
POLICY TRANSMITTAL NO. 04-50	DATE: AUGUST 30, 2004
OKLAHOMA HEALTH CARE AUTHORITY	DEPARTMENT OF HUMAN SERVICES OFFICE OF PLANNING, POLICY & RESEARCH

TO: ALL OFFICES

SUBJECT: MANUAL MATERIAL

OAC 317:25-1-1 through 25-1-13; 25-3-1 through 25-3-3; 25-5-1 through 25-5-5; 25-5-10 through 25-5-14; 25-5-25 through 25-5-32, 25-5-40 through 25-5-41.1; 25-7-1 through 25-7-3; 25-7-5; 25-7-6; 25-7-10; 25-7-11; 25-7-13; and 25-7-25 through 25-7-30.

EXPLANATION: SoonerCare rules are revised to remove references to the SoonerCare Plus program which ended effective January 1, 2004 and to reflect current procedures in the SoonerCare Choice program. Additionally, SoonerCare Choice has been renamed SoonerCare.

Original signed on 8-26-04

Mary Stalnaker, Director
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WF # 04-V (DT)

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 a “DHS” number, such as personnel policy at DHS:2-1 and personnel rules at OAC 340:2-1. The “340” is the Title number that designates DHS 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, DHS 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, DHS: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) 521-3611.

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317:25-7-1

317:25-7-1, 1 page only, revised 6-25-04

317:25-7-2

317:25-7-2, 1 page only, revised 6-25-04

317:25-7-3

317:25-7-3, pages 1-2, revised 6-25-04

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317:25-7-5, pages 1-3, revised 6-25-04
317:25-7-6, 1 page only, revised 6-25-04
317:25-7-10, pages 1-2, revised 6-25-04
317:25-7-11, 1 page only, revised 6-25-04
317:25-7-13, 1 page only, revised 6-25-04
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317:25-7-29, pages 1-2, revised 6-25-04
317:25-7-30, 1 page only, revised 6-25-04

317:25-7-1. Purpose

The purpose of this Subchapter is to describe the rules governing the statewide SoonerCare program. The rules provide assurances that Medicaid clients have adequate access to primary care, while reducing costs and preventing unnecessary and inappropriate utilization.

317:25-7-2. SoonerCare: overview

(a) The Oklahoma Health Care Authority (OHCA) operates a Primary Care Case Management (PCCM) system for SoonerCare eligible individuals. The program enrolls Medicaid recipients with Primary Care Provider/Case Managers PCP/CMS who provide and/or authorize all primary care services and all necessary specialty services, with the exception of services described in subsection (c) of this Section for which authorization is not required.

(b) In exchange for a fixed, periodic rate, which is paid per member per month, the Primary Care Provider/Case Manager (PCP/CM) provides, or otherwise assures the delivery of medically-necessary primary care medical services, including referrals for specialty services for an enrolled group of eligible individuals. The PCP/CM assists the client in gaining access to the health care system and monitors the client's condition, health care needs and service delivery.

(c) Services which do not require a referral from the PCP/CM include behavioral health services, vision for refraction services, dental services, child abuse/sexual abuse examinations, prenatal and obstetrical services, family planning services for clients under age 18, emergency physician and hospital services, and services delivered to Native Americans at IHS, tribal, or urban Indian clinics.

(d) Non-capitated Medicaid covered services delivered by the PCP/CM are reimbursed at the Medicaid fee-for-service rate under the procedure code established for each individual service. To the extent services are provided or authorized by the Primary Care Provider/Case Manager, the OHCA does not make Medicaid payments for services delivered outside the scope of coverage of the Medicaid program, thus a referral by the Primary Care Provider/Case Manager does not guarantee payment.

317:25-7-3. Definitions

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

"Aged, Blind and Disabled" means the Medicaid covered populations under 42 U.S.C., Section 1396a (a)(10)(A)(i) and (F).

