OKLAHOMA HEALTH CARE AUTHORITY
REGULARLY SCHEDULED BOARD MEETING
October 13, 2016 at 1:00 P.M.
Duncan Regional Hospital
1407 N Whisenant Drive
Duncan, 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 Approval of September 8, 2016 OHCA Board Meeting Minutes

Item to be presented by Becky Pasternik-Ikard, Chief Executive Officer

3. Discussion Item – Chief Executive Officer's Report

    a) All-Star Introduction
        - August 2016 All-Star – Natasha Kester, Medical Authorization Analyst (Garth Splinter)

    b) Financial Update – Carrie Evans, Chief Financial Officer

    c) Medicaid Director's Update – Garth Splinter, Deputy CEO

        1.) CMS CMMI CPC Classic and CPC+ Initiative Updates – Melody Anthony, Deputy State Medicaid Director

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

4. Discussion Item – State Fiscal Year 2018 Budget Request Overview

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

5. Discussion Item – Access Monitoring Review Plan

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

6. 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

7. Action Item – Consideration and Vote of Agency Recommended Rulemaking Pursuant to Article I of the Administrative Procedures Act.

Action Item – a) Consideration and Vote upon a Declaration of a Compelling Public Interest for the promulgation of ***all Emergency Rules*** in item seven in accordance with 75 Okla. Stat. § 253.

Action Item – b) 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) ADDING agency rules at OAC 317:30-3-19.2 to comply with enhanced enrollment screening provisions contained in the Affordable Care Act. The proposed additions outline screening procedures to be followed by provider contracting staff for providers (or anyone with a 5% or more direct or indirect ownership interest in the company) who pose an increased financial risk of fraud, waste or abuse to the SoonerCare program. Rules add information regarding applicants who are seeking new or renewed contract enrollment as being subject to a fingerprint-based criminal background check if they are designated as high risk in accordance with Federal law. Rules also specify types of criminal convictions for which an applicant shall (regarding felonies) or may (regarding misdemeanors) be denied enrollment. Rules also state that there is no right to appeal an OHCA decision denying an application for contract enrollment based on the applicant's criminal history.
Budget Impact: Budget neutral

(Reference APA WF # 16-08)

b) AMENDING agency rules at OAC 317:30-5-2 to clarify licensing provisions and contracting requirements for medical residents, to reinstate the bundled reimbursement structure for obstetrical care, and to clarify direct physician care visit limits. Proposed revisions remove language specific to non-licensed physicians in a training program. The revisions for medical licensure requirements are necessary to comply with federal regulations that require all ordering or referring physicians be enrolled as participating providers. Rules regarding reimbursement for obstetrical care are amended to reinstate the use of the global CPT codes for routine obstetrical care billing. The reinstatement of the global reimbursement is necessary to prevent an unintended administrative burden to providers. Finally, the proposed revisions regarding direct physician care visit limits clarify that SoonerCare Choice members are exempt from primary care office visits limits. The proposed revision is necessary to comply with current Waiver parameters and to ensure the access to care for Choice members is not impacted.
Budget Impact: Budget neutral

(Reference APA WF # 16-12)

c) AMENDING agency rules at OAC 317:30-5-22, 317:30-5-226, 317:30-5-229, 317:30-5-356, and 317:30-5-664.8 to reinstate the use of the global care CPT codes for routine obstetrical care billing, which can be used if the provider had provided care for a member for greater than one trimester. The reinstatement of the global reimbursement is necessary to prevent an unintended administrative burden to providers.
Budget Impact: Budget neutral

(Reference APA WF # 16-15A)

d) AMENDING agency rules at OAC 317:35-5-2 and 317:35-22-2 to reinstate the use of the global care CPT codes for routine obstetrical care billing, which can be used if the provider had provided care for a member for greater than one trimester. The reinstatement of the global reimbursement is necessary to prevent an unintended administrative burden to providers.
Budget Impact: Budget neutral
(Reference APA WF # 16-15B)

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

8. Action Item – Consideration and Vote of Authority for Expenditure of Funds

a) Consideration and Vote of Authority for an Increase in Expenditure of Funds for Consulting Services

Item to be presented by Ed McFall, Chairman

9. 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) and (7).

   a) Discussion of Pending Supreme Court Litigation
   b) Discussion Regarding Selection of CEO, Becky Pasternik-Ikard

10. New Business

11. ADJOURNMENT

NEXT BOARD MEETING
November 10, 2016
Northwestern Oklahoma State University
Enid, OK

MINUTES OF A REGULARLY SCHEDULED BOARD MEETING
OF THE HEALTH CARE AUTHORITY BOARD
September 8, 2016
The Children's Center Rehabilitation Hospital
Bethany, 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 and The Children's Center Rehabilitation Hospital on September 7, 2016 at 11:45 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 September 2, 2016 at 8:20 a.m.

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

BOARD MEMBERS PRESENT:	Chairman McFall, Vice-Chairman Armstrong, Member Bryant, Member Case, Member McVay, Member Robison
BOARD MEMBERS ABSENT:	Member Nuttle

OTHERS PRESENT:	OTHERS PRESENT:
George Miller	Emily Shipley, OHCA
Michael Milligan, The Children's Center	Albert Gray, The Children's Center
Virginia Ragan, SOFS	Mike Herndon, OHCA
Tim Haws, Bethany Schools	Melissa McCully, OHCA
Joni Bruce, OK Family Network	Mike Fogarty
Sherris H-Ososanya, OHCA	Johnney Johnson, OHCA
Melinda Thomason, OHCA	Tyler Talley, eCapitol
Gary Huddleston, Aetna	Anne Roberts, Integris
Jean Ann Ingram, SOFS	Randy Curry, SWOSU College of Pharmacy Rural Health
David Dude, American Cancer Society	Mary Carter, BCBSOK
Jodi Fenner, Amerigroup	Barbara Gibbons, OHCA
Shelly Patterson, OHCA	Hillary Burkholder, OHCA
Kyle Janzen, OHCA	Kent Shellenberger, Bethany Public Schools
Vickie Kersey, OHCA	Fred Oraene, OHCA
Burl Beasley, OHCA	Jimmy Durant, SSM Health
LouAnn McFall	

DISCUSSION AND POSSIBLE VOTE ON APPROVAL OF BOARD MINUTES OF THE REGULARY SCHEDULED BOARD MEETING HELD AUGUST 11, 2016.

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 Bryant moved for approval of the August 11, 2016 board meeting minutes as published. The motion was seconded by Member Robison.
FOR THE MOTION:	Vice-Chairman Armstrong, Member Case
ABSTAINED:	Chairman McFall, Member McVay
BOARD MEMBERS ABSENT:	Member Nuttle

NICO GOMEZ, CHIEF EXECUTIVE OFFICER'S REPORT

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

The following OHCA All-Star was recognized.

- June 2016 All-Star – Sherris Harris-Ososanya, Waiver Development Coordinator (Melinda Thomason presented)
- July 2016 All-Star – Johnney Johnson, Tribal Relations Coordinator (Emily Shipley presented)

ITEM 3b / MEDICAID DIRECTOR'S UPDATE
Becky Pasternik-Ikard, State Medicaid Director

Ms. Ikard provided an update for July 2016 data that included a report on the number of SoonerCare enrollees in different areas of the Medicaid program including Insure Oklahoma numbers. She discussed the charts provided for in-state contracted providers. For more detailed information, see Item 3b in the board packet.

ITEM 3c / PRESENTATION OF THE 2016 BRICKNER AWARD
Nico Gomez, CEO & Chairman Ed McFall

Mr. Gomez and Chairman McFall presented Dr. Steven A. Crawford the 2016 Defender of Health Care T.J. Brickner award. Steve Crawford, M.D., the Christian N. Ramsey, Jr., M.D. Endowed Chair in Family Medicine, is Professor and Chair of the University of Oklahoma College of Medicine's Department of Family and Preventive Medicine. He oversees an academic clinical department that includes two family medicine residency programs and clinics training 60 residents a year, a primary care sports medicine fellowship program, a 27-month Physician Associate masters level program training 50 students a year, department faculty coordination of three required and four elective medical school courses, and an active primary care research program. Dr. Crawford is the Chief of the Family Medicine Service at the OU Medical Center hospitals and has served as chair of the Board of Trustees of the OU Medical Center, the American Academy of Family Physician's Commission on Governmental Advocacy, the Oklahoma Health Care Authority's Medical Advisory Committee; he has also served as president of the Oklahoma County Medical Society and the Oklahoma Academy of Family Physicians; and is a member of the Oklahoma State Health Department's Immunization Advisory Committee.

