

OKLAHOMA HEALTH CARE AUTHORITY  
MEDICAL ADVISORY COMMITTEE MEETING  
September 4, 2025, at 1:00 P.M.  
Oklahoma Health Care Authority  
4345 N. Lincoln Blvd.  
Oklahoma City, OK. 73105

**AGENDA**

Public access via Zoom:

[https://www.zoomgov.com/webinar/register/WN\\_W\\_kEBfUMQ8KwXuHyU6F41w](https://www.zoomgov.com/webinar/register/WN_W_kEBfUMQ8KwXuHyU6F41w)

Telephone: 1-669-254-5252    Webinar ID: 161 802 0693

\*Please note: Since the physical address for the MAC Meeting has resumed, any livestreaming option provided is provided as a courtesy. Should such livestreaming option fail or have technical issues, the MAC Meeting will not be suspended or reconvened because of this failure or technical issue.

1. Welcome, Roll Call, and Public Comment Instructions.....Jason Rhynes, O.D., Chair
2. Discussion and Vote on the July 10, 2025, MAC Meeting Minutes.....Jason Rhynes, O.D., Chair
3. MAC Member Comments/Discussion.....Jason Rhynes, O.D., Chair
4. Medicaid Director’s Update.....Christina Foss, Chief of Staff and State Medicaid Director
5. Change of Service Provision Updates (Attachment “A”).....Stephanie Mavredes, Deputy Director of SoonerSelect
  - i. Aetna Drug Maintenance List
  - ii. Humana Custom Drug Maintenance
  - iii. Oklahoma Complete Health Custom Drug Maintenance
  - iv. Aetna Reinstating PA Requirements for Certain J Codes
  - v. Humana Reinstating PA Requirements for Certain J Codes
  - vi. Humana Removal of PA Requirements for Hospice Rev Code
6. Proposed Rule Changes: Presentation, Discussion, and Vote.....Heather Cox, Policy and Program Management Director (Attachment “B”)
  - i. APA WF# 25-12 Clinic Services Update (Four Walls)
  - ii. APA WF# 25-15 340B Program Revisions
  - iii. APA WF# 25-16 Provider Attestation Revisions
  - iv. APA WF# 25-08 Birthing Centers and Licensed Midwives
  - v. APA WF# 25-01 Functional Family Therapy
  - vi. APA WF# 25-14 Paid Family Caregiver
  - vii. APA WF# 25-09 FQHC and RHC Policy Revisions
7. New Business.....Jason Rhynes, O.D., Chair
8. Adjournment.....Jason Rhynes, O.D., Chair

NEXT BOARD MEETING  
November 6, 2025, at 1:00 P.M.  
Oklahoma Health Care Authority  
4345 N. Lincoln Blvd  
Oklahoma City, OK 73105

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Oklahoma Health Care Authority  
MEDICAL ADVISORY COMMITTEE  
MINUTES of the July 10<sup>th</sup>, 2025, Meeting  
4345 N. Lincoln Blvd., Oklahoma City, OK 73105

**1. Welcome, Roll Call, and Public Comment Instructions:**

Chairman, Dr. Jason Rhynes called the meeting to order at 1:02 PM.

***Delegates present were:*** Dr. Steven Crawford, Ms. Janet Cizek, Ms. Wanda Felty, Dr. Arlen Foulks (arrived at 1:09pm), Mr. Tracy Ellis, Ms. Melissa Miller, Dr. J. Daniel Post, Dr. Jason Rhynes

***Alternates present were:*** Ms. Heather Pike, Ms. Beth Scrutchins providing a quorum.

***Delegates absent without an alternate were:*** Mr. Nick Barton, Mr. Brett Coble, Dr. Raymond Smith, Dr. Marny Dunlap, Whitney Yeates.

**2. Approval of March 6<sup>th</sup>, 2025, Minutes**

Medical Advisory Committee

**The motion to approve the minutes was by Ms. Janet Cisek by Dr. Steven Crawford and passed unanimously.**

**3. MAC Member Comments/Discussion:**

Dr. Crawford requested a follow up on the molecular testing that has been discussed in previous MAC meetings.

Ms. Foss stated that OHCA has had a meeting with a couple stakeholder groups recently on this subject and is working on getting some additional data from OHCA's Data Governance team to determine differences between some panel tests and individual tests savings compared to cost. Ms. Foss added that an update will be provided soon. Dr. Crawford asked when the Committee can expect an update. Ms. Foss stated that she is looking to share that in the next couple of weeks.

Chairman Dr. Rhynes provided an update on the email he sent prior to the MAC meeting regarding the Oklahoma Complete Health Optometry and Ophthalmology panel and claims issue. Due to a glitch in the system, over 300 Optometry and Ophthalmology providers have had issues with receiving payments for services provided. Chairman Dr. Rhynes asked the CEO of Oklahoma Complete Health to discuss the issue after the MAC meeting and would like a timeline of when the issue would be remedied.

**4. State Medicaid Director Update**

Christina Foss, Chief of Staff/State Medicaid Director

Ms. Foss provided an overview of a few key changes that Oklahoma will see coming out of the Reconciliation Bill.

Oklahoma Health Care Authority  
MEDICAL ADVISORY COMMITTEE  
MINUTES of the July 10<sup>th</sup>, 2025, Meeting  
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- Finance Changes: There are some changes around provider tax provisions, which include freezing provider taxes at current levels in all states and slowly starting to bring down the rate. Currently, CMS allows states to go up to about 6% in provider taxes, OHCA's provider tax is capped at 4%. This bill would slowly drop provider taxes that are above 3.5% by 0.5% year by year. A 0.5% drop equates to about \$200 million in total with a state share of \$40 million. Hospital provider taxes would not be affected until 2032; however, the ambulance provider program would be affected in 2028 due to being at 6%. OHCA's Nursing Home provider tax and that supplemental payment program should not be affected by this. As for the Directed Payment Program, those rates that are higher than 100% of the Medicare rate will start decreasing 10% in 2028. OHCA staff continue to analyze what that looks like for some of the other programs and are engaging with their actuaries.
- Community Engagement: Provisions will need to be effective and in place by December 2026. There are some provisions in the bill that allow for exemptions to extend beyond that date if the state is making a good effort to comply. There are also quite a few mandatory exceptions and hardship waivers. In 2020, OHCA submitted a waiver and provided a list of people that wouldn't be required to comply with the community engagement requirements. The list in the federal bill extends beyond that, so they do provide quite a few exemptions. Provision requirements include at least 80 hours of either community service work programs or at least halftime enrollment in an educational program of any combination of those.
- Eligibility: The provision also increases the frequency of the redeterminations for the Expansion population. OHCA currently redetermines eligibility annually, but the provision will increase to every six months.

Congress also passed a Rural Health Transformation Bill which is meant to help some of those rural hospitals that might be affected by the provisions discussed above. This bill creates about \$50 billion over the next five years. States will need to submit a plan for the funds no later than the end of this year and can be used for several different things. The bill is written vaguely, but states can anticipate some guidance on that soon. Dr. Crawford asked who the lead for the Rural Health Transformation plan will be. Ms. Foss stated that OHCA is still evaluating the bill and hasn't quite determined who will be the lead. Dr. Crawford also asked for an estimation of the number of people that will probably drop off Medicaid due to work requirements. Ms. Foss stated that the team is still looking at all the data around that, but said they think it will probably affect about 200,000 members.

Dr. Crawford asked if OHCA will have enough Dentists in the state to take care of the caries that will occur after fluoride is removed from community water systems. Ms. Foss stated that she will get back to him on the number of Dentists OHCA is contracted with.

Ms. Felty asked requested an update on caregiver exceptions. Ms. Foss stated that the team is still waiting to see if CMS put any guidance around that, or if they will leave it up to states to determine.

Oklahoma Health Care Authority  
MEDICAL ADVISORY COMMITTEE  
MINUTES of the July 10<sup>th</sup>, 2025, Meeting  
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Dr. Ellis asked if the County Health Department's role will change with the increase of redetermination. Ms. Foss stated that other than the redeterminations going from annually to every six months, the process will remain the same.

Ms. Foss added that there are other provisions including cost sharing requirements for expansion adults, verification through death master files, modify retroactive coverage, and provisions related to immigrant populations.

**5. Financial Reports:**

Tasha Black, Senior Director of Budget and Procurement

Ms. Black presented the financial report ending in May 2025. OHCA is 0.8 %, or \$8.4 billion, under budget in revenues and 0.9%, or \$8.5 billion under budget in expenditure with the result that our budget variance is a positive \$7.1. The budget variance is primarily attributed to the following: Medicaid Program Variance is a positive \$60.1 million state dollars, and administration is \$17.9 million state dollars.

For more detailed information, see Attachment A of the Committee packet.

**6. Change of Service Provision:**

Stephanie Mavredes, Deputy State Medicaid Director

Ms. Mavredes presented the following six Change of Service Provisions:

- i. New Gene Cell Therapy
- ii. Aetna New and Established Patient Codes
- iii. Humana Patient Code: T1001
- iv. Humana Patient Codes: 0016U, 0017U, 0022U, and 0023U
- v. OCH Split Fill
- vi. OCH GLP1

For more detailed information, see Attachment B of the Committee packet.

**7. Legislative Update**

Bradley Downs, Legislative Liaison

Mr. Downs provided a brief recap of some of the highlights from the last legislative session.

- OHCA Request Bills:
  - SB56: This bill authorizes the healthcare authority to build a framework for parents or family members, close relatives of juveniles who have private duty, nursing level of

Oklahoma Health Care Authority  
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need, to be reimbursed for some of the services that are being provided in the home. OHCA Policy and Population Care Management teams are working on ironing out the details and getting this submitted to CMS for proposed implementation in 2026.

- SB903: This bill makes changes to the MAC, which would require 25% of the MAC come from a Beneficiary Advisory Council. Additionally, a member representing the Managed Care plans. The bill also allows OHCA to cleanly make these changes so that OHCA can comply with federal regulations.
- HB2052: This bill exempts OHCA MCEs from certain commercial insurance mandates that are in Title 36.
- Other Bills Impacting OHCA:
  - HB1576: This bill requires that OHCA provide coverage for rapid whole genome sequencing for certain eligible populations. The Governor vetoed this bill, but the Legislature overrode the veto. This will have an up to \$2.6 million impact on the agency.
  - HB1808: This bill makes some changes to prior authorizations, including three year prior authorization durations for drugs, treating chronic conditions, and 24-hour turnaround for urgent prior authorizations. OHCA is looking at this bill from a HealthChoice perspective, but it will be applicable to Medicaid when it doesn't conflict with federal law.
  - SB806: This bill requires OHCA to cover nutrition services, which are defined broadly, ranging from case management to pantry stocking or produce prescriptions.
  - HB1575: This bill requires OHS to conduct a feasibility study for a potential unified enrollment and eligibility system for various public assistance programs, including Medicaid.

For more detailed information, see Attachment C of the Committee packet.

**8. New Business:**

Chairman, Jason Rhynes, O.D.

There was no new business addressed.

**9. Adjourn:**

Chairman, Jason Rhynes, O.D.

Chairman Rhynes asked for a motion to adjourn. Motion was provided by Dr. Crawford and seconded by Ms. Wanda Felty, there was no dissent and the meeting adjourned at 2:05pm.

# SoonerSelect

## SoonerSelect Medical Contracted Entity (CE) Requests to Change Service Provisions

The SoonerSelect Medical Contract at Section 1.7: Covered Benefits and Section 1.8: Medical Management states that medical contracted entities (CEs) may not impose prior authorization guidelines/criteria or utilization management practices that are more restrictive than OHCA without OHCA prior approval.

On August 6, 2025, Aetna Better Health of Oklahoma (ABHOK) submitted a formal request to OHCA for review and approval to change service provisions.

OHCA subject matter experts (SMEs) reviewed the requests, evaluating them in comparison to OHCA historical processes and practices, standard business practice in other markets, and available data to determine whether to approve the requests.

OHCA decisions are noted in the table below:

<b>SoonerSelect Medical Requests to Change Service Provisions</b>				
<b>OHCA's CURRENT PROCESSING PROTOCOL</b>	<b>PROPOSED MODIFICATION TO CLAIMS PROCESSING PROTOCOL</b>	<b>REASON FOR PROPOSED CHANGE</b>	<b>ANTICIPATED IMPACT</b>	<b>OHCA DECISION</b>
<b>Custom Drug Maintenance List</b>				
OHCA maintains an agency approved Maintenance Drug List	ABHOK is requesting a change in service to develop and implement a custom drug maintenance list that will contain all products on the current OHCA list and allow for the inclusion of new medications/products ensuring that the custom drug list is equally or less restrictive than OHCA.	Encourage pharmacies to convert 30-day supplies to 90 days.	Members will benefit from a broader selection of maintenance medications available for extended day supply, reducing the frequency of pharmacy visits and saving in out-of-pocket costs associated with copays. Easier access to longer supplies may improve adherence to prescribed therapies, potentially leading to better health outcomes. The flexibility to add to the maintenance list will also assist ABHOK's ability to improve our quality measures in 2026.	Approved 8/14/2025  <i>Item will be presented at the September 2025, MAC meeting</i>

# SoonerSelect

## SoonerSelect Medical Contracted Entity (CE) Requests to Change Service Provisions

The SoonerSelect Medical Contract at Section 1.7: Covered Benefits and Section 1.8: Medical Management states that medical contracted entities (CEs) may not impose prior authorization guidelines/criteria or utilization management practices that are more restrictive than OHCA without OHCA prior approval.

