OKLAHOMA HEALTH CARE AUTHORITY

# MEDICAL ADVISORY COMMITTEE MEETING

# AGENDA

**May 21, 2015**
**1:00 p.m. – 3:30pm**
**Charles Ed McFall Board Room**

I. Welcome, Roll Call, and Public Comment Instructions: **Chairman, Steven Crawford, M.D.**

II. Public Comments (2 minute limit)

III. MAC Member Comments/Discussion

IV. **Action Item**: Approval of Minutes of the March 12, 2015 Medical Advisory Committee Meeting

V. Financial Report: SFY 15 as of March 31, 2015: **Gloria Hudson, Director of General Accounting**

VI. SoonerCare Operations Update: **Kevin Rupe, Member Services Director**

VII. Strategic Planning Conference; An invitation to participate: **Dana Northrup, Planning Coordinator**

VIII. Legislative Update: **Carter Kimble, Director of Governmental Relations**

IX. Budget Report: **Nico Gomez, Chief Executive Officer**

X. Proposed Rule Changes: Presentation, Discussion and Vote: **Demetria Bennett, Policy Development Coordinator**

- 15-03 DRG Hospital
- 15-04 Revoke payment for removal of benign skin lesions and eliminate coverage for adult sleep studies
- 15-05 High Risk Obstetrical Services
- 15-06 Coverage for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)
- 15-08 Urine drug screening and testing
- 15-09 Timely Filing

XI. Proposed State Plan Amendments and Rate Changes (Informational Only – not actionable): **Demetria Bennett, Policy Development Coordinator**

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

XIII. Adjourn

**Next Meeting**
**Thursday, July 16, 2015; 1:00 p.m. – 3:30pm**
**Charles Ed McFall Board Room**
**4345 N Lincoln Blvd; Oklahoma City, OK 73105**

Oklahoma Health Care Authority
MEDICAL ADVISORY COMMITTEE
MINUTES of the March 12, 2015 Meeting
at 4345 N. Lincoln Blvd, Oklahoma City, OK 73105

# Minutes

## Welcome and Roll Call

Chairman Crawford called the meeting to order at 1:05PM and asked for a roll call. Delegates present were Ms. Bierig, Ms. Booten-Hiser (by phone), Dr. Crawford, Ms. Fritz, Ms. Galloway, Dr. Gastorf (by phone), Ms. Hastings, Mr. Jones, Dr. Kirkpatrick (came in after the roll call), Ms. Mays, Dr. McNeill, Dr. Post, Ms. Pratt-Reid (by phone), Dr. Rhynes, Mr. Snyder, Mr. Tallent, Dr. Walton, and Dr. Wright (by phone). Alternates present were Ms. Baer, Dr. Cyrus, Dr. Rhoades, and Mr. Rains-Sims providing a quorum. Delegates absent without an alternate present were Dr. Cavallaro, Ms. Felty, Mr. Goforth, Ms. Moran, Mr. Patterson, Dr. Simon, and Dr. Woodward.

## Public Comments

Melanie Johnson from Choices For Life expressed her concerns about the last sentence of agenda item 14-39, Therapeutic Foster Care (TFC). The last sentence limits the services provided by Treatment Parent Specialists (TPS) to 1.5 hours per day. Ms. Johnson contended that the time for relationship building, a crucial part of successful treatment, should be 2 hours per day as backed up by research.

Doug Feelrath, Chief Executive Officer of Choices For Life, supported Ms. Johnson's points. He noted that services for individuals in TFC are capped so that more services from licensed staff restrict TPS services. The rule change moves away from the model that produces more change in the individuals in TFC according to Mr. Feelrath.

## Member Comments

Dr. Crawford asked for the agency to relook at the issue of members temporarily out of nursing home care being charged to hold a bed in the nursing home while the member is gone.

## Approval of Minutes

Mr. Tallent moved that the minutes of the January 15, 2015 meeting be accepted as submitted online. Dr. Walton seconded the motion and the vote to accept was unanimous.

## Financial Update

Gloria Hudson, Director of General Accounting for the Oklahoma Health Care Authority (OHCA), gave the financial report for the state fiscal year 2015, first six months. She appended her written report to say that if current trends hold, the agency would remain slightly under budget.

## Budget Report

Nico Gomez, Chief Executive Officer of OHCA, updated the budget that starts July 1, 2016. Recently, reports from the State Board of Equalization indicated that the agency should make a significant cut in the budget submitted last October. The document Mr. Gomez reviewed supports the report he will give to the State Senate March 17.

Mr. Gomez pointed out that the Federal Medical Assistance Percentage (FMAP) will drop in October to a rate of 60.99%, not seen since the 1980's; the Children's Health Insurance Plan (CHIP) is due to expire September 30, 2015 and the reauthorization of CHIP is uncertain; more Oklahomans are eligible for

Medicaid; and SFY-14 carry-overs all impact the budget. The goal is to minimize the impact on members, but there must be reductions that will be painful.

## SoonerCare Operations Update

Kevin Rupe, Chief Operation Officer for OHCA, gave the SoonerCare Operations report. He said that member enrollment numbers continue to grow at a slow but steady pace; provider enrollment is growing at a much higher increase; and capacities remain at about 60%.

## State Innovation Model (SIM) Grant Update

Becky Pasternik-Ikard, Deputy Medicaid Director for OHCA introduced the SIM grant submitted by the Oklahoma Health Improvement Program (OHIP) to continue its four-year mission and awarded in December to start February 1, 2015 for one year.

Alex Miley, SIM Project Director for the Oklahoma State Department of Health, reviewed the contracts that would move health transformation forward with efficiency and effectiveness, financial analysis, information technology, and assessing the health workforce. She presented the timeline for implementation and examples of the public and private organizations that will be called to participate.

Ms. Pasternik-Ikard completed the update by emphasizing the importance of the grant for SoonerCare members and the significant contribution OHCA would be making to fulfill the grant.

## Legislative Update

Carter Kimble, Director of Government Relations for OHCA, reviewed the status of legislation that the agency is tracking. Today, 3/12/15, was the deadline for bills to crossover to the other chamber. He highlighted five bills that were still active.

HB 1556 would require the agency to release requests for proposals for care coordination models for individuals who are dually eligible for Medicaid and Medicare. SB 127 would change the responsibility for hiring the agency's CEO from the OHCA board to the governor. SB 308 would allow the legislature to amend language of the rules submitted by the agency. SB 640 would unify the assessment processes for determining Waiver and Long Term Care eligibility under a medical needs model. SB 734 would require the agency to add obligations to the agency's fact-finding functions for hearings and appeals.

Dr. Crawford asked how many individuals would be impacted by HB 1556. Mr. Kimble responded that approximately 135,000 would be covered by the care coordination model proposals.

Ms. Mays asked for confirmation that SB 640 would result in one assessment tool for one agency. Mr. Kimble confirmed.

## Presentation, Discussion, and Action on Proposed Rule Changes

Demetria Bennett, Policy Development Coordinator for OHCA presented the proposed rules changes (PRC) as posted online on January 16, 2015 and reviewed by two face-to-face tribal consultation meetings. The feedback resulted in changes in all but one case that will be addressed later.

a) **14-13 Psychosocial Rehabilitation (PSR) Service Eligibility Criteria & PSR Day Program Progress Note Clarification:** Dr. Walton asked for and received confirmation that

testing for children under three would not be covered. He specified that testing by psychologists and psychiatrists for autism spectrum disorders (ASD) are critical before age three. Further discussion revealed that Dr. Walton's concern applied to 14-15. Mr. Rains-Sims moved for acceptance of the change, Mr. Tallent seconded the motion and it passed unanimously.