"Board" means the board designated by the Oklahoma legislature to establish policies and adopt and promulgate rules for the Oklahoma Health Care Authority.

"CEO" means the Chief Executive Officer of the Oklahoma Health Care Authority.

"Custody" means the custodial status, as reported by the Department of Human Services.

"Medicaid" means the medical assistance program authorized by 42 U.S.C., Section 1396a et seq. The program provides medical benefits for certain low-income persons. It is jointly administered by the federal and state governments.

"Medicare" means the program defined at 42 U.S.C. '1395 et seq.

"OHCA" means the Oklahoma Health Care Authority.

"OKDHS" means the Oklahoma Department of Human Services.

"PCCM" means Primary Care Case Management.

"PCP/CM" means Primary Care Provider/Case Manager, including a Provider or Physician Group.

"Primary Care Case Management" means a managed care health service delivery system in which health services are delivered and coordinated by Primary Care Provider/Case Managers.

"Primary Care Provider/Case Manager" means a provider under contract to the Oklahoma Health Care Authority to provide primary care services and case management, including all medically-necessary referrals.

"Provider or Physician Group" means a partnership, limited partnership, limited liability company, corporation or professional corporation composed of doctors of medicine and/or doctors of osteopathy and/or advanced nurse practitioner, and/or physician assistants who provide health care of the nature provided by independent practitioners and is permitted by state and federal law and regulations to receive Medicaid provider payments.

317:25-7-5. Primary care provider/case managers

For provision of health care services, the OHCA contracts with qualified Primary Care Provider/Case Managers. All providers serving as PCP/CMs must have a valid Medicaid Fee-for Service contract as well as a SoonerCare contract. Additionally, all PCP/CMs, excluding Provider or Physician Groups, must agree to accept a minimum capacity of patients, however this does not guarantee PCP/CMs a minimum patient volume. Primary Care Provider/Case Managers are limited to:

(1) **Physicians.** Any physician licensed to practice medicine in the state in which he or she practices who is engaged in a general practice or who is board eligible or certified in family medicine, general internal medicine or general pediatrics may serve as a PCP/CM. In addition, physicians who meet all requirements for employment by the Federal Government as a physician, are employed by the Federal Government in an IHS facility, and practice in one of the four designated primary care specialties may serve as a PCP/CM. The Chief Executive Officer (CEO) of the OHCA may designate physicians to serve as PCP/CMs who are licensed to practice medicine in the state in which they practices who are specialized in areas other than those described above. In making this determination, the CEO may consider such factors as the percentage of primary care services delivered in the physician's practice, the availability of primary care providers in the geographic area of the state in which the physician's practice is located, the extent to which the physician has historically provided services to Medicaid clients, and the physician's medical education and training.

(A) For physicians serving as SoonerCare PCP/CMs, the State caps the number of members per physician at 2,500. However, the CEO in his/her discretion may increase this number in under served areas based on a determination that this higher cap is in conformance with usual and customary standards for the community.

(i) Physicians may expand their capacity if they practice in conjunction with physician assistants or with advanced practice nurses. Physicians are eligible to serve an additional 875 members for each full-time equivalent physician assistant or advanced practice nurses with which he or she practices, up to a maximum of 1750 additional members.

(ii) If a physician practices at multiple sites, the capacity at each site is determined based on the number of hours per week the physician holds office hours, not to exceed 1 FTE, and the number of physician assistants or advanced practice nurses in practice at each site. Thus, the physician cannot exceed a maximum total capacity of 4250 members.

(B) In areas of the State where cross-state utilization patterns have developed because of limited provider capacity in the State, the CEO may authorize contracts with out-of-state providers for PCP/CM services. Out-of-State PCP/CMs are required to comply with all access standards imposed on Oklahoma physicians.

