Oklahoma Health Care Authority

The Oklahoma Health Care Authority (OHCA) values your feedback and input. It is very important that you provide your comments regarding the proposed rule change by the comment due date. Comments can be submitted on the OHCA's Proposed Changes Blog.

OHCA COMMENT DUE DATE: February 16, 2018

The proposed policy was presented at the November 7, 2017 Tribal Consultation as an Emergency Rule and is scheduled to be presented to the Medical Advisory Committee on January 18, 2018 as an Emergency Rule. The proposed Permanent Rule is scheduled to be presented to the OHCA Board of Directors on March 22, 2018.

Reference: APA WF #17-28

SUMMARY:

Federally Qualified Health Center Services (FQHC) Alternative Payment Methodology (APM) – The proposed policy revisions will introduce a new optional payment methodology for Federally Qualified Health Centers (FQHCs).

LEGAL AUTHORITY
The Oklahoma Health Care Authority Act, Section 5007 (F)(1) and (3) of Title 63 of Oklahoma Statutes; Section 5003 through 5016 of Title 63 of Oklahoma Statutes; The Oklahoma Health Care Authority Board; Section 1902(bb)(6)(B) of the Social Security Act; 42 CFR 491.1

RULE IMPACT STATEMENT:

STATE OF OKLAHOMA
OKLAHOMA HEALTH CARE AUTHORITY

TO: Tywanda Cox
Federal and State Policy

FROM: Carmen Johnson
Federal and State Authorities

SUBJECT: Rule Impact Statement
APA WF #17-28

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A. Brief description of the purpose of the rule:

The proposed policy revisions will introduce a new optional payment methodology for Federally Qualified Health Centers (FQHCs). Currently, FQHCs are reimbursed through a Prospective Payment System (PPS) methodology. The proposed revision will add the Alternative Payment Methodology (APM) as an optional reimbursement method for FQHCs. In order to align with the methodology change, the FQHC policy will also be updated to reflect the term and definition for APM.

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:

FQHCs will be affected by the proposed rule since they will be implementing the new reimbursement method. FQHCs will be able to focus more on the quality of care than the volume of visits.

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

SoonerCare members will benefit by receiving more quality care as this new methodology will give the FQHCs an opportunity to focus more on members and their needs.

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 no probable economic impact of the proposed rule upon any classes of persons or political subdivisions.

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 proposed 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.

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

Prepared: October 27, 2017

RULE TEXT

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 75. FEDERALLY QUALIFIED HEALTH CENTERS

317:30-5-660.1. Health Center multiple sites contracting

(a) Health Centers may contract as SoonerCare Traditional providers and as a PCP/CM under SoonerCare Choice (Refer to OAC 317:25-7-5).
(b) Health Centers are required to submit a list of all entities affiliated or owned by the Center including any programs that do not have Health Center status, along with all OHCA provider numbers.
(c) Payment for FQHC services is based on a Prospective Payment System (PPS)~~.~~ or an Alternative Payment Methodology (APM) (Refer to OAC 317:30-5-664.10) In order to be eligible for reimbursement under this method for covered services, in traditional primary care settings, each site must submit an approval copy of the Health Resource and Service Administration (HRSA) Notice of Grant Award Authorization for Public Health Services Funds under Section 330, (or a copy of the letter from CMS designating the facility as a "Look Alike" FQHC) at the time of enrollment.

317:30-5-660.5. Health Center service definitions

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

"APM" means Alternative Payment Methodology as defined in the state plan.

"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.

"Encounter or Visit" means a face-to-face contact between an approved health care professional as authorized in the FQHC state plan pages and an eligible SoonerCare member for the provision of defined services through a Health Center within a

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24-hour period ending at midnight, as documented in the patient's medical record.

"Licensed Behavioral Health Professional (LBHP)" means licensed psychologists, licensed clinical social workers (LCSWs), licensed marital and family therapists (LMFTs), licensed professional counselors (LPCs), licensed behavioral practitioners (LBPs), and licensed alcohol and drug counselors (LADCs).