**b)** **14-15 Behavioral Health Outpatient Billable Hours:** Dr. Walton reiterated his concern about the strike-out in 317:30-5-276(c)(5), "Testing for a child younger than three must be medically necessary and meet established criteria as set forth in the Prior Authorization Manual." Mr. Rains-Sims pointed out that treatment for ASD was not covered and reported that workgroups met that determined that most behavioral health testing was not medically necessary for children under three. Dr. Crawford pointed out that ASD would come under developmental delays. Dr. Walton moved to put off the approval of the rule until the next MAC meeting. Mr. Tallent seconded the motion. Ms. Bennett noted that this meeting was the last one that could consider permanent rule changes. Cindy Roberts, Deputy Chief Executive Officer for OHCA, noted that the testing for ASD was not a behavioral health issue and should be addressed in another section of the rules. Ms. Fritz asked that the motion be amended to hold to the end of the current meeting awaiting additional clarification. The vote to hold passed with three objections.

**c)** **14-18 Policy Change for State Plan Personal Care Services:** After the reading of the summary, Dr. Post moved for acceptance; Ms. Galloway seconded the motion and it passed unanimously.

**d)** **14-19A & B Transition of Waivers:** After the reading of the summary, Mr. Tallent moved for acceptance; Ms. Fritz seconded the motion; and it passed unanimously.

**e)** **14-20 Hospital Presumptive Eligibility:** After the reading of the summary, Ms. Fritz asked if the change was (federally) mandated. After confirmation, she moved for acceptance; Mr. Snyder seconded the motion; and it passed unanimously.

**f)** **14-22 DME Policy:** After the reading of the summary, Mr. Tallent moved for acceptance; Mr. Rains-Sims seconded the motion; and it passed unanimously.

**g)** **14-23 Developmental Disabilities Services (DDS) Policy:** After the reading of the summary, Mr. Rains-Sims moved for acceptance; Mr. Tallent seconded the motion; and it passed unanimously.

**h)** **14-25 Dental:** After the reading of the summary, Dr. Kirkpatrick moved for acceptance; Dr. Walton seconded the motion; and it passed unanimously.

**i)** **14-28 Allergy Testing:** After the reading of the summary, Dr. Post moved for acceptance and Mr. Tallent seconded the motion. In the discussion that followed, Dr. McNeill asked for clarifications on the provider qualifications. Ms. Bennett responded that specific training was added, but could not specify the provider group. Dr. Crawford tabled the motion pending information from the agency.

**j)** **14-33 Tax Equity Fiscal Responsibility Act (TEFRA) Program:** After the reading of the summary, Mr. Tallent moved for acceptance; Dr. Walton seconded the motion; and it passed unanimously.

**k)** **14-36 Long-term Care Eligibility:** After the reading of the summary, Dr. McNeill moved for acceptance; Dr. Post seconded the motion; and it passed unanimously.

**l)** **14-44 Electronic Notices:** After the reading of the summary, Mr. Tallent moved for acceptance; Dr. Walton seconded the motion; and it passed unanimously.

**m)** **14-28 Allergy Testing (continued):** Dr. Lopez, Chief Medical Officer of OHCA, read 317:30-5-14.1(a)(2), the section specifying the "Provider Requirements" for allergy testing. Dr. McNeill said that he had no objections to the motion for acceptance. Dr. Crawford asked if immunotherapy could be provided by a member's primary care provider (PCP). Dr. Lopez confirmed. Dr. Rhynes asked if the tear-lab test, currently covered by Medicaid fit under this rule change. Dr. James Claflin, an allergist and a consultant with OHCA, confirmed that the tear-lab test was not specifically for allergies and could be performed without the training specified in the rule. Dr. Claflin went on to explain the rationale for the rule change. Dr. McNeill asked about the availability of allergy specialists in rural areas and Dr. Claflin noted that only about 30% of members presenting with nasal diseases have allergies. Allergy test vendors have profited from the reliance of general practitioners on their testing mechanisms. Dr. Crawford called for the vote and it passed with one vote "no."

**n)** **14-46A & B Developmental Disabilities Services (DDS):** After the reading of the summary, Mr. Tallent moved for acceptance; Mr. Snyder seconded the motion; and it passed unanimously.

**o)** **14-49A & B Insure Oklahoma Eligibility:** After the reading of the summary, Mr. Tallent moved for acceptance; Dr. McNeill seconded the motion; and it passed unanimously.

**p)** **14-50 Telemedicine:** After the reading of the summary, Ms. Mays moved for acceptance; Mr. Tallent seconded the motion. In discussion, Dr. Walton asked if the originating site fee was being eliminated and noted that fewer folks may be willing to provide the site without the fee. Ms. Bennett confirmed that the $23 fee would not be billable. Dr. Crawford admonished the agency to monitor possible reductions in accessibility due to the fee elimination. He called for the vote and it passed unanimously.

**q)** **14-52A & B SoonerRide:** After the reading of the summary, Mr. Tallent moved for acceptance; Ms. Fritz seconded the motion; Dr. McNeill received confirmation that dually eligible members qualified for SoonerRide; the vote was called; and it passed unanimously.

**r)** **14-58 High Risk Obstetrical Services:** After the reading of the summary, Mr. Tallent moved for acceptance; Ms. Fritz seconded the motion; and it passed unanimously.

**s)** **14-60 Federally Qualified Health Centers (FQHC):** After the reading of the summary, Ms. Fritz moved for acceptance; Mr. Tallent seconded the motion; and it passed unanimously.

**t)** **14-38 Individual Plan of Care:** After the reading of the summary, Mr. Tallent moved for acceptance; Ms. Fritz seconded the motion; and it passed unanimously.

**u)** **14-39 Therapeutic Foster Care:** After the reading of the summary, Dr. McNeill moved for acceptance; Dr. Post seconded the motion; and it passed unanimously.

**v)** **14-42 History and Physical Evaluation:** After the reading of the summary, Ms. Fritz moved for acceptance; Mr. Tallent seconded the motion; and it passed unanimously.

**w)** **14-45 Psychiatric Residential Treatment Programs Staffing Ratios:** After the reading of the summary, Mr. Tallent moved for acceptance; Mr. Rains-Sims seconded the motion; and it passed unanimously.

**x)** **14-42 History and Physical Evaluation (clarification):** Dr. McNeill asked if he could get a clarification on the provider type that could do the history and physical evaluation. Dr. Lopez confirmed that physicians assistants (PA) or an advanced practice nurse (APN) could. It did not have to be a psychiatrist.

**y)** **14-47 First Visit by the Physician in Active Treatment:** After the reading of the summary, Mr. Rains-Sims moved for acceptance; Mr. Tallent seconded the motion; and it passed unanimously.

**z)** **14-48 Targeted Case Management (TCM):** After the reading of the summary, Ms. Galloway moved for acceptance; Mr. Tallent seconded the motion; and it passed unanimously.

**aa)** **14-53 Mental Health Substance Use Screenings:** After the reading of the summary, Ms. Fritz reported that her packet did not contain the text of the rule. A copy was provided. She questioned the timing of the screening. Mr. Rains-Sims elaborated on the summary to say that the screening referenced in the rule occurred after the member presented to a treatment provider. Mr. Tallent moved for acceptance; Ms. Galloway seconded the motion; and it passed unanimously.

**bb)** **14-55 Distinction between LBHP & Licensure Candidate:** After the reading of the summary, Mr. Tallent moved for acceptance; Mr. Rains-Sims seconded the motion; and it passed unanimously.