(2) **Advanced Practice Nurses.** Advanced Practice Nurses who have prescriptive authority may serve as PCP/CMs for the Primary Care Case Management system if licensed to practice in the state in which he or she practices. Additionally, Advanced Practice Nurses who meet all requirements for employment by the Federal Government as an advanced practice nurse, and is employed by the Federal Government in an Indian Health Service facility, may serve as a PCP/CM. Advanced Practice Nurses who have prescriptive authority may serve as primary care case managers for a maximum number of 1,250 members. However, the CEO in his/her discretion may increase this number.

(3) **Physician Assistants.** Physician Assistants may serve as PCP/CMs if licensed to practice in the state in which he or she practices. Additionally, Physician Assistants who meet all requirements for employment by the Federal Government as a Physician Assistant, and are employed by the Federal Government in an Indian Health Service facility, may serve as a PCP/CM. Physician Assistants may serve as primary care case managers for a maximum number of 1,250 members. However, the CEO in his/her discretion may increase this number.

(4) **Medical Residents.**

(A) Medical residents may serve as PCP/CMs when the following conditions are met:

(i) The resident is licensed to practice in the state in which he or she practices.

(ii) The resident is at least at the Post-Graduate 2 (PG-2) level.

(iii) The resident serves as a PCP/CM only within his or her continuity clinic setting (for example, Family Practice residents may only serve as the PCP/CM within the Family Practice Residency clinic setting).

(iv) The resident works under the supervision of a licensed attending physician.

(v) The resident specifies the residency program or clinic to which payment will be made.

(B) Medical residents practicing as a PCP/CM may not exceed a capacity of more than 875 members. However, the CEO in his/her discretion may increase this number.

(5) Provider or physician group.

(A) Provider or physician groups must agree to accept a minimum enrollment capacity and may not exceed 2,500 members per provider participating in the provider group.

(B) Enrollment capacity may be increased if the participating group practices in conjunction with a licensed physician assistant or advanced practice nurse.

317:25-7-6. Primary Care Provider/Case Manager Payment to Subcontractors

(a) Under the provisions of the SoonerCare Contract, the contractor is responsible for providing all capitated services contained in the benefit package. In the event that the PCP/CM orders a capitated service, the PCP/CM is responsible to make timely payment to the subcontractor or other provider.

(b) For purposes of subsection (a) of this Section timely payment or adjudication means payment or denial of a claim within 30 days of presentation to the PCP/CM.

(c) No subcontractor of the PCP/CM may charge more than the Medicaid fee-for-service schedule for these services in the benefit package. The subcontractor may not bill the recipient for the services to the SoonerCare recipient until the PCP/CM has refused payment and the subcontractor/medical provider has appealed under OAC 317:2-1-2.1 and the OHCA permits the subcontractor to bill the recipient.

317:25-7-10. Enrollment with a Primary Care Provider/Case Manager

(a) All Medicaid clients described in OAC 317:25-7-12 are enrolled with a PCP/CM. Medicaid applicants have the opportunity to select a PCP/CM during the application process. Enrollment with a PCP/CM for clients determined to be eligible on or before the fifteenth day of the month are effective on the first day of the following month. Enrollment with a PCP/CM for clients determined to be eligible after the fifteenth day of the month are effective on the first day of the second month following determination.

(1) The OHCA offers all beneficiaries the opportunity to choose a PCP/CM from a directory which lists available PCP/CMs.

(2) If a SoonerCare member moves more than the authorized distance/driving time from their current PCP/CM, that member will be disenrolled and assigned to an appropriate PCP/CM. When a notice of PCP/CM assignment is sent to a client, the client is advised of the right to change the PCP/CM, at any time, or after the effective date of enrollment with the PCP/CM pursuant to OAC 317:25-7-27.

(b) Clients are restricted to receive services from the PCP/CM or from a provider to which the client has been referred by the PCP/CM. Notwithstanding this provision, subject to limitations which may be placed on services by the Medicaid agency, clients may self refer for behavioral health services, vision for refraction services, dental services, child abuse/sexual abuse examinations, prenatal and obstetrical services, family planning services for clients under age 18, services delivered to Native Americans at IHS, tribal, or urban Indian clinics, and emergency physician and hospital services.

