Rules Agenda

November 13, 2008

I. Items subject to the Administrative Procedures Act (Emergency)

Page 2 A. Revising SoonerCare eligibility rules to allow individuals to apply for nursing home care (or private ICF/MR) at the OKDHS human services center of their choice. **(Reference APA WF # 08-33)**

Page 5 B. Revising Insure Oklahoma/O-EPIC rules to expand Individual Plan (IP) benefits to cover physical, occupational, and speech therapy services for adults in an outpatient hospital setting and outpatient behavioral health services provided by an individual Licensed Behavioral Health Professional. **(Reference APA WF # 08-35)**

Page 12 C. Revising SoonerCare rules to: (1) incorporate the patient-centered medical home model of care in which providers are paid a monthly care coordination payment in addition to reimbursement for SoonerCare compensable services at the fee-for-service rate; (2) require provider or physician groups to designate a medical director to serve as primary contact with OHCA; (3) include a section on provider networks; and (4) include language regarding the development of a payment for excellence program. **(Reference APA WF # 08-19)**

I. Items subject to the Administrative Procedures Act (Emergency)

A. **CHAPTER 35. MEDICAL ASSISTANCE FOR ADULTS AND CHILDREN-ELIGIBILITY**
Subchapter 9. ICF/MR, HCBW/MR, and Individuals Age 65 or Older in Mental Health Hospitals
Part 3. Application Procedures
OAC 317:35-9-26. [AMENDED]
Subchapter 19. Nursing Facility Services
OAC 317:35-19-6. [AMENDED]
(Reference APA WF # 08-33)

FINDING OF EMERGENCY: The Agency finds that a compelling public interest exists which necessitates promulgation of emergency rules and requests emergency approval of rule revisions to allow individuals to apply for SoonerCare compensable nursing home services or private Intermediate Care Facilities for the Mentally Retarded (ICF/MR) services at the OKDHS human services center of their choice. Without this change, individuals will continue to be required to apply in the county in which they live. This currently creates a barrier for individuals to enroll in SoonerCare by creating an unnecessary delay caused by administrative procedures for eligibility. This change will help serve the best interests of the individuals desiring to apply for and who qualify for SoonerCare services.

SUMMARY: Agency rules are revised to allow individuals to apply for SoonerCare compensable nursing home and ICF/MR services at the OKDHS human services center of their choice. Current eligibility rules require individuals to apply at the local office in the county where the individual lives. Federal regulation 42 C.F.R. Section 435.902 requires eligibility to be determined in a manner that is consistent with simplicity of administration and the best interests of the applicant. Additionally, 42 C.F.R. Section 435.930 requires agencies to furnish Medicaid promptly to members without delay caused by the agency's administrative procedures. Allowing individuals to apply at the OKDHS human services center of their choice will help eliminate a barrier and serve the best interests of the individuals desiring to apply for and who qualify for SoonerCare services.

BUDGET IMPACT: Agency staff has determined that the revisions are budget neutral to the agency.

RULE LENGTH IMPACT: These revisions will have no significant

impact on the length of agency rules.

MEDICAL ADVISORY COMMITTEE: The Medical Advisory Committee considered the proposed rule revisions on September 18, 2008, and recommended Board approval.

PROPOSED EFFECTIVE DATE: January 1, 2009, or immediately upon Governor's approval, whichever is later.

AUTHORITY: The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; 42 C.F.R. Section 435.902; 42 C.F.R. Section 435.930

RESOLUTION:
Resolved, that the Oklahoma Health Care Authority Board does hereby approve the Administrative Rules, subject to the Administrative Procedure Act, as indicated:
SoonerCare eligibility rules are revised to allow individuals to apply for nursing home care (or private ICF/MR) at the OKDHS human services center of their choice.

CHAPTER 35. MEDICAL ASSISTANCE FOR ADULTS AND CHILDREN-ELIGIBILITY
SUBCHAPTER 9. ICF/MR, HCBW/MR, AND INDIVIDUALS AGE 65 OR OLDER IN MENTAL HEALTH HOSPITALS
PART 3. APPLICATION PROCEDURES

317:35-9-26. Application procedures for private ICF/MR
~~A request for payment for private ICF/MR is made to the local office in the county where the applicant lives.~~ Individuals may apply for private ICF/MR at the OKDHS human services center (HSC) of their choice. A written application is not required for an individual who has an active ~~Medicaid~~ SoonerCare case. The ~~DHS~~ OKDHS Notification Regarding Patient in a Nursing Facility, Intermediate Care Facility for the Mentally Retarded or Hospice form ~~(ABCDM-83)~~ 08MA083E, when received in the ~~county office~~ HSC, also constitutes an application request and is handled the same as an oral request. The local ~~county office~~ HSC will send the ICF/MR ~~DHS~~ OKDHS form ~~ABDCM-37D~~ 08MA038E~~, Notice to Nursing Care Facility or LTCA,~~ within three working days of receipt of ~~DHS~~ OKDHS forms ~~ABCDM-83~~ 08MA083E and ~~ABCDM-96~~ 08MA084E, Management of Recipient's Funds, indicating actions that are needed or have been taken regarding the ~~client~~ member.

SUBCHAPTER 19. NURSING FACILITY SERVICES

317:35-19-6. Application procedures for NF

~~A request for payment for NF is made to the local office in the county where the applicant lives.~~ Individuals may apply for nursing home care at the OKDHS human services center (HSC) of their choice. A written application is not required for an individual who has an active ~~Medicaid~~ SoonerCare case. For NF, ~~DHS~~ OKDHS Form ~~ABCDM-83~~ 08MA083E, Notification Regarding Patient in a Nursing Facility, Intermediate Care Facility for the Mentally Retarded or Hospice form, when received in the ~~county office~~ HSC, also constitutes an application request and is handled the same as an oral request.

B. **CHAPTER 45. INSURE OKLAHOMA/ OKLAHOMA EMPLOYER AND EMPLOYEE PARTNERSHIP FOR INSURANCE COVERAGE**
Subchapter 11. Insure Oklahoma/O-EPIC IP
Part 3. Insure Oklahoma/O-EPIC IP Member Health Care Benefits
OAC 317:45-11-10. through 317:45-11-11. [AMENDED]
(Reference APA WF # 08-35)

FINDING OF EMERGENCY: The Agency finds that a compelling public interest exists which necessitates promulgation of emergency rules and requests emergency approval of rule revisions to the Insure Oklahoma/O-EPIC Individual Plan (IP) benefits package. IP benefits are revised to cover: (1) physical, occupational and speech therapy services for adults in an outpatient hospital setting; and (2) outpatient behavioral health services provided by an individual Licensed Behavioral Health Professional (LBHP). Without the addition of the therapies benefit, IP members will continue to be unable to have coverage for these therapies that may be recommended as medically necessary following an injury or illness and help the effected individuals more quickly and safely return to full working function and prevent further injury from occurring. Without the coverage of outpatient behavioral health services by an individual LBHP, members will have to travel further for behavioral health services and their choices will be limited. In many cases, the members will also have to wait long periods of time for appointments in mental health centers.