On August 8, 2025, Humana Healthy Horizons of Oklahoma submitted a formal request to OHCA for review and approval to change service provisions.

OHCA subject matter experts (SMEs) reviewed the requests, evaluating them in comparison to OHCA historical processes and practices, standard business practice in other markets, and available data to determine whether to approve the requests.

OHCA decisions are noted in the table below:

<b>SoonerSelect Medical Requests to Change Service Provisions</b>				
<b>OHCA's CURRENT PROCESSING PROTOCOL</b>	<b>PROPOSED MODIFICATION TO CLAIMS PROCESSING PROTOCOL</b>	<b>REASON FOR PROPOSED CHANGE</b>	<b>ANTICIPATED IMPACT</b>	<b>OHCA DECISION</b>
<b>Custom Drug Maintenance List</b>				
OHCA maintains an agency approved Maintenance Drug List.	Humana Healthy Horizons of Oklahoma is requesting a change in service to develop and implement a custom drug maintenance list that will contain all products on the current OHCA list and allow for the inclusion of new medications/ products ensuring that the custom drug list is equally or less restrictive than OHCA.	Pharmacies encouraged to convert 30-day supplies to 90 days.	Members will benefit from a broader selection of maintenance medications available for extended day supply, reducing the frequency of pharmacy visits and saving in out-of-pocket costs associated with copays. Easier access to longer supplies may improve adherence to prescribed therapies, potentially leading to better health outcomes.	Approved 8/13/2025  <i>Item will be presented at the September 2025, MAC meeting</i>

# SoonerSelect

## SoonerSelect Medical Contracted Entity (CE) Requests to Change Service Provisions

The SoonerSelect Medical Contract at Section 1.7: Covered Benefits and Section 1.8: Medical Management states that contracted entities (CEs) may not impose prior authorization guidelines/criteria or utilization management practices that are more restrictive than OHCA without OHCA prior approval.

On 06/18/2025 Oklahoma Complete Health submitted a formal request to OHCA for review and approval to change service provisions.

OHCA subject matter experts (SMEs) reviewed the request, evaluating it in comparison to OHCA historical processes and practices, standard business practice in other markets, and available data to determine whether to approve the request.

OHCA decisions are noted in the table below:

<b>SoonerSelect Medical Requests to Change Service Provisions</b>				
<b>OHCA'S CURRENT PROCESSING PROTOCOL</b>	<b>PROPOSED MODIFICATION TO CLAIMS PROCESSING PROTOCOL</b>	<b>REASON FOR PROPOSED CHANGE</b>	<b>ANTICIPATED IMPACT</b>	<b>OHCA DECISION</b>
<b>Custom Drug Maintenance List</b>				
OHCA maintains an agency approved Maintenance Drug List	Oklahoma Complete Health is requesting a change in service to develop and implement a custom drug maintenance list that will contain all products on the current OHCA list and allow for the inclusion of new medications/ products ensuring that the custom drug list is equally or less restrictive than OHCA.	Encourage pharmacies to convert 30-day supplies to 90 days.	Members will benefit from a broader selection of maintenance medications available for extended day supply, reducing the frequency of pharmacy visits and saving in out-of-pocket costs associated with copays. Easier access to longer supplies may improve adherence to prescribed therapies, potentially leading to better health outcomes. The flexibility to add to the maintenance list will also assist OCH's ability to improve our quality performance measures in 2026.	APPROVED 06/19/2025  <i>Item will be presented at the September 2025, MAC meeting.</i>

# SoonerSelect

## SoonerSelect Medical Contracted Entity (CE) Requests to Change Service Provisions

The SoonerSelect Medical Contract at Section 1.7: Covered Benefits and Section 1.8: Medical Management states that medical contracted entities (CEs) may not impose prior authorization guidelines/criteria or utilization management practices that are more restrictive than OHCA without OHCA prior approval.

On August 6, 2025, Aetna Better Health of Oklahoma submitted a formal request to OHCA for review and approval to change service provisions.

OHCA subject matter experts (SMEs) reviewed the requests, evaluating them in comparison to OHCA historical processes and practices, standard business practice in other markets, and available data to determine whether to approve the requests.

OHCA decisions are noted in the table below:

<b>SoonerSelect Medical Requests to Change Service Provisions</b>				
<b>PROCEDURE CODE(S) IMPACTED</b>	<b>OHCA'S CURRENT CLAIMS PROCESSING PROTOCOL</b>	<b>PROPOSED MODIFICATION TO CLAIMS PROCESSING PROTOCOL</b>	<b>ANTICIPATED IMPACT</b>	<b>OHCA DECISION</b>
<b>Reinstating Prior Authorization Requirements for J Codes</b>				
J3490, J3590, J8499 – All “miscellaneous” codes for unclassified drugs.	OHCA currently does not require prior authorization for the J codes listed.	Aetna is requesting to require prior authorization for the “Unspecified” J codes; J3490, J3590, and J8499.	A post claim review process in the past 90 days has shown a “significant” number of very high-cost genetic drugs are being billed on these unspecified J codes. Reinstating a prior authorization process would reduce the risk of these drugs being administered without prior authorization.	Approved 8/19/2025  <i>Item will be presented at the September 2025, MAC meeting</i>

# SoonerSelect

## SoonerSelect Medical Contracted Entity (CE) Requests to Change Service Provisions

The SoonerSelect Medical Contract at Section 1.7: Covered Benefits and Section 1.8: Medical Management states that medical contracted entities (CEs) may not impose prior authorization guidelines/criteria or utilization management practices that are more restrictive than OHCA without OHCA prior approval.

On August 22, 2025, Humana Health Horizons of Oklahoma submitted a formal request to OHCA for review and approval to change service provisions.

OHCA subject matter experts (SMEs) reviewed the requests, evaluating them in comparison to OHCA historical processes and practices, standard business practice in other markets, and available data to determine whether to approve the requests.

OHCA decisions are noted in the table below:

<b>SoonerSelect Medical Requests to Change Service Provisions</b>				
<b>PROCEDURE CODE(S) IMPACTED</b>	<b>OHCA'S CURRENT CLAIMS PROCESSING PROTOCOL</b>	<b>PROPOSED MODIFICATION TO CLAIMS PROCESSING PROTOCOL</b>	<b>ANTICIPATED IMPACT</b>	<b>OHCA DECISION</b>
<b>Reinstating Prior Authorization Requirements for J Codes</b>				
J3490, J3590, J8499 – All “miscellaneous” codes for unclassified drugs.	OHCA currently does not require prior authorization for the J codes listed.	Humana is requesting to require prior authorization for the “Unspecified” J codes; J3490, J3590, and J8499.	A post claim review process in the past 90 days has shown a “significant” number of very high-cost genetic drugs are being billed on these unspecified J codes. Reinstating a prior authorization process would reduce the risk of these drugs being administered without prior authorization.	Approved 8/25/2025  <i>Item will be presented at the September 2025, MAC meeting</i>



## SoonerSelect Medical Contracted Entity (CE) Requests to Change Service Provisions

The SoonerSelect Medical Contract at Section 1.7: Covered Benefits and Section 1.8: Medical Management states that medical contracted entities (CEs) may not impose prior authorization guidelines/criteria or utilization management practices that are more restrictive than OHCA without OHCA prior approval.

On July 16, 2025, Humana Health Horizons of Oklahoma submitted a formal request to OHCA for review and approval to change service provisions.

OHCA subject matter experts (SMEs) reviewed the requests, evaluating them in comparison to OHCA historical processes and practices, standard business practice in other markets, and available data to determine whether to approve the requests.

OHCA decisions are noted in the table below:

<b>SoonerSelect Medical Requests to Change Service Provisions</b>				
<b>PROCEDURE CODE(S) IMPACTED</b>	<b>OHCA'S CURRENT CLAIMS PROCESSING PROTOCOL</b>	<b>PROPOSED MODIFICATION TO CLAIMS PROCESSING PROTOCOL</b>	<b>ANTICIPATED IMPACT</b>	<b>OHCA DECISION</b>
<b>Not Adding Prior Authorization Requirements for Revenue Code 658</b>				
Revenue Code 658 – Hospice Service – Hospice Room and Board Nursing Facility	Beginning 10/1/2025, OHCA will require a prior authorization for Revenue Code 658.	Humana Healthy Horizons of Oklahoma is requesting to not add Revenue Code 658 to their prior authorization list. Humana Healthy Horizons requires prior authorizations for all inpatient admissions which is inclusive of hospice.	No impact is anticipated for Enrollees/Providers, or benefit costs.	Approved for dates of service on or after 10/1/2025.  <i>Item will be presented at the September 2025, MAC meeting.</i>

## **September 4, 2025 MAC Proposed Rule Amendment Summary**

These proposed **EMERGENCY** rules were previously presented at Tribal Consultation and were subject to at least a 15-day public comment period.

*The Agency is requesting the effective date to be immediately upon gubernatorial approval for the following items:*

**APA WF# 25-12 Clinic Services Update (Four Walls)** — The proposed emergency revisions align existing ITU (Indian/Tribal/Urban) policy with new federal requirements. Effective January 1, 2025, OHCA will implement the mandatory “four walls” exception for clinic services provided by Indian Health Services (IHS) clinics and Tribal clinics, as required by the 2024 Outpatient Prospective Payment System final rule. Services furnished by an IHS or Tribal clinic, outside the “four walls” of the clinic, have been covered as Clinic Services under 42 CFR 440.90 under a temporary exemption. The 2024 OPSS Final Rule made this exemption permanent. This emergency revision removes a provision requiring ITU facilities to be designated FQHCs in order to bill for off-site services.

**Budget Impact:** Budget neutral.

**APA WF# 25-15 340B Program Revisions** - These rule revisions seek to remove certain high-cost drugs and therapies from the 340B Drug Pricing Program. The 340B program is a federal initiative that allows health care organizations to purchase certain drugs directly from pharmaceutical manufacturers at a discount. The revision creates a 340B Carve Out Drug list, consisting of cell and gene therapies, drugs currently under a value-based agreement, or Brand Preferred Drugs where the cost to the Medicaid program is \$500,000 or higher, annually. Drugs on this list would be prohibited from being dispensed or administered to Oklahoma Medicaid Members if purchased at 340B prices.

**Budget Impact:** Budget neutral, with potential for future cost savings.

**APA WF# 25-16 Provider Attestation Revisions** — The proposed policy changes implement Executive Order 2025-16 (issued July 31, 2025), which directs OHCA to update provider contracting requirements. All SoonerCare providers will be required to submit a signed attestation disclosing whether they or any related entities engage in abortion-related activities, including referral or affiliation. The revisions also specify that OHCA may terminate or decline to renew provider contracts for failure to align with Oklahoma’s public policy objectives or for non-compliance with the Executive Order.

**Budget Impact:** Budget neutral

*The Agency is requesting an effective date of November 1, 2025, or upon gubernatorial approval for the following item:*

**APA WF# 25-08 Birthing Centers and Licensed Midwives** — The proposed policy changes establish coverage and reimbursement methodologies for birthing centers and licensed midwives. Senate Bill 1739 (2024) ended state licensing of birthing centers and directed OHCA to cover services provided by freestanding birthing centers, certified nurse midwives, and licensed midwives. These changes allow for coverage of birthing centers and licensed midwives' services for normal, uncomplicated, low-risk births. Birthing centers must be accredited by the Commission for the Accreditation of Birth Centers (CABC). Licensed midwives must be Certified Midwives or Certified Professional Midwives licensed by the Oklahoma State Department of Health (OSDH) to provide midwifery services. Birthing centers will be reimbursed a facility fee based on the Ambulatory Payment Classification (APC) fee schedule. Licensed midwives will be reimbursed 80% of the physician fee schedule rate for services within their statutory scope of practice. Laboratory and imaging services ordered by licensed midwives will be reimbursed 100% of the physician fee schedule rate. Revisions are also necessary to allow licensed midwives to provide referrals for doula services.

**Budget Impact:** Budget neutral due to shift in billing provider type.

*The Agency is requesting an effective date of January 1, 2026, or upon gubernatorial approval for the following items:*

**APA WF# 25-01 Functional Family Therapy** — OHCA, in collaboration with Oklahoma Juvenile Affairs (OJA) and Oklahoma Human Services (OHS), seeks to add coverage for Functional Family Therapy (FFT). FFT is a short-term, evidence-based therapeutic intervention designed to improve family functioning and address behavioral issues in adolescents who are at risk of or engaged in delinquent behavior, substance abuse, or other challenges. The therapy is rooted in a systemic approach, focusing on the relationships within the family rather than treating the individual in isolation. The proposed policy defines eligible populations, eligible providers, referral requirements, service limitations and exclusions.

**Budget Impact:** The estimated total cost for SFY2026 is \$1,614,954 with \$524,376 in state share and SFY2027 is \$3,229,908 with \$1,048,751 in state share.