Chairman McFall took this time to recognize Nico Gomez for his dedication and work for the OHCA as well as the state and presented him with a plaque. Chairman McFall described Gomez as a "man of integrity, principle, transparency, hard work" and "an agency trailblazer." He praised Gomez's leadership through stressful times, including the past legislative session. Nico said that he is humbled and thanked the board, staff and his family for their support. He stated that he has learned in this position that you are not alone. He said that his hope is in the staff at the agency as it continues on because they know the mission of the agency and are incredible people.

ITEM 3d / CHILDREN'S CENTER UPDATE
Albert Gray, Chief Executive Officer

Mr. Gray presented Nico with artwork from the children at The Center in gratitude for making a difference in the lives of children with special health care needs in Oklahoma. Mr. Gray gave an update on their new building and information about their facilities and programs with the children. He discussed how important the partnership is between The Children's Center and Soonercare for the children.

Mr. Gomez mentioned that Member Nuttle had arrived some time ago and called him to join the board table at 1:33pm.

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

There were no recommendations regarding conflicts.

ITEM 5 / CONSIDERATION AND VOTE OF AUTHORITY FOR EXPENDITURE OF FUNDS FOR THE REQUEST FOR PROPOSAL (RFP) FOR THE SERVICES OF A VENDOR TO PROIVDE SICKLE CELL DISEASE SERVICES
Vickie Kersey, Director of Fiscal Planning & Procurement

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

ITEM 6 / PROPOSED EXECUTIVE SESSION AS RECOMMENDED BY THE CHIEF OF LEGAL SERVICES AND AUTHORIZED BY THE OPEN MEETINGS ACT, 25 OKLAHOMA STATUTES §307(B) (4) and (7).
Nicole Nantois, Chief of Legal Services

Chairman McFall entertained a motion to go into Executive Session at this time.

MOTION:	Vice –Chairman Armstrong moved for approval to move into Executive Session. The motion was seconded by Member Robison.
FOR THE MOTION:	Chairman McFall, Member Bryant, Member Case, Member McVay, Member Nuttle

ITEM 7 / CONSIDERATION AND VOTE TO OFFER THE APPOINTMENT OF AN INTERIM OR PERMANENT CHIEF EXECUTIVE OFFICER FOR THE OKLAHOMA HEALTH CARE AUTHORITY WITHIN THE OHCA PAY BAN SALARY FOR AGENCY ADMINISTRATORS PER OMES PAY BAN GUIDELINES
Chairman Ed McFall

MOTION:	Member McVay moved for approval to offer Becky Pasternik-Ikard the permanent CEO of the Oklahoma Health Care Authority position. The motion was seconded by Member Case.
FOR THE MOTION:	Chairman McFall, Vice-Chairman McFall, Member Bryant, Member Robison, Member Nuttle

ITEM 8 / NEW BUSINESS

There was no new business.

ITEM 9 / ADJOURNMENT

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

Meeting adjourned at 3:35 p.m., 9/8/16

NEXT BOARD MEETING
October 13, 2016
Duncan Regional Hospital
Duncan, OK

Lindsey Bateman
Board Secretary

Minutes Approved: _____

*Initials:*_____

FINANCIAL REPORT

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

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

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

ATTACHMENTS

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

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

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

OKLAHOMA HEALTH CARE AUTHORITY
Total Medicaid Program Expenditures
by Source of State Funds
SFY 2017, For the Two Month Period Ending August 31, 2016

Category of Service	Total	Health Care Authority	Quality of Care Fund	HEEIA	SHOPP Fund	BCC Revolving Fund	Other State Agencies
SoonerCare Choice	$ 6,580,645	$ 6,559,191	$ -	$ 19,725	$ -	$ 1,728	$ -
Inpatient Acute Care	249,543,944	101,481,352	81,114	656,049	76,250,540	229,976	70,844,912
Outpatient Acute Care	83,519,494	54,938,479	6,934	734,672	27,213,505	625,903	
Behavioral Health - Inpatient	10,790,758	1,883,827	-	41,453	6,661,677	-	2,203,801
Behavioral Health - Psychiatrist	1,685,877	1,428,193	-	-	257,683	-	-
Behavioral Health - Outpatient	3,172,476	-	-	-	-	-	3,172,476
Behaviorial Health-Health Home	5,916,604	-	-	-	-	-	5,916,604
Behavioral Health Facility- Rehab	35,824,796	-	-	-	-	14,794	35,824,796
Behavioral Health - Case Management	3,337,159	-	-	-	-	-	3,337,159
Behavioral Health - PRTF	11,140,583	-	-	-	-	-	11,140,583
Residential Behavioral Management	3,560,801	-	-	-	-	-	3,560,801
Targeted Case Management	13,185,423	-	-	-	-	-	13,185,423
Therapeutic Foster Care	(27,133)	(27,133)	-	-	-	-	-
Physicians	85,962,206	74,589,247	9,683	(88,967)	-	819,260	10,632,983
Dentists	24,109,449	24,104,712	-	2,967	-	1,771	-
Mid Level Practitioners	494,819	491,144	-	3,675	-	-	-
Other Practitioners	8,921,525	8,792,911	74,394	43,289	-	10,931	-
Home Health Care	3,289,594	3,286,169	-	1,407	-	2,018	-
Lab & Radiology	7,000,770	6,812,003	-	148,768	-	40,000	-
Medical Supplies	8,128,190	7,617,782	451,922	51,432	-	7,054	-
Clinic Services	28,018,666	27,184,329	-	149,326	-	33,686	651,325
Ambulatory Surgery Centers	1,524,039	1,505,419	-	18,341	-	279	-
Personal Care Services	2,304,426	-	-	-	-	-	2,304,426
Nursing Facilities	104,441,208	64,559,551	39,881,657	-	-	-	-
Transportation	11,498,853	11,080,428	411,628	-	-	6,797	-
GME/IME/DME	42,923,376	-	-	-	-	-	42,923,376
ICF/IID Private	11,194,577	9,196,378	1,998,199	-	-	-	-
ICF/IID Public	1,579,381	-	-	-	-	-	1,579,381
CMS Payments	46,817,453	46,676,140	141,314	-	-	-	
Prescription Drugs	96,180,440	93,142,352	-	2,569,254	-	468,834	-
Miscellaneous Medical Payments	30,267	30,267	-	-	-	-	-
Home and Community Based Waiver	37,628,201	-	-	-	-	-	37,628,201
Homeward Bound Waiver	15,738,287	-	-	-	-	-	15,738,287
Money Follows the Person	36,580	17,405	-	-	-	-	19,175
In-Home Support Waiver	4,824,621	-	-	-	-	-	4,824,621
ADvantage Waiver	35,486,859	-	-	-	-	-	35,486,859
Family Planning/Family Planning Waiver	937,182	-	-	-	-	-	937,182
Premium Assistance*	10,835,882	-	-	10,835,882	-	-	-
Telligen	2,413,474	2,413,474	-	-	-	-	-
Electronic Health Records Incentive Payments	4,203,071	4,203,071	-	-	-	-	-
Total Medicaid Expenditures	**$ 1,024,754,820**	**$ 551,966,689**	**$ 43,056,847**	**$ 15,187,272**	**$ 110,383,405**	**$ 2,263,032**	**$ 301,912,370**

* Includes $10,776,969.19 paid out of Fund 245

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

REVENUE		FY17 Actual YTD
Revenues from Other State Agencies	$	122,703,173
Federal Funds		188,241,671
TOTAL REVENUES	**$**	**310,944,845**

EXPENDITURES		Actual YTD
Department of Human Services		
Home and Community Based Waiver	$	37,628,201
Money Follows the Person		19,175
Homeward Bound Waiver		15,738,287
In-Home Support Waivers		4,824,621
ADvantage Waiver		35,486,859
Intermediate Care Facilities for Individuals with Intellectual Disabilities Public		1,579,381
Personal Care		2,304,426
Residential Behavioral Management		2,742,909
Targeted Case Management		12,179,112
Total Department of Human Services		**112,502,970**
State Employees Physician Payment		
Physician Payments		10,632,983
Total State Employees Physician Payment		**10,632,983**
Education Payments		
Graduate Medical Education		25,162,701
Graduate Medical Education - Physicians Manpower Training Commission		1,217,289
Indirect Medical Education		16,543,386
Direct Medical Education		-
Total Education Payments		**42,923,376**
Office of Juvenile Affairs		
Targeted Case Management		580,315
Residential Behavioral Management		817,892
Total Office of Juvenile Affairs		**1,398,207**
Department of Mental Health		
Case Management		3,337,159
Inpatient Psychiatric Free-standing		2,203,801
Outpatient		3,172,476
Health Homes		5,916,604
Psychiatric Residential Treatment Facility		11,140,583
Rehabilitation Centers		35,824,796
Total Department of Mental Health		**61,595,420**
State Department of Health		
Children's First		162,812
Sooner Start		400,508
Early Intervention		203,747
Early and Periodic Screening, Diagnosis, and Treatment Clinic		173,122
Family Planning		33,940
Family Planning Waiver		901,903
Maternity Clinic		-
Total Department of Health		**1,876,033**
County Health Departments		
EPSDT Clinic		77,694
Family Planning Waiver		1,338
Total County Health Departments		**79,033**
State Department of Education		**30,571**
Public Schools		**28,866**
Medicare DRG Limit		**70,000,000**
Native American Tribal Agreements		**-**
Department of Corrections		**-**
JD McCarty		**844,912**
Total OSA Medicaid Programs	**$**	**301,912,370**
OSA Non-Medicaid Programs	**$**	**11,653,481**
Accounts Receivable from OSA	**$**	**2,621,006**