"Other ambulatory services" means other health services covered under the ~~State~~state plan other than core services.

"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 or oral surgery, a doctor of optometry, or a doctor of podiatry;

"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 ~~State~~state plan.

317:30-5-661.4. Behavioral health professional services provided at Health Centers and other settings

(a) Medically necessary behavioral health services that are primary, preventive, and therapeutic and that would be covered if provided in another setting may be provided by Health Centers. Services provided by a Health Center (refer to OAC 317:30-5-241 for a description of services) must meet the same requirements as services provided by other behavioral health providers. Rendering providers must be eligible to individually enroll or meet the requirements as an agency/organization provider specified in OAC 317:30-5-240.2 and 317:30-5-280. Behavioral Health Services include:

(1) Assessment/Evaluation;
(2) Crisis Intervention Services;
(3) Individual/Interactive Psychotherapy;
(4) Group Psychotherapy;
(5) Family Psychotherapy;
(6) Psychological Testing; and
(7) Case Management (as an integral component of services 1-6 above).

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(b) Medically necessary behavioral health professional therapy services are covered when provided in accordance with a documented individualized treatment plan, developed to treat the identified behavioral health disorder(s). A one-on-one standard clinical session must be completed by a health care professional authorized in the approved FQHC ~~State Plan~~state plan pages in order to bill the PPS or APM encounter rate for the session. Services rendered by providers not authorized under the approved FQHC state plan pages to bill the PPS or APM encounter rate will be reimbursed pursuant to the SoonerCare fee-for-service fee schedule and must comply with rules found at OAC 317:30-5-280 through 317:30-5-283. Behavioral health services must be billed on an appropriate claim form using the appropriate ~~Current Procedural Terminology (CPT)~~ procedure code and guidelines. The time indicated on the claim form must be the time actually spent with the member.
(c) Centers are reimbursed the PPS or APM rate for services when rendered by approved health care professionals, as authorized under FQHC state plan pages, if the Health Center receives funding pursuant to Section 330 or is otherwise funded under Public Law to provide primary health care services at locations off-site (not including satellite or mobile locations) to Health Center patients on a temporary or intermittent basis, unless otherwise limited by Federal law.
(d) Health Centers that operate day treatment programs in school settings must meet the requirements found at OAC 317:30-5-240.2(b)(7).
(e) In order to support the member's access to behavioral health services, these services may take place in settings away from the Health Center. Off-site behavioral health services must take place in a confidential setting.

317:30-5-661.7. Allowable Places of services
(a) Services provided to members within the four walls of the Health Center and approved Health Center satellites including mobile health clinics operated by the Center are allowable for reimbursement under the PPS~~.~~ or APM.SPA
(b) Off-site services provided by employed practitioners of the Health Center to patients temporarily homebound or in any skilled nursing facility because of a medical condition that prevents the patient from going to the Health Center for health care are also allowable for reimbursement under the PPS or APM encounter rate if the service would be reimbursed the PPS or APM at the Center. It is expected that services provided in off-site settings should be, in most cases, temporary and intermittent,

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i.e., when the member cannot come to the clinic due to health reasons.

317:30-5-664.1. Provision of other health services outside of the Health Center core services

(a) If the Center chooses to provide other SoonerCare ~~State Plan~~state plan covered health services which are not included in the Health Center core service definition in OAC 317:30-5-661.1, the practitioners of those services are subject to the same program coverage limitations, enrollment and billing procedures described by the OHCA, and these services (e.g., home health services) are not included in the PPS settlement methodology or APM settlement methodology in OAC 317:30-5-664.12.