**cc)** **14-15 Behavioral Health Outpatient Billable Hours:** Dr. Crawford recounted that the unanswered question concerned the assessment done by a psychologist of a child under three for ASD. Dr. Walton said that psychologists could now bill for testing a child under three. Ms. Bennett noted that the agency's business practices had already implemented the changes in 2014 as part of a previously approved PRC. Mr. Rains-Sims said that the codes were open even though the Prior Authorization Manual had changed. He said that the Department of Mental Health and Substance Abuse would not have a problem undoing the strikeout for the testing paragraph. Ms. Fritz emphasized the need to do testing on children under three for ASD.

Dr. Walton submitted a motion "to accept 14-15 with the exception of the language pertaining to the psychological assessment/testing of children under the age of three." Ms. Mays seconded the motion. The vote to approve the motion as amended passed unanimously.

## Informational Items

Chairman Crawford noted that new proposed rule changes would be posted on the agency's website for public comment and the MAC members would receive notification when they were posted.

## New Business

No one introduced new business.

## Adjournment

Dr. Walton moved that the meeting be adjourned and Ms. Mays seconded the motion. There was no dissent and the meeting adjourned at 2:07PM with a notice that the next meeting will be May 21, 2015.

# FINANCIAL REPORT

For the Nine Months Ended March 31, 2015
Submitted to the CEO & Board

- Revenues for OHCA through March, accounting for receivables, were **$2,956,700,579** or **1% under** budget.
- Expenditures for OHCA, accounting for encumbrances, were **$2,918,188,357 or 1.6% under** budget.
- The state dollar budget variance through March is a **positive $17,283,629.**
- The budget variance is primarily attributable to the following (in millions):

| | | |
|---|---|---|
| **Expenditures:** | | |
| Medicaid Program Variance | | 14.6 |
| Administration | | 4.4 |
| **Revenues:** | | |
| Drug Rebate | | 1.4 |
| Taxes and Fees | | 2.5 |
| Overpayments/Settlements | | 8.4 |
| FY15 Carryover Committed to FY16 | | (14.0) |
| **Total FY 15 Variance** | **$** | **17.3** |

**ATTACHMENTS**

Oklahoma Health Care Authority **MEDICAL ADVISORY COMMITTEE MEETING**

## Summary of Revenues & Expenditures:OHCA

Fiscal Year 2015, For the Nine Months Ended March 31, 2015

| REVENUES | FY15 Budget YTD | FY15 Actual YTD | Variance | % Over/ (Under) |
|---|---|---|---|---|
| State Appropriations | $ 729,243,789 | $ 729,243,789 | $ - | 0.0% |
| Federal Funds | 1,712,547,050 | 1,679,004,012 | (33,543,038) | (2.0)% |
| Tobacco Tax Collections | 33,668,714 | 36,203,158 | 2,534,444 | 7.5% |
| Quality of Care Collections | 57,682,136 | 57,473,099 | (209,037) | (0.4)% |
| SFY 15 Carryover Committed to SFY16 | 14,000,000 | - | (14,000,000) | 100.0% |
| Prior Year Carryover | 61,029,661 | 61,029,661 | - | 0.0% |
| Federal Deferral - Interest | 191,746 | 191,746 | - | 0.0% |
| Drug Rebates | 174,688,944 | 178,412,972 | 3,724,028 | 2.1% |
| Medical Refunds | 33,919,572 | 44,663,950 | 10,744,378 | 31.7% |
| Supplemental Hospital Offset Payment Program | 155,787,425 | 155,787,425 | - | 0.0% |
| Other Revenues | 12,577,954 | 12,690,766 | 112,812 | 0.9% |
| **TOTAL REVENUES** | **$ 2,985,336,992** | **$ 2,954,700,579** | **$ (30,636,413)** | **(1.0)%** |

| EXPENDITURES | FY15 Budget YTD | FY15 Actual YTD | Variance | % (Over)/ Under |
|---|---|---|---|---|
| **ADMINISTRATION - OPERATING** | **$ 43,230,310** | **$ 38,471,630** | **$ 4,758,680** | **11.0%** |
| **ADMINISTRATION - CONTRACTS** | **$ 95,307,795** | **$ 89,541,145** | **$ 5,766,650** | **6.1%** |
| **MEDICAID PROGRAMS** | | | | |
| Managed Care: | | | | |
| SoonerCare Choice | 29,569,707 | 27,278,961 | 2,290,747 | 7.7% |
| Acute Fee for Service Payments: | | | | |
| Hospital Services | 679,784,545 | 677,692,171 | 2,092,374 | 0.3% |
| Behavioral Health | 14,963,412 | 14,520,337 | 443,075 | 3.0% |
| Physicians | 368,873,591 | 363,227,764 | 5,645,827 | 1.5% |
| Dentists | 102,253,824 | 95,493,677 | 6,760,147 | 6.6% |
| Other Practitioners | 31,080,250 | 28,597,451 | 2,482,798 | 8.0% |
| Home Health Care | 15,619,039 | 14,855,242 | 763,798 | 4.9% |
| Lab & Radiology | 56,298,066 | 56,457,083 | (159,017) | (0.3)% |
| Medical Supplies | 29,716,448 | 29,721,022 | (4,574) | (0.0)% |
| Ambulatory/Clinics | 93,457,917 | 90,819,262 | 2,638,655 | 2.8% |
| Prescription Drugs | 356,073,201 | 356,915,660 | (842,459) | (0.2)% |
| OHCA Therapeutic Foster Care | 1,508,412 | 1,312,927 | 195,485 | 13.0% |
| Other Payments: | | | | |
| Nursing Facilities | 432,594,571 | 422,072,697 | 10,521,874 | 2.4% |
| Intermediate Care Facilities for Individuals with Intellectual Disabilities Private | 45,411,952 | 44,280,154 | 1,131,797 | 2.5% |
| Medicare Buy-In | 102,359,181 | 100,199,700 | 2,159,482 | 2.1% |
| Transportation | 52,667,655 | 52,321,520 | 346,135 | 0.7% |
| Money Follows the Person-OHCA | 767,021 | 473,791 | 293,231 | 0.0% |
| Electonic Health Records-Incentive Payments | 18,952,198 | 18,952,198 | - | 0.0% |
| Part D Phase-In Contribution | 58,023,605 | 57,477,649 | 545,956 | 0.9% |
| Supplemental Hospital Offset Payment Program | 337,506,318 | 337,506,318 | - | 0.0% |
| **Total OHCA Medical Programs** | **2,827,480,912** | **2,790,175,582** | **37,305,330** | **1.3%** |
| OHCA Non-Title XIX Medical Payments | 89,382 | - | 89,382 | 0.0% |
| **TOTAL OHCA** | **$ 2,966,108,399** | **$ 2,918,188,357** | **$ 47,920,042** | **1.6%** |
| **REVENUES OVER/(UNDER) EXPENDITURES** | **$ 19,228,593** | **$ 36,512,222** | **$ 17,283,629** | |