OKLAHOMA HEALTH CARE AUTHORITY
SUMMARY OF REVENUES & EXPENDITURES:
Fund 205: Supplemental Hospital Offset Payment Program Fund
SFY 2017, For the Two Month Period Ending August 31, 2016

REVENUES		FY 17 Revenue
SHOPP Assessment Fee	$	48,818,892
Federal Draws		67,322,839
Interest		22,603
Penalties		-
State Appropriations		(7,550,000)
TOTAL REVENUES	$	108,614,333

EXPENDITURES	Quarter		FY 17 Expenditures
Program Costs:	7/1/16 - 9/30/16		
Hospital - Inpatient Care	76,250,540	$	76,250,540
Hospital -Outpatient Care	27,213,505		27,213,505
Psychiatric Facilities-Inpatient	6,661,677		6,661,677
Rehabilitation Facilities-Inpatient	257,683		257,683
Total OHCA Program Costs	110,383,405	$	110,383,405
Total Expenditures		$	110,383,405

CASH BALANCE		
	$	(1,769,072)

OKLAHOMA HEALTH CARE AUTHORITY
SUMMARY OF REVENUES & EXPENDITURES:
Fund 230: Nursing Facility Quality of Care Fund
SFY 2017, For the Two Month Period Ending August 31, 2016

REVENUES	Total Revenue	State Share
Quality of Care Assessment	$ 12,773,351	$ 12,773,351
Interest Earned	6,942	6,942
TOTAL REVENUES	**$ 12,780,292**	**$ 12,780,292**

EXPENDITURES	FY 17 Total $ YTD	FY 17 State $ YTD	Total State $ Cost
Program Costs			
Nursing Facility Rate Adjustment	$ 39,259,663	$ 15,315,195	
Eyeglasses and Dentures	50,934	19,869	
Personal Allowance Increase	571,060	222,771	
Coverage for Durable Medical Equipment and Supplies	451,922	176,295	
Coverage of Qualified Medicare Beneficiary	1,032,756	402,878	
Part D Phase-In	141,314	55,127	
ICF/IID Rate Adjustment	839,791	327,602	
Acute Services ICF/IID	1,158,409	451,895	
Non-emergency Transportation - Soonerride	411,628	160,576	
Total Program Costs	**$ 43,917,476**	**$ 17,132,208**	**$ 17,132,208**
Administration			
OHCA Administration Costs	$ 83,955	$ 41,977	
DHS-Ombudsmen	-	-	
OSDH-Nursing Facility Inspectors	-	-	
Mike Fine, CPA	-	-	
Total Administration Costs	**$ 83,955**	**$ 41,977**	**$ 41,977**
Total Quality of Care Fee Costs	**$ 44,001,431**	**$ 17,174,185**	
TOTAL STATE SHARE OF COSTS			**$ 17,174,185**

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

OKLAHOMA HEALTH CARE AUTHORITY
SUMMARY OF REVENUES & EXPENDITURES:
Fund 245: Health Employee and Economy Improvement Act Revolving Fund
SFY 2017, For the Two Month Period Ending August 31, 2016

REVENUES	FY 16 Carryover	FY 17 Revenue	Total Revenue
Prior Year Balance	$ 5,199,281	$ -	$ 3,042,960
State Appropriations	(2,000,000)	-	-
Tobacco Tax Collections	-	6,762,137	6,762,137
Interest Income	-	20,301	20,301
Federal Draws	183,445	6,652,552	6,652,552
TOTAL REVENUES	**$ 3,382,726**	**$ 13,434,990**	**$ 16,477,950**

EXPENDITURES		FY 16 Expenditures	FY 17 Expenditures	Total $ YTD
Program Costs:				
	Employer Sponsored Insurance		$ 10,776,969	$ 10,776,969
	College Students/ESI Dental		56,367	21,989
Individual Plan				
	SoonerCare Choice		$ 19,011	$ 7,416
	Inpatient Hospital		653,591	254,966
	Outpatient Hospital		723,023	282,051
	BH - Inpatient Services-DRG		39,599	15,448
	BH -Psychiatrist		-	-
	Physicians		(41,618)	(16,235)
	Dentists		2,857	1,114
	Mid Level Practitioner		3,675	1,433
	Other Practitioners		42,325	16,511
	Home Health		1,407	549
	Lab and Radiology		146,493	57,147
	Medical Supplies		48,143	18,781
	Clinic Services		147,480	57,532
	Ambulatory Surgery Center		18,341	7,155
	Prescription Drugs		2,484,410	969,168
	Miscellaneous Medical		-	-
	Premiums Collected		-	(24,609)
Total Individual Plan			**$ 4,288,738**	**$ 1,648,428**
	College Students-Service Costs		**$ 62,653**	**$ 24,441**
Total OHCA Program Costs			**$ 15,184,727**	**$ 12,471,826**
Administrative Costs				
	Salaries	$ 32,930	$ 333,568	$ 366,497
	Operating Costs	12,791	4,528	17,320
	Health Dept-Postponing	-	-	-
	Contract - HP	294,045	271,676	565,721
Total Administrative Costs		**$ 339,766**	**$ 609,772**	**$ 949,538**
Total Expenditures				**$ 13,421,364**
NET CASH BALANCE		**$ 3,042,960**		**$ 3,056,585**

OKLAHOMA HEALTH CARE AUTHORITY
SUMMARY OF REVENUES & EXPENDITURES:
Fund 250: Belle Maxine Hilliard Breast and Cervical Cancer Treatment Revolving Fund
SFY 2017, For the Two Month Period Ending August 31, 2016

REVENUES	FY 17 Revenue	State Share
Tobacco Tax Collections	$ 134,920	$ 134,920
TOTAL REVENUES	**$ 134,920**	**$ 134,920**

EXPENDITURES	FY 17 Total $ YTD	FY 17 State $ YTD	Total State $ Cost
Program Costs			
SoonerCare Choice	$ 1,728	$ 74	
Inpatient Hospital	229,976	9,919	
Outpatient Hospital	625,903	26,995	
Inpatient Services-DRG	-	-	
Psychiatrist	-	-	
TFC-OHCA	-	-	
Nursing Facility	-	-	
Physicians	819,260	35,335	
Dentists	1,771	76	
Mid-level Practitioner	0	-	
Other Practitioners	10,931	471	
Home Health	2,018	87	
Lab & Radiology	40,000	1,725	
Medical Supplies	7,054	304	
Clinic Services	33,686	1,453	
Ambulatory Surgery Center	279	12	
Prescription Drugs	468,834	20,221	
Transportation	6,644	287	
Miscellaneous Medical	153	7	
Total OHCA Program Costs	**$ 2,248,237**	**$ 96,966**	
OSA DMHSAS Rehab	$ 14,794	$ 638	
Total Medicaid Program Costs	**$ 2,263,032**	**$ 97,604**	
TOTAL STATE SHARE OF COSTS			**$ 97,604**

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.

