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POLICY TRANSMITTAL NO. 07-49	DATE: AUGUST 24, 2007
OKLAHOMA HEALTH CARE AUTHORITY/FAMILY SUPPORT SERVICES DIVISION	DEPARTMENT OF HUMAN SERVICES OFFICE OF LEGISLATIVE RELATIONS AND POLICY

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TO: ALL OFFICES

SUBJECT: MANUAL MATERIAL

OAC 317:30-5-660 through 30-5-660.5; 30-5-661.1 through 30-5-661.7;  
30-5-664.1; 30-5-664.3 through 30-5-664.6; and 30-5-664.8 through  
30-5-664.12.

EXPLANATION: **Policy revisions were approved by the Board and the Governor as required by the Administrative Procedures Act.**

Federally Qualified Health Centers rules are revised to provide needed clarity by reorganizing the rules to be more user friendly for providers and recipients. Revisions reflect changes made during the permanent rulemaking process.

Original signed on 8-24-07

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Mary Stalnaker, Director  
Family Support Services Division

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Sharon Neuwald, Coordinator  
Office of Legislative Relations and Policy

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WF # 07-T

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## **INSTRUCTIONS FOR FILING MANUAL MATERIAL**

OAC is the acronym for Oklahoma Administrative Code. If OAC appears before a number on an Appendix or before a Section in text, it means the Appendix or text contains rules or administrative law. Lengthy internal policies and procedures have the same Chapter number as the OAC Chapter to which they pertain following an "OKDHS" number, such as personnel policy at OKDHS:2-1 and personnel rules at OAC 340:2-1. The "340" is the Title number that designates OKDHS as the rulemaking agency; the "2" specifies the Chapter number; and the "1" specifies the Subchapter number.

The chronological order for filing manual material is: (1) OAC 340 by designated Chapter and Subchapter number; (2) if applicable, OKDHS numbered text for the designated Chapter and Subchapter; and (3) all OAC Appendices with the designated Chapter number. For example, the order for filing personnel policy is OAC 340:2-1, OKDHS:2-1, and OAC 340:2 Appendices behind all Chapter 2 manual material. Any questions or assistance with filing manual material will be addressed by contacting Policy Management Unit staff at 405-521-4326.

### **REMOVE**

317:30-5-660  
317:30-5-660.1  
317:30-5-660.2  
317:30-5-660.3  
317:30-5-660.4  
317:30-5-660.5  
317:30-5-661.1  
317:30-5-661.2  
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317:30-5-661.4  
317:30-5-661.5  
317:30-5-661.6  
317:30-5-661.7  
317:30-5-664.1  
317:30-5-664.3  
317:30-5-664.4

### **INSERT**

317:30-5-660, 1 page only, revised 6-25-07  
317:30-5-660.1, 1 page only, revised 6-25-07  
317:30-5-660.2, 1 page only, revised 6-25-07  
317:30-5-660.3, 1 page only, revised 6-25-07  
317:30-6-660.4, 1 page only, revised 6-25-07  
317:30-5-660.5, 1 page only, revised 6-25-07  
317:30-5-661.1, 1 page only, revised 6-25-07  
317:30-5-661.2, 1 page only, revised 6-25-07  
317:30-5-661.3, 1 page only, revised 6-25-07  
317:30-5-661.4, 1 page only, revised 6-25-07  
317:30-5-661.5, 1 page only, revised 6-25-07  
317:30-5-661.6, 1 page only, revised 6-25-07  
317:30-5-661.7, 1 page only, revised 6-25-07  
317:30-5-664.1, 1 page only, revised 6-25-07  
317:30-5-664.3, 1 page only, revised 6-25-07  
317:30-5-664.4, 1 page only, revised 6-25-07