Oklahoma Health Care Authority **MEDICAL ADVISORY COMMITTEE MEETING**

**Total Medicaid Program Expenditures by Source of State Funds**

Fiscal Year 2015, For the Nine Months Ended March 31, 2015

| Category of Service | Total | Health Care Authority | Quality of Care Fund | HEEIA | SHOPP Fund | BCC Revolving Fund | Other State Agencies |
|---|---|---|---|---|---|---|---|
| SoonerCare Choice | $ 27,389,379 | $ 27,267,685 | $ - | $ 110,418 | $ - | $ 11,276 | $ - |
| Inpatient Acute Care | 820,279,471 | 467,352,049 | 365,015 | 2,684,316 | 264,224,184 | 1,106,766 | 84,547,140 |
| Outpatient Acute Care | 263,983,855 | 205,587,832 | 31,203 | 2,914,969 | 52,200,545 | 3,249,306 | |
| Behavioral Health - Inpatient | 39,054,805 | 8,835,270 | - | 202,185 | 20,150,127 | - | 9,867,223 |
| Behavioral Health - Psychiatrist | 6,616,529 | 5,685,067 | - | - | 931,462 | - | - |
| Behavioral Health - Outpatient | 20,641,929 | - | - | - | - | - | 20,641,929 |
| Behaviorial Health-Health Home | 519,243 | - | - | - | - | - | 519,243 |
| Behavioral Health Facility- Rehab | 183,398,541 | - | - | - | - | 65,273 | 183,398,541 |
| Behavioral Health - Case Management | 15,635,654 | - | - | - | - | - | 15,635,654 |
| Behavioral Health - PRTF | 66,488,332 | - | - | - | - | - | 66,488,332 |
| Residential Behavioral Management | 17,078,822 | - | - | - | - | - | 17,078,822 |
| Targeted Case Management | 49,885,765 | - | - | - | - | - | 49,885,765 |
| Therapeutic Foster Care | 1,312,927 | 1,312,927 | - | - | - | - | - |
| Physicians | 408,893,891 | 358,686,209 | 43,576 | 4,128,205 | - | 4,497,979 | 41,537,922 |
| Dentists | 95,508,056 | 95,483,793 | - | 14,379 | - | 9,884 | - |
| Mid Level Practitioners | 2,288,170 | 2,273,561 | - | 13,242 | - | 1,368 | - |
| Other Practitioners | 26,388,332 | 25,982,213 | 334,773 | 65,809 | - | 5,537 | - |
| Home Health Care | 14,859,919 | 14,839,735 | - | 4,677 | - | 15,506 | - |
| Lab & Radiology | 57,692,415 | 56,071,442 | - | 1,235,332 | - | 385,641 | - |
| Medical Supplies | 29,921,746 | 27,621,129 | 2,033,651 | 200,724 | - | 66,242 | - |
| Clinic Services | 90,647,124 | 84,524,470 | - | 505,623 | - | 152,236 | 5,464,796 |
| Ambulatory Surgery Centers | 6,296,003 | 6,123,696 | - | 153,447 | - | 18,860 | - |
| Personal Care Services | 9,674,402 | - | - | - | - | - | 9,674,402 |
| Nursing Facilities | 422,072,697 | 265,416,660 | 156,654,055 | - | - | 1,982 | - |
| Transportation | 52,046,917 | 50,019,370 | 1,963,970 | - | - | 63,576 | - |
| GME/IME/DME | 68,528,082 | - | - | - | - | - | 68,528,082 |
| ICF/IID Private | 44,280,154 | 36,261,092 | 8,019,062 | - | - | - | - |
| ICF/IID Public | 34,440,374 | - | - | - | - | - | 34,440,374 |
| CMS Payments | 157,677,348 | 157,142,736 | 534,613 | - | - | - | |
| Prescription Drugs | 363,962,424 | 355,517,055 | - | 7,046,764 | - | 1,398,605 | - |
| Miscellaneous Medical Payments | 274,603 | 260,868 | - | - | - | 13,735 | - |
| Home and Community Based Waiver | 138,106,969 | - | - | - | - | - | 138,106,969 |
| Homeward Bound Waiver | 65,881,895 | - | - | - | - | - | 65,881,895 |
| Money Follows the Person | 9,996,179 | 473,791 | - | - | - | - | 9,522,389 |
| In-Home Support Waiver | 18,672,212 | - | - | - | - | - | 18,672,212 |
| ADvantage Waiver | 126,904,346 | - | - | - | - | - | 126,904,346 |
| Family Planning/Family Planning Waiver | 5,735,789 | - | - | - | - | - | 5,735,789 |
| Premium Assistance* | 30,985,052 | - | - | 30,985,052 | - | - | - |
| Electronic Health Records Incentive Payments | 18,952,198 | 18,952,198 | - | - | - | - | - |
| **Total Medicaid Expenditures** | **$ 3,812,972,549** | **$ 2,271,690,846** | **$ 169,979,918** | **$ 50,265,142** | **$ 337,506,318** | **$ 11,063,774** | **$ 972,531,825** |

* Includes $30,754,263.31 paid out of Fund 245

Oklahoma Health Care Authority **MEDICAL ADVISORY COMMITTEE MEETING**

## Other State Agencies Medicaid Payments

Fiscal Year 2015, For the Nine Months Ended March 31, 2015

| REVENUE | Actual YTD |
|---|---|
| Revenues from Other State Agencies | $ 440,481,595 |
| Federal Funds | 614,449,593 |
| **TOTAL REVENUES** | **$ 1,054,931,188** |

| EXPENDITURES | Actual YTD |
|---|---|
| **Department of Human Services** | |
| Home and Community Based Waiver | $ 138,106,969 |
| Money Follows the Person | 9,522,389 |
| Homeward Bound Waiver | 65,881,895 |
| In-Home Support Waivers | 18,672,212 |
| ADvantage Waiver | 126,904,346 |
| Intermediate Care Facilities for Individuals with Intellectual Disabilities Public | 34,440,374 |
| Personal Care | 9,674,402 |
| Residential Behavioral Management | 13,193,428 |
| Targeted Case Management | 39,589,794 |
| **Total Department of Human Services** | **455,985,809** |
| **State Employees Physician Payment** | |
| Physician Payments | 41,537,922 |
| **Total State Employees Physician Payment** | **41,537,922** |
| **Education Payments** | |
| Graduate Medical Education | 26,748,238 |
| Graduate Medical Education - Physicians Manpower Training Commission | 3,797,911 |
| Indirect Medical Education | 31,865,924 |
| Direct Medical Education | 6,116,009 |
| **Total Education Payments** | **68,528,082** |
| **Office of Juvenile Affairs** | |
| Targeted Case Management | 2,355,994 |
| Residential Behavioral Management | 3,885,393 |
| **Total Office of Juvenile Affairs** | **6,241,387** |
| **Department of Mental Health** | |
| Case Management | 15,635,654 |
| Inpatient Psychiatric Free-standing | 9,867,223 |
| Outpatient | 20,641,929 |
| Health Homes | 519,243 |
| Psychiatric Residential Treatment Facility | 66,488,332 |
| Rehabilitation Centers | 183,398,541 |
| **Total Department of Mental Health** | **296,550,923** |
| **State Department of Health** | |
| Children's First | 910,672 |
| Sooner Start | 1,894,162 |
| Early Intervention | 3,246,019 |
| Early and Periodic Screening, Diagnosis, and Treatment Clinic | 1,511,305 |
| Family Planning | (45,982) |
| Family Planning Waiver | 5,762,480 |
| Maternity Clinic | 24,904 |
| **Total Department of Health** | **13,303,560** |
| **County Health Departments** | |
| EPSDT Clinic | 570,599 |
| Family Planning Waiver | 19,292 |
| **Total County Health Departments** | **589,891** |
| **State Department of Education** | **106,955** |
| **Public Schools** | **3,676,331** |
| **Medicare DRG Limit** | **77,041,622** |
| **Native American Tribal Agreements** | **1,463,825** |
| **Department of Corrections** | **1,451,481** |
| **JD McCarty** | **6,054,037** |
| **Total OSA Medicaid Programs** | **$ 972,531,825** |
| **OSA Non-Medicaid Programs** | **$ 56,149,966** |
| **Accounts Receivable from OSA** | **$ (26,249,397)** |