(b) Other health services include, but are not limited to:

(1) dental services (refer to OAC 317:30-5-696) except for primary preventive dental services;

(2) eyeglasses (OAC 317:30-5-430 and OAC 317:30-5-450);

(3) clinical lab tests performed in the Center lab (other than the specific laboratory tests set out for Health Centers' certification and covered as Health Center services);

(4) technical component of diagnostic tests such as x-rays and EKGs (interpretation of the test provided by the Center physician is included as physician professional services);

(5) durable medical equipment (refer to OAC 317:30-5-210);

(6) emergency ambulance transportation (refer to OAC 317:30-5-335);

(7) prescribed drugs (refer to OAC 317:30-5-70);

(8) 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;

(9) specialized laboratory services furnished away from the clinic;

(10) Psychosocial Rehabilitation Services [refer to OAC 317:30-5-241.3]; and

(11) behavioral health related case management services(refer to OAC 317:30-5-241.6).

317:30-5-664.3. Health Center encounters

(a) Health Center encounters that are billed to the OHCA must meet the definition in this Section and are limited to services covered by OHCA. Only encounters provided by the authorized health care professional on the approved FQHC state plan pages within the scope of their licensure trigger a PPS or APM encounter rate.

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(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 Health Center within a 24-hour period ending at midnight, as documented in the member's medical record.
(c) A Health Center may bill for one medically necessary encounter per 24 hour period. Medical review will be required for additional visits for children. Payment is limited to four visits per member per month for adults.
(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;
(5) physical therapy;
(6) occupational therapy;
(7) podiatry;
(8) behavioral health;
(9) speech;
(10) hearing;
(11) medically necessary Health Center encounters with a RN or LPN 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);
(12) any other medically necessary health services (i.e. optometry and podiatry) are also reimbursable as permitted within the Health Center's 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 a physician's professional service are reimbursable within the encounter if the service or supply is:

(1) of a type commonly furnished in physicians' offices;
(2) of a type commonly rendered either without a charge or included in the health clinic's bill;
(3) furnished as an incidental, although integral, part of a physician's professional services;
(4) furnished under the direct, personal supervision of a physician; and
(5) in the case of a service, furnished by a member of the clinic's health care staff who is an employee of the clinic.

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

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317:30-5-664.10. Health Center reimbursement

(a) In accordance with Section 702 of the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000, reimbursement is provided for core services and other health services at a Health Center facility-specific Prospective Payment System (PPS) rate per visit (encounter) or an Alternative Payment Method (APM) rate determined according to the methodology described in OAC 317:30-5-664.12.

(b) As claims/encounters are filed, reimbursement for SoonerCare Choice members is made for all medically necessary covered primary care and other approved health services at the PPS or APM rate.

(c) Primary and preventive behavioral health services rendered by health care professionals authorized in the FQHC approved state plan pages will be reimbursed at the PPS or APM encounter rate.

(d) Vision services provided by Optometrists within the scope of their licensure for non-dual eligible members and allowed under the Medicaid ~~State Plan~~state plan are reimbursed pursuant to the SoonerCare fee-for-service fee schedule.

317:30-5-664.12. Determination of Health Center PPS or APM rate

(a) **Methodology.** The methodology for establishing each facility's PPS rate is found in Attachment 4.19 B of the OHCA's ~~State Plan,~~state plan as amended effective January 1, 2001, and incorporated herein by reference. The methodology for establishing each facility's APM rate is found in Attachment 4.19 B of OHCA's state plan as amended effective April 1, 2018 and incorporated herein by reference.

(b) **Scope of service adjustment.** If a Center significantly changes its scope of services, the Center may request in writing that new baseline encounter rates be determined. Adjustments to encounter rates are made if it is determined that a significant change in the scope-of-service has occurred which impacts the base rate, as indicated within the ~~State Plan.~~state plan. If there is a change in scope-of-service, it is the responsibility of the FQHC to request OHCA to review services that have had a change to the scope-of-service. The OHCA may initiate a rate adjustment in accordance with procedures in the ~~State Plan,~~state plan, based on audited financial statements or cost reports, if the scope of services has been modified or would otherwise result in a ~~changeto~~change to the Center's current rate. If a new rate is set, the rate will be effective on the date the change in scope-of-service was implemented.

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