Oklahoma Health Care Authority
MEDICAL ADVISORY COMMITTEE
May 12, 2022
1:00 – 3:30 PM

Charles Ed McFall Board Room

AGENDA

Public Access via Zoom:
https://okhca.zoom.us/j/81984948981?pwd=UGNZQk5RR0ZqSVBhV1JCTjZLTmZVQT09
Telephone: 1-346 -248 -7799 **Webinar ID:** 819 8494 8981

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

I. Welcome, Roll Call, and Public Comment Instructions: **Chairman, Jason Rhynes, O.D.**

II. Action Item: Approval of Minutes of the March 12th, 2022: **Medical Advisory Committee Meeting**

III. Public Comments (2 minute limit)

IV. MAC Member Comments/Discussion

V. Legislative Update**: Katelynn Burns, Legislative Liaison**

VI. Financial Report: **Tasha Black, Senior Director of Financial Services**

VII. SoonerCare Operations: **Amy Bradt, Senior Director of Provider Engagement**

VIII. Proposed Rule Changes: Presentation, Discussion, and Vote: **Sandra Puebla, Senior Director of Federal & State Authorities**

- **A. APA WF 22-03 Clinical Trials Routine Services and Dental Out-of-State Services**
- **B. APA WF 22-07 Tribal Residential Substance Use Disorder (SUD) Policy Updates**
- **C. APA WF 22-08 Hospice Benefit for Expansion Adults**
- **D. APA WF 22-09 Termination of SoonerPlan**
- **E. APA WF 22-10 Long-term Care Facility (LTC) Pay-for-Performance (PFP) Program**

IX. New Business: **Chairman, Jason Rhynes, O.D.**

X. Future Meeting: **Chairman, Jason Rhynes, O.D.**
July 14, 2022

September 8, 2022
November 10, 2022

XI. Adjourn **Chairman, Jason Rhynes, O.D.**

Oklahoma Health Care Authority
MEDICAL ADVISORY COMMITTEE
MINUTES of the March 10, 2022 Meeting
4345 N. Lincoln Blvd., Oklahoma City, OK 73105

I. Welcome, Roll Call, and Public Comment Instructions:

Chairman, Dr. Jason Rhynes called the meeting to order at 1:00 PM.

Delegates present were: Mr. Nick Barton, Ms. Joni Bruce, Mr. Brett Coble, Dr. Steven Crawford, Ms. Janet Cizek, Ms. Wanda Felty, Dr. Arlen Foulks, Ms. Jennifer King, Ms. Melissa Miller, Dr. Daniel Post, Dr. Jason Rhynes, Dr. Eve Switzer and Dr. Whitney Yeates, providing a quorum.

Alternates present were:

Delegates absent without an alternate were**:** Ms. Tina Johnson, and Dr. Raymond Smith.

II. Approval of the January 13th, 2022 Minutes

Medical Advisory Committee

The motion to approve the minutes was by Dr. Daniel Post and seconded by Ms. Wanda Felty and passed unanimously.

III. Public Comments (2-minute limit):

There were no public comments.

IV. MAC Member Comments/Discussion:

There were no MAC member comments.

V. Legislative Update:

Katelynn Burns, Legislative Liaison

There was no current update.

VI. CQS Update:

Nathan Valentine, Chief Quality Officer

Dr. Valentine presented an overview of Comprehensive Quality Strategy (CQS) to the MAC members. Which included some key challenges, tactics, and 5 areas of focus. He also discussed the process overview, some common concerns, and priorities, as well as the next steps. For more detailed information, please see item 6 in the MAC agenda.

VII. SoonerCare Operations Update:

Traylor Rains, Deputy State Medicaid Director

Mr. Rains presented the SoonerCare Operations update to the committee. Information is based on data for November 2021. Patient Centered Medical Home enrollment is at 757,852 which is up by 19,261. Sooner Care Traditional has a current enrollment of 386,568 which is 2,361 more than the previous month. SoonerPlan has an enrollment of 10,409 and Insure Oklahoma has a total enrollment of 10,409. In total, SoonerCare enrollment is at 1,165,675. For more detailed information, please see item 7 in the MAC agenda.

VIII. **Proposed Rule Changes: Presentation, Discussion, and Vote:**
Sandra Puebla, Senior Director of Federal & State Authorities

APA WF # 21-17 Dental Revisions — The proposed revisions will remove the certification requirement for primary care physicians (PCPs) to provide fluoride varnish during the course of a well-child health screening. The proposed revisions will also update the timeframe for dental prophylaxis from once every 184 days to once every six (6) months. Finally, language regarding coverage for periodontal maintenance will be added.

Budget Impact: The estimated budget impact for removing the certification requirements for PCPs to provide fluoride varnish, for SFY2023, will be an increase in the total amount of $97,682; with $26,767 state share. The estimated budget impact, for SFY2024, will be an increase in the total amount of $117,218; with $38,260 state share.

The estimated budget impact for adding coverage for periodontal maintenance, for SFY2023, will be an increase in the total amount of $1,288,682; with $258,104 state share. The estimated budget impact, for SFY2024, will be an increase in the total amount of $1,718,243; with $351,469 state share.

Changing the timeframe for dental prophylaxis is budget neutral.

Proposed Rule Timeline:
Tribal consultation: January 4, 2022
Public comment period: February 1, 2022 – March 3, 2022
Permanent rule public hearing: March 8, 2022
OHCA Board meeting: March 16, 2022
Permanent rule effective date: Contingent upon Legislative and/or Governor approval; estimated effective date: September 2022

The rule change motion to approve was by Dr. Steven Crawford and seconded by Dr. Whitney Yeates and passed unanimously.

APA WF # 21-28 Policy clarification for Qualified Medicare Beneficiary Plus (QMBP) – The proposed revisions clarify policy on how the Agency deems income from an ineligible spouse to an eligible member within the Aged, Blind and Disabled (ABD) eligibility group. The proposed revisions will also clarify that when the eligible member's countable income is over the Social Security Income (SSI) standard, the eligible member must still be evaluated for the Medicare savings program called QMBP.

Budget Impact: Budget neutral

Proposed Rule Timeline:
Tribal consultation: January 4, 2022
Public comment period: February 1, 2022 – March 3, 2022
OHCA Board meeting: March 16, 2022
Permanent rule public hearing: March 8, 2022
Permanent rule effective date: Contingent upon Legislative and/or Governor approval; estimated effective date: September 2022

The rule change motion to approve was by Dr. Steven Crawford and seconded by Dr. Whitney Yeates and passed unanimously.

APA WF # 21-29 Partial Hospitalization Program (PHP) Services for Adults — The proposed revisions add PHP services for individuals ages 21 through 64 with substance use disorder, mental health diagnoses, and/or co-occurring disorders. Currently, PHP services are a benefit offered to children under the age of 21, only. The proposed rulemaking will delineate covered service components, provider qualifications, as well as the reimbursement methodology for these services. Additionally, the proposed revisions will reorganize current policy at OAC 317:30-5-241.2 (Psychotherapy, Multi-systemic therapy, PHP, and day treatment programs) into independent sections for clarity and easier retrieval. Moreover, the proposed revisions will clarify that the clinical team for PHP services for children may include a physician, physician's assistant, or advanced registered nurse practitioner. Finally, the proposed rulemaking will correct minor formatting and grammatical errors.

Budget impact: The proposed permanent rule changes will result in a total budget impact of $771,715; with $160,864 state share for SFY2023 and $1,394,585; with $290,701 state share for SFY 2024. The state match will be paid by the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS).

Proposed Rule Timeline:
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The rule change motion to approve was by Dr. Steven Crawford and seconded by Dr. Whitney Yeates and passed unanimously.

APA WF # 21-32 Obstetric (OB) Ultrasound Coverage – The proposed revisions will amend policy to provide coverage of OB ultrasounds when performed at the emergency room setting when medically necessary without requiring prior authorization.

