Other)*		498,758	$133,184,060	$267
	Higher Cost	*(Aged, Blind or Disabled; TEFRA; BCC)*		46,024	$49,062,769	$1,066
SoonerCare Traditional			196,936	**235,746**	**$257,267,458**	
	Lower Cost	*(Children/Parents; Other)*		125,154	$96,126,154	$768
	Higher Cost	*(Aged, Blind or Disabled; TEFRA; BCC & HCBS Waiver)*		110,592	$161,141,305	$1,457
SoonerPlan*			48,266	**41,330**	**$492,643**	$12
Insure Oklahoma			23,567	**17,941**	**$6,541,587**	
	Employer-Sponsored Insurance		14,795	13,532	$4,098,538	$303
	*Individual Plan**		8,772	4,409	$2,443,048	$554
TOTAL			**828,131**	**839,799**	**$446,548,517**	

The enrollment totals above include all members enrolled during the report month; therefore, some members may not have expenditure data.
Custody expenditures are excluded. Non-member specific expenditures of $146,943,287 are excluded.

Effective July 2014, members with other forms of credible health insurance coverage were no longer eligible for Choice PCMH.

*In January 2014, SoonerPlan's qualifying income guidelines decreased from 185% to 133% of FPL and Insure Oklahoma IP's qualifying income guidelines decreased from 200% to 100% of FPL.

Net Enrollee Count Change from Previous Month Total	(866)

New Enrollees	17,822

Members that have not been enrolled in the past 6 months.

Dual Enrollees & Long-Term Care Members (subset of data above)

Medicare and SoonerCare		Monthly Average SFY2014	Enrolled April 2015
Dual Enrollees		**109,653**	**110,697**
	Child	*192*	170
	Adult	*109,461*	110,527

		Monthly Average SFY2014	Enrolled April 2015	FACILITY PER MEMBER PER MONTH
Long-Term Care Members		**15,358**	**14,876**	**$4,046**
	Child	63	59	
	Adult	15,295	14,817	

Child is defined as an individual under the age of 21.

SOONERCARE CONTRACTED PROVIDER INFORMATION

Provider Counts		Monthly Average SFY2014	Enrolled April 2015
Total Providers		**38,330**	**42,070**
	In-State	29,277	31,768
	Out-of-State	9,053	10,302

Provider Network includes providers who are contracted to provide health care services by locations, programs, types, and specialties. Providers are being counted multiple times if they have multiple locations, programs, types, and specialties.

Program	% of Capacity Used
SoonerCare Choice	44%
SoonerCare Choice I/T/U	19%
Insure Oklahoma IP	1%

Select Provider Type Counts	*In-State*		*Totals*	
	Monthly Average SFY2014	*Enrolled April 2015**	Monthly Average SFY2014	Enrolled April 2015
Physician	*8,452*	*9,225*	*13,597*	15,907
Pharmacy	*936*	*924*	*1,266*	1,226
Mental Health Provider	*4,864*	*4,857*	*4,902*	4,915
Dentist	*1,069*	*1,125*	*1,206*	1,306
Hospital	*183*	*192*	*685*	965
Optometrist	*565*	*608*	*594*	644
Extended Care Facility	*356*	*345*	356	345

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

Total Primary Care Providers**	*5,410*	*6,198*	7,011	8,348
Patient-Centered Medical Home	*2,099*	*2,376*	2,188	2,465

**Including Physicians, Physician Assistants and Advance Nurse Practitioners.

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

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 3. HOSPITALS

317:30-5-41. Inpatient hospital coverage/limitations

(a) Covered hospital inpatient services are those medically necessary services which require an inpatient stay ordinarily furnished by a hospital for the care and treatment of inpatients and which are provided under the direction of a physician or dentist in an institution approved under OAC:317:30:5-40.1(a) or (b). ~~Effective October 1, 2005, claims for inpatient admissions provided on or after October 1st in acute care or critical access hospitals are reimbursed utilizing a Diagnosis Related Groups (DRG) methodology.~~Claims for inpatient admissions in acute care or critical access hospitals are reimbursed the lesser of the billed charges or the Diagnosis Related Groups (DRG) amount.

(b) **Inpatient status.** OHCA considers a member an inpatient when the member is admitted to the hospital and is counted in the midnight census. In situations when a member inpatient admission occurs and the member dies, is discharged following an obstetrical stay, or is transferred to another facility on the day of admission, the member is also considered an inpatient of the hospital.

(1) **Same day admission.** If a member is admitted and dies before the midnight census on the same day of admission, the member is considered an inpatient.

(2) **Same day admission/discharge C obstetrical and newborn stays.** A hospital stay is considered inpatient stay when a member is admitted and delivers a baby, even when the mother and baby are discharged on the date of admission (i.e., they are not included in the midnight census). This rule applies when the mother and/or newborn are transferred to another hospital.

(3) **Same day admission/discharges other than obstetrical and newborn stays.** In the event a member is admitted as an inpatient, but is determined to not qualify for an inpatient payment based on OHCA criteria, the hospital may bill on an outpatient claim for the ancillary services provided during that time.

(4) **Discharges and Transfers**. A hospital inpatient is considered discharged from a hospital paid under the DRG-based payment system when:

~~(A) **Discharges.** A hospital inpatient is considered discharged from a hospital paid under the DRG-based payment system when:~~

~~(i)~~(A) The patient is formally released from the hospital; or

~~(ii)~~(B) The patient dies in the hospital; or

~~(iii)~~(C) The patient is transferred to a hospital that is excluded from the DRG-based payment system, or transferred to a distinct part psychiatric or rehabilitation unit of the same hospital. Such instances will result in two or more

claims. Effective January 1, 2007, distinct part psychiatric and rehabilitation units excluded from the Medicare Prospective Payment System (PPS) of general medical surgical hospitals will require a separate provider identification number.

317:30-5-47. Reimbursement for inpatient hospital services

Reimbursement will be made for inpatient hospital services ~~rendered on or after October 1, 2005,~~ in the following manner:

(1) Covered inpatient services provided to eligible SoonerCare members admitted to in-state acute care and critical access hospitals will be reimbursed ~~at a prospectively set rate which compensates hospitals an amount per discharge for discharges classified according to the Diagnosis Related Group (DRG) methodology. For each SoonerCare member's stay, a peer group base rate is multiplied by the relative weighting factor for the DRG which applies to the hospital stay.~~ the lesser of the billed charges or the Diagnosis Related Group (DRG) amount. In addition to the billed charges or DRG payment, whichever is less, an outlier payment may be made to the hospital for very high cost stays. Additional outlier payment is applicable if ~~the DRG payment~~ either the amount billed by the hospital or DRG payment, whichever applies, is less than a threshold amount of the hospital cost. Each inpatient hospital claim is tested to determine whether the claim qualified for a cost outlier payment. Payment is equal to a percentage of the cost after the threshold is met.

(2) ~~The DRG payment~~The lesser of the billed charges or DRG amount and outlier, if applicable, represent full reimbursement for all non-physician services provided during the inpatient stay. Payment includes but is not limited to:

(A) laboratory services;

(B) prosthetic devices, including pacemakers, lenses, artificial joints, cochlear implants, implantable pumps;

(C) technical component on radiology services;

(D) transportation, including ambulance, to and from another facility to receive specialized diagnostic and therapeutic services;

(E) pre-admission diagnostic testing performed within 72 hours of admission; and

(F) organ transplants.

(3) Hospitals may submit a claim for payment only upon the final discharge of the patient or upon completion of a transfer of the patient to another hospital.

(4) Covered inpatient services provided to eligible members of the Oklahoma SoonerCare program, when treated in out-of-state hospitals will be reimbursed in the same manner as in-state hospitals.

(5) Cases which indicate transfer from one acute care hospital to another will be monitored under a retrospective utilization

review policy to help ensure that payment is not made for inappropriate transfers.

(6) The transferring hospital will be paid the lesser of the calculated transfer fee or the DRG base payment amount for a non-transfer. No outlier payment will be made on transfers.

~~(6)~~(7) If the transferring or discharge hospital or unit is exempt from the DRG, that hospital or unit will be reimbursed according to the method of payment applicable to the particular facility or units.

~~(7)~~(8) Covered inpatient services provided in out-of-state specialty hospitals may be reimbursed at a negotiated rate not to exceed 100% of the cost to provide the service. Negotiation of rates will only be allowed when the OHCA determines that the specialty hospital or specialty unit provides a unique (non-experimental) service required by SoonerCare members and the provider will not accept the DRG payment rate. Prior authorization is required.

~~(8)~~(9) New providers entering the SoonerCare program will be assigned a peer group and will be reimbursed at the peer group base rate for the DRG payment methodology or the statewide median rate for per diem methods.

~~(9)~~(10) When services are delivered via telemedicine to hospital inpatients, the originating site facility fee will be paid outside the DRG payment.

~~(10)~~(11) All inpatient services are reimbursed per the ~~DRG~~ methodology described in this section and/or as approved under the Oklahoma State Medicaid Plan.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 3. GENERAL PROVIDER POLICIES
PART 3. GENERAL MEDICAL PROGRAM INFORMATION

317:30-3-59. General program exclusions - adults

The following are excluded from SoonerCare coverage for adults:

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

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

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

(4) Refractions and visual aids.

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

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

(7) Non-therapeutic hysterectomies.

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

(9) Medical services considered experimental or investigational.

(10) Services of a Certified Surgical Assistant.

(11) Services of a Chiropractor. Payment is made for Chiropractor services on Crossover claims for coinsurance and/or deductible only.

(12) Services of an independent licensed Physical and/or Occupational Therapist.

(13) Services of a Psychologist.

(14) Services of an independent licensed Speech and Hearing Therapist.

(15) Payment for more than four outpatient visits per month (home or office) per member, except those visits in connection with family planning or related to emergency medical conditions.
(16) Payment for more than two nursing facility visits per month.
(17) More than one inpatient visit per day per physician.
(18) Payment for removal of benign skin lesions~~ unless medically necessary~~.
(19) Physician services which are administrative in nature and not a direct service to the member including such items as quality assurance, utilization review, treatment staffing, tumor board review or multidisciplinary opinion, dictation, and similar functions.
(20) Charges for completion of insurance forms, abstracts, narrative reports or telephone calls.
(21) Payment for the services of social workers, licensed family counselors, registered nurses or other ancillary staff, except as specifically set out in OHCA rules.
(22) Mileage.
(23) A routine hospital visit on the date of discharge unless the member expired.
(24) Direct payment to perfusionist as this is considered part of the hospital reimbursement.
(25) Inpatient chemical dependency treatment.
(26) Fertility treatment.
(27) Payment to the same physician for both an outpatient visit and admission to hospital on the same date.

