

## **Oklahoma Health Care Authority**

It is very important that you provide your comments regarding the proposed rule change by the comment due date. Comments are directed to the [Oklahoma Health Care Authority \(OHCA\) Proposed Changes Blog](#).

**OHCA COMMENT DUE DATE:** February 17, 2017

The proposed policy is a Permanent Rule. The proposed policy was presented at the January 3, 2017 Tribal Consultation and is scheduled to be presented to the Medical Advisory Committee on March 9, 2017 and the OHCA Board of Directors on March 23, 2017.

**Reference: APA WF 16-29**

### **SUMMARY:**

**General Policy Language Cleanup** – The proposed policy revisions update references to the physical address of the Oklahoma Health Care Authority, amend language to remove references to outdated terms and correct formatting errors for clarity and consistency.

### **LEGAL AUTHORITY**

The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; 42 CFR 440.165

### **RULE IMPACT STATEMENT:**

#### **STATE OF OKLAHOMA OKLAHOMA HEALTH CARE AUTHORITY**

**TO:** Tywanda Cox  
Health Policy

**FROM:** Carmen Johnson  
Health Policy

**SUBJECT:** Rule Impact Statement  
APA WF # 16-29

#### **A. Brief description of the purpose of the rule:**

Policy is being revised to update The Oklahoma Health Care Authority's physical address, and to correct formatting

errors and minor language cleanup of misspelled words. Revisions also include replacing the words "recipient" and "patient" with the word "member". In addition, the word "certified" will be added to nurse midwives. This change will allow policy language to reflect language utilized by the Oklahoma Nursing Board.

- B. A description of the classes of persons who most likely will be affected by the proposed rule, including classes that will bear the cost of the proposed rule, and any information on cost impacts received by the agency from any private or public entities:

No classes of persons will be affected by this proposed rule since the language revisions merely reflect clean-up, correcting formatting errors and updating the OHCA physical address.

- C. A description of the classes of persons who will benefit from the proposed rule:

No classes of persons will benefit from the updated information or language cleanup.

- D. A description of the probable economic impact of the proposed rule upon the affected classes of persons or political subdivisions, including a listing of all fee changes and, whenever possible, a separate justification for each fee change:

There is not a probable economic impact for this proposed rule.

- E. The probable costs and benefits to the agency and to any other agency of the implementation and enforcement of the proposed rule, the source of revenue to be used for implementation and enforcement of the proposed rule, and any anticipated effect on state revenues, including a projected net loss or gain in such revenues if it can be projected by the agency:

This rule is budget neutral and will not have an impact on the OHCA budget.

- F. A determination of whether implementation of the proposed rule will have an economic impact on any political subdivisions or require their cooperation in implementing or

enforcing the rule:

There is no economic impact on political subdivisions.

- G. A determination of whether implementation of the proposed rule will have an adverse effect on small business as provided by the Oklahoma Small Business Regulatory Flexibility Act:

The proposed rule will not have an adverse effect on small businesses as provided by the Oklahoma Small Business Regulatory Flexibility Act.

- H. An explanation of the measures the agency has taken to minimize compliance costs and a determination of whether there are less costly or non-regulatory methods or less intrusive methods for achieving the purpose of the proposed rule:

The agency has taken measures to determine that there is no less costly or non-regulatory method or less intrusive method for achieving the purpose of the proposed rule.

- I. A determination of the effect of the proposed rule on the public health, safety and environment and, if the proposed rule is designed to reduce significant risks to the public health, safety and environment, an explanation of the nature of the risk and to what extent the proposed rule will reduce the risk:

The proposed rule should have no effect on the public health, safety, and environment.

- J. A determination of any detrimental effect on the public health, safety and environment if the proposed rule is not implemented:

OHCA does not believe there is a detrimental effect on the public health and safety if the rule is not passed.

- K. The date the rule impact statement was prepared and if modified, the date modified:

Prepared December 2, 2016  
Modified December 19, 2016

## **RULE TEXT**

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

**SUBCHAPTER 3. GENERAL PROVIDER POLICIES**

**PART 1. GENERAL SCOPE AND ADMINISTRATION**

**317:30-3-17. Discrimination laws**

The Oklahoma Health Care Authority has assured compliance with the regulations of the Department of Health and Human Services, Title 45, Code of Federal Regulations, Part 80 (which implements Public Law 88-352, Civil Rights Act of 1964, Section 601), Part 84 (which implements Public Law 93-112, Rehabilitation Act of 1973, Section 504), Part 90 (which implements Public Law 94-135, Age Discrimination Act of 1975, Section 301), Title 9 of the Education Amendments of 1972; and Executive Orders 11246 and 11375.