Budget impact: The proposed permanent rule changes will result in a total budget impact of $166,991.75; with $46,156.52 state share for SFY2023 and $200,390.10; with $65,407.33 state share for SFY2024.

Proposed Rule Timeline:
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Board meeting: March 16, 2022
Permanent rule public hearing: March 8, 2022
Permanent rule effective date: Contingent upon Legislative and Governor approval; estimated effective date: Sept. 2022

The rule change motion to approve was by Dr. Steven Crawford and seconded by Dr. Whitney Yeates and passed unanimously.

APA WF # 21-35 Lodging and Meals Revisions — The proposed revisions will outline who can request the lodging and meal services and the timeframe that the request must be submitted. Additionally, a clause addressing emergency situations will be added to override the timeframe. The proposed revisions will also outline the information that must be submitted with each request. Further revisions will define meal requirements and what constitutes a meal. Additional revisions will outline how lodging providers and members authorize the member's length of stay. Authorization for length of stay includes having the lodging provider create a document/attestation that lists all the dates that the member has stayed in the facility and requiring the member's review and signature of the document/attestation before he/she/they checks out of the lodging provider's facility. Furthermore, the revisions will specify that it is the responsibility of both, the lodging provider and the member, to ensure that the document/attestation is verified and signed. Additional policy changes will add descriptions and processes for incidental charges and complaints. These changes are necessary to align the policy with current business practices.

Budget Impact: Budget neutral.

Proposed Rule Timeline:
Tribal consultation: January 4, 2022
Public comment period: February 1, 2022 – March 3, 2022
OHCA Board meeting: March 16, 2022
Permanent rule public hearing: March 8, 2022
Permanent rule effective date: Contingent upon Legislative and/or Governor approval; estimated effective date: September 2022

The rule change motion to approve was by Dr. Steven Crawford and seconded by Dr. Whitney Yeates and passed unanimously.

APA WF # 21-37 Private Duty Nursing (PDN) Revisions — The proposed revisions will update how assessments for PDN services are conducted; clarify who can sign the PDN treatment plan; update grammatical and formatting errors; and reorganize policy for better clarity and understanding. These revisions are necessary to align the PDN policy with current business practices.

Budget Impact: The proposed rule changes could create a budget savings for the agency. By allowing the OHCA care management nurses to conduct PDN assessments virtually, the nurses' time will be spent on other priorities for our members instead of traveling to conduct the assessments.

Proposed Rule Timeline:
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Permanent rule public hearing: March 8, 2022
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The rule change motion to approve was by Dr. Steven Crawford and seconded by Dr. Whitney Yeates and passed unanimously.

APA WF # 21-38A Developmental Disabilities Services (DDS) Updates for Specialized Foster Care, Agency Companion, Employment Services and Self-Directed Services – The proposed revisions to the DDS policy will add language to clarify that occupation and physical therapy services can include assistive technology, positioning, and mobility. Additional revisions for speech-language pathology services state that a provider cannot bill or receive reimbursement solely for writing the member's

report or recording other documentation. Final revisions will correct formatting and grammatical errors, as well as align policy with current business practices.

Budget Impact: Budget Neutral

Proposed Rule Timeline:
Tribal consultation: January 4, 2022
Public comment period: February 1, 2022 – March 3, 2022
OHCA Board meeting: March 16, 2022
Permanent rule public hearing: March 8, 2022
Permanent rule effective date: Contingent upon Legislative and Governor approval; estimated effective date: Sept. 2022

The rule change motion to approve was by Dr. Steven Crawford and seconded by Dr. Whitney Yeates and passed unanimously.

APA WF # 21-38B Developmental Disability Services (DDS) Updates for Specialized Foster Care (SFC), Agency Companion, Employment Services and Self-Directed Services – The proposed revisions to the DDS policy will add new guidelines to staff that address provisions for the member's safety including: requirements for member's pets; appropriate supervision as it relates to unrelated habilitation training specialist staffing the home; and outlining actions taken by the provider following an injury to the service recipient. Other revisions will add language to clarify home standard exceptions concerning when adult members will be allowed to share bedrooms; the exception for the division director or designee to allow use of non-traditional bedding for temporary respite; and bedding types that are not usually allowed.

Revisions to the specialized foster care (SFC) section outline substitute supervision criteria. Revisions will also update SFC travel requirements to clarify transportation limits for vacation and what are considered non-covered trips. Other revisions will update the minimum contribution fee from $250 to $300 per month for the SFC providers who serve adults. New language will also provide clarification on the case manager's role in reporting issues of concern.

Further revisions will add job coaching as a self-directed service in the In-Home Supports Waiver for Adults, In-Home Supports Waiver for Children, and the Community Waiver when the member lives in a non-residential setting.

Finally, revisions will update and remove outdated language and definitions, remove obsolete references, revoke/combine sections to comply with Executive Order 2020-03, which requires state agencies to reduce unnecessary and outdated rules. Revisions will also correct formatting and grammatical errors, as well as align policy with current business practices.

Budget Impact: Budget Neutral

Proposed Rule Timeline:
Tribal consultation: January 4, 2022
Public comment period: February 1, 2022 – March 3, 2022
OHCA Board meeting: March 16, 2022
Permanent rule public hearing: March 8, 2022
Permanent rule effective date: Contingent upon Legislative and Governor approval; estimated effective date: Sept. 2022

The rule change motion to approve was by Dr. Steven Crawford and seconded by Dr. Whitney Yeates and passed unanimously.

APA WF # 21-39 Laboratory Services - The proposed revisions will remove outdated language referencing "custom panels particular to the ordering provider" from the list of non-compensable laboratory services to reflect current business practices. Further revisions will update policy for better ease and understanding.

Budget Impact: Budget Neutral

Proposed Rule Timeline:
Tribal consultation: January 4, 2022
Public comment period: February 1, 2022 – March 3, 2022
OHCA Board meeting: March 16, 2022
Permanent rule public hearing: March 8, 2022
Permanent rule effective date: Contingent upon Legislative and Governor approval; estimated effective date: Sept. 2022

The rule change motion to approve was by Dr. Steven Crawford and seconded by Dr. Whitney Yeates and passed unanimously.

APA WF # 21-40 Pregnant Women Copayment Language Cleanup — The proposed rule changes will further clarify that no copayment is assessed to pregnant women covered by SoonerCare. The policy changes align Oklahoma's administrative rules regarding copayments for pregnant women and with current business practices.

Budget Impact: Budget neutral.

Proposed Rule Timeline:

Tribal consultation: January 4, 2022
Public comment period: February 1, 2022 – March 3, 2022
OHCA Board meeting: March 16, 2022
Permanent rule effective date: Contingent upon Legislative and/or Governor approval; estimated effective date: September 2022

The rule change motion to approve was by Dr. Steven Crawford and seconded by Dr. Whitney Yeates and passed unanimously.

APA WF # 21-41A&B Outdated/Obsolete Policy Language Cleanup — The proposed rule changes will amend language to remove obsolete references. Additional revisions will combine sections of policy to remove the number of sections that are currently in Title 317. These changes are necessary to comply with Oklahoma Executive Order 2020-03.

Budget Impact: Budget neutral.

Proposed Rule Timeline:
Tribal consultation: January 4, 2022
Public comment period: February 1, 2022 – March 3, 2022
OHCA Board meeting: March 16, 2022
Permanent rule public hearing: March 8, 2022
Permanent rule effective date: Contingent upon Legislative and/or Governor approval; estimated effective date: September 2022

The rule change motion to approve was by Dr. Steven Crawford and seconded by Dr. Whitney Yeates and passed unanimously.

APA WF # 21-42 Rural Health Centers (RHC) and Federally Qualified Health Centers (FQHC) Visit Limitation Revisions — The proposed revisions will add language that allows for a SoonerCare Choice member, who has chosen an RHC/FQHC as his/her/their Patient Centered Medical Home (PCMH)/Primary Care Provider (PCP), to exceed the four (4) visit limitation.

Budget Impact: Budget neutral.