OHCA Board Meeting
October 13, 2016
(August 2016 Data)

SOONERCARE ENROLLMENT/EXPENDITURES

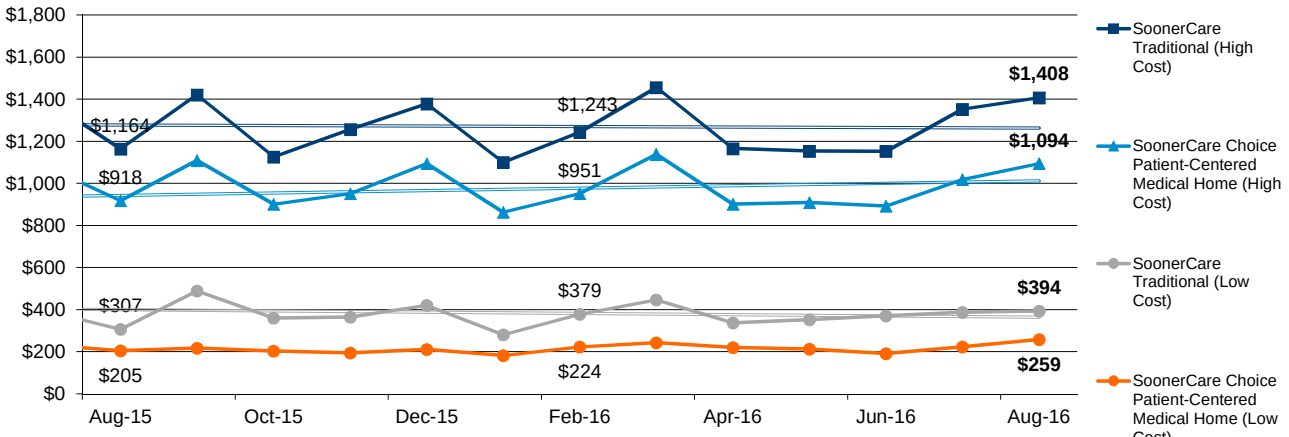
Delivery System			Enrollment August 2016	Children August 2016	Adults August 2016	Enrollment Change	Total Expenditures August 2016	PMPM August 2016	Forecasted August 2016 Trend PMPM
SoonerCare Choice Patient-Centered Medical Home			**538,128**	**442,970**	**95,158**	**6,225**	**$175,398,999**		
	Lower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

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

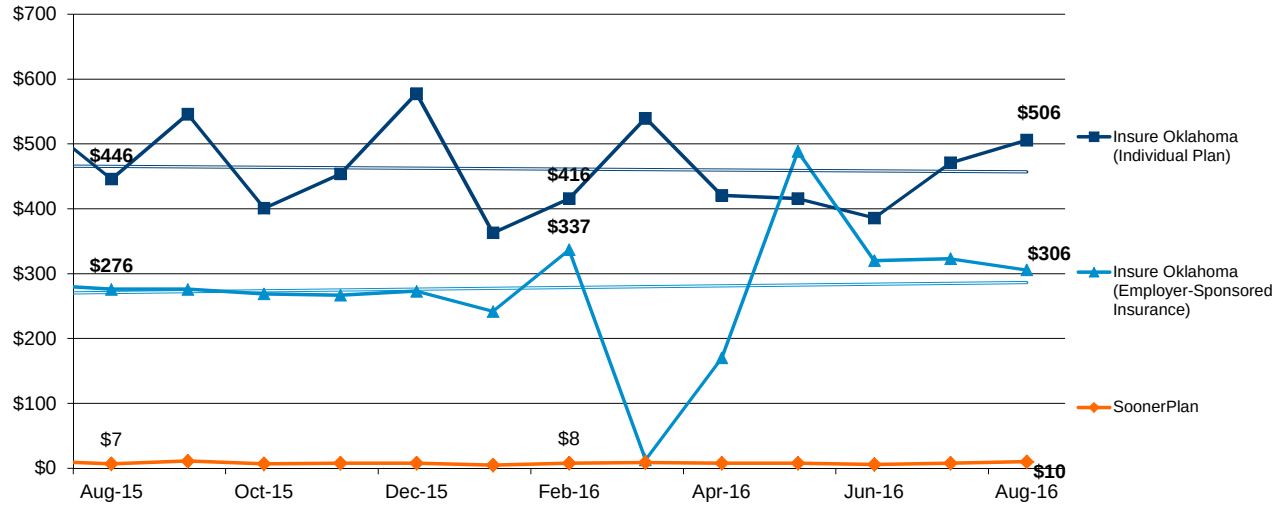
Total In-State Providers: 33,803 (+585) **(In-State Providers counted multiple times due to multiple locations, programs, types, and specialties)**

Physician	Pharmacy	Dentist	Hospital	Mental Health	Optometrist	Extended Care	Total PCPs	PCMH
10,274	960	1,263	199	5,923	666	232	6,840	2,630

PER MEMBER PER MONTH COST BY GROUP



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



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

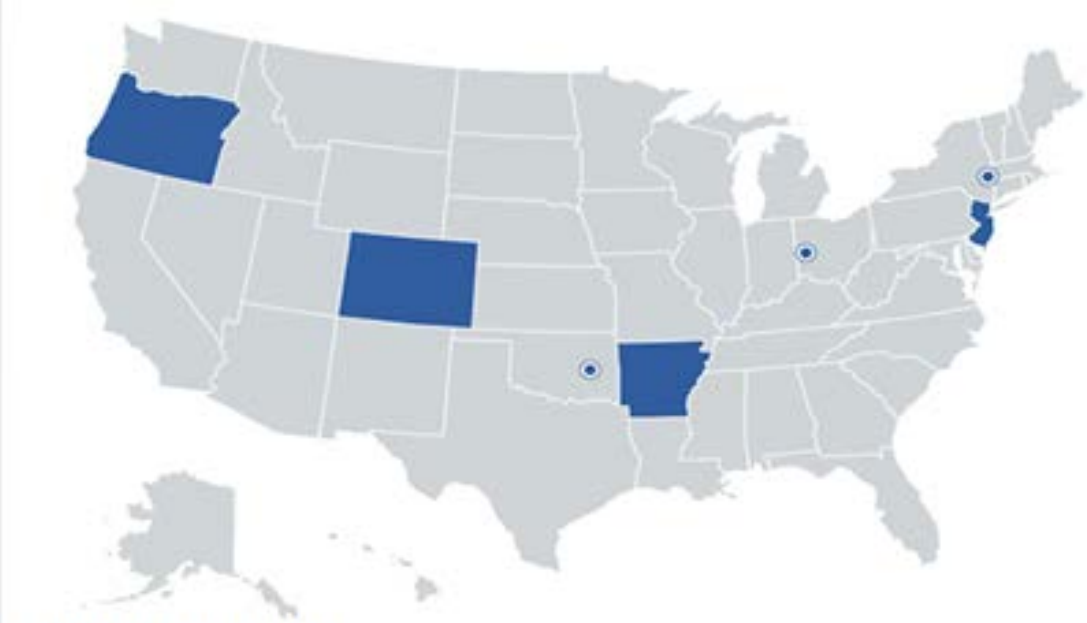
Comprehensive Primary Care (CPC) Current and Future

OHCA Board Meeting
October 13, 2016
Melody Anthony, MS
Deputy State Medicaid Director

Oklahoma HealthCare Authority

CPC CLASSIC REGIONS

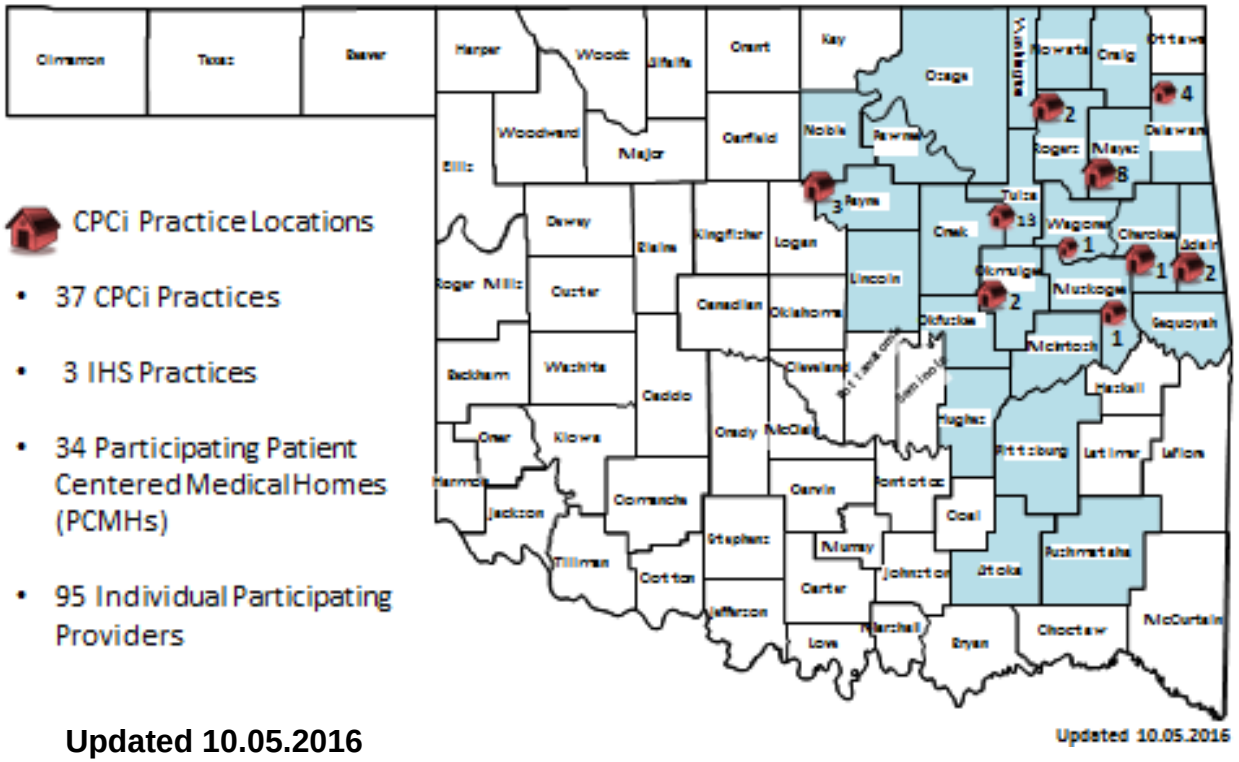
Current Comprehensive Primary Care Initiative (National)