**APA WF# 25-14 Paid Family Caregiver** — In accordance with Senate Bill 56 (2025 Regular Session) and Section 5013.2 of Title 63 of the Oklahoma Statutes, OHCA is proposing emergency policy revisions to implement the Paid Family Caregiver (PFC) program. This new program is intended for children approved for Private Duty Nursing (PDN) who require care beyond personal care services, but which can be safely provided by a trained family caregiver. The caregiver must meet OHCA-established criteria and be employed and trained by a PDN agency. Additional revisions clarify and streamline the prior authorization process for both PDN and PFC services and require service documentation at treatment plan recertification.

**Budget Impact:** Budget neutral

**APA WF# 25-09 FQHC and RHC Policy Revisions** — The proposed policy changes update the definition of Rural Health Center (RHC) and Federally Qualified Health Center

(FQHC) core services. The Consolidated Appropriations Act, 2023 (P.L. 117-328) added Marriage and Family Therapist (MFT) services and Mental Health Counselor (MHC) services to the definition of RHC/FQHC core services. Those services will be added to the list of RHC/FQHC core services in OHCA policy. The following provider types meet the definition of an MHC: Licensed Professional Counselor (LPC), Licensed Behavioral Health Provider (LBHP), and providers with a Licensed Drug and Alcohol Counselor/Mental Health (LADC-MH) credential. The policy changes also include clarification that certain medical services provided by an optometrist or podiatrist in an RHC or FQHC can be reimbursed at the encounter rate.

**Budget Impact:** TBD

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

**SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES**

**PART 110. INDIAN HEALTH SERVICES, TRIBAL PROGRAMS, AND URBAN  
INDIAN CLINICS (I/T/Us)**

**317:30-5-1096. Off-site services**

I/T/U covered services provided off-site or outside of the I/T/U setting, including but not limited to hospice services, mobile clinics, or places of residence, are compensable at the OMB rate ~~when billed by an I/T/U that has been designated as a Federally Qualified Health Center~~. The I/T/U must meet provider participation requirements listed in OAC 317:30-5-1088. I/T/U off-site services may be covered if the services rendered were within the provider's scope of practice and are of the same integrity of services rendered at the I/T/U facility.

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

**SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES**

**PART 7. PHARMACIES**

**317:30-5-87. 340B Drug Discount Program**

(a) The 340B Drug Discount Program is a drug-pricing program established under section 256b of Title 42 of the United States Code (U.S.C) under which a manufacturer of covered outpatient drugs agrees that it will not charge a 340B covered entity more than the 340B price for a 340B covered outpatient drug.

(b) Covered entities participating in the 340B Drug Discount Program will adhere to the following provisions outlined in this Section and as defined in 42 U.S.C. §256b. Covered entities must:

(1) Notify the OHCA Pharmacy Department in writing within thirty (30) days of any changes in 340B Program participation, as well as any changes in name, address, National Provider Identification (NPI), SoonerCare Provider Number, etc.

(2) Maintain their status on the Health Resources & Services Administration (HRSA) Medicaid Exclusion File (MEF) and report any changes to the OHCA within thirty (30) days.

(3) Execute a contract addendum with the OHCA in addition to their provider contract.

(4) Drugs designated by OHCA as 340B Carve Out Drugs shall be prohibited from being dispensed or administered to Oklahoma Medicaid members if purchased at 340B prices. Drugs that may be designated by OHCA as 340B Carve Out Drugs are:

(A) Cell and gene therapies;

(B) Drugs currently under a value based agreement; or

(C) Brand Preferred Drugs where the cost to the Oklahoma Medicaid program is \$500,000 or higher, annually.

(c) To prevent a duplicate discount, quarterly adjustments will be made to all pharmacy or medical claims for drugs submitted by covered entities when billed using the registered SoonerCare Provider Number on the MEF.

(1) All pharmacy claims submitted by covered entities shall be adjusted by the 340B ceiling price whether purchased through the 340B Program or otherwise.

(2) Medical claims submitted by covered entities with procedure code modifiers indicating the use of the 340B purchased drugs shall be adjusted by the 340B ceiling price. OHCA will adjust each claim by subtracting the 340B ceiling price from the amount reimbursed and multiplying the difference by the quantity submitted. OHCA will use the 340B ceiling price applicable to the quarter in which the claim is paid. Medical claims submitted by covered entities with a procedure code modifier indicating the use of non 340B purchased drugs will not be adjusted by the 340B ceiling price and will be submitted for federal rebates as required by CMS. Covered entities are required to use an appropriate procedure code modifier on all physician administered drug lines when submitting medical claims.

(3) If a 340B covered entity fails to pay quarterly adjustments invoiced by OHCA within forty-five (45) days of receipt, it may result in a debt to the State of Oklahoma subject to applicable interest pursuant to prompt payment methodology at OAC 260:10-3-3.

(4) The quarterly adjustments invoiced, including applicable interest, must be paid regardless of any disputes made by the covered entity. If a covered entity fails to pay OHCA the adjustments invoiced within forty-five (45) days of receipt, the adjustments invoiced and applicable interest will be deducted from the facility's payment.

(d) Contract pharmacies for covered entities may be permitted to bill drug products purchased under the 340B Drug Discount Program to the Oklahoma Medicaid Program when certain conditions are met and an agreement is in place between the OHCA, the contract pharmacy, and the covered entity. These pharmacies will be subject to the recovery process stated in this Section.

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

**SUBCHAPTER 3. GENERAL PROVIDER POLICIES**

**PART 1. GENERAL SCOPE AND ADMINISTRATION**

**317:30-3-2. Provider agreements**

- (a) In order to be eligible for payment, providers must have ~~on file with OHCA~~, an approved Provider Agreement on file with OHCA. Through this agreement, the provider certifies all information submitted on claims is accurate and complete, assures that the State Agency's requirements are met and assures compliance with all applicable Federal and State regulations. These agreements are renewed at least every five (5) ~~5~~ years with each provider.
- (b) As a condition of the Provider Agreement, each provider further assures:
- (1) **Lobbying restrictions.** ~~The provider further assures compliance~~ Compliance with Section 1352, Title 31 of the U.S. Code and implemented at 45 CFR Part 93 which provides that if payments pursuant to services provided under Medicaid are expected to exceed \$100,000.00, the provider certifies federal funds have not been used nor will they be used to influence the making or continuation of the agreement to provide services under Medicaid. Upon request, the Authority will furnish a standard form to the provider for the purpose of reporting any non-federal funds used for influencing agreements.
  - (2) **Debarment status.** ~~That The provider assures~~ in accordance with 31 USC 6101 and Executive Order 12549, the provider is not presently and has not within the last three (3) years been that they are not presently or have not in the last three years been debarred, suspended, proposed for debarment or declared ineligible by any ~~Federal~~ federal department or agency.
  - (3) **Contact Information.** For information regarding Provider Agreements or for problems related to a current agreement, contact the Oklahoma Health Care Authority, Provider Enrollment, P.O. Box 54015, Oklahoma City, Oklahoma 73154, or call 1-800-522-0114 option 5 toll free or 405-522-6205 for the Oklahoma City area, or via e-mail: [providerenrollment@okhca.org](mailto:providerenrollment@okhca.org).
- (c) As a condition of participation in the SoonerCare program, providers must also:
- (1) Submit a signed attestation disclosing whether they or any related entities engage in abortion-related activities, including whether they:
    - (A) Perform, refer for, or are affiliated with the performance of abortions not permitted under state law; or
    - (B) Are under common ownership or control with an entity engaged in abortion-related activities inconsistent with state law.
  - (2) Acknowledge that failure to comply with these requirements may result in denial, exclusion, non-renewal, or termination from the SoonerCare program.
  - (3) Cooperate with OHCA credentialing and contracting procedures established to implement Executive Order 2025-16 and Oklahoma's public policy objectives related to unborn life.

**317:30-3-19.3. Denial of application for new or renewed provider enrollment contract**

(a) The following words and terms, when used in this Section, shall have the following meaning, unless the context clearly indicates otherwise:

- (1) "**Affiliates**" means persons having a relationship in which any of them directly or indirectly controls or has the ability to control one or more of the others.
- (2) "**Applicant**" means providers and/or persons with a five percent or more direct or indirect ownership interest therein, as well as providers' officers, directors, and managing employees.
- (3) "**Conviction**" or "**convicted**" means a person has been convicted of a criminal offense pursuant to 42 U.S.C. § 1320a-7(i), or, for civil offenses, has had a judgment of conviction entered against him or her by a Federal, State, or local court, regardless of whether an appeal from the judgment is pending.
- (4) "**Person**" means any natural person, partnership, corporation, not-for-profit corporation, professional corporation, or other business entity.
- (5) "**Provider**" means any person having or seeking to obtain a valid provider enrollment contract with the Oklahoma Health Care Authority (OHCA) for the purpose of providing services to eligible SoonerCare members and receiving reimbursement therefor.

(b) When deciding whether to approve an application for a new or renewed provider enrollment contract, OHCA may consider the following factors as they relate to the applicant and any of the applicant's affiliates, including, but not limited to:

- (1) any false or misleading representation or omission of any material fact or information required or requested by OHCA as part of the application process;
- (2) any failure to provide additional information to OHCA after receiving a written request for such additional information;
- (3) any false or misleading representation or omission of any material fact in making application for any license, permit, certificate, or registration related to the applicant's profession or business in any State;
- (4) any fine, termination, removal, suspension, revocation, denial, consented surrender, censure, sanction, involuntary invalidation of, or other disciplinary action taken against any license, permit, certificate, or registration related to the applicant's profession or business in any State;
- (5) any previous or current involuntary surrender, removal, termination, suspension, ineligibility, exclusion, or otherwise involuntary disqualification from participation in Medicaid in any State, or from participation in any other governmental or private medical insurance program, including, but not limited to, Medicare and Workers' Compensation;
- (6) any Medicaid or Medicare overpayment of which the applicant has been notified, as determined exclusively by OHCA that was received, but has not made reimbursement, unless such reimbursement is the subject of an OHCA reimbursement agreement that is not in default;
- (7) any previous failure to correct deficiencies in the applicant's business or professional operations after having received notice of the deficiencies from the OHCA or any State or Federal licensing or auditing authority;
- (8) any previous violation of any State or Federal statute or regulation that relates to the applicant's current or past participation in Medicaid, Medicare, or any other governmental or private medical insurance program;
- (9) any pending charge or prior conviction of any civil or criminal offense relating to the furnishing of, or billing for, medical care, services, or supplies, or which is considered theft,

fraud, or a crime involving moral turpitude;

(10) any pending charge or prior criminal conviction for any felony or misdemeanor offense that could reasonably affect patient care, including, but not limited to, those offenses listed in OAC 317:30-3-19.4;

(11) any denial of a new or renewed provider enrollment contract within the past two (2) years that was based on the applicant's or an affiliate's prior conduct;

(12) any submission of an application that conceals the involvement in the enrolling provider's operation of a person who would otherwise be ineligible to participate in Medicaid or Medicare;

(13) any business entity that is required to register with a State office or agency in order to conduct its operations therein, including, but not limited to, the Oklahoma Secretary of State, any failure to obtain and/or maintain a registration status that is valid, active, and/or in good standing; ~~and-~~

~~(14) any other factor that impacts the quality or cost of medical care, services, or supplies that the applicant furnishes to SoonerCare members, or otherwise influences the fiscal soundness, effectiveness, or efficiency of the OHCA program.~~

(14) any provider, applicant, or affiliate that performs, refers for, or is otherwise affiliated with the performance of abortions not permitted under state law;

(15) any provider, applicant, or affiliate that is under common ownership or control with an entity engaged in abortion-related activities inconsistent with state law;

(16) any failure to provide a signed attestation disclosing whether the provider or any related entity engages in abortion-related activities, as required by Executive Order 2025-16; and

(17) any other factor that impacts the quality or cost of medical care, services, or supplies that the applicant furnishes to SoonerCare members, or otherwise influences the fiscal soundness, effectiveness, or efficiency of the OHCA program.

(c) OHCA shall provide any applicant who is denied a new or renewed provider enrollment contract a written notice of the denial. Any denial shall become effective on the date it is sent to the applicant.

(d) Any OHCA decision to deny a provider's contract application in accordance with this Section shall be a final agency decision that is not administratively appealable.

### **317:30-3-19.5. Termination of provider agreements**

Pursuant to the terms of the Oklahoma Health Care Authority's (OHCA) Standard Provider Agreement, both OHCA and a provider may terminate the agreement without cause on sixty (60) days' notice, or for-cause on thirty (30) days' notice. In addition, OHCA can terminate the agreement immediately in order to protect the health and safety of members, or upon evidence of fraud (including, but not limited to, a credible allegation of fraud as defined by 42 C.F.R. ' 455.2). Conduct that may serve as a basis for a for-cause termination of a provider includes, but is not limited to, any of the following:

(1) **Noncompliance.** The provider is determined not to be in compliance with the enrollment requirements described in Oklahoma Administrative Code (OAC) 317:30-3-2 and 317:30-3-19.3, or in the enrollment application applicable for its provider type. OHCA may, but is not required to, request additional documentation from the provider to determine compliance.