Oklahoma Health Care Authority **MEDICAL ADVISORY COMMITTEE MEETING**

## Fund 205: Supplemental Hospital Offset Payment Program Fund

Fiscal Year 2015, For the Nine Months Ended March 31, 2015

| REVENUES | | | | FY 15 Revenue |
|---|---|---|---|---|
| SHOPP Assessment Fee | | | | $ 155,534,103 |
| Federal Draws | | | | 212,246,463 |
| Interest | | | | 122,968 |
| Penalties | | | | 130,354 |
| State Appropriations | | | | (22,700,000) |
| TOTAL REVENUES | | | | $ 345,333,889 |

| EXPENDITURES | Quarter | Quarter | *Thru Fund 340* Quarter | FY 15 Expenditures |
|---|---|---|---|---|
| Program Costs: | 7/1/14 - 9/30/14 | 10/1/14 - 12/31/14 | 1/1/15 - 3/31/15 | |
| Hospital - Inpatient Care | 92,872,986 | 92,764,153 | 78,587,045 | $ 264,224,184 |
| Hospital -Outpatient Care | 15,052,817 | 15,729,600 | 21,418,128 | $ 52,200,545 |
| Psychiatric Facilities-Inpatient | 6,919,304 | 7,316,146 | 5,914,677 | $ 20,150,127 |
| Rehabilitation Facilities-Inpatient | 272,784 | 288,429 | 370,249 | $ 931,462 |
| Total OHCA Program Costs | 115,117,891 | 116,098,329 | 106,290,098 | $ 337,506,317 |
| Total Expenditures | | | | $ 337,506,317 |

| CASH BALANCE | $ 7,827,571 |
|---|---|

*** Expenditures and Federal Revenue processed through Fund 340

## Fund 230: Quality of Care Fund Summary

Fiscal Year 2015, For the Nine Months Ended March 31, 2015

| REVENUES | Total Revenue | State Share |
|---|---|---|
| Quality of Care Assessment | **$ 57,442,295** | **$ 57,442,295** |
| Interest Earned | **30,804** | **30,804** |
| **TOTAL REVENUES** | **$ 57,473,099** | **$ 57,473,099** |

| EXPENDITURES | FY 15 Total $ YTD | FY 15 State $ YTD | Total State $ Cost |
|---|---|---|---|
| **Program Costs** | | | |
| Nursing Facility Rate Adjustment | $ 153,932,268 | $ 58,032,465 | |
| Eyeglasses and Dentures | 203,107 | 76,571 | |
| Personal Allowance Increase | 2,518,680 | 949,542 | |
| Coverage for Durable Medical Equipment and Supplies | 2,033,651 | 766,687 | |
| Coverage of Qualified Medicare Beneficiary | 774,567 | 292,012 | |
| Part D Phase-In | 534,613 | 534,613 | |
| ICF/IID Rate Adjustment | 3,923,999 | 1,479,348 | |
| Acute Services ICF/IID | 4,095,063 | 1,543,839 | |
| Non-emergency Transportation - Soonerride | 1,963,970 | 740,417 | |
| **Total Program Costs** | **$ 169,979,918** | **$ 64,415,493** | **$ 64,415,493** |
| **Administration** | | | |
| OHCA Administration Costs | $ 378,798 | $ 189,399 | |
| DHS-Ombudsmen | 177,158 | 177,158 | |
| OSDH-Nursing Facility Inspectors | 400,000 | 400,000 | |
| Mike Fine, CPA | 2,500 | 1,250 | |
| **Total Administration Costs** | **$ 958,456** | **$ 767,807** | **$ 767,807** |
| **Total Quality of Care Fee Costs** | **$ 170,938,374** | **$ 65,183,300** | |
| **TOTAL STATE SHARE OF COSTS** | | | **$ 65,183,300** |

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 **MEDICAL ADVISORY COMMITTEE MEETING**

## Fund 245: Health Employee and Economy Act Revolving Fund

Fiscal Year 2015, For the Nine Months Ended March 31, 2015

| REVENUES | FY 14 Carryover | FY 15 Revenue | Total Revenue |
|---|---|---|---|
| Prior Year Balance | $ 13,950,701 | $ - | $ 7,207,270 |
| State Appropriations | - | - | - |
| Tobacco Tax Collections | - | 29,776,879 | 29,776,879 |
| Interest Income | - | 249,097 | 249,097 |
| Federal Draws | 160,262 | 20,399,871 | 20,399,871 |
| All Kids Act | (6,651,067) | 93,964 | 93,964 |
| **TOTAL REVENUES** | **$ 7,459,896** | **$ 50,519,811** | **$ 57,633,118** |

| EXPENDITURES | | FY 14 Expenditures | FY 15 Expenditures | Total $ YTD |
|---|---|---|---|---|
| **Program Costs:** | | | | |
| | Employer Sponsored Insurance | | $ 30,493,302 | $ 30,493,302 |
| | College Students | | 230,789 | 83,038 |
| | All Kids Act | | 260,962 | 260,962 |
| **Individual Plan** | | | | |
| | SoonerCare Choice | | $ 106,305 | $ 38,249 |
| | Inpatient Hospital | | 2,659,246 | 956,797 |
| | Outpatient Hospital | | 2,872,288 | 1,033,449 |
| | BH - Inpatient Services-DRG | | 199,350 | 71,726 |
| | BH -Psychiatrist | | - | - |
| | Physicians | | 4,118,128 | 1,481,702 |
| | Dentists | | 13,743 | 4,945 |
| | Mid Level Practitioner | | 12,505 | 4,499 |
| | Other Practitioners | | 64,641 | 23,258 |
| | Home Health | | 4,677 | 1,683 |
| | Lab and Radiology | | 1,221,954 | 439,659 |
| | Medical Supplies | | 189,646 | 68,235 |
| | Clinic Services | | 499,742 | 179,807 |
| | Ambulatory Surgery Center | | 146,413 | 52,680 |
| | Prescription Drugs | | 6,941,607 | 2,497,590 |
| | Miscellaneous Medical | | - | - |
| | Premiums Collected | | - | (398,098) |
| **Total Individual Plan** | | | **$ 19,050,246** | **$ 6,456,181** |
| | **College Students-Service Costs** | | **$ 229,649** | **$ 82,628** |
| | **All Kids Act- Service Costs** | | **$ 195** | **$ 70** |
| **Total OHCA Program Costs** | | | **$ 50,265,142** | **$ 37,376,180** |
| **Administrative Costs** | | | | |
| | Salaries | $ 30,565 | $ 1,013,333 | $ 1,043,898 |
| | Operating Costs | 125,839 | 422,265 | 548,104 |
| | Health Dept-Postponing | - | - | - |
| | Contract - HP | 96,221 | 592,007 | 688,228 |
| **Total Administrative Costs** | | **$ 252,625** | **$ 2,027,605** | **$ 2,280,231** |
| **Total Expenditures** | | | | **$ 39,656,410** |
| **NET CASH BALANCE** | | **$ 7,207,270** | | **$ 17,976,708** |