Oklahoma HealthCare Authority

WHERE OUR CHOICE CPC CLASSIC PROVIDERS ARE LOCATED

Comprehensive Primary Care Initiative (CPCi): September 2016



Updated 10.05.2016

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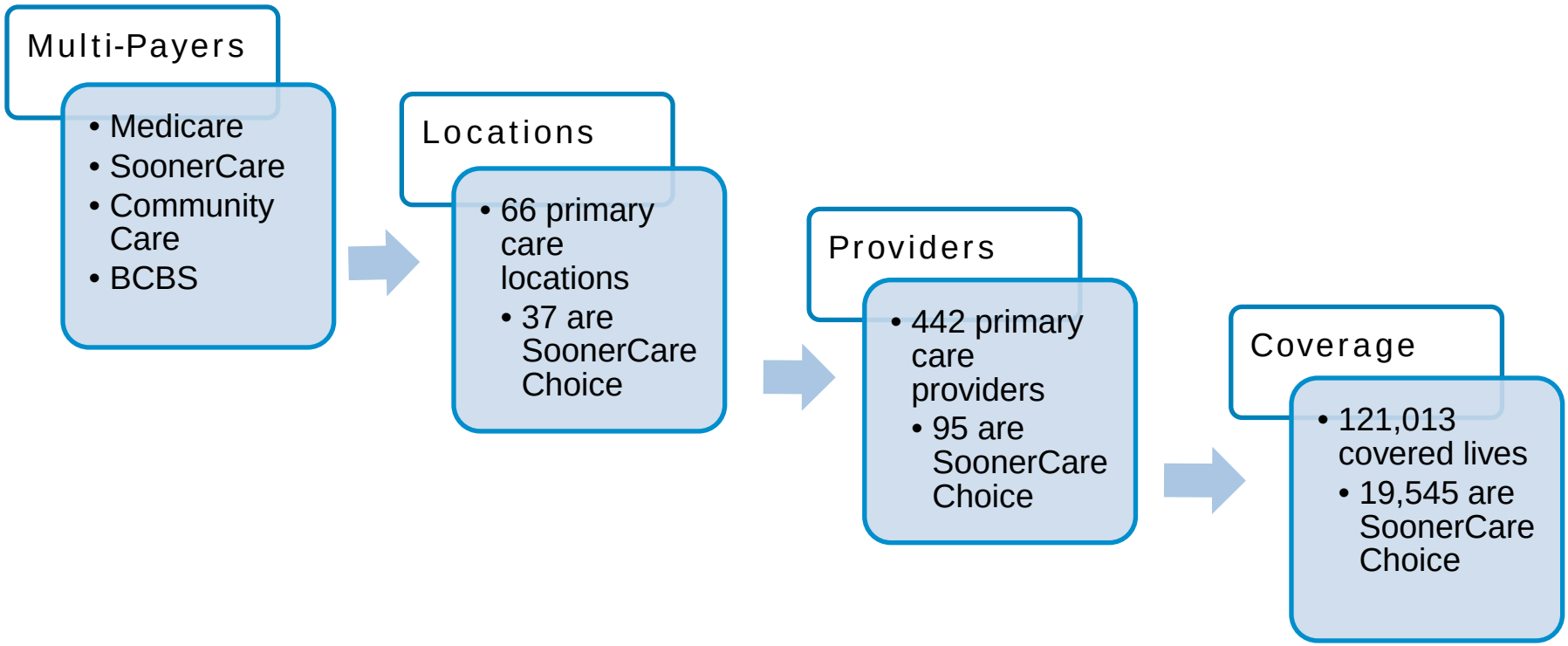
CPC CLASSIC PARTICIPATION IN THE GREATER TULSA REGION



Oklahoma HealthCare Authority

CPC CLASSIC'S PRIMARY FOCUS FOR THE PROVIDERS

Multi-payers

Primary/Preventative Care

Transformation at the Primary Care Site

Covered Lives

Actionable Data

Oklahoma HealthCare Authority

2014 CMS SHARED SAVINGS

Greater Tulsa Region was the only location that received shared savings from Medicare

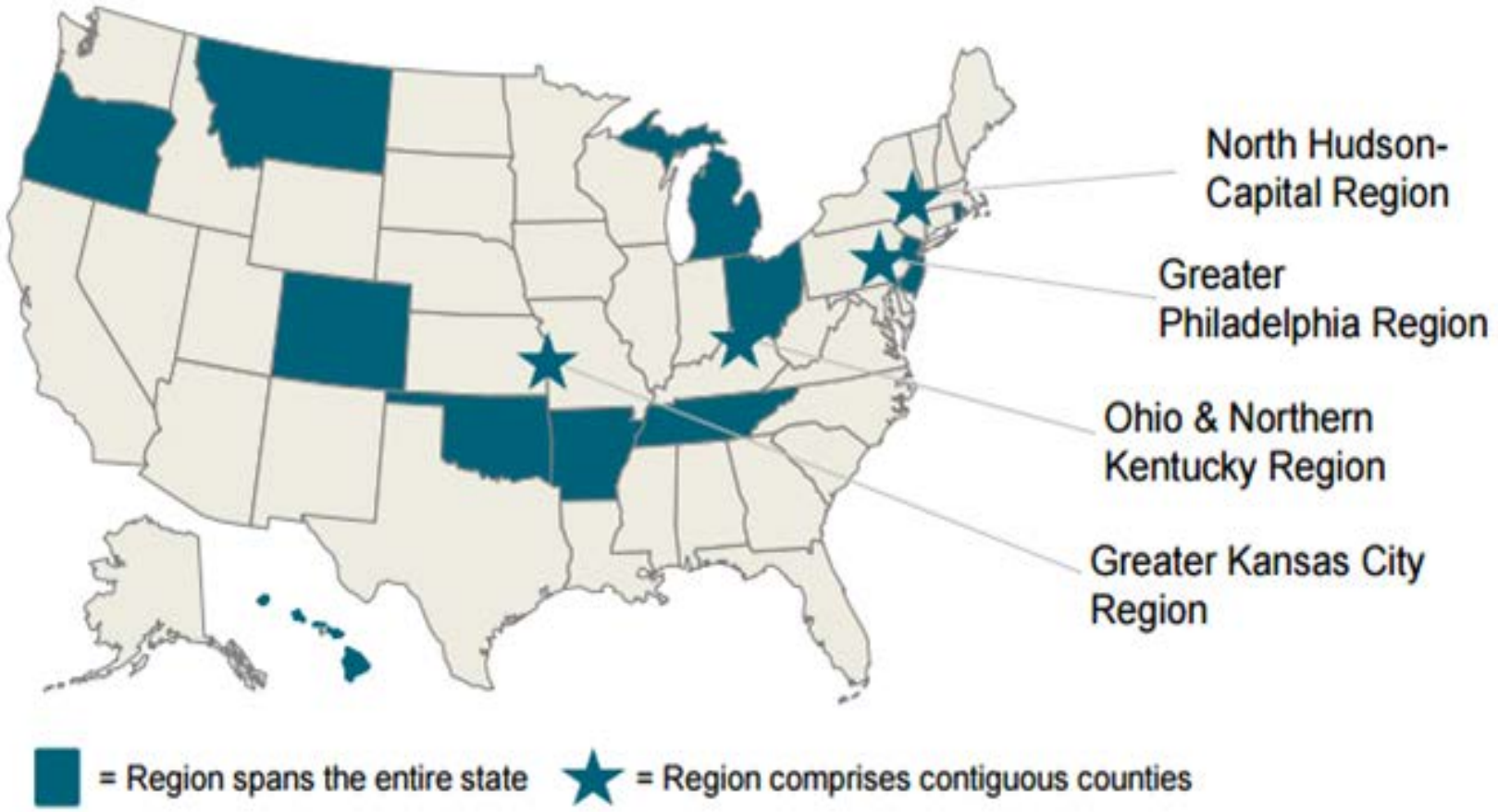
- Medicare distributed more than $547K dollars to 49 CPC classic locations