(2) **Provider exclusion, debarment, or suspension.** The provider or any owner, managing employee, authorized or delegated official, medical director, supervising physician, or other health care personnel thereof is:

- (A) Excluded from the Medicare, Medicaid, or any other Federal health care program, as defined in 42 C.F.R. ' 1001.2; or
- (B) Debarred, suspended, or otherwise excluded from participating in any other Federal procurement or nonprocurement program or activity.
- (3) **Convictions.** Conviction of the provider or any of its affiliates for a Federal or State offense that OHCA has determined to be detrimental to the best interests of the program and its members. Such offenses may include, but are not limited to, those offenses enumerated in OAC 317:30-3-19.3 and OAC 317:30-3-19.4.
- (4) **False or misleading information.** The provider submitted or caused to be submitted misleading or false information on its enrollment application to be enrolled or to maintain enrollment in the SoonerCare program. In addition to termination of a contract, offenders may be referred for prosecution, which could result in fines or imprisonment, or both, in accordance with current law and regulations.
- (5) **On-site review.** OHCA determines, upon on-site review, that the provider is no longer operational, able to furnish SoonerCare covered items, or able to safely and adequately render services; or is not meeting SoonerCare enrollment requirements under statute or regulation to supervise treatment of, or to provide SoonerCare covered items or services for SoonerCare members.
- (6) **Misuse of billing number.** The provider knowingly sells to or allows another individual or entity to use its billing number. This does not include those providers who enter into a valid reassignment of benefits as specified in 42 U.S.C. ' 1396a(a)(32) or a change of ownership as outlined in 42 C.F.R. ' 455.104(c) (within thirty-five (35) days of a change in ownership).
- (7) **Abuse of billing privileges.** The provider submits a claim or claims for services that reasonably could not have been rendered, or that do not accurately reflect those services actually rendered, to a specific individual on the date of service. These instances include, but are not limited to: upcoding; unbundling of services; services that are purportedly provided to a member who has died prior to the date of service; services that are purportedly provided on a date on which the directing physician or member is not in the State or country or is otherwise physically incapable of providing or receiving the service; or the equipment necessary for testing was not present where the testing is said to have occurred, or was incapable of operating correctly at the supposed time of testing.
- (8) **Failure to report.** The provider did not comply with the reporting requirements specified in the SoonerCare Provider Agreement or any applicable State and/or Federal statutes or regulations, including without limitation, changes in the provider's licenses, certifications, and/or accreditations provided at the time of enrollment. Providers shall report and update a change in mailing address within fourteen (14) days of such change.
- (9) **Failure to document or provide OHCA access to documentation.**
- (A) The provider did not comply with the documentation or OHCA access requirements specified in the SoonerCare Provider Agreement.
- (B) OHCA may suspend all SoonerCare payments to a provider who refuses or fails to produce for inspection those financial and other records as are required by 42 C.F.R. ' 431.107 and the executed SoonerCare Provider Agreement, until such time as all requested records have been submitted to OHCA for review.
- (10) **Adverse audit determinations.** The provider receives an adverse Program Integrity audit that demonstrates fraud, waste, abuse, and/or repeated failure or inability to comply with SoonerCare billing and provision of service requirements.

(11) In accordance with Executive Order 2025-16, OHCA may immediately terminate a provider agreement if the provider or any related entity is determined not to be fully aligned with Oklahoma's objectives related to the protection of unborn life. This includes, but is not limited to:

- (1) The provider or any related entity performs, refers for, or is affiliated with the performance of abortions not permitted under state law;
- (2) The provider is under common ownership or control with an entity engaged in abortion-related activities inconsistent with state law;
- (3) The provider failed to submit a complete and truthful attestation disclosing its involvement in abortion-related activities as required under OAC 317:30-3-2;
- (4) OHCA determines, in its sole discretion, that the provider is not fully aligned with the requirements of Executive Order 2025-16.
- (5) OHCA determines that the provider is not fully aligned with the requirements of any applicable Executive Order requiring termination of provider agreement for non-compliance.

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

**SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES**

**PART 19. CERTIFIED NURSE MIDWIVES**

**317:30-5-229. Reimbursement**

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

~~(1) Medical verification of pregnancy is required. A written statement from the physician or certified nurse midwife verifying the applicant is pregnant and the expected date of delivery is acceptable. Pregnancy may also be verified by submission of a copy of a laboratory report indicating the individual is pregnant.~~

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

~~(3) Providers must use OKDHS Form FSS-NB-1 or the eNB1 application on the Secure Website to notify the county DHS office of the child's birth. the NODOS/NB1 form (found on the OHCA website at <https://oklahoma.gov/ohca/providers/forms.html>) for a newborn child delivered by a SoonerCare member. A claim may then be filed for charges for the newborn under the case number and the newborn's name and assigned person code. Newborn charges billed on the mother's person code will be denied.~~

~~(4) Obstetrical care should be billed using the appropriate CPT codes for Maternity Care and Delivery. The date of delivery should be used as the date of service for charges for total obstetrical care. Inclusive dates of care should be indicated on the claim form as part of the description. The date the patient was first seen must be on the claim form. Payment for total obstetrical care includes all routine care performed by the attending provider. For payment of total OB care, the provider must have provided care for more than one trimester. To bill for prenatal care only, the claim is filed after the member leaves the provider's care. Payment for routine or minor medical problems will not be made separately to the OB provider outside of antepartum visits. The antepartum care during the prenatal care period includes all care by the OB provider except major illness distinctly unrelated to the pregnancy.~~

**PART 87. BIRTHING CENTERS**

**317:30-5-890. Eligible providers**

Eligible providers are freestanding birthing centers that are not currently licensed as a hospital and meet the following requirements:

(1) Must be accredited by the Commission for the Accreditation of Birth Centers (CABC);

(2) Have a current contract with the Oklahoma Health Care Authority;

(3) Have a current written agreement with a board-certified Obstetrician-Gynecologist (OB-GYN) to provide coverage for consultation, collaboration, or referral services;

(4) Have a current SoonerCare-contracted clinical director who is a physician, certified nurse midwife (CNM), advanced practice registered nurse (APRN), or licensed midwife and is responsible for establishing patient protocols and other functions as defined in requirements for state licensure. This individual may, or may not, be the physician providing individual

patient coverage for consultation, collaborative, or referral service; and

(5) Have a written agreement with a referral hospital which is a Class II hospital. Class II hospital is defined as a facility with 24-hour availability of OB-GYN and capability of performing a C-section within 30 minutes of the decision to operate. The 30-minute timeframe is subject to each hospital's unique circumstance, logistical issues that include, but are not limited to, obtaining informed consent, transporting the patient, and any other potential problems that may arise.

### **317:30-5-890.1. Definitions**

The following words or terms, when used in this Part, shall have the following meaning, unless the context clearly indicates otherwise:

(1) “Birthing center” means a freestanding facility, place, or institution, which is maintained or established primarily for the purpose of providing services of a licensed midwife, certified nurse-midwife, or licensed medical doctor to assist or attend a woman in delivery and birth, and where a woman is scheduled in advance to give birth following a normal, uncomplicated, low-risk pregnancy.

(2) “Certified Midwife” means an individual with a non-nursing graduate degree, educated in midwifery, and certified by the American Midwifery Certification Board (AMCB) who is not a Nurse-Midwife.

(3) “Certified Nurse Midwife” means a person educated in the discipline of nursing and midwifery, certified by the American College of Nurse-Midwives (ACNM), and licensed by the state to engage in the practice of midwifery and as an Advanced Practice Registered Nurse (APRN).

(4) “Certified Professional Midwife” means an individual that graduated from an accredited midwifery program or apprenticeship and is certified by the North American Registry of Midwives (NARM).

(5) “Licensed Midwife” means a Certified Professional Midwife or Certified Midwife who is licensed by the state under 59 O.S. § 3040.6 to engage in the practice of midwifery.

(6) “Low-risk” means a normal, uncomplicated pregnancy with expectation of a normal, uncomplicated birth as defined by generally accepted criteria of maternal and fetal health.

(7) “Newborn” means an infant during the first 28 days following birth.

(8) “Normal” means, as applied to pregnancy, labor, delivery, the postpartum period, and the newborn period, circumstances under which a licensed provider has determined that the member does not have a condition that requires obstetrical intervention.

### **317:30-5-891. Coverage by category**

(a) **Adults and children.** Birthing center services for adults are covered and includes admission to the birthing center of low-risk, normal, uncomplicated pregnancies, with an anticipated normal, spontaneous vaginal delivery for the period of labor and delivery.

(b) **Newborn.** Coverage for newborns includes those services within the scope of practice of the provider as defined by state law.

(c) **Individuals eligible for Part B of Medicare.** Birthing center services provided to Medicare eligible recipients should be billed directly to the fiscal agent.

### **317:30-5-892. Reimbursement**

Birthing centers will be reimbursed a facility charge determined by the Ambulatory Payment

Classification (APC) fee schedule maintained by CMS. The facility charge represents payment in full for birthing center services. Separate payment will be made for lab services and midwife or physician obstetrical care, delivery, and postpartum care as appropriate.

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

Billing for birthing center services will be on UB-04. Claims must be submitted in accordance with guidelines found at OAC 317:30-3-11 and 317:30-3-11.1.

## **PART 116. LICENSED MIDWIVES**

### **317:30-5-1235. Eligible Providers**

Eligible Providers shall:

(1) Have and maintain one of the following midwifery certifications;

(A) Certified Midwife certification issued by the American Midwifery Certification Board (AMCB) or;

(B) Certified Professional Midwife issued by the North American Registry of Midwives (NARM).

(2) Have and maintain a current license by the Oklahoma State Department of Health as described in Section 3040.6 of Title 59 of Oklahoma Statutes and OAC 310:395-7-2; and

(3) Have a current contract with the Oklahoma Health Care Authority (OHCA).

### **317:30-5-1236. Covered Services**

(a) **Adults and children.** OHCA covers medical services (as described in OAC 317:30-5, Part 1, Physicians) provided in a birthing center by a licensed midwife when rendered within their licensure and scope of practice as defined by state law and regulations. Coverage includes obstetrical care such as antepartum care, delivery, postpartum care, and care of the normal newborn.

(b) **Newborns.** OHCA covers medical services for newborns (as described in OAC 317:30-5, Part 1, Physicians) provided in a birthing center by a licensed midwife when rendered within their licensure and scope of practice as defined by state law and regulations. Services are covered for the newborn during the first six (6) weeks following birth, unless care is transferred to a physician or advanced practice registered nurse specializing in the care of infants and children.

(c) **Limitations.** Medical services rendered by licensed midwives are subject to the same limitations described in OAC 317:30-5, Part 1, Physicians. There is no coverage for home births.

### **317:30-5-1237. Reimbursement**

(a) **Payment.** Payment for covered services (as described in OAC 317:30-5-1226) to eligible providers (as described in OAC 317:30-5-1225) shall be made when the same service would have been covered if ordered or performed by a physician.

(1) Payment to licensed midwives is made at 80% of the physician fee schedule for the rendered service. Payment for lab and imaging services ordered by licensed midwives is made at 100% of the physician fee schedule.

### **(b) Billing.**

(1) **Adults and children.** Obstetrical care should be billed using the appropriate CPT codes for Maternity Care and Delivery. The date of delivery should be used as the date of service for charges for total obstetrical care. Inclusive dates of care should be indicated on the

claim form as part of the description. The date the patient was first seen must be on the claim form. Payment for total obstetrical care includes all routine care performed by the attending provider. For payment of total OB care, the provider must have provided care for more than one trimester. To bill for prenatal care only, the claim is filed after the member leaves the provider's care. Payment for routine or minor medical problems will not be made separately to the OB provider outside of antepartum visits. The antepartum care during the prenatal care period includes all care by the OB provider except major illness distinctly unrelated to the pregnancy.

(2) **Newborns.** Providers must complete the NODOS/NB1 form (found on the OHCA website at <https://oklahoma.gov/ohca/providers/forms.html>) for a newborn child delivered by a SoonerCare member. A claim may then be filed for charges for the newborn under the case number and the newborn's name and assigned person code. Charges billed on the mother's person code for services rendered to the child will be denied.

## PART 114. DOULA SERVICES

### 317:30-5-1217. General coverage

#### (a) Covered benefits.

(1) **Prenatal/postpartum visits.** There is a total of eight (8) visits allowed for the member. The doula must work with the member to determine how best to utilize the benefit to meet the needs of the member.

(2) **Labor and delivery.** There is one (1) visit allowed, regardless of the duration.

#### (b) Visit requirements.

(1) The minimum visit length is sixty (60) minutes.

(2) Visits must be face-to-face.

(A) Prenatal and postpartum visits may be conducted via telehealth.

(B) Labor and delivery services may not be conducted via telehealth.

#### (c) Service locations.

##### (1) Prenatal and postpartum.

(A) Doulas must coordinate directly with the member and their family to determine the most appropriate service location for prenatal and postpartum visits.

(B) Service locations may include the following:

(i) Member's place of residence;

(ii) Doula's office;

(iii) Physician's office;

(iv) Hospital; or

(v) In the community.

(2) **Labor and delivery services.** There is no coverage for home birth(s).

(d) **Referral requirements.** Doula services must be recommended by a physician or other licensed practitioner of the healing arts who is operating within the scope of their practice under State law.