Proposed Rule Timeline:
Tribal consultation: January 4, 2022
Public comment period: February 1, 2022 – March 3, 2022
OHCA Board meeting: March 16, 2022
Permanent rule public hearing: March 8, 2022

Permanent rule effective date: Contingent upon Legislative and/or Governor approval; estimated effective date: September 2022

The rule change motion to approve was by Dr. Steven Crawford and seconded by Dr. Whitney Yeates and passed unanimously.

APA WF # 21-43 Opioid Treatment Provider (OTP) Policy Changes— The proposed revisions will update current OTP service and documentation requirements to align with the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) provider certification standards. The proposed rulemaking will also correct minor formatting and grammatical errors.

Budget impact: Budget neutral

Proposed Rule Timeline:
Tribal consultation: January 4, 2022
Public comment period: February 1, 2022 - March 3, 2022
OHCA Board meeting: March 16, 2022
Permanent rule public hearing: March 8, 2022
Permanent rule effective date: Contingent upon Legislative and Governor approval; estimated effective date: Sept. 2022

The rule change motion to approve was by Dr. Steven Crawford and seconded by Dr. Whitney Yeates and passed unanimously.

APA WF # 21-45 Referrals for Specialty Services Revisions — The proposed revisions will update retrospective administrative referrals for specialty services within the SoonerCare Choice program. The changes will outline how retrospective administrative referral requests are made and the information that must be provided for the OHCA to process the request. These changes are necessary to align policy with current business practices.

Budget Impact: Budget neutral.

Proposed Rule Timeline:
Tribal consultation: January 4, 2022
Public comment period: February 1, 2022 – March 3, 2022
OHCA Board meeting: March 16, 2022
Permanent rule public hearing: March 8, 2022
Permanent rule effective date: Contingent upon Legislative and/or Governor approval; estimated effective date: September 2022

The rule change motion to approve was by Dr. Steven Crawford and seconded by Dr. Whitney Yeates and passed unanimously.

IX. MAC Meeting Dates for Calendar 2022:

Chairman, Jason Rhynes, O.D.

May 12, 2022
July 14, 2022
September 8, 2022
November 10, 2022

X. **New Business:**

Chairman, Jason Rhynes, O.D.

No new business was addressed.

XI. Adjourn:

Chairman, Jason Rhynes, O.D.
Chairman Rhynes asked for a motion to adjourn. Motion was provided by Dr. Steven Crawford and seconded by Dr. Arlen Foulks, there was no dissent and the meeting adjourned at 2:21pm.

OKLAHOMA
Health Care Authority

FINANCIAL REPORT

For the Nine Month Period Ending March 31, 2022
Submitted to the CEO & Board

- Revenues for OHCA through March, accounting for receivables, were **$4,955,275,345** or **1.8% under** budget.

- Expenditures for OHCA, accounting for encumbrances, were **$4,559,582,396** or **2.3% under** budget.

- The state dollar budget variance through March is a positive **$15,846,374**
- The budget variance is primarily attributable to the following (in millions):

Expenditures:		
Medicaid Program Variance		19.2
Administration		4.8
Revenues:		
Drug Rebate		(3.5)
Medical Refunds		(2.4)
Taxes and Fees		(2.3)
Total FY 22 Variance	**$**	**15.8**

ATTACHMENTS

OKLAHOMA HEALTH CARE AUTHORITY
Summary of Revenues & Expenditures: OHCA
SFY 2022, For the Nine Month Period Ending March 31, 2022

REVENUES	FY22 Budget YTD	FY22 Actual YTD	Variance	% Over/ (Under)
State Appropriations	$ 806,896,486	$ 806,896,486	$ -	0.0%
Federal Funds	3,464,160,651	3,403,494,320	(60,666,331)	(1.8)%
Tobacco Tax Collections	34,925,647	34,898,814	(26,833)	(0.1)%
Quality of Care Collections	68,122,388	65,885,089	(2,237,299)	(3.3)%
Prior Year Carryover	30,960,827	30,960,827	-	0.0%
Federal Deferral - Interest	109,190	109,190	-	0.0%
Rate Preservation Fund	123,103,539	123,103,539	-	0.0%
Drug Rebates	348,130,257	330,849,762	(17,280,495)	(5.0)%
Medical Refunds	31,115,035	19,249,195	(11,865,841)	(38.1)%
Prior Year Carryover Supplemental Hospital Offset Payment Program	3,415,272	3,415,272	-	0.0%
Supplemental Hospital Offset Payment Program	133,388,624	133,388,624	-	0.0%
Other Revenues	3,022,407	3,024,229	1,822	0.1%
TOTAL REVENUES	**$ 5,047,350,323**	**$ 4,955,275,345**	**$ (92,074,977)**	**(1.8)%**

EXPENDITURES	FY22 Budget YTD	FY22 Actual YTD	Variance	% (Over)/ Under
ADMINISTRATION - OPERATING	**$ 50,113,083**	**$ 41,987,525**	**$ 8,125,559**	**16.2%**
ADMINISTRATION - CONTRACTS	**$ 109,991,504**	**$ 104,863,636**	**$ 5,127,868**	**4.7%**
MEDICAID PROGRAMS				
Managed Care:				
SoonerCare Choice	45,358,344	38,792,478	6,565,866	14.5%
Acute Fee for Service Payments:				
Hospital Services	1,166,123,610	1,102,642,919	63,480,691	5.4%
Behavioral Health	20,718,975	20,796,259	(77,284)	(0.4)%
Physicians	404,905,366	397,696,797	7,208,569	1.8%
Dentists	164,506,249	133,863,085	30,643,163	18.6%
Other Practitioners	49,469,622	49,874,120	(404,498)	(0.8)%
Home Health Care	25,899,018	22,820,410	3,078,608	11.9%
Lab & Radiology	34,877,274	32,528,494	2,348,780	6.7%
Medical Supplies	60,319,649	58,732,388	1,587,262	2.6%
Ambulatory/Clinics	354,938,716	352,740,822	2,197,894	0.6%
Prescription Drugs	825,407,646	814,628,102	10,779,545	1.3%
OHCA Therapeutic Foster Care	361,478	405,540	(44,062)	(12.2)%
Other Payments:				
Nursing Facilities	505,652,514	553,059,740	(47,407,226)	(9.4)%
Intermediate Care Facilities for Individuals with Intellectual Disabilities Private	51,045,219	48,755,965	2,289,255	4.5%
Medicare Buy-In	165,215,033	165,439,353	(224,320)	(0.1)%
Transportation	88,647,626	76,939,038	11,708,588	13.2%
Money Follows the Person-OHCA	158,650	269,753	(111,103)	(70.0)%
Electronic Health Records-Incentive Payments	102,764	102,764	-	0.0%
Part D Phase-In Contribution	52,061,265	51,402,672	658,592	1.3%
Supplemental Hospital Offset Payment Program	482,933,062	482,933,062	-	0.0%
Telligen	8,607,696	8,307,474	300,222	3.5%
Total OHCA Medical Programs	**4,507,309,777**	**4,412,731,235**	**94,578,542**	**2.1%**
OHCA Non-Title XIX Medical Payments	89,382	-	89,382	0.0%
TOTAL OHCA	**$ 4,667,503,746**	**$ 4,559,582,396**	**$ 107,921,351**	**2.3%**
REVENUES OVER/(UNDER) EXPENDITURES	**$ 379,846,576**	**$ 395,692,950**	**$ 15,846,374**	

OKLAHOMA HEALTH CARE AUTHORITY
Total Medicaid Program Expenditures
by Source of State Funds
SFY 2022, For the Nine Month Period Ending March 31, 2022