34 of our 37 SoonerCare Choice locations received a payment

BCBSOK and Community Care also distributed shared savings payments

Oklahoma HealthCare Authority

CPC+ SELECTED REGIONS



Oklahoma HealthCare Authority

WHAT WE KNOW TODAY ABOUT CPC+

247 locations have applied, 60 of those are SoonerCare Choice (preliminary data)

Potential statewide participation with six payers

CPC+

64,278 SoonerCare Choice-covered lives (preliminary data)

Medicare, SoonerCare, Community Care, BCBSOK, Advantage Medicare Plan (CC) and UnitedHealthcare within the 14 regions

Oklahoma HealthCare Authority

MAJOR DIFFERENCES BETWEEN CPC CLASSIC AND CPC+

	CPC	CPC +Track 1	CPC+ Track 2
Care Management Fee	$20 PBPM PY 1-2 $15 PBPM PY 3-4	$15 PBPM on average	$28 PBPM on average; $100 for highest-risk tier
Office Visit Payments	100 percent FFS	100 percent FFS	100 percent FFS for non-E&M services. Reduced FFS+ up-front PCP payments for E&M
Incentive payments	Shared savings based on quality metrics and total cost of care	$2.50 PBPM based on quality and utilization metrics	$4 PBPM based on quality and utilization metrics
HIT Partners	Not required	Not required	Required

Oklahoma HealthCare Authority

THANK YOU!

For Additional Information:

Melody Anthony, MS

Deputy State Medicaid Director

405-522-7360

Oklahoma HealthCare Authority

OKLAHOMA HEALTH CARE AUTHORITY
SFY 2018
Budget Request Detail

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

Notes:

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

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

Access Monitoring Review Plan

October 13, 2016

Oklahoma HealthCare Authority

WHAT IS AN ACCESS MONITORING REVIEW PLAN?

On November 2, 2015, the Centers for Medicare & Medicaid Services (CMS) issued the Access to Covered Medicaid Services final rule. The rule requires states to analyze and monitor access to care for Medicaid fee-for-service programs through an Access Monitoring Review Plan (AMRP).

Oklahoma HealthCare Authority

OHCA'S ACCESS MONITORING REVIEW PLAN

In accordance with 42 CFR 447.203 OHCA developed an AMRP for the defined service categories provided under a fee-for-service arrangement:

- Primary care services (including those provided by a physician, federally-qualified health center, clinic, or dental provider)
- Physician specialist services (e.g., cardiology)
  Behavioral health services (including mental health and substance use disorder)
- Pre- and post-natal obstetric services, including labor and delivery
- Home health services

Oklahoma HealthCare Authority

ACCESS MONITORING REVIEW PLAN: TIMELINE

- **Initially, the AMRP was to be submitted to CMS by July 1, 2016; however, the deadline for submission was extended until October 1, 2016.**

- **The AMRP timeline includes:**
  - Development by OHCA's Federal and State Authorities staff January through August of 2016.
  - Review by the Member Advisory Task Force (MATF) on February 8, 2016, and April 2, 2016.
  - A face-to-face tribal consultation was held on March 1, 2016.

Oklahoma HealthCare Authority

ACCESS MONITORING REVIEW PLAN: TIMELINE CONT.

- The OHCA Medical Advisory Committee (MAC) was consulted on March 10, May 19 and July 21 of 2016.

- To allow for public inspection, the plan was posted on the OHCA public website from April 18, 2016 through May 19, 2016. Based on feedback, the AMRP was revised and reposted August 8, 2016, through September 9, 2016.

- A final presentation of the AMRP is to the OHCA Board on October 13, 2016.

Oklahoma HealthCare Authority

ACCESS MONITORING REVIEW PLAN: NEXT STEPS

- **The AMRP was submitted to CMS on September 28, 2016.**

- **Certain categories of services will be reviewed every three years, and an updated AMRP will be submitted to CMS.**

- **OHCA must conduct and submit an access review when promulgating a State Plan Amendment that affects payment methodology and/or rates.**

Oklahoma HealthCare Authority

ACCESS MONITORING REVIEW PLAN: QUESTIONS AND COMMENTS

Provide feedback at:

http://okhca.org/PolicyBlog.aspx

Email: tywanda.cox@okhca.org

Phone: (405) 522-7153

Oklahoma HealthCare Authority

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

SUBCHAPTER 3. GENERAL PROVIDER POLICIES

PART 1. GENERAL SCOPE AND ADMINISTRATION

317:30-3-19.2. Denial of application for new or renewed provider enrollment contract based on criminal history

(a) **Definitions.** The following words and terms, when used in this section, shall have the following meaning:

(1) **"Applicant"** means providers, persons with a five percent or more direct or indirect ownership interest therein, as well as providers' officers, directors, and managing employees.

(2) **"Criminal conviction"** means an individual or entity has been convicted of a criminal offense pursuant to 42 U.S.C. § 1320a-7(i).

(b) Applicants designated as "high" risk in accordance with Federal law, including, but not limited to, 42 C.F.R. § 424.518 and 42 C.F.R. Part 455, Subpart E, or if otherwise required by State and/or Federal law, shall be subject to a fingerprint-based criminal background check as a condition of new or renewed contract enrollment.

(c) Any applicant subject to a fingerprint-based criminal background check as provided in subsection (b) of this Section, shall be denied enrollment if he/she has a felonious criminal conviction and may be denied enrollment for a misdemeanor criminal conviction relating, but not limited, to:

(1) The provision of services under Medicare, Medicaid, or any other Federal or State health care program;

(2) Homicide, murder, or non-negligent manslaughter;

(3) Aggravated assault;

(4) Kidnapping;

(5) Robbery;

(6) Abandonment, abuse, or negligence of a child;

(7) Human trafficking;

(8) Negligence and/or abuse of a patient;

(9) Forcible rape and/or sexual assault;

(10) Terrorism;

(11) Embezzlement, fraud, theft, breach of fiduciary duty, or other financial misconduct; and/or

(12) Controlled Substances.

(d) There is no right to appeal any OHCA decision denying an application for contract enrollment based on the applicant's criminal history. However, nothing in this section shall preclude an applicant whose criminal conviction has been

overturned on final appeal, and for whom no other appeals are pending or may be brought, from reapplying for enrollment.

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 1. PHYSICIANS

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

(a) **Adults**. Payment for adults is made to physicians for medical and surgical services within the scope of the Oklahoma Health Care Authority's (OHCA) 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.

~~(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 physician s providing treatment. Additional visits per month are allowed for those services related to emergency medical conditions and for services in connection with Family Planning. SoonerCare Choice members are exempt from the four visits per month limitation.~~

(G) Physician services on an outpatient basis include:

(i) A maximum of four primary care visits per member per month, with the exception of SoonerCare Choice members, or

(ii) A maximum of four specialty visits per member per month.

(iii) Additional visits are allowed per month for treatment related to emergency medical conditions and Family Planning services.

(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 as per current guidelines.
(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.
(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 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; and

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

~~(U) 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.~~

(U) Payment for services rendered by medical residents in an outpatient academic setting when the following conditions are met:

(i) the resident has obtained a medical license or a special license for training from the appropriate regulatory state medical board; and

(ii) has the appropriate contract on file with the OHCA to render services within the scope of their license.

(V) 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.

(W) Screening and follow up Pap Smears as per current guidelines.

(X) 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.

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

(Z) Donor expenses incurred for complications are covered only if they are directly and immediately attributable to the donation procedure. 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 members 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 ~~claims~~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 that addresses the 5A's and office note 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 and not separately billable.

(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) A medical geneticist physician or licensed genetic counselor provides documentation 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) Routine eye examinations for the sole purpose of prescribing glasses or visual aids, determination of refractive state, treatment of refractive errors or purchase of lenses, frames or 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~~member (home or office) per ~~member~~month, except ~~those~~ visits in connection with family planning ~~or~~, services related to emergency medical conditions~~.~~,or primary care services provided to SoonerCare Choice members.

(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.

(X) Sleep studies.

(b) **Children**. Payment is made to physicians for medical and surgical services for members under the age of 21 within the scope of the Authority's SoonerCare program, provided the services are medically necessary for the diagnosis and treatment of illness or injury, or to improve the functioning of a malformed body member. Medical and surgical services for children are comparable to those listed for adults. For services rendered to a minor child, the child's parent or court-appointed legal guardian must provide written authorization prior to the service being rendered, unless there is an explicit state or federal exception to this requirement. In addition to those services listed for adults, the following services are covered for children.