(1) The following providers may recommend doula services:

(A) Obstetricians;

(B) Certified Nurse ~~Midwives~~ Midwives;

(C) Physicians;

- (D) Physician Assistants; ~~or~~
- (E) ~~Certified Nurse Practitioners.~~ Advanced Practice Registered Nurses; or
- (F) Licensed Midwives.

(2) The SoonerCare Referral Form must be completed and submitted, noting the recommendation for doula services.

**(e) Prior authorization (PA) requirements.**

- (1) A PA is not required to access the standard doula benefit package.
- (2) A PA may be submitted, for members with extenuating medical circumstances, if there is need for additional visits beyond the eight (8) prenatal/postpartum visits.

**(f) Medical records requirements.** The medical record must include, but is not limited to, the following:

- (1) Date of service;
- (2) Person(s) to whom services were rendered;
- (3) Start and stop time for the service(s);
- (4) Specific services performed by the doula on behalf of the member;
- (5) Member/family response to the service;
- (6) Any new needs identified during the service; and
- (7) Original signature of the doula, including the credentials of the doula.

**(g) Auditing review.** All doula services are subject to post-payment reviews and audits by the OHCA.

**(h) Reimbursement.**

- (1) All doula services, that are outlined in Part 114 of this Chapter, are reimbursed per the methodology established in the Oklahoma Medicaid State Plan.
- (2) There are no allotted incentive payments.

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

**SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES**

**PART 21. OUTPATIENT BEHAVIORAL HEALTH SERVICES**

**317:30-5-240.2. Provider participation standards**

(a) **Accreditation and certification status.** Any agency may participate as an Outpatient Behavioral Health (OPBH) provider if the agency is qualified to render a covered service and meets the OHCA requirements for provider participation.

(1) Private, Community-based Organizations must be accredited as a provider of outpatient behavioral health services from one of the accrediting bodies listed in (c)(1) below and be an incorporated organization governed by a board of directors or be certified by the certifying agency in accordance with 43A O.S. §§ 3-317, 3-323A, 3-306.1, or 3-415;

(2) State-operated programs under the direction of ODMHSAS must be accredited by one of the accrediting bodies or be certified by the certifying agency in accordance with 43A O.S. §§ 3-317, 3-323A, 3-306.1 or 3-415;

(3) Freestanding Psychiatric Hospitals must be licensed and certified by the State Survey Agency as meeting Medicare psychiatric hospital standards and JCAHO accreditation;

(4) General Medical Surgical Hospitals must be appropriately licensed and certified by the State Survey Agency as meeting Medicare standards, including a JCAHO or AOA accreditation;

(5) Federally Qualified Health Centers/Community Health Centers facilities that qualify under OAC 317:30-5-660;

(6) Indian Health Services/Tribal Clinics/Urban Tribal Clinics facilities that qualify under federal regulation;

(7) Rural Health Clinics facilities that qualify under OAC 317:30-5-355;

(8) Public Health Clinics and County Health Departments;

(9) Public School Systems.

(b) **Certifications.** In addition to the accreditation in paragraph (a) above or ODMHSAS certification in accordance with 43A O.S. §§ 3-317, 3-323A, 3-306.1 or 3-415, provider specific credentials are required for the following:

(1) Substance Abuse agencies (OAC 450:18-1-1);

(2) Evidence Based Best Practices but not limited to:

(A) Assertive Community Treatment (OAC 450:55-1-1);

(B) Multi-Systemic Therapy (Office of Juvenile Affairs);

(C) Function Family Therapy; and

~~(C)~~(D) Peer Support/Community Recovery Support;

(3) Systems of Care (OAC 340:75-16-46);

(4) Mobile and Facility-based Crisis Intervention (OAC 450:23-1-1);

(5) Case Management (OAC 450:50-1-1);

(6) RBMS in group homes (OAC 377:10-7) or therapeutic foster care settings (OAC 340:75-8-4);

(7) Day Treatment - CARF, JCAHO, ACHC or COA for Day Treatment Services; and

(8) Partial Hospitalization/Intensive Outpatient CARF, JCAHO, ACHC or COA for Partial Hospitalization services.

**(c) Provider enrollment and contracting.**

(1) Organizations who have JCAHO, CARF, COA, ACHC or AOA accreditation or ODMHSAS certification in accordance with 43A O.S. §§ 3-317, 3-323A, 3-306.1 or 3-415 will supply the documentation from the accrediting body or certifying agency, along with other information as required for contracting purposes to the OHCA. The contract must include copies of all required state licenses, accreditation and certifications.

(2) If the contract is approved, a separate provider identification number for each outpatient behavioral health service site will be assigned. Each site operated by an outpatient behavioral health facility must have a separate provider contract and site-specific accreditation and/or certification as applicable. A site is defined as an office, clinic, or other business setting where outpatient behavioral health services are routinely performed. When services are rendered at the member's residence, a school, or when provided occasionally at an appropriate community based setting, a site is determined according to where the professional staff perform administrative duties and where the member's chart and other records are kept. Failure to obtain and utilize site specific provider numbers will result in disallowance of services.

(3) All behavioral health providers are required to have an individual contract with OHCA in order to receive SoonerCare reimbursement. This requirement includes outpatient behavioral health agencies and all individual rendering providers who work within an agency setting. Individual contracting rendering provider qualification requirements are set forth in OAC 317:30-3-2 and 317:30-5-240.3.

**(d) Standards and criteria.** Eligible organizations must meet each of the following:

(1) Have a well-developed plan for rehabilitation services designed to meet the recovery needs of the individuals served.

(2) Have a multi-disciplinary, professional team. This team must include all of the following:

(A) One of the LBHPs;

(B) A Certified Behavioral Health Case Manager II (CM II) or CADC, if individual or group rehabilitative services for behavioral health disorders are provided, and the designated LBHP(s) or licensure candidate(s) on the team will not be providing rehabilitative services;

(C) An AODTP, if treatment of substance use disorders is provided;

(D) A registered nurse, advanced practice nurse, or physician assistant, with a current license to practice in the state in which the services are delivered if Medication Training and Support Service is provided;

(E) The member for whom the services will be provided, and parent/guardian for those under eighteen (18) years of age.

(F) A member treatment advocate if desired and signed off on by the member.

(3) Demonstrate the ability to provide each of the following outpatient behavioral health treatment services as described in OAC 317:30-5-241 et seq., as applicable to their program. Providers must provide proper referral and linkage to providers of needed services if their agency does not have appropriate services.

(A) Assessments and Service Plans;

(B) Psychotherapies;

(C) Behavioral Health Rehabilitation services;

(D) Crisis Intervention services;

- (E) Support Services; and
  - (F) Day Treatment/Intensive Outpatient.
- (4) Be available twenty-four (24) hours a day, seven (7) days a week, for Crisis Intervention services.
  - (5) Provide or have a plan for referral to physician and other behavioral health services necessary for the treatment of the behavioral disorders of the population served.
  - (6) Comply with all applicable federal and state regulations.
  - (7) Have appropriate written policy and procedures regarding confidentiality and protection of information and records, member grievances, member rights and responsibilities, and admission and discharge criteria, which shall be posted publicly and conspicuously.
  - (8) Demonstrate the ability to keep appropriate records and documentation of services performed.
  - (9) Maintain and furnish, upon request, a current report of fire and safety inspections of facilities clear of any deficiencies.
  - (10) Maintain and furnish, upon request, all required staff credentials including certified transcripts documenting required degrees.

### **317:30-5-240.3. Staff credentials**

(a) **Licensed behavioral health professional (LBHPs).** LBHPs are defined as any of the following practitioners:

- (1) An allopathic or osteopathic physician with a current license and board certification in psychiatry or board eligible in the state in which services are provided, or a current resident in psychiatry practicing as described in OAC 317:30-5-2.
- (2) A practitioner with a current license to practice in the state in which services are provided, within one (1) of the areas of practice listed in (A) through (F). The exemptions from licensure under 59 O.S. ' 1353(4) and (5), 59 O.S. ' 1903(C) and (D), 59 O.S. ' 1925.3(B) and (C), and 59 O.S. ' 1932(C) and (D) do not apply to outpatient behavioral health services.
  - (A) Psychology;
  - (B) Social work (clinical specialty only);
  - (C) Professional counselor;
  - (D) Marriage and family therapist;
  - (E) Behavioral practitioner; or
  - (F) Alcohol and drug counselor.
- (3) An advanced practice registered nurse (APRN) certified in a psychiatric mental health specialty, and licensed as a registered nurse (RN) with a current certification of recognition from the board of nursing in the state in which services are provided.
- (4) A physician assistant who is licensed and in good standing in the state in which services are provided and has received specific training for and is experienced in performing mental health therapeutic, diagnostic, or counseling functions.

(b) **Licensure candidates.** Licensure candidates are practitioners actively and regularly receiving board-approved supervision, and extended supervision by a fully licensed clinician if board's supervision requirement is met but the individual is not yet licensed, to become licensed by one (1) of the areas of practice listed in (2)(A) through (F) above. The supervising LBHP responsible for the member's care must:

- (1) Staff the member's case with the candidate;

- (2) Be personally available, or ensure the availability of an LBHP to the licensure candidate for consultation while they are providing services;
- (3) Agree with the current plan for the member;
- (4) Confirm that the service provided by the candidate was appropriate; and
- (5) The member's medical record must show that the requirements for reimbursement were met and the LBHP responsible for the member's care has reviewed, countersigned, and dated the service plan and any updates thereto so that it is documented that the licensed professional is responsible for the member's care.

(c) **Certified alcohol and drug counselors (CADCs).** CADCs are defined as having a current certification as a CADC in the state in which services are provided.

(d) **Multi systemic therapy (MST) provider.** Master's level therapist who works on a team established by the Oklahoma Juvenile Affairs Office (OJA) which may include bachelor's level staff.

(e) **Functional family therapy (FFT) provider.** Providers must be part of an active FFT team.

(1) **FFT Team.** An active FFT team must be trained and certified and receive ongoing consultation and monitoring by FFT, LLC. and shall meet the following requirements:

(A) be employed by a certified behavioral health agency; and

(B) be comprised of three (3) to eight (8) full time practitioners with up to one (1) of those practitioners acting in the role of a functional family supervisor. In the event an established team falls below the minimum of three (3) members, the provider agency must actively recruit and train a replacement practitioner to restore the team to compliance.

(2) **Functional Family Practitioner** A practitioner must have a master's degree in psychology, social work, counseling or closely related field. In some cases, upon consultation with FFT LLC, bachelor's level practitioners may be acceptable. An FFT practitioner must:

(A) be certified to provide FFT services through FFT LLC, while adhering to ongoing training, reporting and consultation requirements for direct service of the functional family therapy model implementation; and

(B) maintain a caseload minimum of ten (10) active cases for a full-time FFT practitioner and a minimum of five (5) active cases for a part time FFT practitioner.

(3) **Functional Family Supervisor.** A supervisor must have at minimum, a master's degree in the fields noted above.

(i) An FFT supervisor must have completed all required FFT, LLC. trainings, and the FFT externship; and

(ii) maintain a caseload minimum of five (5) active cases.

~~(e)~~(f) **Peer recovery support specialist (PRSS)/Family peer recovery support specialist (F-PRSS).** The PRSS and F-PRSS must be certified by ODMHSAS pursuant to requirements found in OAC 450:53.

~~(f)~~(g) **Qualified behavioral health aide (QBHA).** QBHAs must:

(1) Possess current certification as a Behavioral Health Case Manager I;

(2) Have successfully completed the specialized training and education curriculum provided by the ODMHSAS;

(3) Be supervised by a bachelor's level individual with a minimum of two (2) years case management or care coordination experience;

(4) Have service plans be overseen and approved by an LBHP or licensure candidate; and

(5) Function under the general direction of an LBHP, or licensure candidate and/or systems of care team, with an LBHP or licensure candidate available at all times to provide back up, support, and/or consultation.

~~(g)~~**(h) Behavioral health case manager.** For behavioral health case management services to be compensable by SoonerCare, the provider performing the services must be an LBHP, licensure candidate, CADC or have and maintain a current certification as a Behavioral Health Case Manager II (CM II) or Behavioral Health Case Manager I (CM I) from ODMHSAS in accordance with requirements found in OAC 450:50

(1) A Wraparound Facilitator Case Manager must be an LBHP, licensure candidate or CADC that meets the qualifications for CM II and has the following:

(A) Successful completion of the ODMHSAS training for wraparound facilitation within six (6) months of employment; and

(B) Participate in ongoing coaching provided by ODMHSAS and employing agency;

(C) Successfully complete wraparound credentialing process within nine (9) months of beginning process; and

(D) Direct supervision or immediate access and a minimum of one (1) hour weekly clinical consultation with a qualified mental health professional, as required by ODMHSAS.

(2) An Intensive Case Manager must be an LBHP, licensure candidate, or CADC that meets the provider qualifications of a CM II and has the following:

(A) A minimum of two (2) years behavioral health case management experience; and

(B) Crisis diversion experience.