Category of Service	Total	Health Care Authority	Quality of Care	Insure Oklahoma	SHOPP	BCC	Other State Agencies
SoonerCare Choice	$ 38,792,478	$ 38,786,818	$ -	$ -	$ -	$ 5,660	$ -
Inpatient Acute Care	1,270,101,328	669,013,544	365,015	1,161,088	374,897,576	781,578	223,882,527
Outpatient Acute Care	521,236,118	429,232,908	31,203	1,447,247	87,306,089	3,218,671	-
Behavioral Health - Inpatient	74,310,198	13,728,278	-	167,517	17,519,881	-	42,894,524
Behavioral Health - Psychiatrist	10,277,498	7,067,981	-	-	3,209,516	-	-
Behavioral Health - Outpatient	13,567,388	-	-	-	-	-	13,567,388
Behaviorial Health-Health Home	3,084,224	-	-	-	-	-	3,084,224
Behavioral Health Facility- Rehab	178,952,373	-	-	-	-	134,704	178,952,373
Behavioral Health - Case Management	4,791,493	-	-	-	-	-	4,791,493
Behavioral Health - PRTF	8,698,188	-	-	-	-	-	8,698,188
Behavioral Health - CCBHC	148,473,660	-					148,473,660
Residential Behavioral Management	15,230,031	-	-	-	-	-	15,230,031
Targeted Case Management	47,450,166	-	-	-	-	-	47,450,166
Therapeutic Foster Care	405,540	405,540	-	-	-	-	-
Physicians	485,726,960	395,471,401	43,576	1,490,118	-	2,181,820	86,540,045
Dentists	133,882,148	133,807,154	-	19,063	-	55,931	-
Mid Level Practitioners	956,948	955,875	-	785	-	288	-
Other Practitioners	49,033,160	48,508,375	334,773	115,202	-	74,809	-
Home Health Care	22,824,185	22,816,245	-	3,775	-	4,165	-
Lab & Radiology	32,707,932	32,428,356	-	179,438	-	100,138	-
Medical Supplies	58,775,109	56,652,852	2,033,649	42,721	-	45,886	-
Clinic Services	360,430,237	345,601,664	-	868,992	-	245,465	13,714,115
Ambulatory Surgery Centers	6,931,417	6,886,018	-	37,724	-	7,675	-
Personal Care Services	6,810,116	-	-	-	-	-	6,810,116
Nursing Facilities	553,059,740	296,580,969	256,470,478	-	-	8,293	-
Transportation	76,687,960	74,503,225	2,076,597	67,979	-	40,159	-
IME/DME	58,248,067	-	-	-	-	-	58,248,067
ICF/IID Private	48,755,965	35,762,537	12,993,428	-	-	-	-
ICF/IID Public	21,592,836	-	-	-	-	-	21,592,836
CMS Payments	216,842,026	216,524,397	317,629	-	-	-	-
Prescription Drugs	814,654,765	811,861,042	-	26,663	-	2,767,060	-
Miscellaneous Medical Payments	319,056	313,378	-	-	-	5,678	-
Home and Community Based Waiver	207,870,891	-	-	-	-	-	207,870,891
Homeward Bound Waiver	54,561,789	-	-	-	-	-	54,561,789
Money Follows the Person	498,667	269,753	-	-	-	-	228,914
In-Home Support Waiver	19,816,944	-	-	-	-	-	19,816,944
ADvantage Waiver	141,604,079	-	-	-	-	-	141,604,079
Family Planning/Family Planning Waiver	1,575,673	-	-	-	-	-	1,575,673
Premium Assistance*	32,062,553	-	-	32,062,552.50	-	-	-
Telligen	8,307,474	8,307,474	-	-	-	-	-
Electronic Health Records Incentive Payments	102,764	102,764	-	-	-	-	-
Total Medicaid Expenditures	**$ 5,750,010,142**	**$ 3,645,588,549**	**$ 274,666,347**	**$ 37,690,866**	**$ 482,933,062**	**$ 9,677,981**	**$ 1,299,588,041**

* Includes $31,710,338.03 paid out of Fund 245

OKLAHOMA HEALTH CARE AUTHORITY
Summary of Revenues & Expenditures:
Other State Agencies
SFY 2022, For the Nine Month Period Ending March 31, 2022

REVENUE	FY22 Actual YTD
Revenues from Other State Agencies	327,017,573
Federal Funds	1,044,998,442
TOTAL REVENUES	**$ 1,372,016,015**

EXPENDITURES	Actual YTD
Oklahoma Human Services	
Home and Community Based Waiver	207,870,891
Money Follows the Person	228,914
Homeward Bound Waiver	54,561,789
In-Home Support Waivers	19,816,944
ADvantage Waiver	141,604,079
Intermediate Care Facilities for Individuals with Intellectual Disabilities Public	21,592,836
Personal Care	6,810,116
Residential Behavioral Management	10,008,006
Targeted Case Management	42,354,210
Total Oklahoma Human Services	**504,847,784**
State Employees Physician Payment	
Physician Payments	86,540,045
Total State Employees Physician Payment	**86,540,045**
Education Payments	
Indirect Medical Education	38,096,396
Direct Medical Education	6,382,737
DSH	13,768,934
Total Education Payments	**58,248,067**
Office of Juvenile Affairs	
Targeted Case Management	1,460,968
Residential Behavioral Management	5,222,025
Total Office of Juvenile Affairs	**6,682,993**
Department of Mental Health & Substance Abuse Services	
Case Management	4,791,493
Inpatient Psychiatric Free-standing	42,894,524
Outpatient	13,567,388
Health Homes	3,084,224
Psychiatric Residential Treatment Facility	8,698,188
Certified Community Behavioral Health Clinics	148,473,660
Rehabilitation Centers	178,952,373
Total Department of Mental Health & Substance Abuse Services	**400,461,850**
State Department of Health	
Children's First	-
Sooner Start	828,686
Early Intervention	1,794,709
Early and Periodic Screening, Diagnosis, and Treatment Clinic	781,797
Family Planning	501,097
Family Planning Waiver	1,074,576
Maternity Clinic	1,771
Total Department of Health	**4,982,636**
County Health Departments	
EPSDT Clinic	234,271
Family Planning Waiver	-
Total County Health Departments	**234,271**
State Department of Education	**134,839**
Public Schools	**1,705,440**
Medicare DRG Limit	**207,735,773**
Native American Tribal Agreements	**11,867,590**
Department of Corrections	**4,428,730**
JD McCarty	**11,718,024**
Total OSA Medicaid Programs	**$ 1,299,588,041**
OSA Non-Medicaid Programs	**$ 74,056,459**
Accounts Receivable from OSA	**$ 1,628,485**

OKLAHOMA HEALTH CARE AUTHORITY

SUMMARY OF REVENUES & EXPENDITURES:

Fund 205: Supplemental Hospital Offset Payment Program Fund

SFY 2022, For the Nine Month Period Ending March 31, 2022

REVENUES		FY 22 Revenue
SHOPP Assessment Fee		**129,905,490**
SHOPP Assessment Fee - Expansion		**3,415,272**
Prior Year Carryover - SHOPP Expansion		**3,415,272**
Federal Draws	**$**	**400,243,719**
Interest		**67,862**
Penalties		**-**
TOTAL REVENUES	**$**	**537,047,615**

EXPENDITURES	Quarter	Quarter	Quarter	Quarter		FY 22 Expenditures
Program Costs:	**7/1/21 - 9/30/21**	**10/1/21 - 12/31/21**	**1/1/22 - 3/31/22**	**4/1/22 - 6/30/22**		
Hospital - Inpatient Care	**92,858,282**	**83,639,436**	**73,677,501**		**$**	**250,175,219**
Hospital -Outpatient Care	**22,248,247**	**20,973,326**	**16,900,037**		**$**	**60,121,610**
Psychiatric Facilities-Inpatient	**4,362,577**	**3,920,470**	**3,500,773**		**$**	**11,783,821**
Rehabilitation Facilities-Inpatient	**735,534**	**660,994**	**749,525**		**$**	**2,146,054**
Hospital - Inpatient Care - Expansion	**32,182,661**	**46,700,968**	**45,838,728**		**$**	**124,722,357**
Hospital -Outpatient Care - Expansion	**6,274,106**	**10,282,009**	**10,628,363**		**$**	**27,184,478**
Psychiatric Facilities-Inpatient - Expansion	**1,433,128**	**2,185,256**	**2,117,676**		**$**	**5,736,060**
Rehabilitation Facilities-Inpatient - Expansion	**241,626**	**368,436**	**453,400**		**$**	**1,063,463**
Total OHCA Program Costs	**160,336,162**	**168,730,897**	**153,866,003**	**-**		**482,933,062**
Total Expenditures					**$**	**482,933,062**