SUMMARY: Rules are revised to expand the Insure Oklahoma/O-EPIC IP benefits package to include physical therapy, occupational therapy and speech therapy in an outpatient hospital setting and outpatient behavioral health services provided by an individual LBHP. Currently, adult therapies is not offered as a covered service under the IP program. The added adult therapies benefit will only be compensable when provided in an outpatient hospital setting. This addition to the IP program is consistent with current benefit offerings within many private insurance plans. Without this added benefit, IP members will continue to be unable to have coverage for adult therapies that may be recommended as medically necessary. Following an injury or illness, the provision of adult therapies can help individuals more quickly and safely return to full working function and prevent further injury from occurring. Outpatient behavioral health services are currently offered under the IP program but only at mental health centers. The addition of outpatient behavioral health services by individual LBHPs is

consistent will current benefit offerings within many private insurance plans. By allowing outpatient behavioral health services provided by individual LBHPs, IP members in rural parts of Oklahoma will be better able to access behavioral health services as currently there are limited resources in rural areas.

BUDGET IMPACT: Agency staff have estimated that the addition of these services will have only a minimal budget impact. The state share will be funded through a portion of monthly proceeds from the Tobacco Tax that are collected and dispersed through the Health Employee and Economy Improvement Act (HEEIA) Revolving Fund.

RULE LENGTH IMPACT: These revisions will have no significant impact on the length of agency rules.

MEDICAL ADVISORY COMMITTEE: The Medical Advisory Committee considered the proposed rule revisions on September 18, 2008, and recommended Board approval.

PROPOSED EFFECTIVE DATE: January 1, 2009, or immediately upon Governor's approval, whichever is later.

AUTHORITY: The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; Section 1010.1 et seq. of Title 56 of Oklahoma Statutes

RESOLUTION:
Resolved, that the Oklahoma Health Care Authority Board does hereby approve the Administrative Rules, subject to the Administrative Procedure Act, as indicated:
Insure Oklahoma/O-EPIC Individual Plan benefits are revised to cover: (1) physical, occupational and speech therapy services for adults in an outpatient hospital setting; and (2) outpatient behavioral health services provided by an individual Licensed Behavioral Health Professional.

CHAPTER 45. INSURE OKLAHOMA/ OKLAHOMA EMPLOYER AND EMPLOYEE PARTNERSHIP FOR INSURANCE COVERAGE

SUBCHAPTER 11. INSURE OKLAHOMA/O-EPIC IP

PART 3. INSURE OKLAHOMA/O-EPIC IP MEMBER HEALTH CARE BENEFITS

317:45-11-10. Insure Oklahoma/O-EPIC IP benefits

(a) All ~~O-EPIC~~ IP benefits are subject to rules delineated in OAC 317:30 except as specifically set out in this Section. The scope of IP benefits described in this Section are subject to specific

non-covered services listed in OAC 317:45-11-11.

(b) A PCP referral is required to see any other provider with the exception of the following services:

(1) behavioral health services;

(2) prenatal and obstetrical supplies and services, meaning prenatal care, delivery and 60 days of postpartum care;

(3) family planning supplies and services, meaning an office visit for a comprehensive family planning evaluation, including obtaining a Pap smear;

(4) women's routine and preventive health care services;

(5) emergency medical condition as defined in OAC 317:30-3-1; and

(6) services delivered to American Indians at Indian Health Service, tribal, or urban Indian clinics.

(c) ~~O-EPIC~~ IP covered benefits for in-network services, limits, and applicable co-payments are listed in this subsection. In addition to the benefit-specific limits, there is a maximum lifetime benefit of $1,000,000. Coverage includes:

(1) Anesthesia/Anesthesiologist Standby. Covered in accordance with OAC 317:30-5-7. Eligible services are covered for covered illness or surgery including services provided by a Certified Registered Nurse Anesthetist (CRNA).

(2) Blood and Blood Products. Processing, storage, and administration of blood and blood products in inpatient and outpatient settings.

(3) Chelation Therapy. Covered for heavy metal poisoning only.

(4) Diagnostic X-ray, including Ultrasound. Covered in accordance with OAC 317:30-5-22(b)(2). PCP referral is required. Standard radiology (X-ray or Ultrasound): $0 co-pay. Specialized scanning and imaging (MRI, MRA, PET, or CAT Scan); $25 co-pay per scan.

(5) Emergency Room Treatment, services and supplies for treatment in an emergency. Contracted provider services are subject to a $30 co-pay per occurrence. The emergency room co-pay will be waived if the member is admitted to the hospital or death occurs before admission.

(6) Inpatient Hospital Benefits. Covered in accordance with OAC 317:30-5-41, 317:30-5-47 and 317:30-5-95; $50 co-pay per admission.

(7) Preventive Office Visit. For services of evaluation and medical management (wellness exam); one visit per year with a $10 co-pay. This visit counts as an office visit.

(8) Office Visits/Specialist Visits. Covered in accordance with OAC 317:30-5-9, 317:30-5-10, and 317:30-5-11. For services of evaluation and medical management; up to four visits are covered per month; PCP referral required for specialist visits; $10 co-pay per visit.

(9) Outpatient Hospital/Facility Services.

(A) Includes hospital surgery services in an approved outpatient facility including outpatient services and diagnostic services. Prior authorization required for certain procedures; $25 co-pay per visit.

(B) Therapeutic radiology or chemotherapy on an outpatient basis without limitation to the number of treatments per month for persons with proven malignancies or opportunistic infections; $10 co-pay per visit.

(C) Physical, Occupational and Speech Therapy services. Coverage is limited to one evaluation/re-evaluation visit (unit) per discipline per calendar year and 15 visits (units) per discipline per date of service per calendar year; $10 co-pay per visit.

(10) Maternity (Obstetric). Covered in accordance with OAC 317:30-5-22. Nursery care paid separately under eligible child; $50 inpatient hospital co-pay.

(11) Laboratory/Pathology. Covered in accordance with OAC 317:30-5-20; $0 co-pay.

(12) Mammogram (Radiological or Digital). Covered in accordance with OAC 317:30-5-901; $0 co-pay.

(13) Immunizations ~~for Adults~~. Covered in accordance with OAC 317:30-5-2~~; $10 co-pay per immunization~~.

(14) Assistant Surgeon. Covered in accordance with OAC 317:30-5-8.

(15) Dialysis, Kidney dialysis, and services and supplies, either at home or in a facility; $0 co-pay.

(16) Oral Surgery. Services are limited to the removal of tumors or cysts; Inpatient Hospital $50 or Outpatient Hospital/Facility; $25 co-pay applies.