(1) These laws and regulations prohibit excluding from participation in, denying the benefits of, or subjecting to discrimination, under any program or activity receiving Federal Financial Assistance any person on the grounds of race, color, sex, national origin, and qualified person on the basis of handicap, or unless program-enabling legislation permits, on the basis of age. Under these requirements, payment cannot be made to vendors providing care and/or services under ~~Federally-assisted~~ Federally-assisted programs conducted by the Authority unless such care and service is provided without discrimination on the grounds of race, color, sex, national origin or handicap or without distinction on the basis of age except as legislatively permitted or required.

(2) Written complaints of noncompliance with any of these laws should be made to the Chief Executive Officer of the Oklahoma Health Care Authority, ~~4545~~ 4345 ~~N. North Lincoln Blvd, Boulevard,~~ N. North Lincoln Blvd, Boulevard, Suite 124, Oklahoma City, Oklahoma 73105, or the Secretary of Health and Human Services, Washington, D.C., or both.

**317:30-3-44. Personal care**

Personal care is a service provided in a ~~recipient's~~ member's home. To receive the service, the ~~recipient~~ member must have met the appropriate level of care in accordance with procedures found in OAC 317:35-9. In geographic areas designated as ADvantage Program phase in areas, personal care services may be provided by agency providers who contract with the Medicaid agency for the provision of services. The service may be provided by individual personal care providers in geographic areas where there is insufficient agency providers to adequately serve the population.

**SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES**

## **PART 6. INPATIENT PSYCHIATRIC HOSPITALS**

### **317:30-5-95.24. Prior Authorization of inpatient psychiatric services for children**

(a) All inpatient psychiatric services for members under 21 years of age must be prior authorized by the OHCA or its designated agent. All inpatient acute and residential psychiatric services will be prior authorized for an approved length of stay. Admission requirements for services must be provided in accordance with Code of Federal Regulations, Title 42 Public Health, Part 441 and 456. Additional information will be required for a SoonerCare compensable approval on enhanced treatment units or in special population programs.

(b) Staffing ratios shall always be present for each individual unit not by facility or program. Patients shall be grouped for accommodation by gender, age, and treatment needs. At a minimum, children, adolescent, and adult treatment programs shall be separate with distinct units for each population. A unit is determined by separate and distinct sleeping, living, and treatment areas often separated by walls and/or doors. A unit that does not allow clear line of sight due to the presence of walls or doors is considered a separate unit. Each individual unit shall have assigned staff to allow for appropriate and safe monitoring of patients and to provide active treatment.

(c) In an acute care setting, at least one Registered Nurse (RN) must be on duty per unit at all times, with additional RNs to meet program needs. RNs must adhere to Oklahoma Department of Health policy at OAC 310:667-15-3 and OAC 310:667-33-2(a)(3).

(d) Regular residential treatment programs require a staffing ratio of 1:6 during routine waking hours and 1:8 during time residents are asleep with 24 hour nursing care supervised by an RN for management of behaviors and medical complications. At a minimum, the supervising RN must be available by phone and on-site within one hour. If the supervising RN is off-site, then an RN or LPN must be on-site to adhere to a 24 hour nursing care coverage ratio of 1:30 during routine waking hours and 1:40 during time residents are asleep.

(e) Specialty residential treatment at this level is a longer term treatment that requires a higher staff to member ratio because of the need for constant, intense, and immediate reinforcement of new behaviors to develop an understanding of the behaviors. The environment of specialized residential treatment centers requires special structure and configuration (e.g., sensory centers for autistic members) and specialized training for the staff in the area of the identified specialty. The physician will see the child at least one time a week.

(f) A PRTF will not be considered a specialty treatment program for SoonerCare without prior approval of the OHCA behavioral health unit.

(g) A treatment program that has been approved as a specialized treatment program must maintain medical records that document the degree and intensity of the psychiatric care delivered to the children.