SHOPP Revenue transferred to Medicaid Program Fund 340	**$**	**54,114,553**

*** Expenditures and Federal Revenue processed through Fund 340

OKLAHOMA HEALTH CARE AUTHORITY
SUMMARY OF REVENUES & EXPENDITURES:
Fund 230: Nursing Facility Quality of Care Fund
SFY 2022, For the Nine Month Period Ending March 31, 2022

REVENUES	Total Revenue	State Share
Quality of Care Assessment	**$ 65,868,570**	**$ 65,868,570**
*Quality of Care Penalties (*Non-Spendable Revenue)*	**$ 182,884**	**$ 182,884**
Interest Earned	**16,519**	**$ 16,519**
TOTAL REVENUES	**$ 66,067,973**	**$ 66,067,973**

EXPENDITURES	FY 22 Total $ YTD	FY 22 State $ YTD	Total State $ Cost
Program Costs			
Nursing Facility Rate Adjustment	$ 184,021,019	$ 37,902,755	
Eyeglasses and Dentures	178,380	$ 36,741	
Personal Allowance Increase	2,217,920	$ 456,822	
Coverage for Durable Medical Equipment and Supplies	2,033,649	$ 418,864	
Coverage of Qualified Medicare Beneficiary	774,567	$ 159,535	
Part D Phase-In	317,629	$ 317,629	
ICF/IID Rate Adjustment	3,531,970	$ 727,604	
Acute Services ICF/IID	5,258,498	$ 1,083,124	
Non-emergency Transportation - Soonerride	2,076,597	$ 427,680	
NF Covid-19 Supplemental Payment	70,053,159	$ 14,353,892	
ICF Covid-19 Supplemental Payment	4,202,959	$ 861,186	
Ventilator NF DME Supplemental Payment		$ -	
Total Program Costs	**$ 274,666,347**	**$ 56,745,832**	**$ 56,745,832**
Administration			
OHCA Administration Costs	$ 215,296	$ 107,648	
OHS-Ombudsmen	282,655	282,655	
OSDH-Nursing Facility Inspectors	-	-	
Mike Fine, CPA	-	-	
Total Administration Costs	**$ 497,951**	**$ 390,303**	**$ 390,303**
Total Quality of Care Fee Costs	**$ 275,164,298**	**$ 57,136,135**	
TOTAL STATE SHARE OF COSTS			**$ 57,136,135**

Note: Expenditure amounts are for informational purposes only. Actual payments are made from Fund 340. Revenues deposited into the fund are tranferred to Fund 340 to support the costs, not to exceed the calculated state share amount.

OKLAHOMA HEALTH CARE AUTHORITY
SUMMARY OF REVENUES & EXPENDITURES:
Insure Oklahoma Program (Fund 245: HEEIA)
SFY 2022, For the Nine Month Period Ending March 31, 2022

REVENUES	FY 21 Carryover	FY 22 Revenue	Total Revenue
Prior Year Balance	$ 12,826,511		
State Appropriations	-		
Transfer to 340 for Expansion-prior year	(12,929,712)		
Federal Draws - Prior Year	115,189		
Total Prior Year Revenue			11,988
Transfer to 340 for Expansion-current year		(10,070,288)	(10,070,288)
Tobacco Tax Collections	-	28,703,161	28,703,161
Interest Income	-	136,887	136,887
Federal Draws	-	25,977,118	25,977,118
TOTAL REVENUES	$ 11,988	$ 44,746,878	$ 44,758,866

EXPENDITURES		FY 21 Expenditures	FY 22 Expenditures	Total State $ YTD
Program Costs:				
	Employer Sponsored Insurance		$ 31,710,338	$ 31,710,338
	College Students/ESI Dental		352,214	72,565
Individual Plan				
	SoonerCare Choice		$ -	$ -
	Inpatient Hospital		1,157,788	240,533
	Outpatient Hospital		1,431,050	297,497
	BH - Inpatient Services-DRG		166,077	34,499
	BH -Psychiatrist		-	-
	Physicians		1,471,049	305,560
	Dentists		19,039	3,958
	Mid Level Practitioner		785	163
	Other Practitioners		114,309	23,737
	Home Health		3,775	783
	Lab and Radiology		176,978	36,772
	Medical Supplies		40,935	8,512
	Clinic Services		851,408	176,879
	Ambulatory Surgery Center		37,724	7,844
	Skilled Nursing		-	-
	Prescription Drugs		20,401	5,301
	Transportation		67,754	14,077
	Premiums Collected			36,714
Total Individual Plan			$ 5,559,074	$ 1,192,829
	College Students-Service Costs		$ 69,240	$ 14,387
Total OHCA Program Costs			$ 37,690,866	$ 32,990,119
Administrative Costs				
	Salaries	$ 2,283	$ 940,878	$ 943,161
	Operating Costs	2,121	2,249	4,371
	E&E Development DXC	-	-	-
	Contract - DXC	7,584	736,601	744,185
Total Administrative Costs		$ 11,988	$ 1,679,729	$ 1,691,717
Total Expenditures				$ 34,681,836
NET CASH BALANCE		$ 0	$ 10,077,030	$ 10,077,030

OKLAHOMA HEALTH CARE AUTHORITY

Combining Statement of Revenues, Expenditures and Changes in Fund Balance

SFY 2022, For the Nine Month Period Ending March 31, 2022

	Administration Fund 200	Supplemental Hospital Offset Payment Program Fund 205	Quality of Care Fund 230	Rate Preservation Fund 236	Federal Deferral Fund 240	Health Employee and Economy Act Fund 245	Belle Maxine Hilliard Breast & Cervical Cancer Treatment (Tobacco) Fund 250	Medicaid Program (Tobacco) Fund 255	Medicaid Program Fund 340	Clearing Account 1807B	Total Cash Balance
March Beginning Fund Balance:											
Prior year	28,404,233	2,913,409	25,267	33,453,218	13,821,907	4,929,713	-	-	472,528,918	1,453,239	557,529,904
Current year	(3,471,702)	(885,848)	1,353	109,425,368	98,602	15,978,043	-	-	260,024,943	2,430,503	383,601,262
Total	24,932,531	2,027,561	26,619	142,878,586	13,920,510	20,907,756	-	-	732,553,861	3,883,742	941,131,165
March Revenues:											
Prior year	3,022,283	-	-	-	-	-	-	-	9,072	-	3,031,356
Current year	16,421,739	1,153,023	7,777,506	-	10,587	6,320,758	54,719	3,278,929	510,845,563	94,176,473	640,039,298
Total	19,444,022	1,153,023	7,777,506	-	10,587	6,320,758	54,719	3,278,929	510,854,636	94,176,473	643,070,653
March Expenditures:											
Prior year	-	-	-	-	-	-	-	-	-	-	-
Current year	15,829,036	-	-	-	-	4,553,578	-	-	667,339,847	-	687,722,462
Total	15,829,036	-	-	-	-	4,553,578	-	-	667,339,847		687,722,462
Operating Transfers In											
Prior year											
Current year	8,834,654	-	-	13,678,171	-	-	-	-	91,582,831	-	114,095,656
Total	8,834,654	-	-	13,678,171	-	-	-	-	91,582,831	-	114,095,656
Operating Transfers Out											
Prior year	3,361,068	-	-	-	-	4,929,713	-	-	-		8,290,781
Current year	-	-	7,754,386	-	-	10,070,287	54,719	3,278,929	-	1,453,239	22,611,560
Total	3,361,068	-	7,754,386	-	-	15,000,000	54,719	3,278,929	-	1,453,239	30,902,341
Change in CY Fund Balance	***5,955,655***	***267,175***	***24,473***	***123,103,539***	***109,190***	***7,674,935***	***-***	***-***	***195,113,489***	***95,153,737***	***427,402,193***
Ending Fund Balance	**34,021,103**	**3,180,584**	**49,739**	**156,556,757**	**13,931,097**	**7,674,935**	**-**	**-**	**667,651,480**	**96,606,976**	**979,672,671**