(17) ~~Mental~~ Behavioral Health (Mental Health and Substance Abuse) Treatment (Inpatient). Covered in accordance with OAC 317:30-5-95.1; $50 co-pay per admission.

(18) ~~Mental~~ Behavioral Health (Mental Health and Substance Abuse) Treatment (Outpatient). ~~Covered in accordance with OAC 317:30-5-241; $10 co-pay per visit.~~

(A) Agency services. Covered in accordance with OAC 317:30-5-241; $10 co-pay per visit.

(B) Individual provider services. Licensed Behavioral Health Professionals (LBHPs) are defined as follows for the purpose of Outpatient Mental Health Services and Outpatient Substance Abuse Treatment:

(i) Allopathic or Osteopathic Physicians with a current license and board certification in psychiatry or board eligible in the state in which services are provided, or a current resident in psychiatry practicing as described in OAC 317:30-5-2.

(ii) Practitioners with a license to practice in the state in which services are provided or those actively and

regularly receiving board approved supervision, and extended supervision by a fully licensed clinician if board's supervision requirement is met but the individual is not yet licensed, to become licensed by one of the licensing boards listed in (I) through (VI) below. The exemptions from licensure under 59 '1353(4) and (5), 59 '1903(C) and (D), 59 '1925.3(B) and (C), and 59 '1932(C) and (D) do not apply to Outpatient Behavioral Health Services.

(I) Psychology,
(II) Social Work (clinical specialty only),
(III) Professional Counselor,
(IV) Marriage and Family Therapist,
(V) Behavioral Practitioner, or
(VI) Alcohol and Drug Counselor.

(iii) Advanced Practice Nurse (certified in a psychiatric mental health specialty), licensed as a registered nurse with a current certification of recognition from the board of nursing in the state in which services are provided.
(iv) A Physician's Assistant who is licensed in good standing in this state and has received specific training for and is experienced in performing mental health therapeutic, diagnostic, or counseling functions.
(v) LBHPs must have a valid Insure Oklahoma contract in order to bill for services rendered.
(vi) LBHP services require prior authorization and are limited to 8 therapy services per month and 8 testing units per year; $10 co-pay per visit.

~~(19) Substance Abuse Treatment (Outpatient). Covered in accordance with OAC 317:30-5-241; $10 co-pay per visit.~~
~~(20)~~ (19) Durable Medical Equipment and Supplies. Covered in accordance with ~~OAC 317:30-5, Part 17~~ OAC 317:30-5-210 through 317:30-5-218. A PCP referral and prior authorization is required for certain items. DME/Supplies are covered up to a $15,000 annual maximum; exceptions from the annual DME limit are diabetic supplies, oxygen, home dialysis, and parenteral therapy; $5 co-pay for durable/non-durable supplies and $25 co-pay for durable medical equipment.
~~(21)~~ (20) Diabetic Supplies. Covered in accordance with ~~OAC 317:30-5, Part 17~~ OAC 317:30-5-211.15; not subject to $15,000 annual DME limit; $5 co-pay per prescription.
~~(22)~~ (21) Oxygen. Covered in accordance with ~~OAC 317:30-5, Part 17~~ OAC 317:30-5-211.11 through 317:30-5-211.12; not subject to $15,000 annual DME limit; $5 co-pay per month.
~~(23)~~ (22) Pharmacy. Covered in accordance with OAC 317:30-5-72.1 and 317:30-5-72. Prenatal vitamins and smoking cessation products do not count against monthly prescription limits; $5/$10 co-pay per prescription.

~~(24)~~ (23) Smoking Cessation Products. Products do not count against monthly prescription limits. Covered in accordance with ~~OAC 317:30-5-77.2~~ OAC 317:30-5-72.1; $5/$10 co-pay per product.
~~(25)~~ (24) Nutrition Services. Covered in accordance with OAC 317:30-5-1076; $10 co-pay per visit.
~~(26)~~ (25) External Breast Prosthesis, Bras and Prosthetic Garments. Covered in accordance with ~~OAC 317:30-5, Part 17~~ OAC 317:30-5-211.13; $25 co-pay per prosthesis.
~~(27)~~ (26) Surgery. Covered in accordance with OAC 317:30-5-8; $50 co-pay per inpatient admission and $25 co-pay per outpatient visit.
~~(28)~~ (27) Home Dialysis. Covered in accordance with ~~OAC 317:30-5, Part 17~~ OAC 317:30-5-211.13; not subject to $15,000 annual DME limit; $0 co-pay.
~~(29)~~ (28) Parenteral Therapy. Covered in accordance with ~~OAC 317:30-5, Part 17~~ OAC 317:30-5-211.14; not subject to $15,000 annual DME limit; $25 co-pay per month.
~~(30)~~ (29) Family Planning Services and Supplies, including Sterilizations. Covered in accordance with OAC 317:30-3-57; $0 co-pay.
~~(31)~~ (30) Home Health Medications, Intravenous (IV) Therapy and Supplies. Covered in accordance with ~~OAC 317:30-5-211(a)(3)(D)(i) and 317:30-5-41(2)(J)(iii)~~ OAC 317:30-5-211.15 and 317:30-5-42.16(b)(3).
~~(32)~~ (31) Ultraviolet Treatment-Actinotherapy.
~~(33)~~ (32) Fundus photography.
~~(34)~~ (33) Perinatal dental care for pregnant women. Covered in accordance with OAC 317:30-5-696; $0 co-pay.

317:45-11-11. Insure Oklahoma/O-EPIC IP non-covered services

Certain health care services are not covered in the Insure Oklahoma/O-EPIC IP benefit package listed in OAC 317:45-11-10. These services include, but are not limited to:

(1) services that the member's PCP or Insure Oklahoma/O-EPIC does not consider medically necessary;
(2) any medical service when the member refuses to authorize release of information needed to make a medical decision;
(3) organ and tissue transplant services;
(4) treatment of obesity;
(5) procedures, services and supplies related to sex transformation;
(6) supportive devices for the feet (orthotics) except for the diagnosis of diabetes;
(7) cosmetic surgery, except as medically necessary and as covered in OAC 317:30-3-59(19);
(8) over-the-counter drugs, medicines and supplies except contraceptive devices and products, and diabetic supplies;
(9) experimental procedures, drugs or treatments;

(10) dental services (preventive, basic, major, orthodontia, extractions or services related to dental accident) except for pregnant women and as covered in OAC 317:30-5-696;
(11) vision care and services (including glasses), except services treating diseases or injuries to the eye;
(12) physical medicine including ~~speech, physical, occupational,~~ chiropractic, acupuncture and osteopathic manipulation therapy;
(13) hearing services;
(14) transportation [emergent or non-emergent (air or ground)];
(15) rehabilitation (inpatient);
(16) cardiac rehabilitation;
(17) allergy testing and treatment;
(18) home health care with the exception of medications, intravenous (IV) therapy, supplies;
(19) hospice regardless of location;
(20) Temporomandibular Joint Dysfunction (TMD) (TMJ);
(21) genetic counseling;
(22) fertility evaluation/treatment/and services;
(23) sterilization reversal;
(24) Christian Science Nurse;
(25) Christian Science Practitioner;
(26) skilled nursing facility;
(27) ~~longterm~~ long-term care;
(28) stand by services;
(29) thermograms;
(30) abortions (for exceptions, refer to OAC 317:30-5-6);
(31) services of a Lactation Consultant;
(32) services of a Maternal and Infant Health Licensed Clinical Social Worker; and
(33) enhanced services for medically high risk pregnancies as found in OAC 317:30-5-22.1.