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 1. PHYSICIANS

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

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

(1) Coverage includes the following medically necessary services:

(A) Inpatient hospital visits for all SoonerCare covered

stays. All inpatient services are subject to post-payment review by the OHCA, or its designated agent.
(B) Inpatient psychotherapy by a physician.
(C) Inpatient psychological testing by a physician.
(D) One inpatient visit per day, per physician.
(E) Certain surgical procedures performed in a Medicare certified free-standing ambulatory surgery center (ASC) or a Medicare certified hospital that offers outpatient surgical services.
(F) Therapeutic radiology or chemotherapy on an outpatient basis without limitation to the number of treatments per month for members with proven malignancies or opportunistic infections.
(G) Direct physician services on an outpatient basis. A maximum of four visits are allowed per month per member in office or home regardless of the number of physicians providing treatment. Additional visits per month are allowed for those services related to emergency medical conditions and for services in connection with Family Planning.
(H) Direct physician services in a nursing facility for those members residing in a long-term care facility. A maximum of two nursing facility visits per month are allowed. To receive payment for a second nursing facility visit in a month denied by Medicare for a Medicare/SoonerCare member, attach the EOMB from Medicare showing denial and mark "carrier denied coverage".
(I) Diagnostic x-ray and laboratory services.
(J) Mammography screening and additional follow-up mammograms.
(K) Obstetrical care.
(L) Pacemakers and prostheses inserted during the course of a surgical procedure.
(M) Prior authorized examinations for the purpose of determining medical eligibility for programs administered by OHCA. A copy of the authorization, OKDHS form 08MA016E, Authorization for Examination and Billing, must accompany the claim.
(N) If a physician renders direct care to a member on the same day as a dialysis treatment, payment is allowed for a separately identifiable service unrelated to the dialysis.
(O) Family planning includes sterilization procedures for legally competent members 21 years of age and over who voluntarily request such a procedure and execute the federally mandated consent form with his/her physician. A

copy of the consent form must be attached to the claim form. Separate payment is allowed for the insertion and/or implantation of contraceptive devices during an office visit. Certain family planning products may be obtained through the Vendor Drug Program. Reversal of sterilization procedures for the purposes of conception is not allowed. Reversal of sterilization procedures are allowed when medically indicated and substantiating documentation is attached to the claim.

(P) Genetic counseling.

(Q) Laboratory testing (such as complete blood count (CBC), platelet count, or urinalysis) for monitoring members receiving chemotherapy, radiation therapy, or medications that require monitoring during treatment.

(R) Payment for ultrasounds for pregnant women as specified in OAC 317:30-5-22.

(S) Payment to the attending physician in a teaching medical facility for compensable services when the physician signs as claimant and renders personal and identifiable services to the member in conformity with federal regulations.

(T) Payment to clinical fellow or chief resident in an outpatient academic setting when the following conditions are met:

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

(ii) Board certification or completion of an accredited residency program in the fellowship specialty area;

(iii) Hold unrestricted license to practice medicine in Oklahoma;

(iv) If Clinical Fellow, practicing during second or subsequent year of fellowship;

(v) Seeing members without supervision;

(vi) Services provided not for primary purpose of medical education for the clinical fellow or chief resident;

(vii) Submit billing in own name with appropriate Oklahoma SoonerCare provider number;

(viii) Additionally if a clinical fellow practicing during the first year of fellowship, the clinical fellow must be practicing within their area of primary training. The services must be performed within the context of their primary specialty and only to the extent as allowed by their accrediting body.

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

(i) Attending physician performs chart review and signs off on the billed encounter;

(ii) Attending physician is present in the clinic/or hospital setting and available for consultation;

(iii) Documentation of written policy and applicable training of physicians in the training program regarding when to seek the consultation of the attending physician.

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

(i) The member must be at least minimally examined by the attending physician or a licensed physician under the supervision of the attending physician;

(ii) The contact must be documented in the medical record.

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

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

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

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

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

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

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

(Z) Donor search and procurement services are covered for transplants consistent with the methods used by the

Medicare program for organ acquisition costs.

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

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

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

(BB) Ventilator equipment.

(CC) Home dialysis equipment and supplies.

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

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

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

(I) Asking the member to describe their smoking use;

(II) Advising the member to quit;

(III) Assessing the willingness of the member to quit;

(IV) Assisting the member with referrals and plans to quit; and

(V) Arranging for follow-up.

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

(iii) Smoking and Tobacco Use Cessation Counseling is a covered service when performed by physicians, physician assistants, advanced registered nurse practitioners, certified nurse midwives, dentists, Oklahoma State Health Department and FQHC nursing staff, and Maternal/Child Health Licensed Clinical Social Workers with a certification as a Tobacco Treatment Specialist Certification (CTTS). It is reimbursed in addition to any other appropriate global payments for obstetrical care, PCP care coordination payments, evaluation and

management codes, or other appropriate services rendered. It must be a significant, separately identifiable service, unique from any other service provided on the same day.

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

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

(GG) Genetic testing is covered when medically necessary. Genetic testing may be considered medically necessary when the following conditions are met:

(i) The member displays clinical features of a suspected genetic condition or is at direct risk of inheriting the genetic condition in question (e.g., a causative familial variant has been identified); and

(ii) Clinical studies published in peer-reviewed literature have established strong evidence that the result of the test will positively impact the clinical decision-making or clinical outcome for the member; and

(iii) The testing method is proven to be scientifically valid for the identification of a specific genetically-linked inheritable disease or clinically important molecular marker; and

(iv) Documentation is provided from a licensed genetic counselor or physician with genetic expertise that supports the recommendation for testing based on a review of risk factors, clinical scenario, and family history.

(2) General coverage exclusions include the following:

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

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

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

(D) Refractions and visual aids.

(E) Pre-operative care within 24 hours of the day of admission for surgery and routine post-operative care as defined under the global surgery guidelines promulgated by

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

(W) Payment for removal of benign skin lesions~~ unless medically necessary~~.

PART 3. HOSPITALS

317:30-5-42.17. Non-covered services

In addition to the general program exclusions [OAC 317:30-5-2(a)(2)] the following are excluded from coverage:

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

(2) Procedures that result in sterilization which do not meet the guidelines set forth in this Chapter of rules.

(3) Reversal of sterilization procedures for the purposes of conception are not covered.

(4) Medical services considered experimental or investigational.

(5) Payment for removal of benign skin lesions~~ unless medically necessary~~ for adults.

(6) Refractions and visual aids.

(7) Charges incurred while the member is in a skilled nursing or swing bed.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 3. GENERAL PROVIDER POLICIES
PART 3. GENERAL MEDICAL PROGRAM INFORMATION

317:30-3-59. General program exclusions - adults

The following are excluded from SoonerCare coverage for adults:

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

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

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

(4) Refractions and visual aids.

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

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

(7) Non-therapeutic hysterectomies.

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

(9) Medical services considered experimental or investigational.

(10) Services of a Certified Surgical Assistant.

(11) Services of a Chiropractor. Payment is made for Chiropractor services on Crossover claims for coinsurance and/or deductible only.

(12) Services of an independent licensed Physical and/or Occupational Therapist.

(13) Services of a Psychologist.

(14) Services of an independent licensed Speech and Hearing Therapist.

(15) Payment for more than four outpatient visits per month (home or office) per member, except those visits in connection with family planning or related to emergency medical conditions.
(16) Payment for more than two nursing facility visits per month.
(17) More than one inpatient visit per day per physician.
(18) Payment for removal of benign skin lesions unless medically necessary.
(19) Physician services which are administrative in nature and not a direct service to the member including such items as quality assurance, utilization review, treatment staffing, tumor board review or multidisciplinary opinion, dictation, and similar functions.
(20) Charges for completion of insurance forms, abstracts, narrative reports or telephone calls.
(21) Payment for the services of social workers, licensed family counselors, registered nurses or other ancillary staff, except as specifically set out in OHCA rules.
(22) Mileage.
(23) A routine hospital visit on the date of discharge unless the member expired.
(24) Direct payment to perfusionist as this is considered part of the hospital reimbursement.
(25) Inpatient chemical dependency treatment.
(26) Fertility treatment.
(27) Payment to the same physician for both an outpatient visit and admission to hospital on the same date.
(28) Sleep studies.

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 1. PHYSICIANS

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

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

(1) Coverage includes the following medically necessary services:

(A) Inpatient hospital visits for all SoonerCare covered stays. All inpatient services are subject to post-payment review by the OHCA, or its designated agent.
(B) Inpatient psychotherapy by a physician.
(C) Inpatient psychological testing by a physician.
(D) One inpatient visit per day, per physician.
(E) Certain surgical procedures performed in a Medicare certified free-standing ambulatory surgery center (ASC) or a Medicare certified hospital that offers outpatient surgical services.
(F) Therapeutic radiology or chemotherapy on an outpatient basis without limitation to the number of treatments per month for members with proven malignancies or opportunistic infections.
(G) Direct physician services on an outpatient basis. A maximum of four visits are allowed per month per member in office or home regardless of the number of physicians providing treatment. Additional visits per month are allowed for those services related to emergency medical conditions and for services in connection with Family Planning.
(H) Direct physician services in a nursing facility for those members residing in a long-term care facility. A maximum of two nursing facility visits per month are allowed. To receive payment for a second nursing facility visit in a month denied by Medicare for a Medicare/SoonerCare member, attach the EOMB from Medicare showing denial and mark "carrier denied coverage".
(I) Diagnostic x-ray and laboratory services.
(J) Mammography screening and additional follow-up mammograms.
(K) Obstetrical care.
(L) Pacemakers and prostheses inserted during the course of a surgical procedure.
(M) Prior authorized examinations for the purpose of determining medical eligibility for programs administered by OHCA. A copy of the authorization, OKDHS form 08MA016E, Authorization for Examination and Billing, must accompany the claim.
(N) If a physician renders direct care to a member on the same day as a dialysis treatment, payment is allowed for a separately identifiable service unrelated to the dialysis.
(O) Family planning includes sterilization procedures for legally competent members 21 years of age and over who voluntarily request such a procedure and execute the

federally mandated consent form with his/her physician. A copy of the consent form must be attached to the claim form. Separate payment is allowed for the insertion and/or implantation of contraceptive devices during an office visit. Certain family planning products may be obtained through the Vendor Drug Program. Reversal of sterilization procedures for the purposes of conception is not allowed. Reversal of sterilization procedures are allowed when medically indicated and substantiating documentation is attached to the claim.

(P) Genetic counseling.

(Q) Laboratory testing (such as complete blood count (CBC), platelet count, or urinalysis) for monitoring members receiving chemotherapy, radiation therapy, or medications that require monitoring during treatment.

(R) Payment for ultrasounds for pregnant women as specified in OAC 317:30-5-22.

(S) Payment to the attending physician in a teaching medical facility for compensable services when the physician signs as claimant and renders personal and identifiable services to the member in conformity with federal regulations.