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

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

(B) Out of state placements are not authorized unless it is determined that the needed medical services are more readily

available in another state or it is a general practice for members in a particular border locality to use resources in another state. If a medical emergency occurs while a member is out of the State, treatment for medical services is covered as if provided within the State. A prime consideration for placements is proximity to the family or guardian in order to involve the family or guardian in discharge and reintegration planning.

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

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

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

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

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

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

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

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

(C) Services of two physicians for the same type of service to the same member on the same day, except when supplemental skills are required and different specialties are involved.
(D) Pre-operative care within 24 hours of the day of admission for surgery and routine post-operative care as defined under the global surgery guidelines promulgated by Current Procedural Terminology (CPT) and the Centers for Medicare and Medicaid Services (CMS).
(E) Payment to the same physician for both an outpatient visit and admission to hospital on the same date.
(F) Sterilization of members who are under 21 years of age, mentally incompetent, or institutionalized or reversal of sterilization procedures for the purposes of conception.
(G) Non-therapeutic hysterectomies.
(H) Medical Services considered experimental or investigational.
(I) More than one inpatient visit per day per physician.
(J) Induced abortions, except when certified in writing by a physician that the abortion was necessary due to a physical disorder, injury or illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would place the woman in danger of death unless an abortion is performed, or that the pregnancy is the result of an act of rape or incest. (Refer to OAC 317:30-5-6 or 317:30-5-50.)
(K) Physician services which are administrative in nature and not a direct service to the member including such items as quality assurance, utilization review, treatment staffing, tumor board review or multidisciplinary opinion, dictation, and similar functions.
(L) Payment for the services of social workers, licensed family counselors, registered nurses or other ancillary staff, except as specifically set out in OHCA rules.
(M) Direct payment to perfusionist as this is considered part of the hospital reimbursement.
(N) Charges for completion of insurance forms, abstracts, narrative reports or telephone calls.
(O) Mileage.
(P) A routine hospital visit on date of discharge unless the member expired.

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

(1) In certain circumstances, some claims do not automatically "cross over". Providers must file a claim for coinsurance and/or

deductible to SoonerCare within 90 days of the Medicare payment and within one year from the date of service.
(2) If payment was denied by Medicare Part B and the service is a SoonerCare covered service, mark the claim "denied by Medicare" and attach the Medicare EOMB showing the reason for the denial.

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 1. PHYSICIANS

317:30-5-22. Obstetrical care

~~(a) Providers of obstetrical services must bill each antepartum visit separately, utilizing the appropriate evaluation and management service code. The OHCA does not recognize the codes for "global obstetrical care" which bundle these services under a single procedure code. Delivery only and postpartum care services are also billed separately by the rendering provider.~~

~~(b) The following routine obstetrical services are covered as detailed below:~~

(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 antepartum diagnostic ultrasounds will be paid in addition to antepartum care, delivery and postpartum obstetrical care under defined circumstances. To be eligible for payment, all 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 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 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) One additional detailed ultrasound is allowed by a Board Eligible/Board Certified Maternal Fetal Specialist or general obstetrician with documented specialty training in performing detailed ultrasounds. This additional ultrasound is allowed 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 or qualified health care provider not participating in the delivery.

(4) Anesthesia administered by the attending physician is a compensable service and may be 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 a medically indicated 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 multiple gestations. If one fetus is delivered vaginally and additional fetus(es)are delivered by C-section by the same physician, the higher level procedure is paid. If one fetus is delivered vaginally and additional fetus(es)are 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) Reimbursement is allowed for 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 ~~may~~ bill separately for the ~~antenatal~~prenatal and the six weeks postpartum office ~~visits~~visit.

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

(1) 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 postpartum care.

~~(3)~~(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.

~~(4)~~(5) Fetal scalp blood sampling is considered part of ~~DRG reimbursement~~the total OB care.

(e) Obstetrical coverage for children is the same as for adults. Additional procedures may be covered under 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.

PART 19. CERTIFIED NURSE MIDWIVES

317:30-5-226. Coverage by category

(a) **Adults~~ and children 21 and under~~.** Payment is made for certified nurse midwife services within the scope of practice as defined by state law including obstetrical care such as antepartum care, delivery, postpartum care, and care of the

normal newborn during the first 28 days of life. ~~Obstetrical care should be billed using the appropriate evaluation and management codes for antepartum care, as well as the appropriate delivery only and postpartum care services when rendered. Ultrasounds and other procedures for obstetrical care are paid in accordance with OAC 317:30-5-22(b).~~

(1) Obstetrical care should be billed using the appropriate CPT codes for Maternity Care and Delivery. The date of delivery should be 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. The date the patient was first seen must be on the claim form. Payment for total obstetrical care includes all routine care. Ultrasounds and other procedures reimbursed separately from total obstetrical care are paid in accordance with provisions found at OAC 317:30-5-22(b).

(2) For payment of total OB care, the provider 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 provider outside of antepartum visits. The antepartum care during the prenatal care period includes all care by the OB provider except major illness distinctly unrelated to the pregnancy.

(b) **Newborn.** Payment to nurse midwives for services to newborn is the same as for adults ~~and children under 21~~. A newborn is an infant during the first 28 days following birth.

(1) Providers must use OKDHS Form FSS-NB-1, or the eNB1 application on the Secure Website to notify the county DHS office of the child's birth. A claim may then be filed for charges for the baby under the case number and the baby's name and assigned person code.

(2) Charges billed on the mother's person code for services rendered to the child will be denied.

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

317:30-5-229. Reimbursement

In accordance with the Omnibus Budget Reconciliation Act of 1993, effective October 1, 1993, certified nurse midwife services include maternity services, as well as services outside the maternity cycle within the scope of their practice under state law.

(1) Medical verification of pregnancy is required. A written statement from the physician or certified nurse midwife

verifying the applicant is pregnant and the expected date of delivery is acceptable. Pregnancy may also be verified by submission of a copy of a laboratory report indicating the individual is pregnant.

(2) Newborn charges billed on the mother's person code will be denied.

(3) Providers must use OKDHS Form FSS-NB-1 to notify the county DHS office of the child's birth.

(4) ~~Obstetrical care should be billed using the appropriate evaluation and management codes for antepartum care, as well as the appropriate delivery only and postpartum care services when rendered.~~ Obstetrical care should be billed using the appropriate CPT codes for Maternity Care and Delivery. The date of delivery should be 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. The date the patient was first seen must be on the claim form. Payment for total obstetrical care includes all routine care performed by the attending provider. For payment of total OB care, the provider 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 provider outside of antepartum visits. The antepartum care during the prenatal care period includes all care by the OB provider except major illness distinctly unrelated to the pregnancy.

PART 35. RURAL HEALTH CLINICS

317:30-5-356. Coverage for adults

Payment is made to rural health clinics for adult services as set forth in this Section.

(1) **RHC services.** Payment is made for one encounter per member per day. Payment is also limited to four visits per member per month. Refer to OAC 317:30-1, General Provisions, and OAC 317:30-3-65.2 for exceptions to the four visit limit for children under the Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT). Additional preventive service exceptions include:

(A) **Obstetrical care.** A Rural Health Clinic should have a written contract with its physician, nurse midwife, advanced practice nurse, or physician assistant that specifically identifies how obstetrical care will be billed to SoonerCare, in order to avoid duplicative billing situations. The agreement should also specifically

identify the physician's compensation for rural health and non-rural health clinic (other ambulatory) services.

(i) If the clinic compensates the physician, nurse midwife or advanced practice nurse to provide obstetrical care, then the clinic must bill the SoonerCare program for each prenatal visit using the appropriate CPT evaluation and management codes.

(ii) ~~If the clinic does not compensate its practitioners to provide obstetrical care, then the independent practitioner must bill the SoonerCare program for each prenatal visit using the appropriate CPT code described in the SoonerCare provider specific rules for physicians, certified nurse midwives, physician assistants, and advanced practice nurses (refer to OAC 317:30-5-22).~~ If the clinic does not compensate its practitioners to provide obstetrical care, then the independent practitioner must bill the OHCA for prenatal care according to the global method described in the SoonerCare provider specific rules for physicians, certified nurse midwives, physician assistants, and advanced practice nurses (refer to OAC 317:30-5-22).

(iii) Under both billing methods, payment for prenatal care includes all routine or minor medical problems. No additional payment is made to the prenatal provider except in the case of a major illness distinctly unrelated to pregnancy.

(B) **Family planning services.** Family planning services are available only to members with reproductive capability. Family planning visits do not count as one of the four RHC visits per month.