C. **CHAPTER 25. SOONERCARE CHOICE**
Subchapter 7. SoonerCare
Part 1. General Provisions
OAC 317:25-7-1. through 317:25-7-2. [AMENDED]
OAC 317:25-7-3. [AMENDED]
OAC 317:25-7-5. through 317:25-7-6. [AMENDED]
Part 3. Enrollment Criteria
OAC 317:25-7-10. [AMENDED]
OAC 317:25-7-12. through 317:25-7-13. [AMENDED]
Part 5. Enrollment Process
OAC 317:25-7-25. through 317:25-7-28. [AMENDED]
Part 7. Coordination and Continuity of Care
OAC 317:25-7-29. through 317:25-7-30. [AMENDED]
Part 9. Reimbursement
OAC 317:25-7-40. [NEW]
(Reference APA WF # 08-19)

FINDING OF EMERGENCY: The Agency finds that a compelling public interest exists which necessitates promulgation of emergency rules and requests emergency approval of rule revisions to implement a new model for the SoonerCare Choice program that is based on the principles of a patient centered medical home. The patient centered medical home is the base from which health care services are coordinated to provide the most effective and efficient care to the patient. Without this transition, SoonerCare Choice members would be directly impacted by not allowing them the coordination of preventive and primary care services at the level promoted by the patient centered medical home model that is widely endorsed by primary care physicians' professional groups.

SUMMARY: SoonerCare rules are revised to incorporate the patient-centered medical home model of care in which providers are paid a monthly care coordination payment in addition to reimbursement for SoonerCare compensable services at the fee-for-service rate. The medical home model provides a partnership between a patient and a personal physician built around preventive and primary care. Currently, primary care providers (PCPs) in the SoonerCare Choice program are paid a capitated rate per member per month. This monthly fee assures the delivery of medically necessary primary care services and any non-capitated services are reimbursed at the traditional fee-for-service rate. After reviewing claims data, OHCA determined that an improvement to the current payment methodology would include the removal of the base capitation rate, reimbursement of all services based on OHCA's fee-for-service rate, and a monthly care coordination

payment to the member's PCP. The care coordination payment would vary based on the scope of services provided by the PCP. Currently, SoonerCare Choice members select or are aligned with a primary care provider (PCP). Beginning January 1, 2009, PCPs will be responsible for serving as the medical home for enrolled members. Building on the success of the existing network, the OHCA believes this transition will help ensure that members get the right care at the right time from the right provider. OHCA intends to make this transition seamless to SoonerCare Choice members. SoonerCare rules are also amended to: (1) require provider or physician groups to designate a medical director to serve as primary contact with OHCA; (2) include a section on provider networks; and (3) include language regarding the development of a payment for excellence program. Without this transition, SoonerCare Choice members would be directly impacted by not allowing them the coordination of preventive and primary care services at the level promoted by the patient centered medical home model that is widely endorsed by primary care physicians' professional groups.

BUDGET IMPACT: Agency staff has determined that the revisions are budget neutral to the agency.

RULE LENGTH IMPACT: These revisions will have no significant impact on the length of agency rules.

MEDICAL ADVISORY COMMITTEE: The Medical Advisory Committee considered the proposed rule revisions on September 18, 2008, and recommended Board approval.

PROPOSED EFFECTIVE DATE: January 1, 2009, or immediately upon Governor's approval, whichever is later.

AUTHORITY: The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes

RESOLUTION:

Resolved, that the Oklahoma Health Care Authority Board does hereby approve the Administrative Rules, subject to the Administrative Procedure Act, as indicated:

SoonerCare rules are revised to incorporate the patient-centered medical home model of care in which providers are paid a monthly care coordination payment in addition to reimbursement for SoonerCare compensable services at the fee-for-service rate. Rules are also amended to: (1) require

provider or physician groups to designate a medical director to serve as primary contact with OHCA; (2) include a section on provider networks; and (3) include language regarding the development of a payment for excellence program.

CHAPTER 25. SOONERCARE CHOICE
SUBCHAPTER 7. SOONERCARE
PART 1. GENERAL PROVISIONS

317:25-7-1. Purpose

The purpose of this Subchapter is to describe the rules governing the statewide SoonerCare program. The rules provide assurances that ~~Medicaid clients~~ SoonerCare members have adequate access to primary care, while reducing costs and preventing unnecessary and inappropriate utilization.

317:25-7-2. SoonerCare Choice: overview

(a) The Oklahoma Health Care Authority (OHCA) operates a Primary Care Case Management (PCCM) system for SoonerCare Choice eligible members. ~~The program enrolls SoonerCare Choice members with Primary Care Provider/Case Managers PCP/CMs who provide and/or authorize all primary care services and all necessary specialty services, with the exception of services described in subsection (c) of this Section for which authorization is not required.~~ PCCM is a managed care model in which each enrollee has a medical home with a primary care provider (PCP). Enrollees may select their own primary care provider or clinic as their PCP if that provider is enrolled with OHCA as a PCP and as a SoonerCare provider. For those who do not choose a PCP, they will be assigned to one. Members may change PCPs at any time.

(b) ~~In exchange for a fixed, periodic rate, which~~ The PCP is paid a monthly care coordination payment in accordance with the conditions in the PCP's SoonerCare Choice contract ~~per member per month, the Primary Care Provider/Case Manager (PCP/CM)~~ to ~~provides,~~ provide or otherwise ~~assures~~ assure the delivery of medically-necessary preventive and primary care medical services, including securing referrals for specialty services and prior authorizations for an enrolled group of eligible members, with the exception of services described in subsection (c) of this Section for which authorization is not required. The ~~PCP/CM~~ PCP assists the member in gaining access to the health care system and monitors the member's condition, health care needs and service delivery.

(c) Services which do not require a referral from the ~~PCP/CM~~ PCP include preventive or primary care services rendered by another SoonerCare contracted provider, outpatient behavioral health agency services, vision ~~for refraction~~ services for children, dental services, child abuse/sexual abuse examinations, prenatal and

obstetrical services, family planning services, emergency physician and hospital services, disease management services, and services delivered to Native Americans at IHS, tribal, or urban Indian clinics. Female members may access a SoonerCare women's health specialist without a referral for covered routine and ~~preventative~~ preventive health care services. This is in addition to the enrollee's ~~PCP/CM~~ PCP if that source is not a woman's health specialist.