Oklahoma Health Care Authority **MEDICAL ADVISORY COMMITTEE MEETING**

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

Fiscal Year 2015, For the Nine Months Ended March 31, 2015

| REVENUES | FY 15 Revenue | State Share |
|---|---|---|
| Tobacco Tax Collections | $ 594,090 | $ 594,090 |
| **TOTAL REVENUES** | **$ 594,090** | **$ 594,090** |

| EXPENDITURES | FY 15 Total $ YTD | FY 15 State $ YTD | Total State $ Cost |
|---|---|---|---|
| **Program Costs** | | | |
| SoonerCare Choice | $ 11,276 | $ 2,976 | |
| Inpatient Hospital | 1,106,766 | 292,076 | |
| Outpatient Hospital | 3,249,306 | 857,492 | |
| Inpatient Services-DRG | - | - | |
| Psychiatrist | - | - | |
| TFC-OHCA | - | - | |
| Nursing Facility | 1,982 | 523 | |
| Physicians | 4,497,979 | 1,187,017 | |
| Dentists | 9,884 | 2,608 | |
| Mid-level Practitioner | 1,368 | 361 | |
| Other Practitioners | 5,537 | 1,461 | |
| Home Health | 15,506 | 4,092 | |
| Lab & Radiology | 385,641 | 101,771 | |
| Medical Supplies | 66,242 | 17,481 | |
| Clinic Services | 152,236 | 40,175 | |
| Ambulatory Surgery Center | 18,860 | 4,977 | |
| Prescription Drugs | 1,398,605 | 369,092 | |
| Transportation | 63,576 | 16,778 | |
| Miscellaneous Medical | 13,735 | 3,625 | |
| **Total OHCA Program Costs** | $ 10,998,500 | $ 2,902,504 | |
| **OSA DMHSAS Rehab** | $ 65,273 | $ 17,226 | |
| **Total Medicaid Program Costs** | $ 11,063,774 | $ 2,919,730 | |

| | |
|---|---|
| **TOTAL STATE SHARE OF COSTS** | **$ 2,919,730** |

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

# SoonerCare Operations Update

March 2015 Data for May 2015 Board Meeting

## SOONERCARE ENROLLMENT/EXPENDITURES

| Delivery System | | | Monthly Enrollment Average SFY2014 | Enrollment March 2015 | Total Expenditures March 2015 | Average Dollars Per Member Per Month March 2015 |
|---|---|---|---|---|---|---|
| **SoonerCare Choice Patient-Centered Medical Home** | | | 559,363 | **546,156** | **$137,343,534** | |
| | *Lower Cost* | *(Children/Parents; Other)* | | 499,565 | $94,745,614 | $190 |
| | *Higher Cost* | *(Aged, Blind or Disabled; TEFRA; BCC)* | | 46,591 | $42,597,920 | $914 |
| **SoonerCare Traditional** | | | 196,936 | **235,002** | $185,336,016 | |
| | *Lower Cost* | *(Children/Parents; Other)* | | 124,264 | $56,747,288 | $457 |
| | *Higher Cost* | *(Aged, Blind or Disabled; TEFRA; BCC & HCBS Waiver)* | | 110,738 | $128,588,728 | $1,161 |
| **SoonerPlan*** | | | 48,266 | **41,672** | **$385,775** | $9 |
| **Insure Oklahoma** | | | 23,567 | **17,835** | **$5,882,286** | |
| | *Employer-Sponsored Insurance* | | 14,795 | 13,482 | $3,770,634 | $280 |
| | *Individual Plan** | | 8,772 | 4,353 | $2,111,652 | $485 |
| **TOTAL** | | | **828,131** | **840,665** | **$328,947,612** | |

The enrollment totals above include all members enrolled during the report month; therefore, some members may not have expenditure data. Custody expenditures are excluded. Non-member specific expenditures of $133,681,498 are excluded.

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

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

| Net Enrollee Count Change from Previous Month Total | 1,808 |
|---|---|

| New Enrollees | 16,565 |
|---|---|

Members that have not been enrolled in the last 6 months

| Medicare and SoonerCare | | Monthly average SFY2014 | Enrolled March 2015 |
|---|---|---|---|
| **Dual Enrollees** | | **109,653** | **110,717** |
| | *Child* | *192* | 179 |
| | *Adult* | *109,461* | 110,538 |

Child is defined as individual under the age of 21

| | | Monthly Average SFY2014 | Enrolled March 2015 | FACILITY PER MEMBER PER MONTH |
|---|---|---|---|---|
| **Long-Term Care Members** | | **15,358** | **14,932** | **$3,294** |
| | *Child* | 63 | 60 | |
| | *Adult* | 15,295 | 14,872 | |

## SOONERCARE CONTRACTED PROVIDER INFORMATION

| Provider Counts | | Monthly Average SFY2014 | Enrolled March 2015 |
|---|---|---|---|
| **Total Providers** | | **38,330** | **41,631** |
| | *In-State* | 29,277 | 31,490 |
| | *Out-of-State* | 9,053 | 10,141 |

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

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

| Select Provider Type Counts | *In-State* | | *Totals* | |
|---|---|---|---|---|
| | *Monthly Average SFY2014* | *Enrolled March 2015* | Monthly Average SFY2014 | Enrolled March 2015 |
| Physician | *8,452* | *9,180* | *13,597* | 15,774 |
| Pharmacy | *936* | *920* | *1,266* | 1,220 |
| Mental Health Provider | *4,864* | *4,765* | *4,902* | 4,823 |
| Dentist | *1,069* | *1,119* | *1,206* | 1,299 |
| Hospital | *183* | *192* | *685* | 952 |
| Optometrist | *565* | *608* | *594* | 643 |
| Extended Care Facility | *356* | *346* | 356 | 346 |

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

| | | | | |
|---|---|---|---|---|
| Total Primary Care Providers** | *5,410* | *6,149* | 7,011 | 8,263 |
| Patient-Centered Medical Home | *2,099* | *2,356* | 2,188 | 2,445 |

**Including Physicians, Physician Assistants and Advance Nurse Practitioners

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

# Strategic Planning Conference

(1) Looking back over the past year, what activities and/or accomplishments of the Oklahoma Health Care Authority were most notable/important to the Medical Advisory Committee?
(2) Looking ahead to the upcoming year, what are the top priorities the Medical Advisory Committee would like to see the Oklahoma Health Care Authority pursue?

# Legislative Update

# Budget Report

# Proposed Rule Amendment Summaries

May 21, 2015 MAC

A face to face tribal consultation regarding the following proposed changes was held Tuesday, May 5, 2015 in the Board Room of the OHCA.

The following rules are posted for comment from May 6, 2015 through June 6, 2015.

**15-03 DRG Hospital** — The proposed policy revisions clarify reimbursement methodology for DRG hospitals. Rules state that covered inpatient services provided to eligible members admitted to acute care and critical access hospitals will be reimbursed the lesser of the billed charges or the DRG amount.
**Budget Savings: The agency will observe a total savings of $11,181,897; state savings (11 month) of $3,964,760.**

**15-04 Benign Skin Lesions and Adult Sleep Studies** — The proposed policy revisions revoke payment for removal of benign skin lesions for adults. In addition, the proposed policy revisions eliminate coverage for adult sleep studies.
**Budget Savings: The agency estimates that the savings from revoking payment for removal of benign skin lesions for adults will be $37,879 state dollars and $106,832 total dollars for FFY '16. The agency estimates that the savings from eliminating adult sleep studies will be $517,420 state dollars for and $1,459,302 total dollars for FFY '16.**