(c) New SoonerCare members will receive a period of six months of continuous guaranteed Medicaid eligibility following completion of the eligibility and enrollment process. The guaranteed period of eligibility is retroactive to the first day of the month in which they were determined eligible for Medicaid. The guaranteed period of eligibility is linked to the member and not the PCP/CM. The guaranteed period of eligibility ends if any of the conditions listed in (1)-(15) of this subsection occur:

(1) An individual receives services in a nursing facility, in an intermediate care facility for the mentally retarded (ICF-MR) or through a Home and Community Based Waiver.

- (2) An individual becomes privately enrolled in an HMO.
- (3) An individual would be required to travel more than 45 miles or an average of 45 minutes to obtain primary care services, or a greater or lesser distance/driving time as determined pursuant to OAC 317:25-7-10(a).
- (4) An individual is in custody.
- (5) A child is in a subsidized adoption.
- (6) An individual is deceased.
- (7) The State is unable to locate an individual.
- (8) A determination is made that an individual has committed fraud related to the Medicaid program.
- (9) An error has been made in determining income or resources and the person is not eligible for Medicaid services.
- (10) An individual's categorical relationship changes and he or she is no longer in a group eligible for SoonerCare.
- (11) A woman has gained Medicaid eligibility solely due to a period of presumptive eligibility;
- (12) An individual is an unqualified or ineligible alien.
- (13) An individual's Medicaid case has been closed.
- (14) An individual is excluded or terminated from SoonerCare for any reason.
- (15) An individual becomes dually-eligible for Medicare and Medicaid.

317:25-7-11. Geographic coverage areas

The PCCM managed care program is statewide.

317:25-7-13. Enrollment ineligibility

Clients in certain categories are excluded from participation in the SoonerCare program. All other clients are enrolled in the SoonerCare program and subject to the provisions of this Subchapter. Clients excluded from participation in SoonerCare include:

- (1) Individuals receiving services in a nursing facility, in an intermediate care facility for the mentally retarded (ICF-MR) or through a Home and Community Based Waiver.
- (2) Individuals privately enrolled in an HMO.
- (3) Individuals who would be traveling more than 45 miles or an average of 45 minutes to obtain primary care services, or a greater or lesser distance/driving time as determined pursuant to OAC 317:25-7-10(a).
- (4) Children who are known to the OHCA to be in custody, as reported by the Department of Human Services.
- (5) Individuals who are eligible for Medicaid solely due to presumptive eligibility.
- (6) Non-qualified or ineligible aliens.
- (7) Children in subsidized adoptions.
- (8) Individuals who are dually-eligible for Medicaid and Medicare.

317:25-7-25. Recipient enrollment process

(a) Medicaid eligible individuals residing in any of the areas defined in OAC 317:25-7-11 whose eligibility is based on one of the aid categories included in the program as defined in OAC 317:25-7-12 must enroll with a PCP/CM. Parents or guardians will choose on behalf of minor clients in the household. Families with more than one beneficiary may choose a different PCP/CM for each family member. If a beneficiary does not select a PCP/CM, the OHCA will assign the member to one, from the pool of providers within the established distance/driving time who have available capacity.

(b) Until the effective date of enrollment with a PCP/CM, services for a newborn are reimbursed at a fee-for-service rate. Upon eligibility determination, newborns may enroll with a PCP/CM or are assigned to a PCP/CM who is in general practice, family practice or general pediatrics. Enrollment materials will advise the parent or guardian of the right to change the PCP/CM after the effective date of enrollment.

(c) A description of the PCCM program and the PCP/CM directory is provided by the OHCA to OKDHS for distribution to OKDHS county offices.