(d) ~~Non-capitated~~ SoonerCare Choice covered services delivered by the ~~PCP/CM~~ PCP are reimbursed at the SoonerCare ~~Traditional fee-for-service~~ fee schedule rate under the procedure code established for each individual service. To the extent services are provided or authorized by the Primary Care ~~Provider/Case Manager~~ Provider, the OHCA does not make SoonerCare Choice payments for services delivered outside the scope of coverage of the SoonerCare Choice program, thus a referral by the ~~Primary Care Provider/Case Manager~~ PCP does not guarantee payment.

(e) The PCP may charge a co-payment for services provided to SoonerCare members in accordance with OAC 317:30-3-5(d).

(f) Members with chronic conditions may elect to enroll in a health management program to improve their health.

(g) PCPs may elect to participate in Health Access Networks to improve access to care.

317:25-7-3. Definitions

The following words and terms, when used in this Subchapter, ~~shall~~ have the following meaning, unless the context clearly indicates otherwise:

"Aged, Blind and Disabled" means the Medicaid covered populations under 42 U.S.C., Section 1396a (a)(10)(A)(i) and (F).

"Board" means the board designated by the Oklahoma legislature to establish policies and adopt and promulgate rules for the Oklahoma Health Care Authority.

"CEO" means the Chief Executive Officer of the Oklahoma Health Care Authority.

"Custody" means the custodial status, as reported by the Oklahoma Department of Human Services.

"Medicaid" means the medical assistance program authorized by 42 U.S.C., Section 1396a et seq. The program provides medical benefits for certain low-income persons. It is jointly administered by the federal and state governments.

"Medicare" means the program defined at 42 U.S.C. '1395 et seq.

"OHCA" means the Oklahoma Health Care Authority.

"OKDHS" means the Oklahoma Department of Human Services.

"PCCM" means Primary Care Case Management.

"~~PCP/CM~~ PCP" means Primary Care ~~Provider/Case Manager~~ Provider, including a Provider or Physician Group.

"Primary Care Case Management" means a managed care health service delivery system in which health services are delivered and coordinated by Primary Care ~~Provider/Case Managers~~ Providers.

"Primary Care ~~Provider/Case Manager~~ Provider" means a provider under contract ~~to~~ with the Oklahoma Health Care Authority to provide primary care services and case management, including securing all medically-necessary referrals for specialty services and prior authorizations.

"Provider or Physician Group" means a partnership, limited partnership, limited liability company, corporation or professional corporation composed of doctors of medicine and/or doctors of osteopathy and/or advanced ~~nurse practitioner~~ practice nurses, and/or physician assistants who provide health care of the nature provided by independent practitioners and ~~is~~ are permitted by state and federal law and regulations to receive ~~Medicaid~~ SoonerCare provider payments.

"SoonerCare" means the Medicaid program administered by the Oklahoma Health Care Authority.

"SoonerCare Choice" means a comprehensive medical benefit plan featuring a medical home including a Primary Care Provider for each member.

317:25-7-5. Primary care ~~provider/case managers~~ providers

For provision of health care services, the OHCA contracts with qualified Primary Care ~~Provider/Case Managers~~ Providers. All providers serving as ~~PCP/CMs~~ PCPs must have a valid ~~Medicaid Fee-for Service~~ SoonerCare Fee-for-Service contract as well as ~~a~~ an exercised SoonerCare Choice ~~contract~~ addendum. Additionally, all ~~PCP/CMs~~ PCPs, excluding Provider or Physician Groups, must agree to accept a minimum capacity of patients, however this does not guarantee ~~PCP/CMs~~ PCPs a minimum patient volume. Primary Care ~~Provider/Case Managers~~ Providers are limited to:

(1) **Physicians.** Any physician licensed to practice medicine in the state in which he or she practices who is engaged in a general practice or in family medicine, general internal medicine or general pediatrics may serve as a ~~PCP/CM~~ PCP. ~~In addition, physicians who meet all requirements for employment by the Federal Government as a physician, are employed by the Federal Government in an IHS facility, and practice in one of the four designated primary care specialties may serve as a PCP/CM.~~ The Chief Executive Officer (CEO) of the OHCA may designate physicians to serve as ~~PCP/CMs~~ PCPs who are licensed to practice medicine in the state in which they ~~practices~~ practice who are specialized in areas other than those described above. In making this determination, the CEO may consider such factors as the percentage of primary care services delivered in the physician's practice, the availability of primary care

providers in the geographic area of the state in which the physician's practice is located, the extent to which the physician has historically provided services to ~~Medicaid clients~~ SoonerCare members, and the physician's medical education and training.

(A) For physicians serving as SoonerCare Choice ~~PCP/CMs~~ PCPs, the State caps the number of members per physician at 2,500. However, the CEO in his/her discretion may increase this number in under served areas based on a determination that this higher cap is in conformance with usual and customary standards for the community. If a physician practices at multiple sites, the capacity at each site is determined based on the number of hours per week the physician holds office hours, not to exceed one FTE. Thus, the physician cannot exceed a maximum total capacity of 2500 members.

(B) In areas of the State where cross-state utilization patterns have developed because of limited provider capacity in the State, the CEO may authorize contracts with out-of-state providers for ~~PCP/CM~~ PCP services. Out-of-State ~~PCP/CMs~~ PCPs are required to comply with all access standards imposed on Oklahoma physicians.

(2) **Advanced Practice Nurses.** Advanced Practice Nurses who have prescriptive authority may serve as ~~PCP/CMs~~ PCPs for the Primary Care Case Management delivery system if licensed to practice in the state in which he or she practices. ~~Additionally, Advanced Practice Nurses who meet all requirements for employment by the Federal Government as an advanced practice nurse, and is employed by the Federal Government in an Indian Health Service facility, may serve as a PCP/CM.~~ Advanced Practice Nurses who have prescriptive authority may serve as ~~primary care case managers~~ PCPs for a maximum number of 1,250 members. However, the CEO in his/her discretion may increase this number.

(3) **Physician Assistants.** Physician Assistants may serve as ~~PCP/CMs~~ PCPs if licensed to practice in the state in which he or she practices. ~~Additionally, Physician Assistants who meet all requirements for employment by the Federal Government as a Physician Assistant, and are employed by the Federal Government in an Indian Health Service facility, may serve as a PCP/CM.~~ Physician Assistants may serve as ~~primary care case managers~~ PCPs for a maximum number of 1,250 members. However, the CEO in his/her discretion may increase this number.