**REMOVE**

317:30-5-664.5

317:30-5-664.6

317:30-5-664.8

317:30-5-664.9

317:30-5-664.10

317:30-5-664.11

317:30-5-664.12

**INSERT**

317:30-5-664.5, pages 1-2, revised 6-25-07

317:30-5-664.6, pages 1-2, revised 6-25-07

317:30-5-664.8, 1 page only, revised 6-25-07

317:30-5-664.9, 1 page only, revised 6-25-07

317:30-5-664.10, 1 page only, revised 6-25-07

317:30-5-664.11, 1 page only, revised 6-25-07

317:30-5-664.12, 1 page only, revised 6-25-07



**MEDICAL PROVIDERS-FEE FOR SERVICE  
FEDERALLY QUALIFIED HEALTH  
CENTERS SPECIFIC**

**OAC 317:30-5-660**

**317:30-5-660. Eligible providers**

(a) Federally Qualified Health Centers (FQHC) are entities or programs more commonly known as Community Health Centers, Migrant Health Centers, and Health Care for the Homeless Programs. The facilities in this Part are hereafter referred to as "Health Centers" or "Centers".

(b) For purposes of providing covered services under SoonerCare, Health Centers may qualify by one of the following methods:

(1) The entity receives a grant under Section 330 of the Public Health Service (PHS) Act (Public Law 104-229), receives funding from such grants under a contract with the recipient of such a grant and includes an outpatient health program or entity operated by a tribe or tribal organization under the Indian Self-Determination Act (Public Law 93-638);

(2) The Health Resources and Services Administration (HRSA) within the PHS recommends, and the Centers for Medicare and Medicaid Services (CMS) determines that, the entity meets the requirements for receiving such a grant and is designated a FQHC look-alike; or

(3) The Secretary of Health and Human Services (Secretary) determines that an entity may, for good cause, qualify through waiver of requirements. Such a waiver cannot exceed a period of two years.

(c) Any entity seeking to qualify as a FQHC should contact the U.S. Public Health Service.



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**OAC 317:30-5-660.1**

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**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.



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**OAC 317:30-5-660.2**

**317:30-5-660.2. Health Center professional staff**

(a) Health Centers must either directly employ or contract the services of legally credentialed professional staff that are authorized within their scope of practice under state law to provide the services for which claims are submitted to OHCA or its designated agent.

(b) Professional staff contracted or employed by the Health Center recognized by the OHCA for direct reimbursement are required to individually enroll with the OHCA and will be affiliated with the organization which contracts or employs them. Participating Health Centers are required to submit a list of names upon request of all practitioners working within the Center and a list of all individual OHCA provider numbers. Reimbursement for services rendered at or on behalf of the Health Center is made to the organization. Practitioners eligible for direct reimbursement for providing services to a clinic patient outside of the clinic may bill with their individual assigned number if they are not compensated under agreement by the Health Center.

(c) Other providers who are not eligible for direct reimbursement may be recognized by OHCA for the provision and payment of FQHC services to a health center as long as they are legally credentialed under state law and OHCA enrollment requirements.



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**OAC 317:30-5-660.3**

**317:30-5-660.3. Health Center enrollment requirements for other behavioral health services**

(a) For the provision of behavioral health related case management services, Health Centers must meet the requirements found at OAC 317:30-5-585 through 317:30-5-589 and OAC 317:30-5-595 through 317:30-5-599.

(b) For the provision of psychosocial rehabilitation services, Health Centers must contract as an outpatient behavioral health agency and meet the requirements found at OAC 317:30-5-240.

(c) Health Centers which provide substance abuse treatment services must also have a contract with the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS).



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**OAC 317:30-5-660.4**

**317:30-5-660.4. Health Center enrollment requirements for school-based health services**

For the provision of school-based health services (not a health care delivery site), Health Centers must be contracted with a qualified school provider. Reimbursement is made directly to the school. Payment may be made to Health Centers that have a health care delivery site in a school setting (i.e., the school has no responsibility/no contract with OHCA and a parental authorization must be on file).



**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:

"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 a health care professional and an eligible SoonerCare member for the provision of defined services through a Health Center within a 24-hour period ending at midnight, as documented in the patient's medical record.

"Mental Health Professional (MHP)" 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 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;

(C) a resident as defined in OAC 317:25-7-5(4) who meet the requirements for payment under SoonerCare;

"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 plan.