(h) Criteria for classification as a specialized PRTF will require a staffing ratio of 1:3 at a minimum during routine waking hours and 1:6 during time residents are asleep with 24 hour nursing care supervised by a RN for management of behaviors and medical complications. The PRTF will be a secure unit, due to the complexity of needs and safety considerations. Admissions will be restricted to children that meet the medical necessity criteria for RTC and also meet at least two or more of the following:

(1) Have failed at other levels of care or have not been accepted at other levels of care;

(2) Behavioral, emotional, and cognitive problems requiring secure residential treatment that includes 1:1, 1:2, or 1:3 staffing due to the member being a danger to themselves and others, for impairments in socialization problems, communication problems, and restricted, repetitive and stereotyped behaviors. These symptoms are severe and intrusive enough that management and treatment in a less restrictive environment places the child and others in danger but, do not meet acute medical necessity criteria. These symptoms which are exhibited across multiple environments must include at least two or more of the following:

(A) Marked impairments in the use of multiple nonverbal behaviors such as eye-to-eye gaze, facial expression, body postures, and gestures to regulate social interaction;

(B) Inability to regulate impulse control with frequent displays of aggression or other dangerous behavior toward self and/or others regularly;

(C) Failure to develop peer relationships appropriate to developmental level;

(D) Lack of spontaneously seeking to share enjoyment, interests, or achievements with other people;

(E) Lack of social or emotional reciprocity;

(F) Lack of attachment to caretakers;

(G) Require a higher level of assistance with activities of daily living requiring multiple verbal cues 50 percent of the time to complete tasks;

(H) Delay, or total lack of, the development of spoken language which is not accompanied by an attempt to compensate through alternative modes of communication such

as gesture or mime;

(I) Marked impairment in individuals with adequate speech in the ability to initiate or sustain a conversation with others;

(J) Stereotyped and repetitive use of language or idiosyncratic language;

(K) Lack of varied, spontaneous make-believe play or social imitative play appropriate to developmental level;

(L) Encompassing preoccupation with one or more stereotyped and restricted pattern and interest that is abnormal in intensity of focus;

(M) Inflexible adherence to specific, nonfunctional routines or rituals;

(N) Stereotyped and repetitive motor mannerisms (e.g., hand or finger flapping or twisting or complex whole body movements);

(O) Persistent occupation with parts of objects;

(3) Member is medically stable, but has co-morbid medical conditions which require specialized medical care during treatment;

(4) Full scale IQ below 40 (profound mental retardation intellectual disability).

(i) Non-authorized inpatient psychiatric services will not be SoonerCare compensable.

(j) The designated agent will prior authorize all services for an approved length of stay based on the medical necessity criteria described in OAC 317:30-5-95.25 through 317:30-5-95.31.

(k) Out of state placements must be approved by the agent designated by the OHCA and subsequently approved by the OHCA, Medical Services Behavioral Health Division. Requests for admission to Psychiatric Residential Treatment Facilities or acute care units will be reviewed for consideration of level of care, availability, suitability, and proximity of suitable services. A prime consideration for placements will be proximity to the family or guardian in order to involve the family or guardian in Active Treatment, including discharge and reintegration planning. Out of state facilities are responsible for insuring appropriate medical care as needed under SoonerCare provisions as part of the per-diem rate.

(l) Inpatient psychiatric services in all acute hospitals and psychiatric residential treatment facilities are limited to the approved length of stay. OHCA, or its designated agent, will approve lengths of stay using the current OHCA Behavioral Health medical necessity criteria as described in OAC 317:30-5-95.25 through OAC 317:30-5-95.31. The approved length of stay applies to both hospital and physician services. The Child and Adolescent Level of Care Utilization System (CALOCUS®) is a

level of care assessment that will be used as a tool to determine the most appropriate level of care treatment for a member by LBHPs in the community.

### **317:30-5-96.5. Disproportionate share hospitals (DSH)**

Reimbursement for DSH is determined in accordance with the methodology for inpatient hospital services as described in Attachment 4.19 A of the Medicaid State Plan. Copies of the plan may be obtained by writing the Oklahoma Health Care Authority, ~~4545~~4345 North Lincoln Boulevard, Oklahoma City, OK 73105 or may be downloaded from the OHCA website.

## **PART 35. RURAL HEALTH CLINICS**

### **317:30-5-355.1. Definition of services**

The RHC benefit package, as described in Title 42 of the Code of Federal Regulations (CFR), part 440.20, consists of two components: RHC Services and Other Ambulatory Services.

(1) **RHC services.** RHC services are covered when furnished to a member at the clinic or other location, including the member's place of residence. These services are described in this Section.