(T) Payment to clinical fellow or chief resident in an outpatient academic setting when the following conditions are met:

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

(ii) Board certification or completion of an accredited residency program in the fellowship specialty area;

(iii) Hold unrestricted license to practice medicine in Oklahoma;

(iv) If Clinical Fellow, practicing during second or subsequent year of fellowship;

(v) Seeing members without supervision;

(vi) Services provided not for primary purpose of medical education for the clinical fellow or chief resident;

(vii) Submit billing in own name with appropriate Oklahoma SoonerCare provider number;

(viii) Additionally if a clinical fellow practicing during the first year of fellowship, the clinical fellow must be practicing within their area of primary training. The services must be performed within the

context of their primary specialty and only to the extent as allowed by their accrediting body.

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

(i) Attending physician performs chart review and signs off on the billed encounter;

(ii) Attending physician is present in the clinic/or hospital setting and available for consultation;

(iii) Documentation of written policy and applicable training of physicians in the training program regarding when to seek the consultation of the attending physician.

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

(i) The member must be at least minimally examined by the attending physician or a licensed physician under the supervision of the attending physician;

(ii) The contact must be documented in the medical record.

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

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

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

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

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

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

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

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

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

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

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

(BB) Ventilator equipment.

(CC) Home dialysis equipment and supplies.

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

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

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

(I) Asking the member to describe their smoking use;

(II) Advising the member to quit;

(III) Assessing the willingness of the member to quit;

(IV) Assisting the member with referrals and plans to quit; and

(V) Arranging for follow-up.

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

(iii) Smoking and Tobacco Use Cessation Counseling is a covered service when performed by physicians, physician assistants, advanced registered nurse practitioners, certified nurse midwives, dentists, Oklahoma State Health Department and FQHC nursing staff, and Maternal/Child Health Licensed Clinical Social Workers with a certification as a Tobacco Treatment Specialist Certification (CTTS). It is reimbursed in addition to

any other appropriate global payments for obstetrical care, PCP care coordination payments, evaluation and management codes, or other appropriate services rendered. It must be a significant, separately identifiable service, unique from any other service provided on the same day.

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

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

(GG) Genetic testing is covered when medically necessary. Genetic testing may be considered medically necessary when the following conditions are met:

(i) The member displays clinical features of a suspected genetic condition or is at direct risk of inheriting the genetic condition in question (e.g., a causative familial variant has been identified); and

(ii) Clinical studies published in peer-reviewed literature have established strong evidence that the result of the test will positively impact the clinical decision-making or clinical outcome for the member; and

(iii) The testing method is proven to be scientifically valid for the identification of a specific genetically-linked inheritable disease or clinically important molecular marker; and

(iv) Documentation is provided from a licensed genetic counselor or physician with genetic expertise that supports the recommendation for testing based on a review of risk factors, clinical scenario, and family history.

(2) General coverage exclusions include the following:

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

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

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

(D) Refractions and visual aids.

(E) Pre-operative care within 24 hours of the day of admission for surgery and routine post-operative care as

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

(W) Payment for removal of benign skin lesions unless medically necessary.
(X) Sleep studies.

PART 3. HOSPITALS

317:30-5-42.17. Non-covered services

In addition to the general program exclusions [OAC 317:30-5-2(a)(2)] the following are excluded from coverage:

(1) Inpatient admission for diagnostic studies that could be performed on an outpatient basis.
(2) Procedures that result in sterilization which do not meet the guidelines set forth in this Chapter of rules.
(3) Reversal of sterilization procedures for the purposes of conception are not covered.
(4) Medical services considered experimental or investigational.
(5) Payment for removal of benign skin lesions unless medically necessary.
(6) Refractions and visual aids.
(7) Charges incurred while the member is in a skilled nursing or swing bed.
(8) Sleep studies for adults.

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

317:30-5-22. Obstetrical care

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

(b) Procedures paid separately from total obstetrical care are listed in (1) - (8) of this subsection.

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

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

(A) One abdominal or vaginal ultrasound will be covered in the first trimester of pregnancy. The ultrasound must be performed by a ~~board certified~~Board Certified/Board Eligible Obstetrician-Gynecologist (OB-GYN), Radiologist, or a Board Eligible/Board Certified Maternal-Fetal Medicine specialist. In addition, this ultrasound may be performed by a Nurse Midwife, Family Practice Physician or Advance Practice Nurse Practitioner in Obstetrics with a certification in obstetrical ultrasonography.

(B) One ultrasound after the first trimester will be covered.

This ultrasound must be performed by a ~~board certified~~Board Eligible/Board Certified Obstetrician-Gynecologist (OB-GYN), Radiologist, or a Board Eligible/Board Certified Maternal-Fetal Medicine specialist. In addition, this ultrasound may be performed by a Nurse Midwife, Family Practice Physician or Advance Practice Nurse Practitioner in Obstetrics with certification in obstetrical ultrasonography.

~~(C) Additional ultrasounds, including detailed ultrasounds and re-evaluations of previously identified or suspected fetal or maternal anomalies must be performed by an active candidate or Board Certified diplomat in Maternal-Fetal Medicine. Up to six repeat ultrasounds are allowed after which, prior authorization is required.~~

(C) One additional ultrasound is allowed by a Board Eligible/Board Certified Maternal Fetal Specialist to identify or confirm a suspected fetal/maternal anomaly. This additional ultrasound does not require prior authorization. Any subsequent ultrasounds will require prior authorization.

(3) Standby attendance at Cesarean Section (C-Section), for the purpose of attending the baby, is compensable when billed by a physician not participating in the delivery.

(4) Spinal anesthesia administered by the attending physician is a compensable service and is billed separately from the delivery.

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

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

~~(7) One non stress test and/or biophysical profile to confirm a suspected high risk pregnancy diagnosis. The non stress test and/or biophysical profile must be performed by an active candidate or Board Certified diplomate in Maternal Fetal Medicine.~~

~~(8)~~(7) Nutritional counseling in a group setting for members with gestational diabetes. Refer to OAC 317:30-5-1076(5).

(c) Assistant surgeons are paid for C-Sections which include only in-hospital post-operative care. Family practitioners who provide

prenatal care and assist at C-Section bill separately for the prenatal and the six weeks postpartum office visit.

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

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

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

(3) Payment is not made for an assistant surgeon for obstetrical procedures that include prenatal or post partum care.

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

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

(e) Obstetrical coverage for children is the same as for adults with additional procedures being covered due to EPSDT provisions if determined to be medically necessary.

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

(2) Federal Medicaid regulations also require the State to make the determination as to whether the service is medically necessary and do not require the provision of any items or services that the State determines are not safe and effective or which are considered experimental.

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

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

(1) prenatal at risk ante partum management;

(2) a combined maximum of ~~12~~5 fetal non stress test(s) and biophysical profiles (additional units can be prior authorized for multiple fetuses)~~; and~~ with one test per week beginning at 34 weeks gestation and continuing to 38 weeks; and

(3) a maximum of ~~6~~3 repeat ultrasounds not covered under OAC 317:30-5-22(b)(2).

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

(1) ACOG or other comparable comprehensive prenatal assessment;

(2) chart note identifying and detailing the qualifying high risk condition; and

(3) an OHCA High Risk OB Treatment Plan/Prior Authorization Request (CH-17) signed by a Board Eligible/Board Certified Maternal Fetal Medicine (MFM) specialist.

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

(1) Ante partum management for high risk is reimbursed to the primary obstetrical provider. If the primary provider of obstetrical care is not the MFM and wishes to request authorization of the ante partum management fee, the OHCA CH-17 must be signed by the primary provider of OB care. Additionally, reimbursement for enhanced at risk ante partum management is not made during an in-patient hospital stay.

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

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

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 17. MEDICAL SUPPLIERS

317:30-5-210.2. Coverage for children

(a) **Coverage.** Coverage of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) for children includes the specified coverage for adults found in OAC 317:30-5-211.1 through OAC 317:30-5-211.18. In addition the following are covered items for children only:

(1) Orthotics and prosthetics.

(2) Enteral nutrition is considered medically necessary for certain conditions in which, without the products, the member's condition would deteriorate to the point of severe malnutrition.

(A) Enteral nutrition must be prior authorized. PA requests must include:

(i) the member's diagnosis;

(ii) the impairment that prevents adequate nutrition by conventional means;

(iii) the member's weight history before initiating enteral nutrition that demonstrates oral intake without enteral nutrition is inadequate;

(iv) the percentage of the member's average daily nutrition taken by mouth and by tube; and

(v) prescribed daily caloric intake.

(B) Enteral nutrition products that are administered orally and related supplies are not covered.

(3) Continuous positive airway pressure devices (CPAP).

(b) **EPSDT.** Services deemed medically necessary and allowable under federal regulations may be covered by the EPSDT Child Health program even though those services may not be part of the SoonerCare program. These services must be prior authorized.

(c) **Medical necessity.** Federal regulations require OHCA to make the determination as to whether the service is medically necessary and do not require the provision of any items or services that the State determines are not safe and effective or that are considered experimental.

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

317:30-5-20. Laboratory services

This Section covers the guidelines for payment of laboratory services by a provider in his/her office, a certified laboratory and for a pathologist's interpretation of laboratory procedures.

(1) ~~**Covered lab**~~ **Compensable services.** Providers may be ~~paid~~ reimbursed for ~~covered~~compensable clinical diagnostic laboratory services only when they personally perform or supervise the performance of the test. If a provider refers specimen to a certified laboratory or a hospital laboratory serving outpatients, the certified laboratory or the hospital must bill for performing the test.

(A) Reimbursement for lab services is made in accordance with the Clinical Laboratory Improvement Amendment of 1988 (CLIA). These regulations provide that payment may be made only for services furnished by a laboratory that meets CLIA conditions, including those furnished in physicians' offices. Eligible providers must be certified under the CLIA program and have obtained a CLIA ID number from CMS and have a current contract on file with the OHCA.

~~(B) Reimbursement rate for laboratory procedures is the lesser of the CMS National 60% fee or the local carrier's allowable (whichever is lower).~~

~~(C) Medically necessary laboratory services are covered~~.

(B) Only medically necessary laboratory services are compensable.

~~(2) **Compensable outpatient laboratory services.** Medically necessary laboratory services are covered.~~

~~(3)~~(2) **Non-compensable laboratory services.**

(A) Separate payment is not made for blood specimens obtained by venipuncture or urine specimens collected by a laboratory. These services are considered part of the laboratory analysis.

(B) Claims for inpatient full service laboratory procedures are not covered since this is considered a part of the hospital rate.

(C) Billing multiple units of nucleic acid detection, whether using the direct probe or amplified probe technique, for single infectious organisms when testing for more than one infectious organism in a specimen is not permissible.

(D) Laboratory services not considered medically necessary are not covered.