### **317:30-5-241.8. ~~Multi-systemic therapy (MST)~~ Targeted Therapies for Juveniles**

**(a) Multi-systemic therapy (MST).** MST intensive outpatient program services are limited to children within an Office of Juvenile Affairs (OJA) MST treatment program which provides an intensive, family and community-based treatment targeting specific BH disorders in children with SED who exhibit chronic, aggressive, antisocial, and/or substance abusing behaviors, and are at risk for out of home placement. Caseloads are kept low due to the intensity of the services provided.

(1) **Qualified professionals.** All MST services are provided by LBHPs or licensure candidates. Licensure candidate signatures must be co-signed by a fully-licensed LBHP in good standing. Additional team support services may be provided by a behavioral health case manager II (CM II) and/or peer recovery support specialist (PRSS) per OAC 317:30-5-240.3.

(2) **Documentation requirements.** Providers must comply with documentation requirements in OAC 317:30-5-248.

(3) **Limitations.** Services are subject to the following:

(A) Partial billing is not allowed. When only one (1) service is provided in a day, providers should not bill for services performed for less than eight (8) minutes.

(B) MST cannot be billed in conjunction with the following:

(i) Children's psychosocial rehabilitation;

(ii) Partial hospitalization/intensive outpatient treatment;

(iii) Targeted case management;

(iv) Individual, family, and group therapy;

(v) Mobile crisis intervention;

(vi) Peer-to-peer services.

(C) Duration of MST services is between three (3) to six (6) months. Weekly interventions may range from three (3) to twenty (20) hours per week. Weekly hours may be lessened as case nears closure.

(4) **Reimbursement.** MST services are reimbursed pursuant to the methodology described in the Oklahoma Medicaid State Plan.

**(b) Functional Family Therapy (FFT).** Functional Family Therapy is defined as:

**(1) Evidence-based intervention.** FFT is an intensive, short-term, therapeutic model for that offers in-person, face-to-face services in the home to dysfunctional youth experiencing behavioral or emotional problems and their entire family. Referrals for FFT shall be made by the Oklahoma Office of Juvenile Affairs (OJA) or Oklahoma Human Services (OHS). Each referral shall be reviewed and approved by a licensed professional employed by the referring agency prior to the initiation of services. FFT services are provided through a team approach working collaboratively together using the FFT services as defined by FFT LLC.

**(2) Populations.** Target populations are at-risk preadolescents and youth with serious behavioral problems, including but not limited to conduct disorder, violent acting-out, substance use and other identified problematic behaviors. While FFT targets youth eleven (11) to eighteen (18) year-olds, siblings in the home also benefit from FFT services. FFT services are not available for institutionalized individuals.

**(3) Qualified professionals.** All Functional Family Therapy services must be performed or supervised by a fully Licensed Behavioral Health Practitioner (LBHP) or licensure candidate as determined by one of Oklahoma's licensing boards. Licensure candidate signatures must be co-signed by a fully licensed LBHP practitioner in good standing and must meet the FFT provider requirements per OAC 317:30-5-240.3.

**(4) Documentation requirements.** Providers must comply with documentation requirements in OAC 317:30-5-248.

**(5) Coverage and Limitations.** Services are subject to the following:

**(A) Intervention ranges from, on average, twelve (12) to sixteen (16) one-hour sessions for mild cases and up to thirty (30) sessions for more complex cases. The duration of FFT is typically three (3) to five (5) months. Weekly interventions may range from one (1) to three (3) hours per week per family.**

**(B) FFT Services are not Medicaid compensable when:**

- (i) The target child is unavailable at the time of service; or**
- (ii) The target child is residing in an institution.**

**(C) FFT cannot be billed in conjunction with the following:**

- (i) Family Therapy; or**
- (ii) Acute, Acute II/PRTF, and Residential SUD.**

**(6) Reimbursement.** FFT services are reimbursed pursuant to the methodology described in the Oklahoma Medicaid State Plan.

**TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY**  
**CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE**  
**SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES**  
**PART 61. HOME HEALTH AGENCIES**

**317:30-5-550. Paid Family Caregiver**

Paid Family Caregiver (PFC) is a service that allows a family member of the qualifying child, i.e., parent, parent-in-law, sibling, grandparent, guardian, an individual related by blood and/or marriage, and any other individual with a close association that is the equivalent of a family relationship; to work for a home care agency to provide home care services to qualified children under the age of 21. Individuals eligible to be employed as a complex caregiver must be 18 years or older. PFC services are provided:

- (1) In the member's primary residence, unless it is medically necessary for the complex caregiver to accompany the individual in the community.
- (2) In accordance with the Oklahoma Nursing Practice Act, § 567.3a, complex care giver may provide care to qualifying members under the direction and supervision of a Registered Nurse or Licensed Practical Nurse, through a home care agency.
  - (A) The complex caregiver may not drive the vehicle during transportation.
  - (B) PFC services are not available for non-routine extended home absences unrelated to medically necessary treatment or medical care. [Refer to Oklahoma Administrative Code 317:30-5-558(4) and (13)].
  - (C) PFC hours authorized by OHCA and/or SoonerSelect may total up to forty (40) hours per week and are authorized concurrent with, not in addition too, any PDN hours authorized by OHCA and/or SoonerSelect.

**317:30-5-551. Eligible providers**

(a) A home health agency that desires to be reimbursed by SoonerCare for paid family caregiver (PFC) must meet the following requirements prior to providing services to eligible SoonerCare members:

- (1) The agency must be fully contracted with OHCA as a provider; and,
  - (2) The agency must meet the requirements of Oklahoma Administrative Code (OAC) 317:30-5-545, and it must be licensed by the Oklahoma State Health Department (OSDH) as a home care agency.
- (b) The complex caregiver must meet the following requirements:
- (1) be at least 18 years of age;
  - (2) pass criminal and abuse registry background checks
- (c) The complex caregiver, within the agency, must receive eighty (80) hours of training, competency evaluation, and other qualification criteria as a complex caregiver, including but not limited to
- (1) Agency New Employee Orientation;
  - (2) Communicating with the Care Team;
  - (3) Documentation;
  - (4) Safety Care;

- (5) Medications;
- (6) Respiratory Care;
- (7) Neurological care;
- (8) Nutrition;
- (9) Genitourinary care;
- (10) Integumentary care; and
- (11) Social Determinants of Health

**317:30-5-552. Coverage by category**

(a) Adults. SoonerCare does not cover adults [twenty-one (21) years of age and over] for paid family caregivers.

(b) Children. SoonerCare does cover children [under twenty-one (21) years of age] if:

- (1) The member is eligible for SoonerCare; and
- (2) The Oklahoma Health Care Authority (OHCA), in its discretion, deems the services medically necessary. Medical necessity is determined in accordance with Oklahoma Administrative Code (OAC) 317:30-5-560.1.

**317:30-5-553. Paid Family Caregiver (PFC) coverage limitations**

Coverage limitations at OAC 317:30-5-558 are applicable to all PFC services.

**317:30-5-554. How Paid Family Caregiver (PFC) services are authorized**

PFC services may be initiated after completion of steps outlined in OAC 317:30-5-559.

**317:30-5-554.1. Treatment plan**

(a) The treatment plan for a member receiving paid family caregiver services must meet requirements outlined in OAC 317:30-5-560.

(b) The treatment plan will be incorporated into the treatment plan request for members receiving PFC services.

**317:30-5-554.2. Prior authorization requirements**

Prior authorization requirements outlined in OAC 317:30-5-560.1 applicable to paid family caregiver services.

**317:30-5-554.3. Record documentation**

Documentation for paid family caregiver services must include the caregiver's credentials and meet all other requirements listed at OAC 317:30-5-560.2.

**PART 62. PRIVATE DUTY NURSING**

**317:30-5-555. Private Duty Nursing (PDN)**

PDN is medically necessary care provided on a regular basis by a licensed practical nurse or registered nurse. During any given period of service, a nurse may only provide care to the eligible member. PDN is the level of care that would routinely be provided by the nursing staff of a hospital or skilled nursing facility. PDN services are provided:

- (1) In the member's primary residence, unless it is medically necessary for a nurse to accompany the individual in the community.

(A) The individual's place of residence is wherever the individual lives, whether the residence is the individual's own dwelling, a relative's home, or other type of living arrangement. The place of residence cannot include a hospital, nursing facility, or intermediate care facility for individuals with intellectual disabilities (ICF/IID).

(B) The place of service in the community cannot include the residence or business location of the provider of PDN services unless the provider of PDN is a live-in caregiver.

(2) To assist during transportation to routine, Medicaid compensable health care appointments and/or to the nearest appropriate emergency room.

(A) The private duty nurse may not drive the vehicle during transportation.

(B) PDN services are not available for non-routine extended home absences unrelated to medically necessary treatment or medical care. [Refer to Oklahoma Administrative Code 317:30-5-558(4) and (13)].

### **317:30-5-556. Eligible providers**

(a) A home health agency that desires to be reimbursed by SoonerCare or SoonerSelect for private duty nursing (PDN) must meet the following requirements prior to providing services to eligible SoonerCare members:

(1) The agency must be fully contracted with OHCA as a provider; and,

(2) The agency must meet the requirements of Oklahoma Administrative Code (OAC) 317:30-5-545, and it must be licensed by the Oklahoma State Health Department (OSDH) as a home care agency.

(b) The provider of PDN services, within the agency, must be a licensed practical nurse or a registered nurse who is currently licensed and in good standing in the state in which services are provided.

### **317:30-5-557. Coverage by category**

(a) **Adults.** SoonerCare does not cover adults [twenty-one (21) years of age and over] for private duty nursing (PDN) with the exception of subsection (c).

(b) **Children.** SoonerCare or SoonerSelect does cover children [under twenty-one (21) years of age] if:

(1) The member is eligible for SoonerCare or SoonerSelect; and

(2) The Oklahoma Health Care Authority (OHCA), or OHCA's Contracted Entity, in its discretion, deems the services medically necessary. Medical necessity is determined in accordance with Oklahoma Administrative Code (OAC) 317:30-5-560.1.

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

(d) **1915(c) home and community-based services (HCBS) waivers.** If private duty nursing services are provided, they will be defined within each waiver and must be prior authorized.

### **317:30-5-558. Private duty nursing (PDN) coverage limitations**

The following provisions apply to all PDN services and provide coverage limitations:

- (1) All services must be prior authorized to receive payment from the Oklahoma Health Care Authority (OHCA), or through SoonerSelect. Prior authorization means authorization in advance of services provided in accordance with Oklahoma Administrative Code (OAC) 317:30-3-31 and 317:30-5-560.1;
- (2) ~~A treatment plan must be completed by an eligible PDN provider before requesting prior authorization and must be updated at least annually and~~ Recertification of a treatment plan is required at least every 60 days to request PDN services in accordance with OAC 317:30-5-560.1 and must:
- (A) be signed by the physician [medical doctor (MD), or doctor of osteopathy, (DO)], a physician assistant (PA), or advanced practice registered nurse (APRN)]; and
  - (B) include documentation for Private Duty Nursing and/or Paid Family Caregiver services covering the previous ten (10) days for ongoing record review.
- (3) An assessment by an OHCA ~~care management~~ or SoonerSelect nurse is required prior to the authorization for services. The assessment will be conducted by the OHCA through one (1) of the following:
- (A) **Telephone.** Audio-only telephonic communication;
  - (B) **Virtually.** Virtual visits are the standard method of assessment. This is a means to use virtual technology to collect medical and other forms of health data for the purposes of assessment and recommendation; or
  - (C) **Face-to-face.** In person face-to-face assessments are completed when determined by OHCA to be the most appropriate assessment method. A face-to-face assessment is not completed at the parent or caregiver's request.
- (4) Care in excess of the designated hours per week granted in the prior authorization is not SoonerCare compensable. Prior-authorized but unused service hours cannot be accumulated for use at a future date or time. If such hours or services are provided, they are not SoonerCare or SoonerSelect compensable.
- (5) Any medically necessary PDN care provided outside of the home must be counted in and cannot exceed the number of hours requested on the treatment plan and approved by OHCA.
- (6) PDN services do not include office time or administrative time in providing the service. The time billed is for direct nursing services only.
- (7) Staff must be engaged in purposeful activity that directly benefits the member receiving services. Staff must be physically able and mentally alert to carry out the duties of the job. At no time will OHCA or SoonerSelect compensate an organization for nursing staff time when sleeping.
- (8) OHCA and SoonerSelect will not approve PDN services if all health and safety issues cannot be met in the setting in which services are provided.
- (9) A provider must not misrepresent or omit facts in a treatment plan.
- (10) It is outside the scope of coverage to deliver care in a manner outside of the treatment plan or to deliver units over the authorized units of care.
- (11) PDN is not authorized in excess of 112 hours per week, not exceeding sixteen (16) hours per day. There may be approval for additional hours for a period not to exceed thirty (30) days, if:
- (A) The member has an acute episode that would otherwise require hospitalization or immediately following a hospital stay; or

(B) The primary caregiver is temporarily and involuntarily unable to provide care.

(C) The OHCA or the SoonerSelect Contracted Entity has discretion and the final authority to approve or deny any additional PDN hours and will take into consideration that the additional hours are not to be a substitute for institutionalized care.