(4) **Medical Residents.**

(A) Medical residents may serve as ~~PCP/CMs~~ PCPs when the following conditions are met:

(i) The resident is licensed to practice in the state in which he or she practices.

(ii) The resident is at least at the Post-Graduate 2 (PG-2) level.

(iii) The resident serves as a ~~PCP/CM~~ PCP only within his or her continuity clinic setting (for example, Family Practice residents may only serve as the ~~PCP/CM~~ PCP within the Family Practice Residency clinic setting).

(iv) The resident works under the supervision of a licensed attending physician.

(v) The resident specifies the residency program or clinic to which payment will be made.

(B) Medical residents practicing as a ~~PCP/CM~~ PCP may not exceed a capacity of more than 875 members. However, the CEO in his/her discretion may increase this number.

(5) **Indian Health Service (IHS) Facilities and Federally Qualified Health Center (FQHC) provider groups.**

(A) Indian Health Service facilities whose professional staff meet the general requirements in paragraphs (1) through (3) of this Section and the provider participation requirements at OAC 317:30-5-1088 may serve as PCPs.

(B) Federally Qualified Health Centers whose professional staff meet the general requirements in paragraphs (1) through (3) of this Section and the provider participation requirements in OAC 317:30-5-660.2 may serve as PCPs.

~~(5)~~ (6) **Provider or physician group capacity and enrollment**.

(A) Provider or physician groups must agree to accept a minimum enrollment capacity and may not exceed 2,500 members per ~~provider~~ physician participating in the provider group.

(B) If licensed physician assistants or advanced practice nurses are members of a group, the capacity may be increased by 1,250 members if the provider is available full-time.

(C) Provider or physician groups must designate a medical director to serve as the primary contact with OHCA.

317:25-7-6. Primary Care ~~Provider/Case Manager~~ Provider ~~Payment to Subcontractors~~ responsibilities

(a) Under the provisions of the SoonerCare Choice Contract, the contractor is responsible for providing ~~all capitated services contained in the benefit package~~ care coordination services for all enrolled members on his/her panel. ~~In the event that the PCP/CM orders a capitated service, the PCP/CM is responsible to make timely payment to the subcontractor or other provider.~~

(b) ~~For purposes of subsection (a) of this Section timely payment or adjudication means payment or denial of a claim within 30 days of presentation to the PCP/CM.~~ PCPs must provide access to medical care twenty-four hours per day, seven days a week, either directly or through coverage arrangements made with other providers, clinics, and/or local hospitals.

~~(c) No subcontractor of the PCP/CM may charge more than the Medicaid fee-for-service schedule for these services in the benefit~~

~~package. The subcontractor may not bill the recipient for the services to the SoonerCare recipient until the PCP/CM has refused payment and the subcontractor/medical provider has appealed under OAC 317:2-1-2.1 and the OHCA permits the subcontractor to bill the recipient.~~

PART 3. ENROLLMENT CRITERIA

317:25-7-10. Enrollment with a Primary Care ~~Provider/Case Manager~~ Provider

(a) All SoonerCare Choice members described in OAC 317:25-7-12 ~~are enrolled~~ may enroll with a ~~PCP/CM~~ PCP. SoonerCare Choice applicants have the opportunity to select a ~~PCP/CM~~ PCP during the application process. Enrollment with a PCP may begin any day of the month. ~~Enrollment with a PCP/CM for members determined to be eligible on or before the fifteenth day of the month are effective on the first day of the following month. Enrollment with a PCP/CM for members determined to be eligible after the fifteenth day of the month are effective on the first day of the second month following determination.~~

(1) The OHCA offers all members the opportunity to choose a ~~PCP/CM~~ PCP from a directory which lists available ~~PCP/CMs~~ PCPs.

(2) ~~If a SoonerCare Choice member moves more than the authorized distance/driving time from their current PCP/CM, that member will be disenrolled and assigned to an appropriate PCP/CM.~~ When a notice of ~~PCP/CM assignment~~ PCP enrollment is sent to a member, the member is advised of the right to change the ~~PCP/CM,~~ PCP at any time~~, or after the effective date of enrollment with the PCP/CM pursuant to OAC 317:25-7-27~~.

(b) Members ~~are restricted to~~ may receive services from the ~~PCP/CM~~ PCP or from a provider to which the member has been referred by the ~~PCP/CM~~ PCP. Notwithstanding this provision, subject to limitations which may be placed on services by the OHCA, members may self refer for preventive or primary care services rendered by another SoonerCare contracted provider, outpatient behavioral health agency services, vision ~~for refraction~~ services for children, dental services, child abuse/sexual abuse examinations, prenatal and obstetrical services, family planning services, services delivered to Native Americans at IHS, tribal, or urban Indian clinics, and emergency physician and hospital services.

317:25-7-12. Enrollment/eligibility requirements

(a) Eligible ~~***SoonerCare***~~ SoonerCare ~~***Choice***~~ members mandatorily enrolled in SoonerCare Choice include ~~Medicaid eligible~~ persons ~~or persons categorized~~ categorically related to AFDC, Pregnancy-related services and ~~as~~ Aged, Blind or Disabled who are not dually-eligible for ~~Medicaid~~ SoonerCare and Medicare.

(b) Children in foster care may voluntarily enroll into SoonerCare Choice.

317:25-7-13. Enrollment ineligibility

Members in certain categories are excluded from participation in the SoonerCare Choice program. All other members are enrolled in the SoonerCare Choice program and subject to the provisions of this Subchapter. Members excluded from participation in SoonerCare Choice include:

(1) Individuals receiving services in a nursing facility, in an intermediate care facility for the mentally retarded (ICF-MR) or through a Home and Community Based Waiver.
(2) Individuals privately enrolled in an HMO.
(3) Individuals who would be traveling more than 45 miles or an average of 45 minutes to obtain primary care services~~, or a greater or lesser distance/driving time as determined pursuant to OAC 317:25-7-10(a)~~.
(4) Children who are known to the OHCA to be in custody, as reported by the Oklahoma Department of Human Services.
(5) Individuals who are eligible for SoonerCare solely due to presumptive eligibility.
(6) Non-qualified or ineligible aliens.
(7) Children in subsidized adoptions.
(8) Individuals who are dually-eligible for ~~Medicaid~~ SoonerCare and Medicare.
(9) Individuals who are in an Institution for Mental Disease (IMD).