~~(4)~~(3) **Covered services by a pathologist.**

(A) A pathologist may be paid for interpretation of inpatient surgical pathology specimen~~. The appropriate CPT procedure code and modifier is used.~~ when the appropriate CPT procedure code and modifier is used.

(B) Full service or interpretation of surgical pathology for outpatient surgery performed in an outpatient hospital or Ambulatory Surgery Center setting.

~~(5)~~(4) **Non-compensable services by a pathologist.** The following are non-compensable pathologist services:

(A) Tissue examinations for identification of teeth and foreign objects.

(B) Experimental or investigational procedures.

(C) Interpretation of clinical laboratory procedures.

317:30-5-20.1. Urine drug screening and testing

(a) **Purpose.** Urine Drug Testing (UDT) is performed to identify aberrant behavior, undisclosed drug use and/or abuse, and verify compliance with treatment. Aberrant behaviors may include early refill requests (self-escalation), reports of "lost or stolen" medications, treatment noncompliance, and UDT that does not include the prescribed drug and may include illicit or non-prescribed controlled substances. Testing for drugs of abuse to monitor treatment compliance should be included in the treatment plan for pain management when chronic opioid therapy is involved.

(1) Qualitative drug testing is used to determine the presence or absence of a drug or drug metabolite in the urine sample and is expressed as a positive or negative result. Qualitative testing can be performed by a CLIA waived or moderate complexity test, or by a high complexity testing method.

(2) Confirmation testing is used to verify the results of a point of care test result.

(3) Quantitative drug testing is specific to the drug or metabolite being tested and is expressed as a numeric result or numeric level.

(4) Specimen validity testing is used to determine if a urine specimen has been diluted, adulterated or substituted. Specimen validity tests include, but are not limited to, creatinine, oxidants, specific gravity, urine pH, nitrates and alkaloids.

(b) **Eligible providers**. Providers performing urine drug testing should have CLIA certification specific to the level of testing performed as described in 317:30-5-20(1)(A). High complexity laboratory services must be performed by an independent laboratory. Medical devices utilized for testing must have been

certified by the Food and Drug Administration as approved to perform at the level of testing being submitted for compensation.

(c) **Compensable services**. Urine drug testing must be ordered by the physician or non-physician provider and must be individualized to the patient and the patient's medical history or assessment indicators as evidenced in the medical documentation.

(1) Compensable testing must be medically indicated as evidenced by patient specific indications in the medical record.

(A)Testing is only compensable if the results will affect patient care.

(B)Drugs or drug classes being tested should reflect only those likely to be present.

(2) The frequency of urine drug screening and/or testing is determined by the patient's history, patient's physical assessment, behavioral assessment, risk assessment, treatment plan and medication history.

(3) Confirmatory testing should be performed only for the drug class represented by the positive screening. A positive screening is indicated when:

(A) The initial test is positive for medications the member is NOT reported to be taking; or

(B) Negative for prescribed medications; or

(C) Positive for illicit drugs when the member denies utilization.

(4) Quantitative testing of urine is compensable when utilized for surveillance of therapeutic levels of prescribed medications, when there is no commercially available qualitative test available, or for when the specific level must be obtained for clinical decision making, i.e. the patient is comatose or obtunded.

(d) **Non-compensable services**. The following tests are not medically necessary and therefore not covered by the OHCA:

(1) Specimen validity testing is considered a quality control measure and is not separately compensable;

(2) Drug testing for patient sample sources of saliva, oral fluids, or hair;

(3) Testing of two different specimen types (urine and blood) from the same patient on the same date of service;

(4) Drug screening and/or testing for medico-legal purposes (court ordered drug screening) or for employment purposes;

(5) Non-specific, standing panel orders for urine drug testing, custom panels specific for the ordering provider, routine testing of therapeutic drug levels or drug panels which have no impact to the member's plan of care;

(6) Scheduled and routine urine drug testing (i.e. testing should be random);
(7) Automatic confirmatory testing for any drug is not medically indicated without specific documented indications;
(8) Confirmatory testing exceeding 3 specific drug classes at an interval of greater than every 30 days will require specific documentation in the medical record to justify the medical necessity of testing; and
(9) Quantitative testing of multiple drug levels that are not specific to the patient's medical history and presentation are not allowed. Justification for testing for each individual drug or drug class level must be medically indicated as reflected in the medical record documentation.

(e) **Documentation requirement.** The medical record must contain documents to support the medical necessity of drug screening and/or testing. Medical records must be furnished on request and may include, but are not limited to, the following:
(1) A treatment plan which adheres to the appropriate state regulatory requirements;
(2) Patient history and physical;
(3) Review of previous medical records if treated by a different physician for pain management;
(4) Review of all radiographs and/or laboratory studies pertinent to the patient's condition;
(5) Current treatment plan;
(6) Opioid agreement and informed consent of UDT, as applicable;
(7) List of prescribed medications;
(8) Risk assessment, as identified by use of a validated risk assessment tool/questionnaire, with appropriate risk stratification noted and utilized;
(9) Office/provider monitoring protocols, such as random pill counts, etc.; and
(10) Review of prescription drug monitoring data or pharmacy profile as warranted.

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

317:30-3-11. Timely filing limitation

(a) ~~According to federal regulations, claims must be received by the Fiscal Agent within one year from the date of service.~~ According to federal regulations, the Authority must require providers to submit all claims no later than 12 months from the date of service. Federal regulations provide no exceptions to this requirement. For dates of service provided on or after July 1, 2015, the timely filing limit, for SoonerCare reimbursement, is 6 months from the date of service. Payment will not be made on claims when more than ~~12~~6 months have elapsed between the date the service was provided and the date of receipt of the claim by the Fiscal Agent. ~~Federal regulations provide no exceptions to this requirement. Because of this requirement, caution should be exercised to assure claims are filed timely in all cases where an application for assistance has been filed. The following procedure is recommended. If the service is approaching the one year time limit and a case number has not been assigned and an approval for medical assistance has not been received, or there is a case number but the medical assistance case has not been approved, or a provider contract has not been approved, file a claim. The claim will be denied, however, the denial is proof of timely filing.~~ A denied claim can be considered proof of timely filing.

(b) Claims may be submitted anytime during the month.

(c) To be eligible for payment under ~~Medicaid~~SoonerCare, claims for coinsurance and/or deductible must meet the Medicare timely filing requirements. If a claim for payment under Medicare has been filed in a timely manner, the Fiscal Agent must receive a ~~Medicaid~~SoonerCare claim relating to the same services within 90 days after the agency or the provider receives notice of the disposition of the Medicare claim.

317:30-3-11.1. Resolution of claim payment

(a) After the submission of a claim from a provider which had been adjudicated by the Authority, a provider may resubmit the claim under the following rules.

(b) The provider must have submitted the claim initially under the timely filing requirements found at OAC 317:30-3-11.

(c) ~~The provider's resubmission of the claim must be received by the Oklahoma Health Care Authority no later than 24 months from the date of service.~~For dates of service provided on or after July 1, 2015, the provider's resubmission of the claim must be received by the Oklahoma health Care Authority no later than 12 months from the

date of service. The only exceptions to the ~~24~~ 12 month resubmission claim deadline are the following:

(1) administrative agency corrective action or agency actions taken to resolve a dispute, or

(2) reversal of the eligibility determination, or

(3) investigation for fraud or abuse of the provider, or

(4) court order or hearing decision.

CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 3. HOSPITALS

317:30-5-44. Medicare eligible individuals

Payment is made to hospitals for services to Medicare eligible individuals as set forth in this section.

(1) Claims filed with Medicare automatically cross over to OHCA. The explanation of Medicare Benefits (EOMB) reflects a message that the claim was referred to SoonerCare. If such a message is not present, a claim for coinsurance and deductible must be filed with the OHCA within 90 days of the date of Medicare payment ~~or~~ and within one year of the date of service in order to be considered timely filed.

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

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

(4) For individuals who have exhausted Medicare Part A benefits, claims must be accompanied by a statement from the Medicare Part A intermediary showing the date benefits were exhausted.

CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 83. RESIDENTIAL BEHAVIOR MANAGEMENT SERVICES IN FOSTER CARE SETTINGS

317:30-5-744. Billing

~~(a) Claims must not be submitted prior to OHCA's determination of the member's eligibility, and must not be submitted later than 1 year after the date of service. If the eligibility of the individual has not been determined after ten months from the date of service, a claim should be submitted in order to assure that the claim is timely filed and reimbursement from SoonerCare funds can be made should the individual be determined eligible at a later date.~~

(a) Claims must be submitted in accordance with guidelines found at

OAC 317:30-3-11 and 317:30-3-11.1.
(b) Claims for dually eligible individuals (Medicare/Medicaid) should be filed directly with the OHCA.

CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 87. BIRTHING CENTERS

317:30-5-893. Billing

Billing for birthing center services will be on HCFA-1500. ~~Under Medicaid, the claim must be received by OHCA within 12 months of the date of service in order to be eligible for payment. If the eligibility of the individual has not been determined after ten months from the date of services, a claim should be submitted in order to assure that the claim is timely filed and reimbursement from Title XIX funds can be made should the individual be determined eligible at a later date.~~Claims must be submitted in accordance with guidelines found at OAC 317:30-3-11 and 317:30-3-11.1.

CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 97. CASE MANAGEMENT SERVICES FOR UNDER AGE 18 AT RISK OF OR IN THE TEMPORARY CUSTODY OR SUPERVISION OF OFFICE OF JUVENILE AFFAIRS

317:30-5-973. Billing

Billing for case management services is on Form HCFA-1500. ~~Claims should not be submitted until Medicaid eligibility of the individual has been determined. However, a claim must be received by OHCA within 12 months of the date of service. If the eligibility of the individual has not been determined after ten months from the date of service, a claim should be submitted in order to assure that the claim is timely filed and reimbursement from Title XIX funds can be made should the individual be determined eligible at a later date.~~Claims must be submitted in accordance with guidelines found at OAC 317:30-3-11 and 317:30-3-11.1.

CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 99. CASE MANAGEMENT SERVICES FOR UNDER AGE 18 IN EMERGENCY, TEMPORARY OR PERMANENT CUSTODY OR SUPERVISION OF THE DEPARTMENT OF HUMAN SERVICES

317:30-5-993. Billing

Billing for case management services is on Form HCFA-1500. ~~Claims should not be submitted until Medicaid eligibility of the individual has been determined. However, a claim must be received by OHCA within 12 months of the date of service. If the eligibility~~

~~of the individual has not been determined after ten months from the date of service, a claim must be submitted in order to assure that the claim is timely filed and reimbursement from Title XIX funds can be made should the individual be determined eligible at a later date.~~Claims must be submitted in accordance with guidelines found at OAC 317:30-3-11 and 317:30-3-11.1.

CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 105. RESIDENTIAL BEHAVIORAL MANAGEMENT SERVICES IN GROUP SETTINGS AND NON-SECURE DIAGNOSTIC AND EVALUATION CENTERS

317:30-5-1045. Billing

(a) Billing is on the HCFA-1500.

~~(b) Claims should not be submitted until the Medicaid eligibility of the individual has been determined. However, a claim must be received by the fiscal agent within 12 months of the date of service. If the eligibility of the individual has not been determined after ten months from the date of service, a claim is submitted in order to assure that the claim is timely filed and reimbursement from Title XIX funds can be made should the individual be determined eligible at a later date.~~

(b) Claims must be submitted in accordance with guidelines found at OAC 317:30-3-11 and 317:30-3-11.1.

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

317:30-5-22. Obstetrical care

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

(b) Procedures paid separately from total obstetrical care are listed in (1) - (8) of this subsection.

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

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

(A) One abdominal or vaginal ultrasound will be covered in the first trimester of pregnancy. The ultrasound must be performed by a ~~board certified~~Board Eligible/Board Certified Obstetrician-Gynecologist (OB-GYN), Radiologist, or a Board Eligible/Board Certified Maternal-Fetal Medicine specialist. In addition, this ultrasound may be performed by a Nurse Midwife, Family Practice Physician or Advance Practice Nurse Practitioner in Obstetrics with a certification in obstetrical ultrasonography.

(B) One ultrasound after the first trimester will be covered.

This ultrasound must be performed by a ~~board certified~~Board Eligible/Board Certified Obstetrician-Gynecologist (OB-GYN), Radiologist, or a Board Eligible/Board Certified Maternal-Fetal Medicine specialist. In addition, this ultrasound may be performed by a Nurse Midwife, Family Practice Physician or Advance Practice Nurse Practitioner in Obstetrics with certification in obstetrical ultrasonography.

~~(C) Additional ultrasounds, including detailed ultrasounds and re-evaluations of previously identified or suspected fetal or maternal anomalies must be performed by an active candidate or Board Certified diplomat in Maternal-Fetal Medicine, or Board Certified Obstetrician-Gynecologist (OB-GYN). Up to six repeat ultrasounds are allowed after which, prior authorization is required.~~

(C) One additional detailed ultrasound is allowed by a Board Eligible/Board Certified Maternal Fetal Specialist to identify or confirm a suspected fetal/maternal anomaly. This additional ultrasound does not require prior authorization. Any subsequent ultrasounds will require prior authorization.

(3) Standby attendance at Cesarean Section (C-Section), for the purpose of attending the baby, is compensable when billed by a physician not participating in the delivery.

(4) Spinal anesthesia administered by the attending physician is a compensable service and is billed separately from the delivery.

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

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

~~(7) One non stress test and/or biophysical profile to confirm a suspected high risk pregnancy diagnosis. The non stress test and/or biophysical profile must be performed by an active candidate or Board Certified diplomate in Maternal Fetal Medicine, or Board Certified Obstetrician-Gynecologist (OB-GYN).~~

~~(8)~~(7) Nutritional counseling in a group setting for members with gestational diabetes. Refer to OAC 317:30-5-1076(5).

(c) Assistant surgeons are paid for C-Sections which include only in-hospital post-operative care. Family practitioners who provide

prenatal care and assist at C-Section bill separately for the prenatal and the six weeks postpartum office visit.

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

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

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

(3) Payment is not made for an assistant surgeon for obstetrical procedures that include prenatal or post partum care.

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

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

(e) Obstetrical coverage for children is the same as for adults with additional procedures being covered due to EPSDT provisions if determined to be medically necessary.

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

(2) Federal Medicaid regulations also require the State to make the determination as to whether the service is medically necessary and do not require the provision of any items or services that the State determines are not safe and effective or which are considered experimental.

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

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

(1) prenatal at risk ante partum management;

(2) a combined maximum of ~~12~~5 fetal non stress test(s) and biophysical profiles (additional units can be prior authorized for multiple fetuses~~); and~~ with one test per week beginning at 34 weeks gestation and continuing to 38 weeks; and

(3) a maximum of ~~6~~3 repeat ultrasounds not covered under OAC 317:30-5-22(b)(2).

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

(1) ACOG or other comparable comprehensive prenatal assessment;

(2) chart note identifying and detailing the qualifying high risk condition; and

(3) an OHCA High Risk OB Treatment Plan/Prior Authorization Request (CH-17) signed by a Board Eligible/Board Certified Maternal Fetal Medicine (MFM) specialist, or Board Certified Obstetrician-Gynecologist (OB-GYN).

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

(1) Ante partum management for high risk is reimbursed to the primary obstetrical provider. If the primary provider of obstetrical care is not the MFM and wishes to request authorization of the ante partum management fee, the OHCA CH-17 must be signed by the primary provider of OB care. Additionally, reimbursement for enhanced at risk ante partum management is not made during an in-patient hospital stay.

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

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

State Plan Amendment Rate Committee (SPARC)
June 18, 2015
Diagnosis-Related Group (DRG) Hospital

1. Is this a "Rate Change" or a "Method Change"?
   Method change

1b. Is this change an increase, decrease, or no impact?
   Decrease

2. Presentation of issue – Why is change being made?
   The Oklahoma Health Care Authority (OHCA) recommends a revision to the current methodology and reimbursement structure for Diagnosis-Related Group (DRG) Hospital Payments.

   The Oklahoma Health Care Authority Board must take action to reduce SoonerCare expenditures to file a balanced budget. As a result, OHCA recommends the following method change. This change is being made to comply with the Oklahoma Constitution, Article X, Section 23, which prohibits a state agency from spending more money than is allocated.

   Federal Requirements:
   State Medicaid programs generally have considerable flexibility in determining the reimbursement methodology and resulting rate for services, within federally-imposed upper limits and specific restrictions. Section 1902(a)(30)(A) of the Social Security Act requires that State Medicaid programs must assure that payment rates :

   - Be consistent with efficiency, economy and quality of care;
   - Are sufficient to enlist enough providers so that Medicaid care and services are available under the state plan at least to the extent that such care and services are available to the general population in that geographic area.

   OHCA Finance staff has reviewed various provider payment types and services that are funded by state appropriations from the legislature to the OHCA. The proposed changes for DRG Payments to Inpatient Acute Care Hospitals and Critical Access Hospitals are outlined below.

3. Current methodology and/or rate structure.

New Methodology	Current Methodology
Reduce Diagnosis-Related Group (DRG) Outlier payments by increasing the DRG threshold to $50,000. Costs (billed amount times hospital specific cost to charge ratio) on the claim must now be $50,000 (was $27,000) greater than the DRG base payment to trigger a high cost outlier payment. The outlier calculation description: *Outlier Amount = (claim total amount billed) X (billing provider's Cost-*	Currently, the DRG threshold is $27,000. It varies from state to state which threshold amount is used and how it is applied.

to-Charge Ratio (CCR) - (DRG Weight X Peer Group Base Rate) – (threshold of $50,000) X (marginal cost factor 70%), or zero, whichever is greater.	
Pay the lesser of billed charges or the Diagnosis-Related Group (DRG) amount. For DRG claims, the payment may not exceed billed charges.	Currently, payment is made at the DRG allowable amount.
Transfers pay the lesser of transfer fee or Diagnosis-Related Group (DRG). In the case of a transfer, the Transfer Allowable Fee for the Transferring Facility shall be calculated as follows: *Transfer Allowable Fee = (MS-DRG Allowable Fee/Mean Length of Stay) X (Length of Stay + 1 day).* The total Transfer Allowable Fee paid to the transferring facility shall be capped at the amount of the MS-DRG Allowable Fee for a non-transfer case. No outlier payments will be paid to the transferring hospital on transfer cases. Payment to the receiving facility, if it is also the discharging facility, will be at the DRG allowable plus outlier if applicable.	Currently, both the transferring facility and the receiving facility are paid at the DRG allowable plus outlier if applicable.

*MS-DRG means Medical Severity Diagnosis Related Groups

4. New methodology or rate.
   See the new methodology in the table above.

5. Budget estimate.
   The change in the outlier threshold will result in an estimated annual savings in the amount of $18,881,600 total dollars; $6,694,786 state share.

   Paying the lesser of the billed charges or DRG will result in an estimated annual savings in the amount of $11,914,717 total dollars; $4,224,561 state share.

   Paying the lesser of the transfer fee or DRG will result in an estimated annual savings in the amount of $2,774,924 total dollars; $983,896 state share.

   All three DRG changes implemented together will result in a total estimated annual savings of $33,571,241 total dollars; $11,903,243 state share.

6. Agency estimated impact on access to care.
   This method change should not have a negative impact to access and quality of care to SoonerCare members.

7. Rate or Method change in the form of a motion.
   The agency requests the State Plan Amendment Rate Committee to approve the method change for the DRG Hospital payments.

8. Effective date of change.
   July 1, 2015.

State Plan Amendment Rate Committee (SPARC)
June 18, 2015
Facility vs. Non-Facility Relative Value Unit (RVU) Expenses

1. Is this a "Rate Change" or a "Method Change"?
   Method change

1b. Is this change an increase, decrease, or no impact?
   Decrease

2. Presentation of issue – Why is change being made?
   The Oklahoma Health Care Authority (OHCA) recommends a revision to the current methodology and reimbursement structure for physician/practitioner Resource Based Relative Value Scale (RBRVS) reimbursement. The OHCA is proposing a methodology similar to Medicare for assigning Relative Value Units (RVUs) based on Facility or Non-Facility place of service. Currently, the OHCA exclusively uses the non-facility RVU.

   The Oklahoma Health Care Authority Board must take action to reduce SoonerCare expenditures to file a balanced budget. As a result, OHCA recommends the following method change. This change is being made to comply with the Oklahoma Constitution, Article X, Section 23, which prohibits a state agency from spending more money than is allocated.

   Federal Requirements:
   State Medicaid programs generally have considerable flexibility in determining the reimbursement methodology and resulting rate for services, within federally-imposed upper limits and specific restrictions. Section 1902(a)(30)(A) of the Social Security Act requires that State Medicaid programs must assure that payment rates :

   - Be consistent with efficiency, economy and quality of care;
   - Are sufficient to enlist enough providers so that Medicaid care and services are available under the state plan at least to the extent that such care and services are available to the general population in that geographic area.

   OHCA Finance staff has reviewed various provider payment types and services that are funded by state appropriations from the legislature to the OHCA. The proposed changes for physician/practitioner Resource Based Relative Value Scale (RBRVS) reimbursement are outlined below.

3. Current methodology and/or rate structure.
   Currently, OHCA applies the non-facility Relative Value Units (RVUs) to all physician/practitioner Resource Based Relative Value Scale (RBRVS) reimbursed services.