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**OAC 317:30-5-661.1**

**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, nurse midwives, and PAs;
- (4) Visiting nurse services to the homebound;
- (5) Mental health professional services and services and supplies incident to the services of MHPs;
- (6) Preventive primary care services;
- (7) Preventive primary dental services.



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**OAC 317:30-5-661.2**

**317:30-5-661.2. Services and supplies "incident to" Health Center encounters**

(a) Services and supplies incident to the service of covered health center providers may be covered if the service or supply is:

- (1) of a type commonly furnished in physician offices;
- (2) of a type commonly rendered either without charge or included in the Health Center's bill;
- (3) furnished as an incidental, although integral, part of professional services furnished by a physician, advanced practice nurse, physician assistant, certified nurse midwife, or specialized advanced practice nurse;
- (4) furnished under the direct, personal supervision of an advanced practice nurse, physician assistant, certified nurse midwife, specialized advanced practice nurse or a physician; and
- (5) in the case of a service, furnished by a member of the Health Center's health care staff who is an employee or contractor of the organization.

(b) "Services and supplies incident to" include 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.



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OAC 317:30-5-661.3

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**317:30-5-661.3. Visiting Nurse services**

Visiting Nurse services may be covered if the Health Center is located in an area in which the Secretary of Health and Human Services has determined that there is a shortage of home health agencies.



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**OAC 317:30-5-661.4**

**317:30-5-661.4. Behavioral health professional services provided at Health Centers**

(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. Services include:

- (1) Assessment/Evaluation/Testing;
- (2) Alcohol and/or Substance Abuse Services Assessment and Treatment plan development;
- (3) Crisis Intervention Services;
- (4) Medication Training and Support;
- (5) Individual/Interactive Psychotherapy;
- (6) Group Psychotherapy; and
- (7) Family Psychotherapy.

(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 mental health and/or substance abuse disorder(s). A minimum of a 45 to 50 minute standard clinical session must be completed by a Health Center in order to bill an encounter for the session.

(c) 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.



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**OAC 317:30-5-661.5**

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

- (a) Preventive primary care services 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 an APN, PA, CNMW, specialized advanced practice nurse practitioner, MHP, or a physician;
  - (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) voluntary 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;
  - (23) thyroid function test; and
  - (24) dental services (specified procedure codes).



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**OAC 317:30-5-661.6**

**317:30-5-661.6. Health Center preventive and primary care  
exclusions**

Preventive primary care Health Center services do not include:  
(1) health education classes, or group education activities,  
including media productions and publications, group or mass  
information programs;  
(2) eyeglasses or hearing aids (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).



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**OAC 317:30-5-661.7**

**317:30-5-661.7. Off-site services**

(a) Off-site Services means services provided at a location other than the Center. Off-site services are considered Health Center services if the physician's or other practitioner's agreement requires that he or she seek reimbursement from the Health Center. Off-site services include services provided at mobile health clinics operated by the Center. Services provided by Centers in school settings (i.e., the school has no responsibility/no contract with OHCA and a parental authorization must be on file) are considered off-site services.

(b) Medically necessary Health Center services provided off-site or outside of the Health Center setting are compensable when billed by the Center. The Health Center must have a written contract with the physician and other Center core practitioners that specify that Center services provided off-site will be billed to Medicaid and, how such providers will be compensated. It is expected that services provided in off-site settings should be, in most cases, temporary and intermittent, i.e., when the member cannot come to the clinic due to health reasons.

(c) In order to support the member's access to behavioral health services, these services may take place in settings away from the Center. Off-site behavioral health services must take place in a confidential setting.



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**OAC 317:30-5-664.1**

**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 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 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 (refer to 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(a)(7)]; and
- (11) Behavioral health related case management services (refer to OAC 317:30-5-585 through 317:30-5-589 and OAC 317:30-5-595 through 317:30-5-599).



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**OAC 317:30-5-664.3**

**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. These services include other health (ambulatory) services included in the State Plan.

(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) For information about multiple encounters, refer to OAC 317:30-5-664.4.