OKLAHOMA HEALTH CARE AUTHORITY
HEALTHY ADULT PROGRAM EXPENDITURES - OHCA
SFY 2022, For the Nine Month Period Ending March 31, 2022

PROGRAM / ACTIVITY	FY22 BUDGETED EXPENDITURES Full Year	FY22 BUDGETED EXPENDITURES Year to Date	FY22 ACTUAL EXPENDITURES YTD through March	BUDGET VARIANCE (Over)/ Under
OHCA MEDICAID PROGRAMS				
Managed Care				
SoonerCare Choice	8,829,743	6,622,307	814,455	5,807,852
Total Managed Care	**8,829,743**	**6,622,307**	**814,455**	**5,807,852**
Fee for Service				
Hospital Services:				
Inpatient Acute Care	260,410,104	195,307,578	150,489,966	44,817,613
SHOPP	158,706,357	158,706,357	158,706,357	-
Outpatient Acute Care	205,586,924	154,190,193	119,110,728	35,079,465
Total Hospitals	**624,703,385**	**508,204,128**	**428,307,050**	**79,897,078**
Behavioral Mental Health:				
Inpatient Services - DRG	8,223,477	6,167,608	10,459,402	(4,291,794)
Outpatient	-	-	-	-
Total Behavioral Mental Health	**8,223,477**	**6,167,608**	**10,459,402**	**(4,291,794)**
Physicians & Other Providers:				
Physicians	165,635,032	124,172,630	**82,234,863**	41,937,767
Dentists	37,697,689	28,273,267	20,490,776	7,782,490
Mid-Level Practitioner	563,844	422,883	208,217	214,666
Other Practitioners	13,705,795	10,279,346	9,236,317	1,043,029
Home Health Care	6,852,897	5,139,673	448,862	4,690,811
Lab & Radiology	13,705,795	10,279,346	8,681,123	1,598,223
Medical Supplies	13,705,795	10,279,346	5,421,009	4,858,337
Clinic Services	135,583,034	100,668,035	62,244,409	38,423,626
Ambulatory Clinics	3,654,573	2,740,929	1,863,920	877,010
Total Physicians & Other Providers	**391,104,453**	**292,255,456**	**190,829,497**	**101,425,959**
Misc Medical & Health Access Network	**277,667**	**208,250**	**45,202**	163,049
Transportation	**27,411,590**	**20,558,692**	**13,136,533**	7,422,159
Health Access Network	**-**	**-**	**935,308**	(935,308)
Prescription Drugs	**363,203,566**	**272,402,675**	**234,550,950**	37,851,724
Total OHCA Medicaid Programs	**1,423,753,882**	**1,106,419,117**	**879,078,397**	**227,340,720**

OHCA Monthly Metrics
May 2022
(March 2022 Data)

SOONERCARE ENROLLMENT/EXPENDITURES

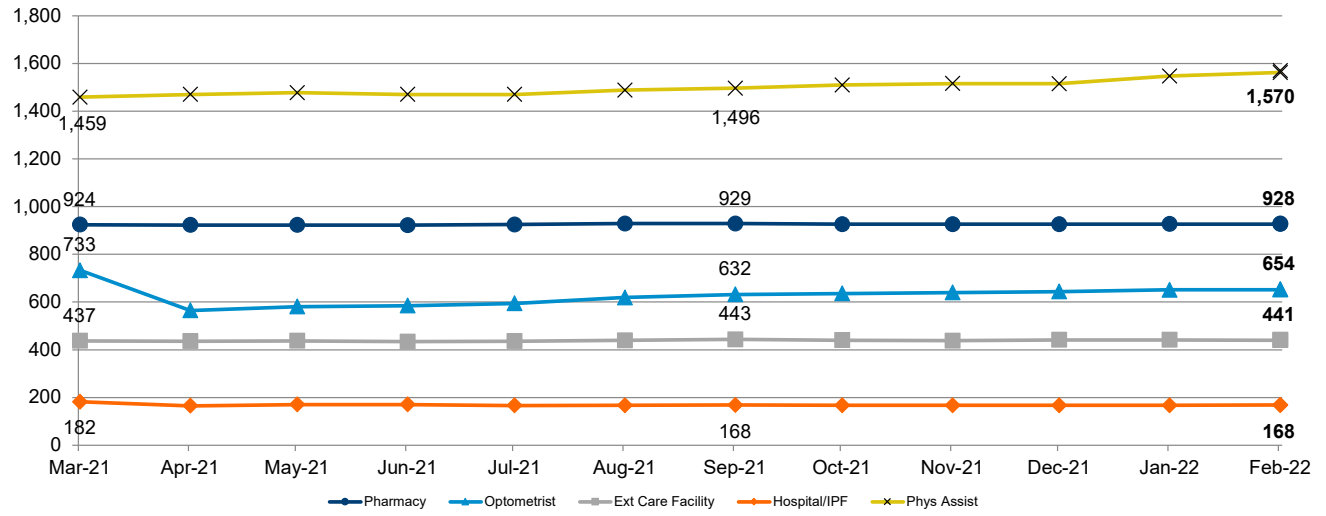
Delivery System		Enrollment March 2022	Children March 2022	Adults March 2022	Enrollment Change	Total Expenditures March 2022	PMPM March 2022
SoonerCare Choice Patient-Centered Medical Home		**786,012**	**539,012**	**247,000**	**-8,754**	**$308,286,201**	
	Children/Parents & Expansion	743,910	525,320	218,590	-6,845	$248,326,589	$334
	Aged/Blind/Disabled & BCC	42,102	13,692	28,410	-1,909	$59,959,611	$1,424
SoonerCare Traditional		**422,853**	**137,447**	**285,406**	**22,645**	**$309,203,517**	
	Children/Parents & Expansion	294,918	132,104	162,814	20,667	$127,089,197	$431
	Aged/Blind/Disabled & BCC	127,935	5,343	122,592	1,978	$182,114,320	$1,423
Insure Oklahoma (ESI)		**10,544**	**453**	**10,091**	**10**	**$3,786,085**	$359
SoonerPlan		**9,220**	**50**	**9,170**	**-119**	**$33,533**	$4
TOTAL (UNDUPLICATED)		**1,228,629**	**676,962**	**551,667**	**13,782**	**$621,309,336**	$506

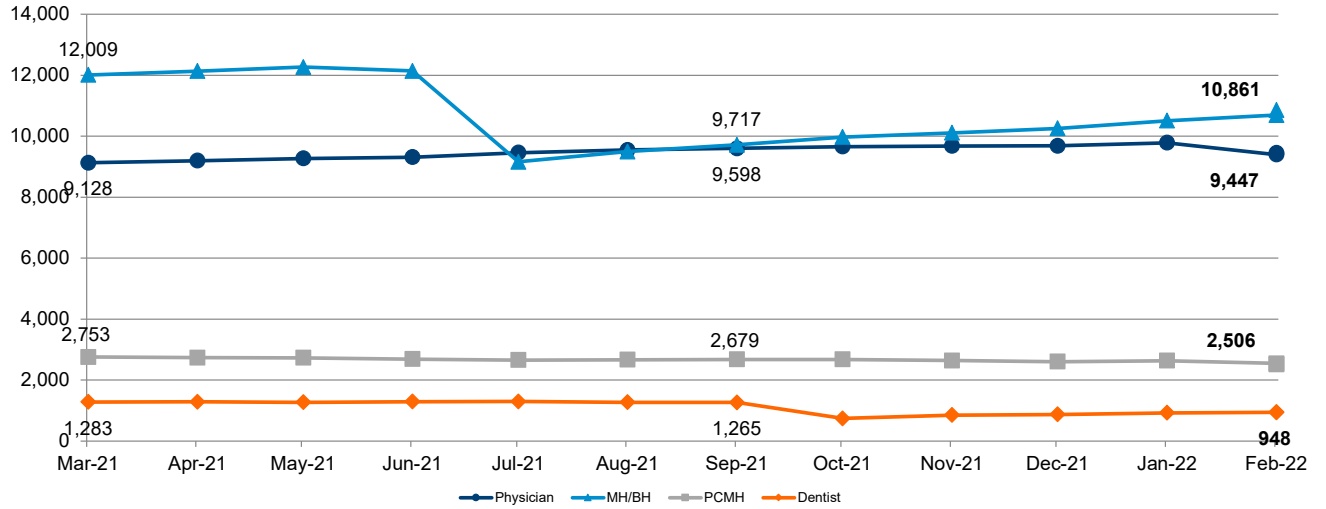
Total Expansion members = 267,227 (55% in PCMH). TEFRA is included with ABD. OTHER is included with Children/Parents. ABD - Traditional includes LTC and HCBS Waiver. Other - Traditional includes Q1 and SLMB.