(d) For purposes of determining the client's choice of PCP/CM, the most recent PCP/CM selection received by the OHCA determines the PCP/CM which the client is enrolled with as long as capacity is available. If capacity is not available then the client is assigned according to the assignment mechanism as defined by the OHCA.

(e) PCP/CMs may not refuse an assignment, seek to disenroll a client, or otherwise discriminate against a client on the basis of age, sex, race, physical or mental disability, national origin or type of illness or condition, unless that condition can be better treated by another provider type, except that IHS, tribal or urban Indian programs may provide services to Native American IHS beneficiaries consistent with federal law.

(f) PCP/CMs must provide access to medical care twenty-four hours per day, seven days per week, either directly or through coverage arrangements made with other providers, clinics, and/or local hospitals.

(g) Until PCP/CM enrollment is effective, Medicaid eligible individuals receive all services on a fee-for-services basis.

317:25-7-26. Automatic re-enrollment

Medicaid recipients who are not in the six-month period of guaranteed eligibility who become disenrolled from a PCP/CM solely by virtue of becoming temporarily (for 180 days or less) ineligible for Medicaid services, are automatically re-enrolled with their previously-selected PCP/CM, subject to capacity. The client is notified of the automatic re-enrollment and any right to disenroll from that PCP/CM.

317:25-7-27. Changing PCP/CMs

(a) The OHCA shall be responsible for changing a member's enrollment from one PCP/CM to another:

(1) without cause up to 4 times per year, upon the member's request; or

(2) upon demonstration of good cause. Good cause shall mean:

(A) those members who are habitually non-compliant with the documented medical directions of the provider; or

(B) those members who pose a threat to employees, or other patients of the PCP/CM; or

(C) as a result of a grievance determination by the OHCA; or

(D) in those cases where reliable documentation demonstrates that the physician-patient relationship has so deteriorated that continued service would be detrimental to the member, the provider or both; or

(E) the member's illness or condition would be better treated by another type of provider.

(b) A written request by the PCP/CM to change the enrollment of a member shall be acted upon by the OHCA within thirty (30) days of its receipt. The decision to change PCP/CMs for cause will be made at the discretion of the OHCA, subject to appeals policies delineated at OAC 317:2-1. The effective date of change shall be set so as to avoid the issue of abandonment.

(c) In the event a SoonerCare PCP/CM contract is terminated by OHCA for any reason, or the PCP/CM terminates participation in the SoonerCare program the CEO may, at his or her discretion, assign members to a participating PCP/CM when it is determined to be in the best interests of the client whose PCP/CM has terminated.

317:25-7-28. Disenrolling a client from SoonerCare

(a) The OHCA may disenroll a member from SoonerCare if:

- (1) the member is no longer eligible for Medicaid services; or
- (2) the member has been incarcerated; or
- (3) the member dies; or
- (4) disenrollment is determined to be necessary by the OHCA; or
- (5) the status of the member changes, rendering him/her ineligible for SoonerCare; or
- (6) the member is already enrolled in the SoonerCare Program, when they are taken or found to be in custody as reported by Department of Human Services; or
- (7) the member is authorized to receive services in a nursing facility, in an intermediate care facility for the mentally retarded (ICF-MR) or through a Home and Community Based Waiver; or
- (8) the member becomes dually-eligible for Medicaid or Medicare.

(b) The OHCA may disenroll the member at any time if the client is disenrolled for good cause, as it is defined in OAC 317:25-7-27. The OHCA will inform the PCP/CM of any disenrollments from his or her member roster.

317:25-7-29. Plan benefit package

(a) The PCP/CM is responsible for delivering primary care and case management services defined in a benefit package developed by the OHCA to all Medicaid beneficiaries enrolled with him/her and is reimbursed for these services on a per-member-per-month pre-determined capitated rate. The PCP/CM benefit package will be determined by the Medical Director, with the approval of the CEO, and will be included with the PCP/CM contract.

(b) Services which are not included in the PCP/CM capitated rates will be reimbursed at a fee-for-service rate under the procedure code established for each individual service.