(12) Family and/or caregivers and/or guardians (hereinafter, "caregivers") are required to provide some of the nursing care to the member without compensation. PDN services shall not be provided solely to allow the member's caregiver to work or go to school, nor solely to allow respite for the caregiver.

(13) PDN services will not be approved for overnight trips away from the member's primary residence that are unrelated to medically necessary treatment or medical care.

(A) For a member to receive Medicaid-reimbursable PDN services on an overnight trip that is related to medically necessary treatment or medical care, all provisions of this Part must be met. If said trip occurs out of state, OAC 317:30-3-89 through 317:30-3-92 must also be met.

(B) In instances in which the member's family is temporarily absent due to vacations, any additional PDN hours must be paid for by the family, or provided by other trained family members without SoonerCare or SoonerSelect reimbursement.

(14) PDN services will not be approved when services are reimbursed or reimbursable by other insurance, other governmental programs, or Medicaid program services that the member receives or is eligible to receive. For example, if a member receives Medicaid-reimbursable PDN services pursuant to an Individualized Education Program (IEP) in a public school, then those PDN school hours will be counted in the member's daily allotment of PDN services.

### **317:30-5-559. How Private Duty Nursing (PDN) services are authorized**

PDN services may be initiated after completion of the following steps:

- (1) A treatment plan for the patient has been created by an eligible PDN provider per Oklahoma Administrative Code (OAC) 317:30-5-560;
- (2) A prior authorization request is submitted with the appropriate Oklahoma Health Care Authority (OHCA) or to the SoonerSelect Contracted Entity with the required data elements and the treatment plan;
- (3) An assessment (telephonic, virtual, or face-to-face) has been conducted by an OHCA care management or SoonerSelect nurse, per OAC 317:30-5-558 (3); and
- (4) An OHCA or SoonerSelect physician, or his or her designee, has determined the medical necessity of the service, including but not limited to, scoring the member's needs on the PDN assessment.

#### **317:30-5-560.1. Prior authorization requirements**

(a) Authorizations For children ages zero to three (0-3), authorizations are provided for a maximum period of six (6) months. For children ages three to twenty (3-20), authorizations are provided for a maximum period of one (1) year.

(b) Authorizations require:

- (1) A treatment plan for the member;

- (2) An assessment (telephonic, virtual, or face-to-face) has been conducted by an Oklahoma Health Care Authority (OHCA) care management nurse, per Oklahoma Administrative Code (OAC) 317:30-5-558 (2); and
  - (3) An OHCA or SoonerSelect physician, or his or her designee, to determine medical necessity including use of the OHCA Private Duty Nursing (PDN) assessment.
- (c) The number of hours authorized may differ from the hours requested on the treatment plan based on the review by an OHCA or SoonerSelect physician.
- (d) If the member's condition necessitates a change in the treatment plan, the provider must request a new prior authorization.
- (e) Changes in the treatment plan may necessitate another assessment (telephonic, virtual, or face-to-face) by an OHCA care management nurse.

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

**SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES**

**PART 35. RURAL HEALTH CLINICS**

**317:30-5-354. Definitions**

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

"APRN" means advanced practice registered nurse.

"C.F.R." means the U.S. Code of Federal Regulations.

"CLIA" means the Clinical Laboratory Improvement Amendments.

"CMS" means the Centers for Medicare and Medicaid Services.

"CNM" means certified nurse midwife.

"Core services" means outpatient services that may be covered when furnished to a patient at the rural health clinic (RHC) or other location, including the patient's place of residence. Services include those defined in OAC 317:30-5-355.2.

"CP" means clinical psychologist.

"CPT" means current procedural terminology.

"CSW" means clinical social worker.

"EPSDT" means the Early and Periodic Screening, Diagnostic and Treatment program for members under twenty-one (21).

"FFS" means the current OHCA's fee-for-service reimbursement rate.

"HCPCS" means Healthcare Common Procedure Coding System.

"Marriage and family therapist" has the same meaning given to the term in Section 1861(III)(2) of the Social Security Act (42 U.S.C § 1395x(III)(2)).

"Mental Health counselor" has the same meaning given to the term in Section 1861(III)(4) of the Social Security Act (42 U.S.C § 1395(III)(4)).

"OAC" means the Oklahoma Administrative Code.

"OHCA" means the Oklahoma Health Care Authority.

"Other ambulatory services" means other outpatient health services covered under the Oklahoma Medicaid State Plan other than the core services listed in OAC 317:30-5-355.2.

"PA" means physician assistant.

"Physician" means:

(A) A doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which the function is performed or who is a licensed physician employed by the Public Health Service;

(B) Within limitations as to the specific services furnished, a doctor of dentistry or dental, a doctor of optometry when performing medical services that are reasonable and necessary for the diagnosis and treatment of illness or injury, or a doctor of podiatry when performing medical services that are reasonable and necessary for the diagnosis and treatment of illness or injury.

"Physicians' services" means professional services that are performed by a physician at the RHC (or are performed away from the Center, excluding inpatient hospital services) whose agreement with the RHC provides that he or she will be paid by the RHC for such services.

"PPS" means prospective payment system all-inclusive per visit rate method specified in the Oklahoma Medicaid State Plan.

"RHC" means rural health clinic.

"Visit" means a face-to-face encounter between a clinic patient and a physician, Physician Assistant (PA), Advanced Practice Registered Nurse (APRN), Certified Nurse Midwife (CMN), Clinical Psychologist (CP), ~~or~~ Clinical Social Worker (CSW), Marriage and Family Therapist (MFT), or Mental Health Counselor (MHC) whose services are reimbursed under the RHC PPS payment method. Encounters with more than one (1) health care professional and multiple encounters with the same health care professional that take place on the same day and at a single location constitute a single visit, except when the patient, after the first encounter, suffers illness or injury requiring additional diagnosis or treatment. Services delivered via audio-only telecommunications and reimbursed pursuant to the fee-for-service (FFS) fee schedule do not constitute a visit and/or an encounter.

### 317:30-5-355.2. Covered services

The Rural Health Center benefit package, as described in 42 C.F.R. § 440.20, consists of RHC services and other ambulatory services.

(1) **RHC services.** RHC services are covered when medically necessary and furnished at the clinic or other outpatient setting, including the member's place of residence, delivered via telehealth, or via audio-only telecommunications pursuant to Oklahoma Administrative Code (OAC) 317:30-3-27 and OAC 317:30-3-27.1.

(A) **Core services.** RHC "core" services include, but are not limited to:

- (i) Services furnished by a physician, Physician Assistant (PA), Advanced Practice Registered Nurse (APRN), Certified Nurse Midwife (CMN/CNM), Clinical Psychologist (CP), ~~or~~ Clinical Social Worker (CSW), Marriage and Family Therapist (MFT), or Mental Health Counselor (MHC).
- (ii) Services and supplies incident to services provided by a physician, PA, APRN, CNM, CP, ~~or~~ CSW, MFT, or MHC are covered in accordance with 42 C.F.R §§ 405.2413 and 405.2415, if the service or supply is:
  - (I) Furnished in accordance with State law;
  - (II) A type commonly furnished in physicians' offices;
  - (III) A type commonly rendered either without charge or included in the RHC's bill;
  - (IV) Furnished as an incidental, although integral, part of a physician's professional services, PA, APRN, CNM, CP ~~or~~ CSW, MFT, or MHC; or
  - (V) Furnished under the direct supervision of a contracted physician, PA, APRN, or CNM; and
  - (VI) Drugs and biologicals which cannot be self-administered or are specifically covered by Medicare law, are included within the scope of RHC services. Drugs and biologicals commonly used in life saving procedures, such as analgesics, anesthetics (local), antibiotics, anticonvulsants, antidotes and emetics, serums and toxoids are not billed separately.
- (iii) Visiting nurse services to the homebound are covered if:
  - (I) The RHC is located in an area in which the Secretary of Health and Human Services has determined there is a shortage of home health agencies;
  - (II) The services are rendered to members who are homebound;

(III) The member is furnished nursing care on a part-time or intermittent basis by a registered nurse, licensed practical nurse, or licensed vocational nurse who is employed by or receives compensation for the services from the RHC; and

(IV) The services are furnished under a written plan of treatment as required by 42 C.F.R § 405.2416.

(iv) Certain virtual communication services.

**(B) Preventive services.** In addition to the professional services of a physician, and services provided by an APRN, PA, and CNM which would be covered as RHC services under Medicare, certain primary preventive services are covered under the SoonerCare RHC benefit. The services must be furnished by or under the direct supervision of an RHC practitioner who is a clinic employee:

(i) Prenatal and postpartum care;

(ii) Screening examination under the EPSDT program for members under twenty-one (21);

(iii) Family planning services; and

(iv) Medically necessary screening mammography and follow-up mammograms.

**(C) Off-site services.** RHC services provided off-site of the clinic are covered if the RHC has a compensation arrangement with the RHC practitioner. SoonerCare reimbursement is made to the RHC and the RHC practitioner receives his or her compensation from the RHC. The RHC must have a written contract with the physician and other RHC "core" practitioners that specifically identify how the RHC services provided off-site are to be billed to SoonerCare. It is expected that services provided in off-site settings are, in most cases, temporary and intermittent, i.e., when the member cannot come to the clinic due to health reasons.

**(2) Other ambulatory services.** Other ambulatory services that may be provided by an RHC include non-primary care services covered by the Oklahoma Medicaid State Plan but are not included in the RHC's core services. These services are separately billable and may be provided by the RHC if the RHC meets the same standards as other contracted providers of those services.

(A) Other ambulatory services include, but are not limited to:

(i) Dental services for members under the age of twenty-one (21) provided by a qualified provider other than a licensed dentist;

(ii) Optometric services provided by a qualified provider other than a licensed optometrist;

(iii) Laboratory tests performed in the RHC lab, including the lab tests required for RHC certification;

(I) Chemical examinations of urine by stick or tablet method or both (including urine ketones);

(II) Hemoglobin or hematocrit;

(III) Blood glucose;

(IV) Examination of stool specimens for occult blood;

(V) Pregnancy tests; and

(VI) Primary culturing for transmittal to a certified laboratory.

- (iv) Technical component of diagnostic tests such as x-rays and EKGs (interpretation of the test provided by the RHC physician is included in the encounter rate);
  - (v) Durable medical equipment;
  - (vi) Transportation by ambulance;
  - (vii) Prescribed drugs;
  - (viii) Prosthetic devices (other than dental) which replace all or part of an internal body organ (including colostomy bags) and supplies directly related to colostomy care and the replacement of such devices;
  - (ix) Specialized laboratory services furnished away from the clinic;
  - (x) Inpatient services;
  - (xi) Outpatient hospital services; ~~and~~
  - (xii) Applied behavior analysis (ABA); and
  - (xiii) Diabetes self-management education and support (DSMES) services.
- (B) Services listed in (2)(A) of this Section, furnished on-site, require a separate provider agreement(s) with the OHCA. Service item (2)(A)(iii) does not require a separate contract when furnished on-site, however, certain conditions of participation apply. (Refer to OAC 317:30-5-361 for conditions.)

### **317:30-5-356. Coverage for adults**

Payment is made to RHCs for adult services as set forth in this Section.

(1) **RHC services.** Payment is made for one (1) encounter per member per day. Payment is also limited to four (4) visits per member per month. This limit may be exceeded if the SoonerCare Choice member has elected the RHC as his/her/their Patient Centered Medical Home/Primary Care Provider. Preventive service exceptions include:

(A) **Obstetrical care.** An RHC should have a written contract with its physician, PA, APRN, or CNM that specifically identifies how obstetrical care will be billed to SoonerCare, in order to avoid duplicative billing situations. The agreement should also specifically identify the physician's compensation for RHC and other ambulatory services.

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

(ii) If the clinic does not compensate its practitioners to provide obstetrical care, then the independent practitioner must bill the OHCA for prenatal care according to the global method described in the SoonerCare provider specific rules for physicians, PAs, APRNs and CNMs (refer to OAC 317:30-5-22).

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

(B) **Family planning services.** Family planning services are available only to members with reproductive capability. Family planning visits do not count as one (1) of the four (4) RHC visits per month.

(2) **Other ambulatory services.** These services are not considered a part of an RHC visit; therefore, these may be billed to the SoonerCare program by the RHC or service provider on the appropriate claim form. Refer to OAC 317:30-1, General Provisions, and OAC 317:30-3-

57, 317:30-5-59, and 317:30-3-60 for general coverage and exclusions under the SoonerCare program. Some specific limitations are applicable to other ambulatory services as set forth in specific provider rules and excerpted as follows:

~~(A) Coverage under optometrists for adults is limited to treatment of eye disease not related to refractive errors.~~

(BA) There is no coverage for eye exams for the purpose of prescribing eyeglasses, contact lenses or other visual aids. (See OAC 317:30-5-431.)

### **317:30-5-359.2. Reimbursement**

(a) **Provider-based clinics.** Payments for provider-based clinics will be made for RHC "core" services listed in OAC 317:30-5-355.2 based on an all-inclusive visit fee established by one of the following:

- (1) An interim rate established by calculating a statewide average rate for RHCs in the state; and
- (2) The statewide average rate will be updated annually by the increase in the Medicare Economic Index (MEI); or
- (3) An Alternative Payment Methodology (APM) established by the RHC periodic rate notification from the Medicare Fiscal Intermediary. In order to receive this rate, the RHC must submit a copy of the periodic rate notification letter for its most recent full cost reporting year received from the fiscal intermediary to the state. The APM rate cannot be lower than mentioned above in (a)(1) or (a)(2).