4. New methodology or rate.
   Pay like Medicare for physician services performed in a facility place of service (21-Inpatient Hospital, 22-Outpatient Hospital, 23-Emergency Room, 24-Ambulatory Surgical Center, 31-Skilled Nursing Facility, or 42-Ambulance Air, etc.). The Medicare Physician Fee Schedule has Relative Value Units (RVUs) for some Current Procedural Terminology (CPT) codes for both facility and non-facility places of service. For the CMS developed fee schedule, each code has three components: work RVU, practice

expense RVU and malpractice expense RVU. For services performed in a facility the practice expense RVU is typically lower because not as much expense is required for overhead, staff, equipment and supplies. The non-facility RVU is for services performed in the office or home and these RVUs are in most cases higher because the physician practice has greater overhead expense. The OHCA will implement an edit that will detect place of service and apply the correct RVU (facility or non-facility), thus applying the correct RVU Practice Expense similar to Medicare. This change will apply to all rendering physicians/practitioners reimbursed based on the physician RBRVS fee schedule.

For example, CPT code 36557 (Insertion of tunneled centrally inserted central venous catheter, without subcutaneous port or pump; under 5 years of age):
Note: These values are used for this demonstration only and are not real values.

Work RVU:	5.09
Non-Facility Practice Expense RVU:	21.20
Malpractice RVU:	0.57

Total RVUs (adjusted for Oklahoma region-Geographic Pricing Cost Index (GPCI): 23.41254
Total RVUs multiplied by the statewide conversion factor 37.8975 results in a fee of $887.28. For state employed physicians, this would be $1,242.19.

In the new method, this service is identified as performed in the hospital setting, and payment will be:

Work RVU:	5.09
Facility Practice Expense RVU:	2.66
Malpractice RVU:	0.57

Total RVUs (adjusted for Oklahoma region- Geographic Pricing Cost Index (GPCI): 7.57938
Total RVUs multiplied by the statewide conversion factor 37.8975 results in a fee of $287.24. For state employed physicians, this would be $402.14.

5. Budget estimate.
   The change will result in an estimated annual savings in the amount of $7,376,605 total dollars; $2,615,498 state share.

6. Agency estimated impact on access to care.
   This method change should not have a negative impact to access and quality of care to SoonerCare members.

7. Rate or Method change in the form of a motion.
   The agency requests the State Plan Amendment Rate Committee to approve the method change for physician/practitioner RBRVS reimbursement.

8. Effective date of change.
   July 1, 2015.

State Plan Amendment Rate Committee (SPARC)
June 18, 2015
Medicare Crossover Claims (Coinsurance and Deductible) for Nursing Facilities

1. Is this a rate change or a method change?
   This is a method change.

1b. Is this change an increase, decrease or no impact?
   This change will decrease crossover claims payment from 100% to 75%. The annual expenditures will decrease by an estimated $6,179,930 ($2,191,197 in State funds).

2. Presentation of Issue – Why is change being made?
   The Oklahoma Health Care Authority (OHCA) recommends a revision to the current methodology for payment of crossovers.

   The Oklahoma Health Care Authority Board must take action to reduce SoonerCare expenditures to file a balanced budget. As a result, OHCA recommends the following rate change. This change is being made to comply with the Oklahoma Constitution, Article X, Section 23, which prohibits a state agency from spending more money than is allocated.

   Federal Requirements:
   State Medicaid programs generally have considerable flexibility in determining the reimbursement methodology and resulting rate for services, within federally-imposed upper limits and specific restrictions. Section 1902(a)(30)(A) of the Social Security Act requires that State Medicaid programs must assure that payment rates :
   - Be consistent with efficiency, economy and quality of care;
   - Are sufficient to enlist enough providers so that Medicaid care and services are available under the state plan at least to the extent that such care and services are available to the general population in that geographic area.

   OHCA Finance staff has reviewed various provider payment types and services that are funded by state appropriations from the legislature to the OHCA. The proposed changes for crossovers are outlined below.

3. Current Methodology/Rate Structure.
   The current rate methodology pays the crossover claims at 100%.

4. New Methodology/Rate Structure.
   The proposed rate methodology is to pay crossover claims at 75%

5. Budget Estimate.
   The annual budget will decrease by an estimated total of $6,179,930 funded by $2,191,197 in state funds.

6. Estimated impact on access to care.
   This change will continue to insure access for this fragile population by insuring the financial viability of these facilities.

State Plan Amendment Rate Committee (SPARC)
June 18, 2015
Medicare Crossover Claims (Coinsurance and Deductible) for Nursing Facilities

7. Rate or Method change in the form of a motion.
   The agency requests the State Plan Amendment Rate Committee to approve the method for Deductibles & Co-insurance for nursing facility Medicare Crossover claims at 75%.

8. Effective Date of Change.
   July 1, 2015

State Plan Amendment Rate Committee (SPARC)
June 18, 2015
Polycarbonate Lens

1. Is this a "Rate Change" or a "Method Change"?
   Rate Change

1b. Is this change an increase, decrease, or no impact?
   Decrease

2. Presentation of issue – Why is change being made?
   The OHCA has paid $6.45 million dollars for polycarbonate lenses for CY 2014 based on claims data retrieved April 2015. Current payment for frames for CY 2014 is less at $5.73 million, and single vision lenses totals $6.57 million in CY 2014.

   Other states pay for polycarbonate lenses based on diagnosis (for members with high probability of falls); based on age limitations (up to 7 years old in Iowa); or require PA for this service. Oklahoma has no limitations on polycarbonate other than "when medically necessary".

   The rate was $7.06 per lens until 2007, when it was restructured and changed to $34.01 per lens. The rate was restructured in September 2007 to align with CMS DME pricing. However, our understanding is the CMS rate is indicative of the lens AND polycarbonate (as one unit), not as an add on code, in addition to the lens.

3. Current methodology and/or rate structure.
   Current rate is set at max fee methodology, and for BR2015 is set at $30.35 per lens. (HCPC V2784), resulting in a payment of $60.70 per pair of glasses for polycarbonate lens.

4. New methodology or rate.
   Many states bundle polycarbonate lens into the cost of the lens. Some states have sole source providers and do not pay separately for polycarbonate lens. The cost of polycarbonate lens to the provider is between $9.00 to $25.00 per pair of glasses, depending on single vision or plastic lenses. Some states reimburse between $4.57 to $45.00 for polycarbonate lens.

   OHCA proposes to decrease the reimbursement of the polycarbonate lens to $10.00 per unit, or $20.00 per pair of glasses.

5. Budget estimate.
   Based on the number of units reimbursed for CY14, should the reimbursement of V2784 polycarbonate lenses be reduced to $10.00 per lens, the estimated annual cost for polycarbonate lens would change from $6.45 million to $2.36 million, a total cost savings of $4,150,150, with state savings of $1,471,505.

6. Agency estimated impact on access to care.
   There is no impact to access to care estimated. Reimbursement will still cover the cost of the polycarbonate lens.

7. Rate or Method change in the form of a motion.
   The agency requests the SPARC to approve the new reimbursement methodology.

8. Effective date of change.
   July 1, 2015.

CODE	DESCRIPTION	RATE 7/1/2014	# UNIQUE CLAIMS 2014	# UNIQUE MEMBERS 2014	# UNITS PAID CY2014	REIMB CY2014	OHCA PA
V2020	**Frames**	$44.88		110,153	125,413	$5,733,575	
V2784	**Polycarbonate**	$30.35	119,472	104,641	235,505	$6,450,037	
	Single Vision Lense, Glass or Plastic						
V2100	Sphere, single vision, plano to plus or minus 4.00, per lens	$28.03	74,640	64,499	141,417	$3,794,678	
V2101	Sphere, single vision, plus or minus 4.12 to plus or minus 7.00d, per lens	$29.54	2,537	2,334	4,305	$129,521	
V2102	Sphere, single vision, plus or minus 7.12 to plus or minus 20.00d, per lens	$41.57	772	680	1,460	$51,577	
V2103	Spherocylinder, single vision, plano to plus or minus 4.00d sphere, 0.12 to 2.00d cylinder, per lens	$24.34	43,939	39,745	78,512	$1,963,061	
V2104	Spherocylinder, single vision, plano to plus or minus 4.00d sphere, 2.12 to 4.00d cylinder, per lens	$26.96	6,135	5,417	9,657	$267,823	
V2105	Spherocylinder, single vision, plano to plus or minus 4.00d sphere, 4.25 to 6.00d cylinder, per lens	$29.35	1,188	1,064	1,761	$52,872	
V2106	Spherocylinder, single vision, plano to plus or minus 4.00d sphere, over 6.00d cylinder, per lens	$32.57	151	123	243	$7,759	
V2107	Spherocylinder, single vision, plus or minus 4.25 to plus or minus 7.00 sphere, 0.12 to 2.00d cylinder, per lens	$30.98	3,379	3,024	5,475	$172,265	
V2108	Spherocylinder, single vision, plus or minus 4.25d to plus or minus 7.00d sphere, 2.12 to 4.00d cylinder, per lens	$32.08	1,104	965	1,641	$53,145	
V2109	Spherocylinder, single vision, plus or minus 4.25 to plus or minus 7.00d sphere, 4.25 to 6.00d cylinder, per lens	$35.49	314	279	456	$16,007	
V2110	Spherocylinder, single vision, plus or minus 4.25 to 7.00d sphere, over 6.00d cylinder, per lens	$35.02	53	52	93	$2,892	
V2111	Spherocylinder, single vision, plus or minus 7.25 to plus or minus 12.00d sphere, 0.25 to 2.25d cylinder, per lens	$36.50	542	489	859	$31,230	
V2112	Spherocylinder, single vision, plus or minus 7.25 to plus or minus 12.00d sphere, 2.25d to 4.00d cylinder, per lens	$39.85	265	226	401	$15,508	
V2113	Spherocylinder, single vision, plus or minus 7.25 to plus or minus 12.00d sphere, 4.25 to 6.00d cylinder, per lens	$44.91	78	68	108	$4,479	
V2114	Spherocylinder, single vision, sphere over plus or minus 12.00d, per lens	$48.65	120	106	212	$9,948	
V2115	Lenticular, (myodisc), per lens, single vision	$52.95	6	4	10	$501	
V2118	Aniseikonic lens, single vision	$52.49	0	0	0	$0	✶
V2121	Lenticular lens, per lens, single	$54.20	0	0	0	$0	✶
V2199	Not otherwise classified, single vision lens	manual	3	3	6	$459	✶
						$6,573,725	
	Bifocal, Glass or Plastic						
V2200	Sphere, bifocal, plano to plus or minus 4.00d, per lens	$36.69	1,353	1,234	2,539	$91,407	
V2201	Sphere, bifocal, plus or minus 4.12 to plus or minus 7.00d, per lens	$39.99	70	61	115	$4,767	
V2202	Sphere, bifocal, plus or minus 7.12 to plus or minus 20.00d, per lens	$47.07	31	29	59	$2,791	
V2203	Spherocylinder, bifocal, plano to plus or minus 4.00d sphere, 0.12 to 2.00d cylinder, per lens	$37.02	673	624	1,159	$43,504	