(A) **Core services.** As set out in Federal Regulations at 42 CFR 440.20(b), RHC "core" services include, but are not limited to:

- (i) Physician's services;
- (ii) Services and supplies incident to a physician's services;
- (iii) Services of advanced practice nurses (APNs), physician assistants (PAs), certified nurse midwives (~~NMs~~)(CNMs) or specialized advanced practice nurse practitioners;
- (iv) Services and supplies incident to the services of APNs and PAs (including services furnished by certified nurse midwives);
- (v) Visiting nurse services to the homebound;
- (vi) Clinical psychologist (CP) and clinical social worker (CSW) services;
- (vii) Services and supplies incident to the services of CPs and CSWs.

(B) **Physicians' services.** In addition to the professional services of a physician, and services provided by an APN, PA and NMW 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 a RHC practitioner who is a clinic employee:

- (i) prenatal and postpartum care;
- (ii) screening examination under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program for members under 21;
- (iii) family planning services;
- (iv) medically necessary screening mammography and follow-up mammograms when medically necessary.

(C) **Services and supplies "incident to".** Services and supplies incident to the service of a physician, physician assistant, advanced practice nurse, clinical psychologist, or clinical social worker are covered if the service or supply is:

- (i) a type commonly furnished in physicians' offices;
- (ii) a type commonly rendered either without charge or included in the rural health clinic's bill;
- (iii) furnished as an incidental, although integral, part of a physician's professional services;
- (iv) 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.

(D) **Visiting nurse services.** Visiting nurse services are covered if:

- (i) the RHC is located in an area in which the Centers for Medicare and Medicaid Services (CMS) 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.

(E) **RHC encounter.** RHC "core" services (including preventive services, i.e., prenatal, EPSDT or family planning) are part of an all-inclusive visit. A "visit" means a face-to-face encounter between a clinic patient and a RHC health professional (i.e., physicians, physician assistants, advanced practice nurses, certified nurse midwives, clinical psychologists and clinical social workers). Encounters with more than one health professional and multiple encounters with the same health

professional that takes place on the same day and a single location, constitute a single visit except when the member, after the first encounter, suffers illness or injury requiring additional diagnosis or treatment. Payment is made for one encounter per member per day. Medical review will be required for additional visits for children. Payment is also limited to four visits per member per month for adults.

(F) **Off-site services.** RHC services provided off-site of the clinic are covered as long as the RHC has a compensation arrangement with the RHC practitioner that SoonerCare reimbursement is made to the RHC and the RHC practitioner receives his or her compensation from the RHC. The rural health clinic must have a written contract with the physician and other RHC "core" practitioners that specifically identify how the rural health clinic 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.** A Rural Health Clinic must provide other items and services which are not "RHC services" as described in (a)(1) of this Section, and are separately billable to the SoonerCare program. Coverage of services are based upon the scope of coverage under the SoonerCare program.

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

- (i) dental services for members under age 21;
- (ii) optometric services;
- (iii) clinical lab tests performed in the RHC lab, including the lab tests required for RHC certification;
- (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) emergency ambulance transportation;
- (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.

(B) Payment is made directly to the RHC on an encounter basis for on-site dental services by a licensed dentist or optometric services by a licensed optometrist for members under age 21. Encounters are billed as one of the following:

(i) **EPSDT dental screening.** An EPSDT dental screening includes oral examination, prophylaxis and fluoride treatment, charting of needed treatment, and, if necessary, x-rays (including two bite wing films). This service must be filed on claim form ADM-36-D for EPSDT reporting purposes.

(ii) **Dental encounter.** A dental encounter consists of all dental treatment other than a dental screening. This service must be billed on the ADM-36-D.

(iii) **Visual analysis.** Visual analysis (initial or yearly) for a child with glasses, or a child who needs glasses, or a medical eye exam. This includes the refraction and medical eye health evaluation. Glasses must be billed separately. Payment is limited to two glasses per year. Any glasses beyond this limit must be prior authorized and determined to be medically necessary.

(C) Services listed in (a)(2)(A), (v)-(viii), of this Section, furnished on-site, require separate provider agreements with the OHCA. Service item (a)(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.)

(D) Other ambulatory services provided off-site by independent practitioners (through subcontracting agreements or arrangements for services not available at the clinic) must be billed to the SoonerCare program by the provider rendering the service. Independent practitioners must meet provider eligibility criteria and must have a current contract with the OHCA.