**15-05 High Risk Obstetrical Services** — The proposed policy revisions to the High risk Obstetrical program include: allowing the provider to be Board Eligible or Board Certified, decreasing the number of units allowed for ultrasounds from six to three; decreasing the number of units for a singleton fetus for biophysical profiles/non-stress tests or any combination thereof to a total of 5, with one test per week beginning at 34 weeks gestation and continuing to 38 weeks; and, decreasing the number of ultrasounds currently granted to the Maternal Fetal Medicine (MFM) doctors to assist in the diagnosis of a high risk condition from six to one. These changes align with the current standards of care and reflect the current number of ultrasounds and biophysical profiles currently being utilized.
**Budget Savings: It is expected that with the proposed change there will be a projected savings of $292,433 total dollars and $103,687 state dollars.**

**15-06 Coverage for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)** — The proposed policy revisions regarding coverage for durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) restrict coverage for continuous positive airway pressure devices (CPAP) to children only.
**Budget Savings: The proposed rule change is projected to save $506,630 total dollars and $179,634 state dollars**

**15-08 Urine drug screening and testing** — The proposed policy revisions establish policy for the appropriate administration of urine drug screening and testing to align with recommended allowances based on clinical evidence and standards of care. Criteria include: purpose for urine testing, coverage requirements, non-covered testing, provider qualifications, and medical record documentation requirements necessary to support medical necessity. Additionally, revisions include clean-up to reimbursement language from general laboratory services policy.
**Budget Savings: It is expected that with the proposed change there will be a projected savings of $11,703,400 total dollars and $4,149,635 state dollars**

**15-09 Timely Filing** — The proposed policy revisions are to restrict the timely filing of claims for reimbursement from 12 months to six months. In addition, policy regarding resubmission is revised to update the deadline from 24 months to 12 months. Changes to the timely filing restrictions are in accordance with federal authority. Timely filing for crossover claims will remain one year. In addition, language corrections are included at 317:30-5-44 to reflect current practice.

**Budget Savings: The proposed rule change is projected to save $3,330,000 total dollars and $1,288,044 state dollars. The rule change would affect 10 percent of the total dollar amount of paid claims initially filed between 6 and 12 months from date of service.**

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

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

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

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

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

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

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

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

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

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

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

~~(iii)~~(C) The patient is transferred to a hospital that is excluded from the DRG-based payment system, or transferred to a distinct part psychiatric or rehabilitation unit of the same hospital. Such instances will result in two or more claims. Effective January 1, 2007, distinct part psychiatric and rehabilitation units excluded from the Medicare Prospective Payment System (PPS) of general medical surgical hospitals will require a separate provider identification number.

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

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

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

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

(A) laboratory services;

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

(C) technical component on radiology services;

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

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

(F) organ transplants.

(3) Hospitals may submit a claim for payment only upon the final discharge of the patient or upon completion of a transfer of the patient to another hospital.
(4) Covered inpatient services provided to eligible members of the Oklahoma SoonerCare program, when treated in out-of-state hospitals will be reimbursed in the same manner as in-state hospitals.
(5) Cases which indicate transfer from one acute care hospital to another will be monitored under a retrospective utilization review policy to help ensure that payment is not made for inappropriate transfers.
(6) The transferring hospital will be paid the lesser of the calculated transfer fee or the DRG base payment amount for a non-transfer. No outlier payment will be made on transfers.
~~(6)~~(7) If the transferring or discharge hospital or unit is exempt from the DRG, that hospital or unit will be reimbursed according to the method of payment applicable to the particular facility or units.
~~(7)~~(8) Covered inpatient services provided in out-of-state specialty hospitals may be reimbursed at a negotiated rate not to exceed 100% of the cost to provide the service. Negotiation of rates will only be allowed when the OHCA determines that the specialty hospital or specialty unit provides a unique (non-experimental) service required by SoonerCare members and the provider will not accept the DRG payment rate. Prior authorization is required.
~~(8)~~(9) New providers entering the SoonerCare program will be assigned a peer group and will be reimbursed at the peer group base rate for the DRG payment methodology or the statewide median rate for per diem methods.
~~(9)~~(10) When services are delivered via telemedicine to hospital inpatients, the originating site facility fee will be paid outside the DRG payment.
~~(10)~~(11) All inpatient services are reimbursed per the ~~DRG~~ methodology described in this section and/or as approved under the Oklahoma State Medicaid Plan.

**15-04 Revoke payment for removal of benign skin lesions and eliminate coverage for adult sleep studies**

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

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

The following are excluded from SoonerCare coverage for adults:

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

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

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

(4) Refractions and visual aids.

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

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

(7) Non-therapeutic hysterectomies.

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

(9) Medical services considered experimental or investigational.

(10) Services of a Certified Surgical Assistant.

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

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

(13) Services of a Psychologist.

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

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

## SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
## PART 1. PHYSICIANS

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

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

(1) Coverage includes the following medically necessary services:

(A) Inpatient hospital visits for all SoonerCare covered stays. All inpatient services are subject to post-payment review by the OHCA, or its designated agent.

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

sterilization procedures for the purposes of conception is not allowed. Reversal of sterilization procedures are allowed when medically indicated and substantiating documentation is attached to the claim.

(P) Genetic counseling.

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

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

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

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

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

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

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

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

(v) Seeing members without supervision;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(BB) Ventilator equipment.

(CC) Home dialysis equipment and supplies.

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

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

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

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

(II) Advising the member to quit;

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

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

(V) Arranging for follow-up.

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

(iii) Smoking and Tobacco Use Cessation Counseling is a covered service when performed by physicians, physician assistants, advanced registered nurse practitioners, certified nurse midwives, dentists, Oklahoma State Health Department and FQHC nursing staff, and Maternal/Child Health Licensed Clinical Social Workers with a certification as a Tobacco Treatment Specialist Certification (CTTS). It is reimbursed in addition to any other appropriate global payments for obstetrical care, PCP care coordination payments, evaluation and management codes, or other appropriate services rendered. It must be a significant, separately identifiable service, unique from any other service provided on the same day.

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

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

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

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

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

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

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

(2) General coverage exclusions include the following:

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

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

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

(D) Refractions and visual aids.

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

(F) Payment to the same physician for both an outpatient visit and admission to hospital on the same date.

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

(H) Non-therapeutic hysterectomies.

(I) Medical services considered experimental or investigational.

(J) Payment for more than four outpatient visits per month (home or office) per member, except those visits in connection with family planning or related to emergency medical conditions.

(K) Payment for more than two nursing facility visits per month.
(L) More than one inpatient visit per day per physician.
(M) Physician services which are administrative in nature and not a direct service to the member including such items as quality assurance, utilization review, treatment staffing, tumor board review or multidisciplinary opinion, dictation, and similar functions.
(N) Charges for completion of insurance forms, abstracts, narrative reports or telephone calls.
(O) Payment for the services of social workers, licensed family counselors, registered nurses or other ancillary staff, except as specifically set out in OHCA rules.
(P) Induced abortions, except when certified in writing by a physician that the abortion was necessary due to a physical disorder, injury or illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would place the woman in danger of death unless an abortion is performed, or that the pregnancy is the result of an act of rape or incest. (Refer to OAC 317:30-5-6 or 317:30-5-50.)
(Q) Speech and Hearing services.
(R) Mileage.
(S) A routine hospital visit on the date of discharge unless the member expired.
(T) Direct payment to perfusionist as this is considered part of the hospital reimbursement.
(U) Inpatient chemical dependency treatment.
(V) Fertility treatment.
(W) Payment for removal of benign skin lesions~~ unless medically necessary~~.
(X) Sleep studies.