V2204	Spherocylinder, bifocal, plano to plus or minus 4.00d sphere, 2.12 to 4.00d cylinder, per lens	$38.70	126	111	209	$8,321	
V2205	Spherocylinder, bifocal, plano to plus or minus 4.00d sphere, 4.25 to 6.00d cylinder, per lens	$41.85	13	12	20	$837	
V2206	Spherocylinder, bifocal, plano to plus or minus 4.00d sphere, over 6.00d cylinder, per lens	$44.95	6	4	11	$478	
V2207	Spherocylinder, bifocal, plus or minus 4.25 to plus or minus 7.00d sphere, 0.12 to 2.00d cylinder, per lens	$40.89	92	82	155	$2,376	
V2208	Spherocylinder, bifocal, plus or minus 4.25 to plus or minus 7.00d sphere, 2.12 to 4.00d cylinder, per lens	$42.92	32	30	55	$2,376	
V2209	Spherocylinder, bifocal, plus or minus 4.25 to plus or minus 7.00d sphere, 4.25 to 6.00d cylinder, per lens	$46.22	3	3	4	$189	
V2210	Spherocylinder, bifocal, plus or minus 4.25 to plus or minus 7.00d sphere, over 6.00d cylinder, per lens	$50.97	0	0	0	$0	
V2211	Spherocylinder, bifocal, plus or minus 7.25 to plus or minus 12.00d sphere, 0.25 to 2.25d cylinder, per lens	$52.87	20	19	34	$1,654	
V2212	Spherocylinder, bifocal, plus or minus 7.25 to plus or minus 12.00d sphere, 2.25 to 4.00d cylinder, per lens	$54.58	7	6	13	$760	
V2213	Spherocylinder, bifocal, plus or minus 7.25 to plus or minus 12.00d sphere, 4.25 to 6.00d cylinder, per lens	$55.14	2	2	2	$120	
V2214	Spherocylinder, bifocal, sphere over plus or minus 12.00d, per lens	$59.93	6	6	11	$675	
V2215	Lenticular (myodisc), per lens, bifocal	$60.84	3	3	6	$375	
V2218	Aniseikonic, per lens, bifocal	$72.40	0	0	0	$0	✶
V2219	Bifocal seg width over 28mm	$31.87	0	0	0	$0	✶
V2220	Bifocal add over 3.25d	$25.85	0	0	0	$0	✶
V2221	Lenticular lens, per lens, bifocal	$63.23	0	0	0	$0	✶
V2299	Specialty bifocal (by report)	manual	3	3	6	$379	✶
						$161,009	

Contact Lenses

V2510	Contact lens, gas permeable, spherical, per lens	$79.42	6	6	8	$559	
V2511	Contact lens, gas permeable, toric, prism ballast, per lens	$114.10	1	1	1	$228	
V2513	Contact lens, gas permeable, extended wear, per lens	$113.21	21	15	31	$3,252	
V2520	Contact lens, hydrophilic, spherical, per lens	$74.65	15	13	25	$1,730	
V2521	Contact lens, hydrophilic, toric, or prism ballast, per lens	$129.96	7	5	11	$1,037	
V2523	Contact lens, hydrophilic, extended wear, per lens	$107.78	42	19	57	$6,067	
V2530	Contact lens, scleral, gas impermeable, per lens (for contact lens modification, see 92325)	$133.88	4	4	6	$803	
V2599	Contact lens, other type	manual	1	1	1	$185	✶

V2700	Balance lens, per lens	$31.36	10	9	11	$308	
V2710	Slab off prism, glass or plastic, per lens	$45.89	1	1	1	$46	
V2715	Prism, per lens	$8.32	671	620	1,184	$9,209	
V2718	Press on lens, Fresnel prism, per lens	$20.44	7	6	13	$111	
V2730	Special base curve glass or plastic per lens	$15.09	0	0	0	$0	✶
V2744	Tint, photochromatic, per lens	$11.74	241	241	458	$5,502	✶
V2780	Oversize lens per lens	$8.97	0	0	0	$0	✶
V2782	Lens, index 1.54 to 1.65 plastic or 1.60 to 1.79, glass, excludes polycarb, per lens	$41.39	1	1	2	$85	✶

V2783	Lens, > Or equal to 1.66 plastic or > than or equal to 1.80 glass, excludes polycarb, per lens	$46.68	25	25	49	$2,358	✶

State Plan Amendment Rate Committee (SPARC)
June 18, 2015
Acute (16 Bed-or-Less) Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID)

1. Is this a rate change or a method change?
   Rate change

1b. Is this change an increase, decrease or no impact?
   Increase

2. Presentation of Issue – Why is change being made?
   The change is made to increase the Quality of Care (QOC) Fee for Acute ICF/IID Facilities per 56 O.S. 2011, Section 2002. This change allows the Oklahoma Health Care Authority (OHCA) to collect additional fees and match them through rate increases to providers. The current fee is $9.09 and will increase to $9.18. The ***fee*** increase of $0.09 per day when matched with federal funds will mean an increase of $0.23 to the ***daily rate*** for this facility type changing the base rate from $155.96 to $156.19. The fee is recalculated annually.

3. Current Methodology/Rate Structure.
   The current rate methodology calls for the establishment of a prospective rate which is based on the reported allowable cost per day.

4. New methodology or rate.
   There is no change in methodology; however there is a rate change as a result of the required annual recalculation of the QOC fee.

5. Budget Estimate.
   The annual budget will increase by an estimated $61,297 funded by $28,710 in state matching funds coming from the increased QOC Fee (which is paid by the facilities) and $37,587 in federal matching funds.

6. Estimated impact on access to care.
   The agency does not anticipate this change will impact access to care.

7. Rate or Method change in the form of a motion.
   The agency requests the State Plan Amendment Rate Committee to approve the rate change as follows:
   - *Base Rate*-to increase the base rate by 0.1474% ($.0.23) from $155.96 to $156.19.

8. Effective Date of Change.
   July 1, 2015

State Plan Amendment Rate Committee (SPARC)
June 18, 2015
Acquired Immune Deficiency Syndrome (AIDS) Rate for Nursing Facilities

1. Is this a rate change or a method change?
   Rate change

1b. Is this change an increase, decrease or no impact?
   Increase

2. Presentation of Issue – Why is change being made?
   The change is made to increase the Quality of Care (QOC) Fee for AIDS rate per 56 O.S. 2011, Section 2002. This change allows the OHCA to collect additional fees and match them through rate increases to providers. The current fee is $10.74 and will increase to $10.79. The ***fee*** increase of $0.05 per day when matched with federal funds will mean an increase of $0.18 to the ***daily rate*** for this facility type changing the base rate from $198.04 to $198.22. The fee is recalculated annually.

3. Current Methodology/Rate Structure.
   The current rate methodology calls for the establishment of a prospective rate based on reported allowable costs.

4. New methodology or rate.
   There is no change in methodology; however there is a rate change as a result of the required annual recalculation of the QOC fee.

5. Budget Estimate.
   The annual budget will increase by an estimated $1,769 funded by $684 state funds coming from the increased QOC Fee (which is paid by the facilities) and federal matching funds of $1085.

6. Estimated impact on access to care.
   The agency does not anticipate this change will impact access to care.

7. Rate or Method change in the form of a motion.
   The agency requests the State Plan Amendment Rate Committee to approve the rate change as follows:
   - *Base Rate*- increase the base rate component by 0.090% ($0.18) from $198.04 to $198.22.

8. Effective Date of Change.
   July 1, 2015

State Plan Amendment Rate Committee (SPARC)
June 18, 2015
Regular Nursing Facilities

1. Is this a rate change or a method change?
   Rate change

1b. Is this change an increase, decrease or no impact?
   Increase

2. Presentation of Issue – Why is change being made?
   The change is made to increase the Quality of Care (QOC) Fee for Regular Nursing Facilities per 56 O.S. 2011, Section 2002. This change allows the Oklahoma Health Care Authority (OHCA) to collect additional fees and match them through rate increases to providers. The current fee is $10.74 and will increase to $10.79. The ***fee*** increase of $0.05 per day when matched with federal funds will mean an increase of $0.18 to the ***daily rate*** for this facility type changing the base rate from $107.24 to $107.29. The fee is recalculated annually.

   The change is made to reflect adherence to the State Plan methodology for ***reallocation*** of Direct Care Costs and changes to the Direct Care Cost Component Pool as a result of the ***decline*** in Medicaid days.

3. Current Methodology/Rate Structure.
   The current rate methodology calls for the establishment of a prospective rate which consists of the following four components:
   (A) A Base Rate Component defined as $107.24 per day.
   (B) A Focus on Excellence (FOE) Component defined by the points earned under this performance program as defined in the state plan. The bonus component paid may be from $1.00 to $5.00 per day based on points earned.
   (C) An Other Component which is defined as the per day amount derived from dividing 30% of the pool of funds available after meeting the needs of the Base and FOE Components by the total estimated Medicaid days for the rate period.
   (D) A Direct Care Component which is defined as the per day amount derived from allocating 70% of the pool of funds available after meeting the needs of the Base and FOE Components to the facilities. This component is determined separately and is different for each facility. The method (as approved in the State Plan) allocates the 70% pool funds to each facility (on a per day basis) based on their relative expenditures for direct care.

4. New methodology or rate.
   There is no change in methodology; however there is a rate change as a result of the annual recalculation of the QOC fee and reallocation of Direct Care Cost per State Plan.

5. Budget Estimate.
   The annual budget will increase by an estimated $833,616 funded by $322,443 in state funds coming from the increased QOC Fee collections (which is paid by the facilities) and the federal matching funds of $511,173.

6. Estimated impact on access to care.
   The agency does not anticipate this change will impact access to care.

7. Rate of Method change in the form of a motion.
   The agency requests the State Plan Amendment Rate Committee to approve the rate change as follows:
   - *Base Rate* - increase the base rate component from $107.24 to $107.29 which matches the increase in the Quality of Care Fee of $0.05 ($10.74 to $10.79).
   - *Pool Amount* – decrease the pool amount in the state plan for the "Other" and "Direct Care" Components from $158,391,182 to $155,145,293 to account for the decrease in days.

8. Effective Date of Change:
   July 1, 2015

State Plan Amendment Rate Committee (SPARC)
June 18, 2015
Regular Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID)

1. Is this a rate change or a method change?
   Rate change

1b. Is this change an increase, decrease or no impact?
   Increase

2. Presentation of Issue – Why is change being made?
   The change is made to increase the Quality of Care (QOC) Fee for Acute ICF/IID Facilities per 56 O.S. 2011, Section 2002. This change allows the Oklahoma Health Care Authority (OHCA) to collect additional fees and match them through rate increases to providers The current fee is $7.20 and will increase to $7.25. The fee increase of $0.05 per day when matched with federal funds will mean an increase of $0.13 to the daily rate for this facility type changing the base rate from $121.83 to $121.96. The fee is recalculated annually.