## **PART 37. ADVANCED PRACTICE NURSE**

### **317:30-5-375. Eligible providers**

The Advanced Practice Nurse must be a registered nurse in good standing with the Oklahoma Board of Nursing, and have acquired knowledge and clinical skills through the completion of a formal program of study approved by the Oklahoma Board of Nursing Registration and have obtained professional certification through the appropriate National Board recognized by the Oklahoma Board of Nursing. Advanced Practice Nurse services are limited to the scope of their practice as defined

in 59 O.S. 567.3a and corresponding rules and regulations at OAC 485:10-5-1 through 10-16-9. Rules regarding Certified Nurse Midwives are referenced in OAC 317:30-5-225. Advanced Practice Nurses who practice in states other than Oklahoma must be appropriately licensed in the state in which they practice. In addition, all providers must have a current contract on file with the Oklahoma Health Care Authority.

## **PART 61. HOME HEALTH AGENCIES**

### **317:30-5-546. Coverage by category**

Payment is made for home health services as set forth in this Section.

(1) **Adults.** Payment is made for home health services provided in the ~~patient's~~ member's residence to all categorically needy individuals. Coverage for adults is as follows.

(A) **Covered items.**

- (i) Part-time or intermittent nursing services;
- (ii) Home health aide services;
- (iii) Standard medical supplies;
- (iv) Durable medical equipment (DME) and appliances; and
- (v) Items classified as prosthetic devices.

(B) **Non-covered items.** The following are not covered:

- (i) Sales tax;
- (ii) Enteral therapy and nutritional supplies;
- (iii) Electro-spinal orthosis system (ESO); and
- (iv) Physical therapy, occupational therapy, speech pathology, or audiological services.

(2) **Children.** Home Health Services are covered for persons under age 21.

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

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

### **317:30-5-661.1. Health Center core services**

Health Center "core" services include:

- (1) Physicians' services and services and supplies incident to a physician's services;
- (2) Services of advanced practice nurse (APNs), physician assistants (PAs), certified nurse midwives (CNMs), or specialized advanced practice nurse practitioners;
- (3) Services and supplies incident to the services of APNs, certified nurse midwives, and PAs;
- (4) Visiting nurse services to the homebound;

- (5) Behavior health professional services as authorized under the FQHC State Plan pages and services and supplies incident thereto;
- (6) Preventive primary care services;
- (7) Preventive primary dental services.

## **PART 108. NUTRITION SERVICES**

### **317:30-5-1076. Coverage by category**

Payment is made for Nutritional Services as set forth in this section.

(1) **Adults.** Payment is made for six hours of medically necessary nutritional counseling per year by a licensed registered dietitian. All services must be prescribed by a physician, physician assistant, advanced practice nurse, or certified nurse midwife and be face to face encounters between a licensed registered dietitian and the member. Services must be expressly for diagnosing, treating or preventing, or minimizing the effects of illness. Nutritional services for the treatment of obesity is not covered unless there is documentation that the obesity is a contributing factor in another illness.

(2) **Children.** Payment is made for medically necessary nutritional counseling as described above for adults. Nutritional services for the treatment of obesity may be covered for children as part of the EPSDT benefit. Additional services which are deemed medically necessary and allowable under federal regulations may be covered by the EPSDT benefit found at 317:30-3-65 and 317:30-3-65.11.

(3) **Home and Community Based Waiver Services for the Intellectually Disabled.** All providers participating in the Home and Community Based Waiver Services for the intellectually disabled program must have a separate contract with OHCA to provide Nutrition Services under this program. All services are specified in the individual's plan of care.

(4) **Individuals eligible for Part B of Medicare.** Payment is made utilizing the Medicaid allowable for comparable services. Services which are not covered under Medicare should be billed directly to OHCA.

(5) **Obstetrical patients.** Payment is made for a maximum of six hours of medically necessary nutritional counseling per year by a licensed registered dietitian for members at risk for or those who have been recently diagnosed with gestational diabetes. The initial consultation may be in a group setting for a maximum of two hours of class time. Thereafter, four hours of nutritional counseling by a licensed registered dietitian may be provided to the

individual if deemed medically necessary, which may include a post-partum visit, typically done at 6 weeks after delivery. All services must be prescribed by a physician, physician assistant, advanced practice nurse or a certified nurse midwife and be face-to-face between a licensed registered dietitian and the member(s). Services must be solely for the prevention, diagnosis, or treatment of gestational diabetes.

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