PART 5. ENROLLMENT PROCESS

317:25-7-25. ~~Recipient~~ Member enrollment process

(a) ~~Medicaid~~ SoonerCare eligible individuals ~~residing in any of the areas defined in OAC 317:25-7-11~~ whose eligibility is based on one of the aid categories included in the program as defined in OAC 317:25-7-12 must enroll with a ~~PCP/CM~~ PCP. Parents or guardians will choose on behalf of minor ~~clients~~ members in the household. Families with more than one ~~beneficiary~~ enrollee may choose a different ~~PCP/CM~~ PCP for each family member. ~~If a beneficiary does not select a PCP/CM, the OHCA will assign the member to one, from the pool of providers within the established distance/driving time who have available capacity.~~

(b) Until the effective date of enrollment with a ~~PCP/CM~~ PCP, services for a newborn are reimbursed at a fee-for-service rate. Upon eligibility determination, newborns may enroll with a ~~PCP/CM~~ PCP ~~or are assigned to a PCP/CM~~ who is in general practice, family practice or general pediatrics. Enrollment materials will advise the parent or guardian of the right to change the ~~PCP/CM~~ PCP after the effective date of enrollment.

(c) A description of the PCCM program and the ~~PCP/CM~~ PCP directory is provided by the OHCA to OKDHS for distribution to OKDHS county offices.
(d) For purposes of determining the ~~client's~~ member's choice of ~~PCP/CM~~ PCP, the most recent ~~PCP/CM~~ PCP selection received by the OHCA determines the ~~PCP/CM~~ PCP which the ~~client~~ member is enrolled with as long as capacity is available. If capacity is not available ~~then~~ or the member does not choose, the ~~client~~ member is assigned according to the assignment mechanism as defined by the OHCA. A member who is eligible for SoonerCare Choice but is not assigned, may request enrollment with a PCP by contacting the SoonerCare Helpline.
(e) ~~PCP/CMs~~ PCPs may not refuse an assignment, seek to disenroll a ~~client~~ member, or otherwise discriminate against a ~~client~~ member on the basis of age, sex, race, physical or mental disability, national origin or type of illness or condition, unless that condition can be better treated by another provider type, except that IHS, tribal or urban Indian programs may provide services to Native American IHS ~~beneficiaries~~ members consistent with federal law.
~~(f) PCP/CMs must provide access to medical care twenty-four hours per day, seven days per week, either directly or through coverage arrangements made with other providers, clinics, and/or local hospitals.~~
~~(g) Until PCP/CM enrollment is effective, Medicaid eligible individuals receive all services on a fee-for-services basis.~~

317:25-7-26. Automatic re-enrollment

~~Medicaid recipients who are not in the six-month period of guaranteed eligibility~~ SoonerCare members who become disenrolled from a ~~PCP/CM~~ PCP solely by virtue of becoming temporarily (for ~~180~~ 365 days or less) ineligible for ~~Medicaid~~ SoonerCare services, are automatically re-enrolled with their previously-selected ~~PCP/CM~~ PCP, subject to capacity. The ~~client~~ member is notified of the automatic re-enrollment and any right to disenroll from that ~~PCP/CM~~ PCP.

317:25-7-27. Changing ~~PCP/CMs~~ PCPs

(a) The OHCA ~~shall be~~ is responsible for changing a member's enrollment from one ~~PCP/CM~~ PCP to another:
(1) without cause ~~up to 4 times per year,~~ upon the member's request; or
(2) upon demonstration of good cause. For purposes of this paragraph, ~~Good~~ good cause ~~shall mean~~ means:
(A) those members who are habitually non-compliant with the documented medical directions of the provider; or
(B) those members who pose a threat to employees, or other patients of the ~~PCP/CM~~ PCP; or

(C) as a result of a grievance determination by the OHCA; or
(D) in those cases where reliable documentation demonstrates that the physician-patient relationship has so deteriorated that continued service would be detrimental to the member, the provider or both; or
(E) the member's illness or condition would be better treated by another type of provider~~.~~; or

(3) when the state imposes an intermediate sanction.

(b) A written request by the ~~PCP/CM~~ PCP to change the enrollment of a member ~~shall be~~ is acted upon by the OHCA within ~~thirty (~~30~~)~~ days of its receipt. The decision to change ~~PCP/CMs~~ PCPs for cause ~~will be~~ is made at the discretion of the OHCA, subject to appeals policies delineated at OAC 317:2-1. The effective date of change ~~shall be~~ is set so as to avoid the issue of abandonment.

(c) In the event a SoonerCare ~~PCP/CM~~ PCP contract is terminated by OHCA for any reason, or the ~~PCP/CM~~ PCP terminates participation in the SoonerCare program the CEO may, at his or her discretion, assign members to a participating ~~PCP/CM~~ PCP when it is determined to be in the best interests of the ~~client~~ member whose ~~PCP/CM~~ PCP has terminated.

317:25-7-28. Disenrolling a ~~client~~ member from SoonerCare

(a) The OHCA may disenroll a member from SoonerCare if:

(1) the member is no longer eligible for ~~Medicaid~~ SoonerCare services; ~~or~~
(2) the member has been incarcerated; ~~or~~
(3) the member dies; ~~or~~
(4) disenrollment is determined to be necessary by the OHCA; ~~or~~
(5) the status of the member changes, rendering him/her ineligible for SoonerCare; ~~or~~
(6) the member is already enrolled in the SoonerCare Program, when they are taken or found to be in custody as reported by the Oklahoma Department of Human Services; ~~or~~
(7) the member is authorized to receive services in a nursing facility, in an intermediate care facility for the mentally retarded (ICF-MR) or through a Home and Community Based Waiver; or
(8) the member becomes dually-eligible for ~~Medicaid~~ SoonerCare ~~or~~ and Medicare.

(b) The OHCA may disenroll the member at any time if the ~~client~~ member is disenrolled for good cause, as it is defined in OAC 317:25-7-27. The OHCA will inform the ~~PCP/CM~~ PCP of any disenrollments from his or her member roster.

(c) OHCA may disenroll a member upon the PCP's request as described in (1) through (5) of this subsection.

(1) The PCP may file a written request asking OHCA to take action including, but not limited to, disenrolling a member when the member:

(A) is physically or verbally abusive to office staff, providers and/or other patients;
(B) is habitually non-compliant with the documented medical directions of the PCP; or
(C) regularly fails to arrive for scheduled appointments without cancelling and the PCP has made all reasonable efforts to accommodate the member.

(2) The request from the PCP for disenrollment of a member must include one of more of the following:
(A) documentation of the difficulty encountered with the member including the nature, extent and frequency of abusive or harmful behavior, violence, and/or inability to treat or engage the member;
(B) identification and documentation of unique religious or cultural issues that may be effecting the PCP's ability to provide treatment effectively to the member; or
(C) documentation of special assistance or intervention offered.

(3) The PCP may not request disenrollment because of a change in the member's health status, the member's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from the member's special needs except when the member's enrollment with the PCP seriously impairs his/her ability to furnish services to this member or other members.

(4) The PCP must document efforts taken to inform the member orally or in writing of any actions that have interfered with the effective provision of covered services, as well as efforts to explain what actions or language of the member are acceptable and unacceptable and the consequences of unacceptable behavior, including disenrollment from the PCP.

(5) The OHCA will give written notice of the disenrollment request to the member.