(b) **Independent clinics.** Payments for independent clinics will be made for RHC "core" services listed in OAC 317:30-5-355.2 based on an all-inclusive visit fee established by one of the following:

- (1) An interim rate established by calculating a statewide average rate for RHCs in the state; and
- (2) The statewide average rate will be updated annually by the increase in the MEI; or
- (3) An APM established by the RHCs periodic rate notification from the Medicare Fiscal Intermediary. In order to receive this rate, the RHC must submit a copy of the periodic rate notification letter for its most recent full cost reporting year received from the fiscal intermediary to the state. The APM rate cannot be lower than mentioned above in (b)(1) or (b)(2).

## **PART 75. FEDERALLY QUALIFIED HEALTH CENTERS**

### **317:30-5-659. Definitions**

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

"APRN" means advanced practice registered nurse.

"C.F.R." means the U.S. Code of Federal Regulations.

"CLIA" means the Clinical Laboratory Improvement Amendments.

"CMS" means the Centers for Medicare and Medicaid Services.

"CNM" means certified nurse midwife.

"Core services" means outpatient services that may be covered when furnished to a patient at the Center or other location, including the patient's place of residence. Services include those defined in OAC 317:30-5-661.1.

"CPT" means current procedural terminology.

"CSW" means clinical social worker.

"**Encounter**" or "**visit**" means a face-to-face contact between an approved health care professional as authorized in the FQHC pages of the Oklahoma Medicaid State Plan and an eligible SoonerCare member for the provision of defined services through a Health Center within a twenty-four (24) hour period ending at midnight, as documented in the patient's medical record.

"FFS" means the current OHCA's fee-for-service reimbursement rate.

"FQHC" means Federally Qualified Health Center.

"HHS" means the U.S. Department of Health and Human Services.

"HRSA" means the Health Resources and Services Administration.

"**Marriage and family therapist (MFT)**" has the same meaning given to the term in Section 1861(III)(2) of the Social Security Act (42 U.S.C § 1395x(III)(2)).

"**Mental health counselor (MHC)**" has the same meaning given to the term in Section 1861(III)(4) of the Social Security Act (42 U.S.C § 1395(III)(4)).

"**Licensed behavioral health professional (LBHP)**" means any of the following practitioners:

(A) An allopathic or osteopathic physician with a current license and board certification in psychiatry or board eligible in the state in which services are provided, or a current resident in psychiatry practicing as described in OAC 317:30-5-2.

(B) A practitioner with a current license to practice in the state in which services are provided, within one (1) of the areas of practice listed in (i) through (vi).

(i) Psychology;

(ii) Social work (clinical specialty only);

(iii) Professional counselor;

(iv) Marriage and family therapist;

(v) Behavioral practitioner; or

(vi) Alcohol and drug counselor.

(C) An advanced practice registered nurse certified in a psychiatric mental health specialty, and licensed as a registered nurse (RN) with a current certification of recognition from the board of nursing in the state in which services are provided.

(D) A physician assistant who is licensed and in good standing in the state and has received specific training for and is experienced in performing mental health therapeutic, diagnostic, or counseling functions.

"OAC" means the Oklahoma Administrative Code.

"OHCA" means the Oklahoma Health Care Authority.

"**Other ambulatory services**" means other health services covered under the Oklahoma Medicaid State Plan other than the core services listed in OAC 317:30-5-661.1.

"PA" means physician assistant.

"Physician" means:

(A) A doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which the function is performed or who is a licensed physician employed by the Public Health Service;

(B) Within limitations as to the specific services furnished, a doctor of dentistry or dental, a doctor of optometry when performing medical services that are reasonable and necessary for the diagnosis and treatment of illness or injury, or a doctor of podiatry when performing medical services that are reasonable and necessary for the diagnosis and

treatment of illness or injury.

**"Physicians' services"** means professional services that are performed by a physician at the Health Center (or are performed away from the Center, excluding inpatient hospital services) whose agreement with the Center provides that he or she will be paid by the Health Center for such services.

**"PPS"** means prospective payment system all-inclusive per visit rate method specified in the Oklahoma Medicaid State Plan.

### **317:30-5-661.1. Coverage of core services**

Health Center services are covered for SoonerCare adults and children as set forth in this Part, unless otherwise specified.

(1) Services furnished by a physician, PA, APRN, CNM, CP, ~~or~~ CSW, MFT, or MHC.

(2) Services and supplies incident to services provided by a physician, PA, APRN, CNM, CP, ~~or~~ CSW, MFT, or MHC are covered in accordance with 42 C.F.R ' 405.2413 and 405.2415, if the service or supply is:

(A) Furnished in accordance with State law;

(B) A type commonly furnished in physicians' offices;

(C) A type commonly rendered either without charge or included in the FQHC's bill;

(D) Furnished as an incidental, although integral, part of a physician, PA, APRN, CNM, CP ~~or~~ CSW, MFT, or MHC services; or

(E) Furnished under the direct supervision of a physician, PA, APRN, or CNM; and

(F) Drugs and biologicals which cannot be self-administered or are specifically covered by Medicare law, are included within the scope of FQHC services. Drugs and biologicals commonly used in life saving procedures, such as analgesics, anesthetics (local), antibiotics, anticonvulsants, antidotes and emetics, serums and toxoids are not billed separately.

(G) "Services and supplies incident to" include but are not limited to services such as minor surgery, reading x-rays, setting casts or simple fractures and other activities that involve evaluation or treatment of a patient's condition. They also include laboratory services performed by the Health Center, specimen collection for laboratory services furnished by an off-site CLIA certified laboratory and injectable drugs.

(3) Visiting nurse services to the homebound are covered if:

(A) The FQHC is located in an area in which the Secretary of Health and Human Services has determined there is a shortage of home health agencies;

(B) The services are rendered to members who are homebound;

(C) The member is furnished nursing care on a part-time or intermittent basis by a registered nurse, licensed practical nurse, or licensed vocational nurse who is employed by or receives compensation for the services from the FQHC; and

(D) The services are furnished under a written plan of treatment as required by 42 C.F.R ' 405.2416.

(4) Preventive primary services in accordance with 42 C.F.R ' 405.2448;

(5) Medical nutrition services in accordance with OAC 317:30-5-1075 through 317:30-5-1076; and

(6) Preventive primary dental services.

### **317:30-5-661.5. Health Center preventive primary care services**

(a) Preventive primary care services, as described in 42 C.F.R ' 405.2448, are those health services that:

- (1) A Health Center is required to provide as preventive primary health services under section 330 of the Public Health Service Act;
- (2) Are furnished by or under the direct supervision of a physician, PA, APRN, CNM, CP, CSW, MFT, MHC or other approved health care professional as authorized in the approved FQHC State Plan pages;
- (3) Are furnished by a member of the Health Center's health care staff who is an employee of the Center or provides services under arrangements with the Center; and
- (4) Includes only drugs and biologicals that cannot be self-administered.

(b) Preventive primary care services which may be paid for when provided by Health Centers include:

- (1) Medical social services;
- (2) Nutritional assessment and referral;
- (3) Preventive health education;
- (4) Children's eye and ear examinations;
- (5) Prenatal and post-partum care;
- (6) Perinatal services;
- (7) Well child care, including periodic screening (refer to OAC 317:30-3-65);
- (8) Immunizations, including tetanus-diphtheria booster and influenza vaccine;
- (9) Family planning services;
- (10) Taking patient history;
- (11) Blood pressure measurement;
- (12) Weight;
- (13) Physical examination targeted to risk;
- (14) Visual acuity screening;
- (15) Hearing screening;
- (16) Cholesterol screening;
- (17) Stool testing for occult blood;
- (18) Dipstick urinalysis;
- (19) Risk assessment and initial counseling regarding risks;
- (20) Tuberculosis testing for high risk patients;
- (21) Clinical breast exam;
- (22) Referral for mammography; and
- (23) Thyroid function test.
- (24) Dental services (specified procedure codes).

(c) Primary care services do not include:

- (1) Health education classes, or group education activities, including media productions and publications, group or mass information programs;
- (2) Eyeglasses, hearing aids or preventive dental services (except under EPSDT);
- (3) Screening mammography provided at a Health Center unless the Center meets the requirements as specified in OAC 317:30-5-900; and
- (4) Vaccines covered by the Vaccines for Children program (refer to OAC 317:30-5-14).

### **317:30-5-664.3. FQHC encounters**

(a) FQHC encounters that are billed to the Oklahoma Health Care Authority (OHCA) must meet the definition in this Section and are limited to services covered by OHCA. Only encounters provided by an authorized health care professional listed in the approved FQHC State Plan pages within the scope of their licensure trigger a Prospective Payment System (PPS) encounter rate.

(b) An encounter is defined as a face-to-face contact between a health care professional and a member for the provision of defined services through a FQHC within a twenty-four (24) hour period ending at midnight, as documented in the member's medical record. Services delivered via audio-only telecommunications do not constitute an encounter.

(c) An FQHC may bill for one (1) medically necessary encounter per twenty-four (24) hour period when the appropriate modifier is applied. Medical review will be required for additional visits for children. For information about multiple encounters, refer to Oklahoma Administrative Code (OAC) 317:30-5-664.4. Payment is limited to four (4) visits per member per month for adults. This limit may be exceeded if the SoonerCare Choice member has elected the FQHC as his/her/their Patient Centered Medical Home/Primary Care Provider.

(d) Services considered reimbursable encounters (including any related medical supplies provided during the course of the encounter) include:

- (1) Medical;
- (2) Diagnostic;
- (3) Dental, medical and behavioral health screenings;
- (4) ~~Vision~~Optometry;
- (5) Physical therapy;
- (6) Occupational therapy;
- (7) Podiatry;
- (8) Behavioral health;
- (9) Speech;
- (10) Hearing;
- (11) Medically necessary FQHC encounters with a registered nurse or licensed practical nurse and related medical supplies (other than drugs and biologicals) furnished on a part-time or intermittent basis to home-bound members-(refer to OAC 317:30-5-661.3); and
- (12) Any other medically necessary health services (i.e. optometry and podiatry) are also reimbursable as permitted within the FQHCs scope of services when medically reasonable and necessary for the diagnosis or treatment of illness or injury, and must meet all applicable coverage requirements.

(e) Services and supplies incident to the services of a physician, PA, APRN, CNM, CP, ~~and~~ CSW, MFT, and MHC are reimbursable within the encounter, as described in 42 C.F.R § 405.2413 and OAC 317:30-5-661.1.

(f) Only drugs and biologicals which cannot be self-administered are included within the scope of this benefit.

### **317:30-5-664.5. Federally Qualified Health Center (FQHC) encounter exclusions and limitations**

(a) Service limitations governing the provision of all services apply pursuant to Oklahoma Administrative Code (OAC) 317:30. Excluded from the definition of reimbursable encounter core services are:

- (1) Services provided by an independently Clinical Laboratory Improvement Amendments certified and enrolled laboratory;
  - (2) Radiology services including nuclear medicine and diagnostic ultrasound services;
  - (3) Venipuncture for lab tests is considered part of the encounter and cannot be billed separately. When a member is seen at the clinic for a lab test only, use the appropriate Current Procedural Terminology code. A visit for "lab test only" is not considered a Center encounter;
  - (4) Medical supplies, equipment, and appliances not generally provided during the course of a Center visit such as diabetic supplies. However, gauze, band-aids, or other disposable products used during an office visit are considered as part of the cost of an encounter and cannot be billed separately under SoonerCare;
  - (5) Supplies and materials that are administered to the member are considered a part of the physician's or other health care practitioner's service;
  - (6) Drugs or medication treatments provided during a clinic visit are included in the encounter rate. For example, a member has come into the Center with high blood pressure and is treated at the Center with a hypertensive drug or drug samples provided to the Center free of charge are not reimbursable services and are included in the cost of an encounter. Prescriptions are not included in the encounter rate and must be billed through the pharmacy program by a qualified enrolled pharmacy;
  - (7) Administrative medical examinations and report services;
  - (8) Emergency services including delivery for pregnant members that are eligible under the Non-Qualified (ineligible) provisions of OAC 317:35-5-25;
  - (9) SoonerPlan family planning services;
  - (10) Long-acting reversible contraceptive devices (devices are not considered part of the FQHC encounter rate and can be billed separately);
  - (11) Optometry and podiatric services other than for dual eligible for Part B of Medicare medical services that are reasonable and necessary for the diagnosis and treatment of illness or injury;
  - (12) Diabetes self-management education and support (DSMES) services (refer to OAC 317:30-5-1080 through 317:30-5-1084); and
  - (13) Other services that are not defined in this rule or the Oklahoma Medicaid State Plan.
- (b) In addition, the following limitations and requirements apply to services provided by FQHCs:
- (1) Physician services are not covered in a hospital; and
  - (2) Behavioral health case management and psychosocial rehabilitation services are limited to FQHCs enrolled under the provider requirements in OAC 317:30-5-240 and contracted with OHCA as an outpatient behavioral health agency.