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

- (1) medical;
- (2) diagnostic;
- (3) addiction, dental, medical and mental health screenings;
- (4) vision;
- (5) physical therapy;
- (6) occupational therapy;
- (7) podiatry;
- (8) mental health;
- (9) alcohol and drug;
- (10) speech;
- (11) hearing;
- (12) 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);
- (13) any other medically necessary health services covered by OHCA are also reimbursable as permitted within the Health Center's scope of services and allowed under OHCA's SoonerCare State Plan and OHCA Administrative Rules.



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**OAC 317:30-5-664.4**

**317:30-5-664.4. Multiple encounters at Health Centers**

(a) A Health Center may bill for more than one medically necessary encounter per 24 hour period under certain conditions.

(b) It is intended that multiple medically necessary encounters will occur on an infrequent basis.

(c) A Center may not develop Center procedures that routinely involve multiple encounters for a single date of service, unless medical necessity warrant multiple encounters.

(d) Each service must have distinctly different diagnoses in order to meet the criteria for multiple encounters. For example, a medical visit and a dental visit on the same day are considered different services with distinctly different diagnoses.

(e) Similar services, even when provided by two different health care practitioners, are not considered multiple encounters.



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**OAC 317:30-5-664.5 (p1)**

**317:30-5-664.5. Health Center encounter exclusions and limitations**

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

(1) Services provided by an independently CLIA 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 client is seen at the clinic for a lab test only, use the appropriate CPT code. A visit for "lab test only" is not considered a Center encounter.

(4) Durable medical equipment or medical supplies 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 client 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) Family planning services provided to individuals enrolled in the Family Planning Waiver;

(10) Other services that are not defined in this rule or the State Plan.

(b) In addition, the following limitations and requirements apply to services provided by Health Centers:

(1) Physician services are not covered in a hospital.

(2) Encounters for PCP/CM covered capitated services provided to eligible SoonerCare Choice members enrolled in the Health Center's panel (except family planning services or HIV/AIDS

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**OAC 317:30-5-664.5 (p2)**

prevention services) are not reimbursed as an encounter. However, PCP/CM covered services are included in the PPS wrap-around/reconciliation process (refer to OAC 317:30-5-664.11 for specific details).

(3) Behavioral health case management and psychosocial rehabilitation services are limited to Health Centers enrolled under the provider requirements in OAC 317:30-5-240, 317:30-5-585, and 317:30-5-595 and contracted with OHCA as an outpatient behavioral health agency.

(4) Behavioral health services are limited to those services furnished to members at or on behalf of the Health Center.

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**OAC 317:30-5-664.6 (p1)**

**317:30-5-664.6. Prescription drugs provided by Health Centers**

(a) Eligible Health Centers may elect to participate in the 340B prescription drug program which limits the purchase cost of covered outpatient drugs.

(b) Centers that are eligible for participation in the 340B program must submit a request to participate to the Office of Pharmacy Affairs which includes their SoonerCare billing information. On an annual basis, a copy of the completed 340B participation form from the Office of Pharmacy Affairs must also be submitted to OHCA's Pharmacy Unit. Additionally, the Center must notify OHCA in writing of any changes in participation as well as any changes in name, address, or the addition of any satellite facilities.

(c) For purposes of SoonerCare reimbursement, Health Centers participating in the 340B program may only dispense 340B drugs to the members who meet the definition of patient as defined by the Office of Pharmacy Affairs and outlined in this subsection:

(1) The Health Center has established a relationship with the member, such that the Center maintains records of the individual's health care; and

(2) The individual receives health care services from a health care professional who is either employed by the Center or provides health care under contractual or other arrangements (e.g., referral for consultation) such that responsibility of the care provided remains with the Center; and

(3) The individual receives a health care service or range of services from the Center which is consistent with the service or range of services for Health Centers.

(d) An individual will not be considered a "patient" of the Center for purposes of 340B funding if the only health care service received by the individual from the Center is the dispensing of a drug or drugs for subsequent self-administration or administration in the home setting.