PART 7. COORDINATION AND CONTINUITY OF CARE

317:25-7-29. ~~Plan benefit package~~ Screening, diagnosis and preventive benefits

(a) The ~~PCP/CM~~ PCP is responsible for coordinating or delivering preventive and primary care ~~and case management~~ services ~~defined in a benefit package developed by the OHCA~~ which are medically necessary to all ~~Medicaid beneficiaries~~ SoonerCare members enrolled with him/her ~~and is reimbursed for these services on a per-member-per-month pre-determined capitated rate~~. ~~The PCP/CM benefit package will be determined by the Medical Director, with the approval of the CEO, and will be included with the PCP/CM contract~~.
~~(b) Services which are not included in the PCP/CM capitated rates will be reimbursed at a fee-for-service rate under the procedure~~

~~code established for each individual service.~~

~~(c)~~ (b) School and health department clinics may conduct EPSDT screening examinations on children who have not been screened by their ~~PCP/CM~~ PCP pursuant to the EPSDT periodicity schedule. If it is ascertained that a child is not current, the school or health department clinic must first contact the ~~PCP/CM~~ PCP and attempt to set up an appointment for the child within three weeks. If the ~~PCP/CM~~ PCP cannot meet this condition, the clinic will be permitted to conduct the screen and bill fee-for-service. ~~The State considers the cost of these screens in the rate setting process.~~

(1) The school or health department clinic must submit a claim for reimbursement, as well as documentation that:

(A) the ~~PCP/CM~~ PCP was contacted and an examination could not be conducted by the ~~PCP/CM~~ PCP within the specified guidelines; and

(B) the ~~PCP/CM~~ PCP has forwarded information for the patient file regarding the diagnosis, services rendered and need for follow-up. This documentation must be returned to the child's record for verification that ~~PCP/CMs~~ PCPs have first been contacted and that school and health department clinics are providing ~~PCP/CMs~~ PCPs with the information necessary to ensure continuity of care.

(2) The school-based clinic or health department must ~~obtain a referral number from the PCP/CM and~~ conduct the screening examination within ~~3~~ three weeks from the date the determination was made that the ~~PCP/CM~~ PCP could not conduct the exam within the specified guidelines.

~~(d) PCP/CM providers are protected from excessive losses incurred through the provision of services to Medicaid clients with conditions which result in costs to the provider which greatly exceed the average cost of a Medicaid client through a stop-loss mechanism.~~

~~(e) The PCP/CM is prohibited from charging a co-payment for services provided to SoonerCare recipients.~~

~~(f) For capitated services purchased by the PCP/CM from a Medicaid contracted provider, the provider is prohibited from charging the PCP/CM more than the current Medicaid fee-for-service schedule for these services, but may charge less.~~

~~(g) The PCP/CM is not obligated to provide emergency services, and is not responsible for authorization or approval for payment for recipients seen in the emergency room. The PCP/CM may not require recipients to seek prior authorization for emergency services. However, the PCP/CM may provide emergency care in an emergency room setting, within his/her legal scope of practice. The PCP/CM may receive reimbursement for Medicaid covered emergency services at the fee-for-service rate.~~

317:25-7-30. Obtaining ~~Medicaid~~ SoonerCare services ~~not covered by~~

~~the PCP/CM~~

(a) Medical services ~~which are not included as capitated primary care services or~~ which are not the responsibility of the ~~PCP/CM~~ PCP to authorize under the ~~case management~~ care coordination component of SoonerCare, as described in ~~OAC 317:25-7-2(d) and~~ OAC 317:25-7-10(b), are obtained in the same manner as under the regular ~~Medicaid~~ SoonerCare fee-for-service program.

(b) Authorization for out-of-state transportation for primary care and specialty care is determined by the OHCA Medical Director.

(c) An eligible SoonerCare member may choose a ~~PCP/CM~~ PCP from the provider directory, including the IHS, tribal and Urban Indian clinics that participate as SoonerCare ~~PCP/CMs~~ PCPs. The member needs to have the Certified Degree of Indian Blood information in order to enroll. An American Indian member in SoonerCare may enroll with a ~~PCP/CM~~ PCP who is not an IHS, tribal, or urban Indian clinic and still use the IHS, tribal or urban Indian clinic for medical care. A referral from the ~~PCP/CM~~ PCP is needed for services that the clinic cannot provide, except for self-referred services. ~~Except services delivered through an Indian facility for which the State receives 100% Federal reimbursement, services are reimbursed at the Medicaid fee-for-service rate under the procedure code established for each individual service.~~

(d) If an IHS, tribal or urban Indian clinic is unable to deliver a service to a SoonerCare enrollee and must refer the ~~client~~ member for the service to a non-IHS, tribal or urban Indian clinic, ~~Medicaid~~ SoonerCare reimbursement is made only when the service is referred by the ~~PCP/CM~~ PCP, unless ~~PCP/CM~~ PCP authorization is not required under ~~OAC 317:25-7-2(d) and~~ OAC 317:25-7-10(b).

~~(e) Capitated services delivered at IHS, tribal, and urban Indian clinics during the preceding year to SoonerCare clients enrolled with non-Indian PCP/CMs are considered during the rate setting process.~~

~~(f) For non-capitated covered Medicaid compensable services provided for individuals enrolled in SoonerCare, reimbursement is made at the Medicaid fee-for-service rate under the procedure code established.~~

(e) The PCP is not obligated to provide emergency services and is not responsible for authorization or approval for payment for members seen in the emergency room. The PCP may not require members to seek prior authorization for emergency services. However, the PCP may provide emergency care in an emergency setting, within his/her legal scope of practice.

(f) Some outpatient procedures require prior authorization. The PCP is responsible for obtaining a list before an outpatient procedure is done.

PART 9. REIMBURSEMENT

317:25-7-40. SoonerCare Choice reimbursement

(a) **Care coordination component.** Participating PCPs are paid a monthly care coordination payment to assure the delivery of medically-necessary preventive and primary care medical services, including referrals for specialty services for an enrolled group of eligible members. The PCP assists the member in gaining access to the health care system and monitors the member's condition, health care needs and service delivery.

(b) **Visit-based fee-for-service component.** SoonerCare Choice covered services provided by the PCP are reimbursed at the SoonerCare fee schedule rate under the procedure code established for each individual service. To the extent services are authorized by the PCP, the OHCA does not make SoonerCare Choice payments for services delivered outside the scope of coverage of the SoonerCare Choice program, thus a referral by the PCP does not guarantee payment.

(c) **Incentive program component.** Subject to the availability of funds, OHCA will develop a bonus payment program to encourage coordination of services, to reward improvement in health outcome and promote efficiency.

(d) **SoonerCare networks.** For every PCP who participates in an OHCA approved health care access network, a per-member-per-month payment is established by OHCA and paid to the network.