Enrollment totals include all members enrolled during the report month. Members may not have expenditure data. Children are members aged 0 - 20 or for Insure Oklahoma enrolled as Students or Dependents. Dual Eligibles (Medicare & Medicaid) are in the Traditional delivery system in both the Low Cost (Q1 & SLMB) and High Cost (ABD) groups. OTHER includes DDSD, PKU, Q1, Refugee, SLMB, STBS and TB.

IN-STATE CONTRACTED PROVIDERS

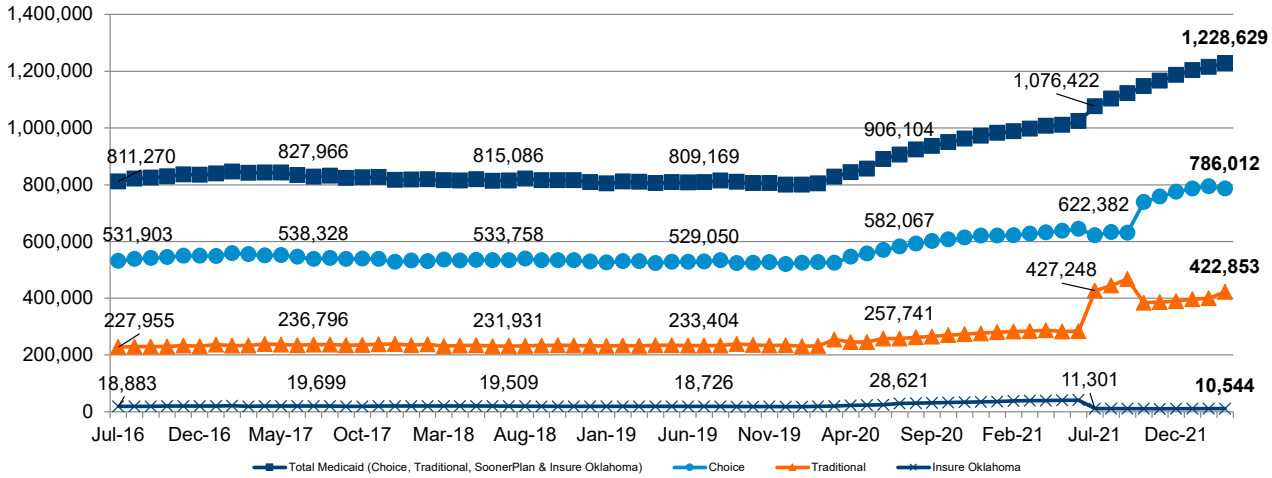
Total In-State Providers: 45,062 (+539) (In-State Providers counted multiple times due to multiple locations, programs, types, and specialties)

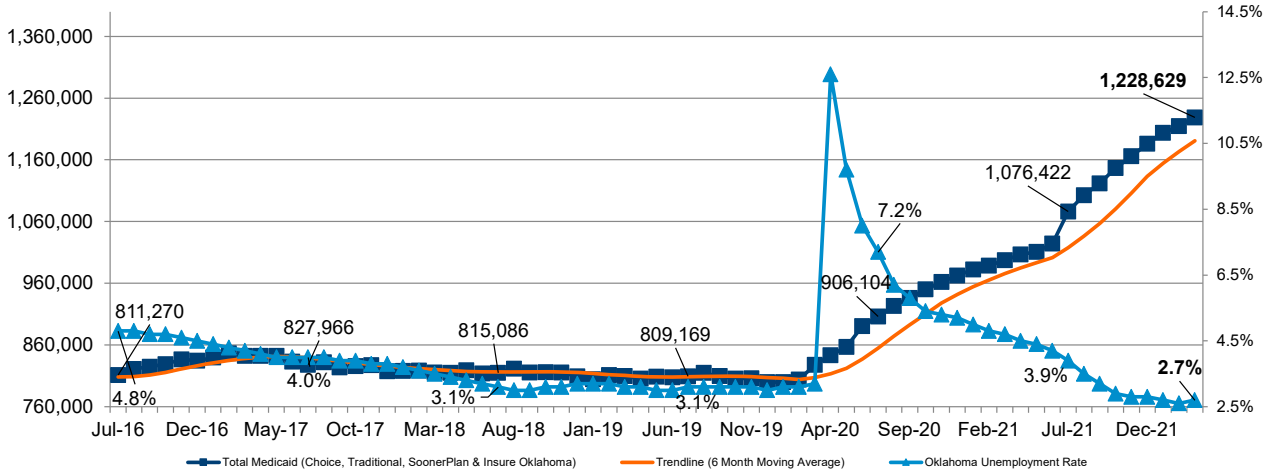




*In general, decreases are due to contract renewal. Decrease during contract renewal period is typical during all renewal periods. MH/BH is Mental Health and Behavioral Health providers. PCMH is Patient-Centered Medical Home (Choice) providers. IPF is Inpatient Psychiatric Facility.

ENROLLMENT BY MONTH





Oklahoma Unemployment Rate is from the Bureau of Labor Statistics 'Local Area Unemployment Statistics' (https://www.bls.gov/lau/) and is seasonally adjusted.

In June 2017 there were changes to the passive renewal system criteria that reduced the number of passively renewed members by 2/3rds. Increase in March 2020 due to COVID-19 economic impact and relief measures (Continuity of care by postponing recertifications). **Expansion was effective in July 2021.**

May MAC
Proposed Rules Amendment Summaries

The following work folders were posted on the Oklahoma Health Care Authority (OHCA) public website for a public comment period.

APA WF 22-03 Clinical Trials Routine Services and Dental Out-of-State Services — The proposed rule revisions will strike outdated language and add new language to the formerly named "Clinical Trials" policy Oklahoma Administrative Code (OAC) 317:30-3-57.1. To comply with new federal guidelines this policy will be renamed "Coverage of routine services in relation to clinical trials" and restructured to address qualifying clinical trials criteria, clinical trials determination standards, routine patient costs, and excluded items. Importantly, new language will be added that states that the Oklahoma Health Care Authority will provide a coverage determination decision for requested and medically necessary routine services within 72-hours for a member participating in a qualifying clinical trial.

Revisions to the out-of-state services policy, at OAC 317:30-3-90, will also add language to assure that clinical trials will be provided in accordance with federal regulations and that clinical trials do not follow all of the OHCA's out-of-state policy requirements. Furthermore, revisions will add a clause regarding the override for prior authorizations that are related to lodging and meals services when they are provided in accordance with an approved clinical trial. Finally, revisions will add language that allows for a SoonerCare member to travel up to one hundred miles (100) from the Oklahoma border to receive dental services.

Budget Impact: The proposed rule changes regarding clinical trial routine services are budget neutral. The clinical trials that have taken place to date involved fully contracted SoonerCare providers; providers which are already reimbursed for routine expenses related to clinical trials.