(e) If the Center subcontracts for pharmacy services, the Center must have a written contract which includes the reimbursement methodology for the subcontractor. The Health Center must be the entity purchasing any 340B drugs and must be the entity billing SoonerCare for any 340B drugs.

(f) Health Centers participating in the 340B program must maintain a separate accounting system for their 340B drugs and any other drugs which were not purchased through the 340B program.

(g) On an annual basis, the Center must submit to OHCA a description of their inventory system and accounting system for both their 340B drugs and any drugs purchased and dispensed outside the 340B program.

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**OAC 317:30-5-664.6 (p2)**

(h) Health Centers participating in the 340B prescription drug program can only bill SoonerCare for their acquisition cost plus dispensing fee for drugs purchased through the 340B program.

(i) Health Centers that purchase drugs outside of the 340B program can bill SoonerCare at the SoonerCare fee schedule for those drugs.

**317:30-5-664.8. Obstetrical care provided by Health Centers**

**(a) Billing written agreement.** In order to avoid duplicative billing situations, a Health Center must have a written agreement with its physician, certified nurse midwife, advanced practice nurse, or physician assistant that specifically identifies how obstetrical care will be billed. The agreement must specifically identify the service provider's compensation for Health Center core services and other health services that may be provided by the Center.

**(b) Prenatal or postpartum services.**

(1) If the Health Center compensates the physician, certified nurse midwife or advanced practice nurse for the provision of obstetrical care, then the Health Center bills the OHCA for each prenatal and postpartum visit separately using the appropriate CPT evaluation and management code(s) as provided in the Health Center billing manual.

(2) If the clinic does not compensate the provider for the provision of obstetrical care, then the provider must bill the OHCA for prenatal care according to the global method described in the SoonerCare Traditional provider specific rules for physicians, certified nurse midwives, physician assistants, and advanced practice nurses (refer to OAC 317:30-5-22).

(3) 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.

**(c) Delivery services.** Delivery services are billed using the appropriate CPT codes for delivery. If the clinic does not compensate the provider for the provision of obstetrical care, then the provider must be individually enrolled and bill for those services using his or her assigned provider number. The costs associated with the delivery must be excluded from the cost settlement/encounter rate setting process (see OAC 317:300-5-664.11).



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OAC 317:30-5-664.9

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317:30-5-664.9. Family planning services provided by Health Centers

Family planning services provided to SoonerCare Traditional and Choice members are considered Health Center core services.



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**OAC 317:30-5-664.10**

**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, effective January 1, 2002, reimbursement is provided for core services and other health services at a Health Center facility-specific Prospective Payment System (PPS) rate per visit (encounter) 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 services (that are not included in the SoonerCare capitation payment, if applicable) and other health services at the current rate for that CPT/HCPCS code.

(c) As claims are filed, reimbursement for SoonerCare Traditional members is made for all medically necessary covered primary care and other health services at the PPS rate.



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**OAC 317:30-5-664.11**

**317:30-5-664.11. PPS rate reconciliation to Health Centers**

(a) PPS reconciliation/wrap-around adjustments will be made for the difference in the facility-specific PPS rate and the fee schedule payments.

(b) OHCA compares the total payments due under the PPS rate per visit method and the payments made under the methods described in OAC 317:30-5-664.10 (b) and (c).

(c) OHCA will make an adjustment for the difference in the payments allowed and the facility-specific PPS rate. The difference in payments will be reconciled not less often than quarterly.



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**OAC 317:30-5-664.12**

**317:30-5-664.12. Determination of Health Center PPS 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, as amended effective January 1, 2001, 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 only if the change in the scope of services results in the inclusion of behavioral health services or dental services or a difference of at least five percent from the Center's current costs (other than overhead). The OHCA may initiate a rate adjustment, based on audited financial statements or cost reports, if the scope of services has been modified to include behavioral health services or dental services or would otherwise result in a change of at least five percent from the Center's current rate. If a new rate is set, the rate change takes effect on the latter of the change of services date or the date of application to the OHCA for rate change.