(c) School and health department clinics may conduct EPSDT screening examinations on children who have not been screened by their PCP/CM pursuant to the EPSDT periodicity schedule. If it is ascertained that a child is not current, the school or health department clinic must first contact the PCP/CM and attempt to set up an appointment for the child within three weeks. If the PCP/CM cannot meet this condition, the clinic will be permitted to conduct the screen and bill fee-for-service. The State considers the cost of these screens in the rate setting process.

(1) The school or health department clinic must submit a claim for reimbursement, as well as documentation that:

(A) the PCP/CM was contacted and an examination could not be conducted by the PCP/CM within the specified guidelines; and

(B) the PCP/CM has forwarded information for the patient file regarding the diagnosis, services rendered and need for follow-up. This documentation must be returned to the child's record for verification that PCP/CMs have first been contacted and that school and health department clinics are providing PCP/CMs with the information necessary to ensure continuity of care.

(2) The school-based clinic or health department must obtain a referral number from the PCP/CM and conduct the screening examination within 3 weeks from the date the determination was made that the PCP/CM could not conduct the exam within the specified guidelines.

(d) PCP/CM providers are protected from excessive losses incurred

through the provision of services to Medicaid clients with conditions which result in costs to the provider which greatly exceed the average cost of a Medicaid client through a stop-loss mechanism.

(e) The PCP/CM is prohibited from charging a co-payment for services provided to SoonerCare recipients.

(f) For capitated services purchased by the PCP/CM from a Medicaid contracted provider, the provider is prohibited from charging the PCP/CM more than the current Medicaid fee-for-service schedule for these services, but may charge less.

(g) The PCP/CM is not obligated to provide emergency services, and is not responsible for authorization or approval for payment for recipients seen in the emergency room. The PCP/CM may not require recipients to seek prior authorization for emergency services. However, the PCP/CM may provide emergency care in an emergency room setting, within his/her legal scope of practice. The PCP/CM may receive reimbursement for Medicaid covered emergency services at the fee-for-service rate.

317:25-7-30. Obtaining Medicaid services not covered by the PCP/CM

(a) Medical services which are not included as capitated primary care services or which are not the responsibility of the PCP/CM to authorize under the case management component of SoonerCare, as described in OAC 317:25-7-2(d) and OAC 317:25-7-10(b), are obtained in the same manner as under the regular Medicaid fee-for-service program.

(b) Authorization for out-of-state transportation for primary care and specialty care is determined by the OHCA Medical Director.

(c) An eligible SoonerCare member may choose a PCP/CM from the provider directory, including the IHS, tribal and Urban Indian clinics that participate as SoonerCare PCP/CMs. The member needs to have the Certified Degree of Indian Blood information in order to enroll. An American Indian member in SoonerCare may enroll with a PCP/CM who is not an IHS, tribal, or urban Indian clinic and still use the IHS, tribal or urban Indian clinic for medical care. A referral from the PCP/CM is needed for services that the clinic cannot provide, except for self-referred services. Except services delivered through an Indian facility for which the State receives 100% Federal reimbursement, services are reimbursed at the Medicaid fee-for-service rate under the procedure code established for each individual service.

(d) If an IHS, tribal or urban Indian clinic is unable to deliver a service to a SoonerCare enrollee and must refer the client for the service to a non-IHS, tribal or urban Indian clinic, Medicaid reimbursement is made only when the service is referred by the PCP/CM, unless PCP/CM authorization is not required under OAC 317:25-7-2(d) and OAC 317:25-7-10(b).

(e) Capitated services delivered at IHS, tribal, and urban Indian clinics during the preceding year to SoonerCare clients enrolled with non-Indian PCP/CMs are considered during the rate setting process.

(f) For non-capitated covered Medicaid compensable services provided for individuals enrolled in SoonerCare, reimbursement is made at the Medicaid fee-for-service rate under the procedure code established.