3. Current Methodology/Rate Structure.
   The current rate methodology calls for the establishment of a prospective rate which is based on the reported allowable cost per day.

4. New methodology or rate.
   There is no change in methodology; however there is a rate change as a result of the required annual recalculation of the QOC fee.

5. Budget Estimate.
   The annual budget will increase by an estimated $28,291 funded by $10,943 in state matching funds coming from the increased QOC Fee (which is paid by the facilities) and $17,348 in federal matching funds.

6. Estimated impact on access to care.
   The agency does not anticipate this change will impact access to care.

7. Rate or Method change in the form of a motion.
   The agency requests the State Plan Amendment Rate Committee to approve the rate change as follows:
   - *Base Rate*- increase the base rate by 0.1067% ($0.13) from $121.83 to $121.96.

8. Effective Date of Change:
   July 1, 2015

State Plan Amendment Rate Committee (SPARC)
June 18, 2015
Developmental Disabilities Services

1. Is this a "Rate Change" or a "Method Change"?
   Method Change

1b. Is this change an increase, decrease, or no impact?
   Budget decrease

2. Presentation of issue – Why is change being made?
   The Developmental Disabilities Services (DDS) is restructuring the Agency Companion services program and offering only the Agency Companion - Contractor services. The redesign of the program eliminates the need for the Agency Companion (Employee) services and the correlating Respite service codes; however, requires a rate to be established for the Agency Companion (Contractor) Intermittent services and its correlating Respite service code.

   Agency Companion Service is a living arrangement developed to meet the specific needs of the service recipient and provide a live-in companion for supervision, supportive assistance, and training in daily living skills, and is provided in a home shared by the companion and the service recipient. The companion is contracted by an agency, but is selected by the waiver participant. Companions may assist or supervise the service recipient with such tasks as meal preparation, laundry, and shopping, but do not perform these activities as discrete services. This service is provided in accordance with a therapeutic goal in the plan of care and is not purely diversional in nature. The companion is responsible for on-going supports and is available whenever required by the service recipient so that the service recipient may successfully cope with the challenges that occur in his/her life. Agency Companion levels include: (1) pervasive – for service recipients with behavioral or emotional challenges; (2) enhanced supervision – for service recipients with extensive needs; (3) close supervision – for service recipients with moderate needs; and (4) intermittent supervision – for service recipients with limited needs.

3. Current methodology and/or rate structure.
   The current rate structure for which the change is requested is fixed and uniform, and established through the State Plan Amendment Rate Committee. The current service codes and rates are as follows:

	Levels / Procedure Code (Therapuetic Leave-) {Respite - S5151}	Intermittent S5126 U1 (TV)	Close S5126 TF (TV)	Enhanced S5126 (TV)	Pervasive S5136 (TV)
EMPLOYEE	**Salary**	**17,000.00**	**25,500.00**	**34,000.00**	**34,000.00**
	Benefits 28.65%	**4,870.50**	**7,305.75**	**9,741.00**	**9,741.00**
	PC Salary & Benefits $34,000 + 28.65% / 15	**2,916.07**	**2,916.07**	**2,916.07**	**2,916.07**
	Recruiter/Trainer - $30,000 + 28.65% / 30 Pervasive Only!				**1,286.50**
	Professional Supports - MSW Level $36,000 + 28.65% / 20 Perva sive Only!				**2,315.70**
	Administration & General Costs - 15%	**3,717.99**	**5,358.27**	**6,998.56**	**7,538.89**
	Total annual costs	**28,504.55**	**41,080.09**	**53,655.63**	**57,798.16**
	Daily Rate Rounded to nearest $0.25	**78.00**	**112.50**	**147.00**	**158.25**

	Procedure Code (Therapuetic Leave) {Respite - S5151}	S5126 U4 (TV)	S5126 TG (TV)	S5136 TG (TV)
INDEPENDENT CONTRACTOR	**Contracted Amount ***	**26,775.00**	**35,700.00**	**35,700.00**
	PC Salary & Benefits $34,000 + 28.65% / 15	**2,916.07**	**2,916.07**	**2,916.07**
	Recruiter/Trainer - $30,000 + 28.65% / 30 Pervasive Only!			**1,286.50**
	Professional Supports - MSW Level $36,000 + 28.65% / 20 Pervasive Only!			**2,315.70**
	Administration & General Costs - 15%	**4,453.66**	**5,792.41**	**6,332.74**
	Total annual costs	**34,144.73**	**44,408.48**	**48,551.01**
	Daily Rate Rounded to nearest $0.25	**93.50**	**121.75**	**133.00**

*** Contracted Companion amount reflects an additional 5% to assist with Self Employment tax.**

4. New methodology or rate.
The table below indicates the service codes to eliminate as well as the basis for the new rate.

Eliminate Service Codes

Agency Companion - Employee (Therapuetic Leave)		
Intermittent	**S5126 U1 (TV)**	**78.00**
Close	**S5126 TF (TV)**	**112.50**
Enhanced	**S5126 (TV)**	**147.00**
Pervasive	**S5136 (TV)**	**158.25**
Respite *	**S5151**	

*Respite Rates Correlating to above services

New Rate

Procedure Code (Therapuetic Leave) {Respite - S5151}			**New**
INDEPENDENT CONTRACTOR	**Contracted Amount ***		**17,850.00**
	PC Salary & Benefits	**$34,000 + 28.65% / 15**	**2,916.07**
	Administration & General Costs - 15%		**3,114.91**
	Total annual costs		**23,880.98**
	Daily Rate	**Rounded**	**65.25**

5. Budget estimate.
The estimated total annualized savings in state share for the proposed rate change is $1,754 with a total federal plus state annualized savings of $4,654. The budget impact is budget neutral for the Oklahoma Health Care Authority.

6. Agency estimated impact on access to care.
Under (a)(30)(A) of the Medicaid Act, the agency expects a minimal but increased impact on access for these services.

7. Rate or Method change in the form of a motion.
The agency requests the State Plan Amendment Rate Committee to approve the method change for Agency Companion (Contractor) Intermittent and Respite Service.

8. Effective date of change.
July 1, 2015

Submitted to the C.E.O. and Board on June 25, 2015

AUTHORITY FOR EXPENDITURE OF FUNDS
Administrative Services for Incontinence Supplies
People First Industries, Inc.

BACKGROUND

To comply with revisions to the EPSDT Program, OHCA is seeking a Contractor to provide and deliver incontinence supplies to eligible SoonerCare members' homes.

SCOPE OF WORK

- Be an enrolled Oklahoma Health Care Authority provider throughout the term of this contract, or the State may terminate this contract for cause.
- Accept all orders of covered products it receives from SoonerCare medical providers.
- Verify SoonerCare eligibility of each member prior to rendering services no earlier than the business day before each shipment.
- Submit claims for reimbursement to the Medicaid Management Information System (MMIS) and when submitting claims, the date of service shall be the date that the member receives the products.
- Contractor will offer Attends as the preferred brand and will offer other brand options if required, on a member-to-member basis.

CONTRACT PERIOD

The term of this Agreement shall begin on June 1, 2015 and end on June 30, 2018. A purchase order will be issued for the first agreement period and a change order to the original purchase order will be issued to the Contractor at the beginning of the following agreement period.

CONTRACT AMOUNT AND PROCUREMENT METHOD

- Will be awarded through the State Use Program, as mandated, giving preference to an in-state sheltered workshop
- This contract will be paying for administrative function only, as supplies (with delivery costs included) will be paid through the MMIS
- Federal matching percentage is 50%
- Estimated contract amount: $354,700

RECOMMENDATION

- Board approval to procure the services discussed above.

SUBMITTED TO THE C.E.O. AND BOARD ON JUNE 25, 2015

AUTHORITY FOR EXPENDITURE OF FUNDS
TEXT 4 HEALTH - VOXIVA

BACKGROUND
The purpose of this Contract is to extend mobile messages beyond the infants' first year to provide parents and other caregivers support to improve the development and well-being of Oklahoma's children.

SCOPE OF WORK
- Voxiva will send members targeted text and email messages via Connect4health; offer the Text4baby, Text4kids, and Txt4health services to Members; and enroll Members in Text4baby, Text4kids, and Txt4health.
- Provide certain OHCA content that Voxiva will deliver to Members, and access certain User Data about their Members' use of the Voxiva Health Services as consented to the OHCA by the Member.
- Provide OHCA with certain marketing tools supporting OHCAs' efforts to market the Voxiva Health Services to Members.

CONTRACT PERIOD
- July 1, 2015 through June 30, 2016 with an annual option to renew through June 30, 2017.

CONTRACT AMOUNT AND PROCUREMENT METHOD
- Will be awarded through an OMES approved Sole Source agreement
- Federal matching percentage is 50%
- George Kaiser Family Foundation will pay the 50% state share for this contract

SFY2016: $139,600

SFY2017: $220,880

RECOMMENDATION
- Board approval to procure the services discussed above.

Recommendation 1: Prior Authorize Ruconest® (C1 Esterase Inhibitor)

The Drug Utilization Review Board recommends prior authorization of Ruconest® (C1 esterase inhibitor) with the following criteria:

Ruconest® (C1 Esterase Inhibitor) Approval Criteria:

1. An FDA approved diagnosis of hereditary angioedema; and
2. Ruconest® must be used for *treatment* of acute attacks of hereditary angioedema; and
3. A patient-specific, clinically significant reason why the member cannot use Berinert® (C1 esterase inhibitor, human).

Recommendation 2: Prior Authorize Hemangeol™ (Propranolol Oral Solution) and Sotylize™ (Sotalol Oral Solution)

The Drug Utilization Review Board recommends the prior authorization of Hemangeol™ (propranolol oral solution) and Sotylize™ (sotalol oral solution) with the following criteria:

Hemangeol™ (Propranolol Hydrochloride Oral Solution) Approval Criteria:

1. An FDA approved diagnosis of treatment of proliferating infantile hemangioma requiring systemic therapy; and
2. A patient-specific, clinically significant reason why the member cannot use the generic propranolol solutions (20mg/5mL and 40mg/5mL) which are available without prior authorization.

Sotylize™ (Sotalol Oral Solution) Approval Criteria:

1. An FDA approved diagnosis of life-threatening ventricular arrhythmias or for the maintenance of normal sinus rhythm in patients with highly symptomatic atrial fibrillation/flutter; and
2. A patient-specific, clinically significant reason why the member cannot use sotalol oral tablets in place of the oral solution formulation; and
3. A quantity limit of 64mL per day or 1,920mL per 30 days will apply.