(2) **Other ambulatory services.** Services defined as "other ambulatory" services are not considered a part of a RHC visit and are therefore billable to the SoonerCare program by the RHC or provider of service on the appropriate claim forms. Other ambulatory services are subject to the same scope of coverage as other SoonerCare services billed to the program, i.e., limited adult services and some services for under 21 subject to same prior authorization process. Refer to OAC 317:30-1, General Provisions, and OAC 317:30-3-57, 317:30-5-59, and 317:30-3-60 for general coverage and exclusions under the SoonerCare program. Some specific limitations are applicable to other ambulatory services as set forth in specific provider rules and excerpted as follows: Coverage under optometrists for adults is limited to treatment of eye disease not related to refractive errors. There is no

coverage for eye exams for the purpose of prescribing eyeglasses, contact lenses or other visual aids. (See OAC 317:30-5-431.)

PART 75. FEDERALLY QUALIFIED HEALTH CENTERS

317:30-5-664.8. Obstetrical care provided by Health Centers

(a) **Billing written agreement.** In order to avoid duplicative billing situations, a Health Center must have a written agreement with its physician, certified nurse midwife, advanced practice nurse, or physician assistant that specifically identifies how obstetrical care will be billed. The agreement must specifically identify the service provider's compensation for Health Center core services and other health services that may be provided by the Center.

(b) **Prenatal or postpartum services.**

(1) If the Health Center compensates the physician, certified nurse midwife or advanced practice nurse for the provision of obstetrical care, then the Health Center bills the OHCA for each prenatal and postpartum visit separately using the appropriate CPT evaluation and management code(s) as provided in the Health Center billing manual.

(2) ~~If the clinic does not compensate its practitioners to provide obstetrical care, then the independent practitioner must bill the SoonerCare program for each prenatal visit using the appropriate CPT code described in the SoonerCare provider specific rules for physicians, certified nurse midwives, physician assistants, and advanced practice nurses (refer to OAC 317:30-5-22).~~If the clinic does not compensate the provider for the provision of obstetrical care, then the provider must bill the OHCA for prenatal care according to the global method described in the SoonerCare Traditional provider specific rules for physicians, certified nurse midwives, physician assistants, and advanced practice nurses (refer to OAC 317:30-5-22).

(3) Under both billing methods, payment for prenatal care includes all routine or minor medical problems. No additional payment is made to the prenatal provider except in the case of a major illness distinctly unrelated to pregnancy.

(c) **Delivery services**. Delivery services are billed using the appropriate CPT codes for delivery. If the clinic does not compensate the provider for the provision of obstetrical care, then the provider must be individually enrolled and bill for those services using his or her assigned provider number. The costs associated with the delivery must be excluded from the

cost settlement/encounter rate setting process (see OAC 317:300-5-664.11).

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 35. MEDICAL ASSISTANCE FOR ADULTS AND CHILDREN-ELIGIBILITY

SUBCHAPTER 5. ELIGIBILITY AND COUNTABLE INCOME

PART 1. DETERMINATION OF QUALIFYING CATEGORICAL RELATIONSHIPS

317:35-5-2. Categorically related programs

(a) In order to be eligible for SoonerCare, an individual must first meet the description of a member eligibility group. For individuals related to the aged, blind, or disabled groups, categorical relationship is established using the same definitions of age, disability and blindness as used by the Social Security Administration (SSA) in determining eligibility for Supplemental Security Income (SSI) or SSA benefits. If the individual is a SSA/SSI recipient in current payment status (including presumptive eligibility), a TANF recipient, an adoption assistance or kinship guardianship assistance recipient, or is under age 19, categorical relationship is automatically established. Categorical relationship to the pregnancy group is established when the determination is made by medical evidence that the individual is or has been pregnant. Effective January 1, 2014, verification of pregnancy is only required if the individual's declaration that she is pregnant is not reasonably compatible with other information available to the agency. Pregnancy-related services include all medical services provided within the scope of the program during the prenatal, delivery and postpartum periods for women in this pregnancy group; see Subchapter 22 of this Chapter for services for unborn children covered under Title XXI. For an individual age 19 or over to be related to the parent and caretaker relative group, the individual must have a minor dependent child. For an individual to be related to the former foster care children group, the individual must not be eligible for the Title XIX pregnancy or parent or caretaker relative groups, must be aged 19-26, and must have been receiving SoonerCare as a foster care child when he/she aged out of foster care in Oklahoma. There is no income or resource test for the former foster care children group. Categorical relationship to Refugee services is established in accordance with OAC 317:35-5-25. Categorical relationship for the Breast and Cervical Cancer Treatment program is established in accordance with OAC 317:35-21. Categorical relationship for the SoonerPlan Family Planning Program is established in accordance with OAC 317:35-5-8. Categorical relationship for pregnancy related benefits covered under Title XXI is established in accordance with OAC 317:35-22. ~~Benefits for pregnancies covered under Title XXI medical~~

~~services are provided within the limited scope of this particular program for antenatal care and delivery only. Each service must be billed using the appropriate CPT codes. To be eligible for SoonerCare benefits, an individual must be related to one of the following eligibility groups:~~Benefits for pregnancies covered under Title XXI medical services are provided within the scope of the program during the prenatal, delivery and postpartum care when included in the global delivery payment. To be eligible for SoonerCare benefits, an individual must be related to one of the following eligibility groups:

(1) Aged
(2) Disabled
(3) Blind
(4) Pregnancy
(5) Children, also including
   (A) Newborns deemed eligible, and
   (B) Grandfathered CHIP children
(6) Parents and Caretaker Relatives
(7) Refugee
(8) Breast and Cervical Cancer Treatment program
(9) SoonerPlan Family Planning Program
(10) Benefits for pregnancies covered under Title XXI
(11) Former foster care children.

(b) The Authority may provide SoonerCare to reasonable categories of individuals under age 21.

(1) Individuals eligible for SoonerCare benefits include individuals between the ages of 19 and 21:
   (A) for whom a public agency is assuming full or partial financial responsibility who are in custody as reported by the Oklahoma Department of Human Services (OKDHS) and in foster homes, private institutions or public facilities; or
   (B) in adoptions subsidized in full or in part by a public agency; or
   (C) individuals under age 21 receiving active treatment as inpatients in public psychiatric facilities or programs if inpatient psychiatric services for individuals under age 21 are provided under the State Plan and the individuals are supported in full or in part by a public agency; or

(2) Individuals eligible for SoonerCare benefits include individuals between the ages of 18 and 21 if they are in custody as reported by OKDHS on their 18th birthday and living in an out of home placement.

SUBCHAPTER 22. PREGNANCY RELATED BENEFITS COVERED UNDER TITLE XXI

317:35-22-2. Scope of coverage for Title XXI Pregnancy

(a) ~~Pregnancy related services provided are for antepartum and delivery only.~~Pregnancy related services provided are prenatal, delivery, postnatal care when included in the global delivery fee, and other related services that are medically necessary to optimize pregnancy outcomes within the defined program benefits.

(b) ~~Only two additional visits per month to other medical consultants, such as a dietitian or licensed genetic counselor for related services to evaluate and/or treat conditions that may adversely impact the fetus are covered.~~Only two visits per month for other related services to evaluate and/or treat conditions that may adversely impact the pregnancy are covered.

Submitted to the C.E.O. and Board on October 13, 2016

AUTHORITY FOR INCREASE IN EXPENDITURE OF FUNDS
Consulting Services

BACKGROUND

OHCA maintains agreements with four contractors to provide consulting services on various policy, audit and rate–setting issues. In February 2012, the OHCA Board of Directors approved $3.5 million for these services. Since approval, additional projects have been identified that require the services of these consultants including but not limited to the following:

1. Nursing Home Supplement UPL Program (50/50 FFP)
2. Audit of Electronic Health Record Payments (90/10 FFP) – Federal Mandate
3. Actuary for the Aged, Blind, and Disabled Care Coordination Program (50/50 FFP)

In addition, the current environment requires more data-driven decision making and independent evaluation of performance and costs, therefore resulting in a greater need for these services.

SCOPE OF WORK

- Analyze impact of policy changes on cost, access and quality of services
- Develop state plan amendments or waivers as needed
- Evaluate OHCA programs and recommend improvements
- Provide financial services including budget neutrality calculations, cost impacts, program feasibility, return on investment, and rate setting for new or existing services
- Assess data vulnerability and provide gap analysis of available data versus needed data
- Provide reports and presentations as necessary on the above issues

CONTRACT PERIOD

July 1, 2013 through June 30, 2019

CONTRACT AMOUNT AND PROCUREMENT METHOD

- Awarded through competitive bidding conducted by OHCA
- Federal matching percentage varies depending on the project
- Not-to-exceed $5.0 million for the period November 1, 2016 – June 30, 2019

RECOMMENDATION

- Board approval for OHCA to continue to utilize these contracts