## PART 3. HOSPITALS

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

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

(1) Inpatient admission for diagnostic studies that could be performed on an outpatient basis.
(2) Procedures that result in sterilization which do not meet the guidelines set forth in this Chapter of rules.
(3) Reversal of sterilization procedures for the purposes of conception are not covered.
(4) Medical services considered experimental or investigational.
(5) Payment for removal of benign skin lesions~~ unless medically necessary~~ for adults.

(6) Refractions and visual aids.
(7) Charges incurred while the member is in a skilled nursing or swing bed.
(8) Sleep studies for adults.

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**317:30-5-22. Obstetrical care**

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

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

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

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

(A) One abdominal or vaginal ultrasound will be covered in the first trimester of pregnancy. The ultrasound must be performed by a Board 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) Additional ultrasounds, including detailed ultrasounds and re-evaluations of previously identified or suspected fetal or maternal anomalies must be performed by an active candidate or Board Certified diplomat in Maternal-Fetal Medicine. Up to six repeat ultrasounds are allowed after which, prior authorization is required.~~

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

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

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

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

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

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

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

(c) Assistant surgeons are paid for C-Sections which include only in-hospital post-operative care. Family practitioners who provide prenatal care and assist at C-Section bill separately for the prenatal and the six weeks postpartum office visit.

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

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

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

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

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

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

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

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

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

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

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

(1) prenatal at risk ante partum management;

(2) a combined maximum of ~~12~~ 5 fetal non stress test(s) and biophysical profiles (additional units can be prior

authorized for multiple fetuses~~; and~~ with one test per week beginning at 34 weeks gestation and continuing to 38 weeks; and

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

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

(1) ACOG or other comparable comprehensive prenatal assessment;

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

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

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

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

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

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

**15-06 Coverage for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)**

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**PART 17. MEDICAL SUPPLIERS**

**317:30-5-210.2. Coverage for children**

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

(1) Orthotics and prosthetics.

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

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

(i) the member's diagnosis;

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

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

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

(v) prescribed daily caloric intake.

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

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

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

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

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**317:30-5-20. Laboratory services**

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

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

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

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

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

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

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

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

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

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

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

(D) Laboratory services not considered medically necessary

are not covered.

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

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

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

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

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

(B) Experimental or investigational procedures.

(C) Interpretation of clinical laboratory procedures.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(B) Negative for prescribed medications; or

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

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

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

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

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

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

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

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

(6) Scheduled and routine urine drug testing (i.e. testing should be random);

(7) Automatic confirmatory testing for any drug is not medically indicated without specific documented indications;

(8) Confirmatory testing exceeding 3 specific drug classes at an interval of greater than every 30 days will require specific documentation in the medical record to justify the medical necessity of testing; and

(9) Quantitative testing of multiple drug levels that are not specific to the patient's medical history and presentation are not allowed. Justification for testing for each individual drug or drug class level must be medically indicated as reflected in the medical record documentation.

(e) **Documentation requirement.** The medical record must contain documents to support the medical necessity of drug screening and/or testing. Medical records must be furnished on request and may include, but are not limited to, the following:

(1) Treatment plan which adheres to the appropriate state regulatory requirements;

(2) Patient history and physical;

(3) Review of previous medical records if treated by other previous physician for pain management;

(4) Review of all radiographs and/or laboratory studies, pertinent to the patient's condition;

(5) Current treatment plan;

(6) Opioid agreement and informed consent of UDT;

(7) List of prescribed medications;

(8) Risk assessment, as identified by use of a validated risk assessment tool/questionnaire, with appropriate risk stratification noted and utilized;

(9) Office/provider monitoring protocols, such as random pill counts, etc.; and

(10) Review of prescription drug monitoring data or pharmacy profile as warranted.

## 15-09 Timely filing

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

**317:30-3-11. Timely filing limitation**

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

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

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

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

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

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

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

received by the Oklahoma health Care Authority no later than 12 months from the date of service. The only exceptions to the ~~24~~ 12 month resubmission claim deadline are the following:

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

(2) reversal of the eligibility determination, or

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

(4) court order or hearing decision.

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**PART 3. HOSPITALS**

**317:30-5-44. Medicare eligible individuals**

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

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

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

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

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

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**PART 83. RESIDENTIAL BEHAVIOR MANAGEMENT SERVICES IN FOSTER CARE SETTINGS**

**317:30-5-744. Billing**

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

~~funds can be made should the individual be determined eligible at a later date.~~

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

(b) Claims for dually eligible individuals (Medicare/Medicaid) should be filed directly with the OHCA.

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**SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES**
**PART 87. BIRTHING CENTERS**

**317:30-5-893. Billing**

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

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

**317:30-5-973. Billing**

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

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

**317:30-5-993. Billing**

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

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

**317:30-5-1045. Billing**

(a) Billing is on the HCFA-1500.

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

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

## Proposed State Plan Amendment and/or Rate Change Summaries

*Information Only*

OHCA has prepared this document to give members of the MAC a preview of proposed rate and state plan revisions, as applicable. This document is for informational purposes only.

**DRG Hospital Readmissions** — The OHCA proposes to reduce payment for hospital readmissions occurring within 30 days since the last hospital discharge date. OHCA will set the target to 102% for CY 2015, decreasing 1% per year until the target is 100%. A target of 102% means we would allow a hospital to have 102% of the potentially-preventable admissions that we would expect based on statewide data before we assess a penalty.

**DRG Hospital Outlier Payment** — The OHCA proposes to reduce DRG outlier payments by increasing DRG threshold to $50,000. Currently the DRG threshold is $27,000.

**DRG Hospital Lesser of Transfer Fee or DRG** — The OHCA proposes to pay lesser of transfer fee or DRG. Payment to the receiving Facility, if it is also the final discharging Facility, will be at the DRG allowable. Currently, both are paid at the DRG allowable. No outlier payments will be allowed for transfers.

**Physician Services in Facility Setting** — The OHCA proposes to pay like Medicare for physician services performed in a facility setting.

**Mid-level Practitioner Reimbursement** — The OHCA proposes to reduce payments to mid-level practitioners to 85% of the appropriate OHCA physician fee schedule.

**Nursing Facility Crossovers** — The OHCA proposes to reduce payments for coinsurance and deductibles from 100% to 75%.

**Durable Medical Equipment** — The OHCA proposes to reimburse for stationary oxygen using the Medicare competitive bid rate. In addition, the agency proposes to eliminate coverage for sterile water and gloves.

**Polycarbonate Lenses** — The OHCA proposes to reduce payments for polycarbonate lenses to $10 per lens.

**Nursing Facility Rates** — The OHCA will revise payments and amend the State Plan for State Fiscal Year 2016. The Quality of Care Fee will increase by five cents per patient day for the Regular Nursing Facilities and Aids patients. The base rate component will increase from $107.24 to $107.29 to account for the increase in the Quality of Care Fee. The Pool amount for the Regular Nursing Facilities Direct Care Cost and Other Cost Components will change from $158,391,182 to $155,145,293. These changes will result in the following daily averages: nursing facilities, $143.70; and AIDS patients, $198.22. The Quality of Care Fee will be increased five cents per day for regular ICF/IID, resulting in a daily rate of $121.96. The Quality of Care Fee will be increased nine cents per day for the Acute ICF/IID, resulting in a daily rate of $156.19.

**Intermittent Agency Companion Contractor Rates** — The OHCA proposes a methodology change, requested by the Department of Human Services, to add an intermittent rate for the Agency Companion Contractor model. This new per diem rate will be $65.25. Current Agency Companion Rates for the Employee model will be eliminated. Agency Companion services may be authorized in the individual plan for members enrolled in the Developmental Disabilities Services Community Waiver or Homeward Bound Waiver.