The proposed rule changes, regarding dental out-of-state services, are budget neutral. These services are already being provided-the new revisions are just eliminating a barrier.

Proposed Rule Timeline:
60-day Tribal Consultation Period: January 4, 2022 - March 5, 2022
Tribal Consultation: January 4, 2022
Emergency Rule Public Comment Period: April 18, 2022 – May 3, 2022
OHCA Board Meeting: June 22, 2022
Emergency Rule Effective Date: Upon Governor's signature or the 45th day post submission of the rules to the Governor (July 5, 2022)

APA WF 22-07 Tribal Residential Substance Use Disorder (SUD) Policy Updates — The proposed revisions will update policy at OAC 317:30-5-1094 to reflect that I/T/U providers will be reimbursed the outpatient OMB rate for rendered residential SUD services. This policy change aligns with the authority in the Oklahoma Medicaid State Plan and with current business practices.

Budget impact: Budget neutral

Proposed Rule Timeline:
60-day Tribal Consultation Period: February 15, 2022 – April 16, 2022
Tribal Consultation: March 1, 2022
Emergency Rule Public Comment Period: March 28, 2022 – April 12, 2022
OHCA Board Meeting: June 22, 2022

Emergency Rule Effective Date: Upon Governor's signature or the 45th day post submission of the rules to the Governor (July 5, 2022)

APA WF 22-08 Hospice Benefit for Expansion Adults — The proposed rule will add hospice services as a covered benefit for members eligible as expansion adults, described in the Code of Federal Regulations (C.F.R.) Title 42 Section 435.119. The proposed rule will outline hospice coverage, eligibility, reimbursement, provider qualifications/requirements, and prior authorization requirements.

Budget impact: The proposed rule to add hospice as a covered service for expansion adults may result in an estimated total cost of $584,135.13, with $58,413.51 in state share for SFY2022; and a total cost of $778,846.84, with $77,884.68 in state share for SFY2023.

Proposed Rule Timeline:
60-day Tribal Consultation Period: April 20, 2021 – June 24, 2021
Tribal Consultation: May 4, 2021
15-Day Emergency Rule Public Comment Period:
- August 18, 2021 – September 2, 2021
- May 3, 2022 – May 17, 2022

OHCA Board Meeting: June 22, 2022
Emergency Rule Effective Date: Upon Governor's signature or the 45th day post submission of the rules to the Governor (July 5, 2022)

APA WF # 22-09 Termination of SoonerPlan — The proposed revisions will revoke policy sections specific to the SoonerPlan program. The SoonerPlan program will terminate effective one day after the COVID-19 Public Health Emergency ends.

Budget Impact: The proposed rule changes are budget neutral.

Proposed Rule Timeline:
Expedited Tribal Consultation Period: April 22, 2022 - May 18, 2022
Tribal consultation: May 3, 2022
Emergency Rule Public Comment Period: May 3, 2022 – May 17, 2022
OHCA Board meeting: June 22, 2022 (This date is subject to change based on when OHCA is informed of the official Public Health Emergency end date.)
Emergency Rule Effective Date: Contingent upon Governor's approval or one day after the COVID-19 Public Health Emergency ends

APA WF 22-10 Long-term Care Facility (LTC) Pay-for-Performance (PFP) Program — Proposed rule revisions will remove outdated language and add new language to the LTC PFP program payment criteria section. These policy revisions will align with the proposed Oklahoma Medicaid State Plan amendment (OK SPA 22-0017). The overall purpose of the proposed rule revisions will be to maintain compliance with federal requirements and continuity of processes.

Budget Impact: Budget neutral

Proposed Rule Timeline:
60-day Tribal Consultation Period: May 3, 2022 – July 2, 2022
Tribal Consultation: May 3, 2022
Emergency Rule Public Comment Period: May 3, 2022 – May 18, 2022
OHCA Board Meeting: June 22, 2022

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

SUBCHAPTER 3. GENERAL PROVIDER POLICIES

PART 3. GENERAL MEDICAL PROGRAM INFORMATION

317:30-3-57.1. ~~Clinical trials~~Coverage of routine services in relation to clinical trials

~~(a) **Definition.** A clinical trial is a federally funded study that is either being conducted under an Investigational New Drug (IND) application or is exempt from having an IND application and helps to prevent, detect, or treat cancer or a life-threatening illness, injury, or disease.~~

~~(b) **Medical necessity.** Clinical trials must be determined to be medically necessary for the individual affected member. Documentation in the member's plan of care should support the medical necessity of the clinical trial for the affected individual member and that the clinical trial is for the medical purposes only. Requests for clinical trials in and of itself shall not constitute medical necessity. The Oklahoma Health Care Authority (OHCA) shall serve as the final authority pertaining to all determinations of medical necessity. Refer to Oklahoma Administrative Code (OAC) 317:30-3-1(f) for policy on medical necessity.~~

~~(c) **Documentation/requirements.** All documentation submitted to request services must demonstrate, through adequate objective medical records, evidence sufficient to justify the member's need for the service, in accordance with OAC 317:30-3-1(f)(2). An OHCA approved clinical trial must include the following:~~

~~(1) The clinical trial does one (1) of the following for the treatment of cancer or a life-threatening illness, injury, or disease:~~

~~(A) Tests how to administer a health care service;~~

~~(B) Tests responses to a health care service;~~

~~(C) Compares effectiveness of a health care service; or~~

~~(D) Studies new uses of a health care service.~~

~~(2) The clinical trial is approved and funded by one (1) of the following:~~

~~(A) Research facilities that have an established peer review program that has been approved by the National Institutes of Health Center (NIH);~~

~~(B) The Centers for Disease Control and Prevention;~~

~~(C) The Agency for Health Care Research and Quality (AHRQ);~~

~~(D) The Centers for Medicare and Medicaid Services (CMS);~~

~~(E) The United State Department of Veterans Affairs (VA);~~

~~(F) The United States Department of Defense (DOD);~~

~~(G) The Food and Drug Administration;~~

~~(H) The United States Department of Energy; or~~

~~(I) Research entities that meet the eligibility criteria for a support grant from a NIH center.~~

~~(3) Is conducted in a facility where the personnel have training and expertise needed to provide the type of care required and there is written protocol for the approved clinical trial;~~

~~(4) Complies with appropriate federal regulations regarding the protection of human subjects; and~~

~~(5) For full guidelines, please refer to www.okhca.org/mau.~~

~~(d) **Routine care costs.**~~

~~(1) The following are included in routine care costs for approved clinical trials and by a SoonerCare contracted provider:~~

~~(A) Costs that are required for the administration of the investigational item or service and are not a covered benefit of the clinical trial;~~

~~(B) Costs regarding the appropriate monitoring of the effects from the item or service; and~~

~~(C) Costs that are necessary for the prevention, diagnosis or treatment of medical complications for a non-covered item or service that was provided in the clinical trial.~~

~~(2) The following are excluded from routine care costs in approved clinical trials:~~

~~(A) The investigational item or service;~~

~~(B) Items or services that the study gives for free;~~

~~(C) Items or services that are only utilized when determining if the individual is eligible for the clinical trial;~~

~~(D) Items or services that are used only for data collection or analysis;~~

~~(E) Evaluations that are designed to only test toxicity or disease pathology;~~

~~(F) Experimental, investigational, and unproven treatments or procedures and all related services provided outside of an approved clinical trial; and~~

~~(G) Any non-FDA approved drugs that were provided or made available to the member during the approved clinical trial will not be covered after the trial ends.~~

~~(3) Applicable plan limitations for coverage for out-of-network and out-of-state providers will apply to routine care costs in an approved clinical trial.~~

~~(4) Applicable utilization management guidelines will apply to routine care costs in an approval clinical trial.~~

~~(e) **Experimental and investigational.** SoonerCare does not cover for medical, surgical, or other health care procedures, which are considered experimental or investigational in nature.~~

(a) **Coverage.** The Oklahoma Health Care Authority (OHCA) will cover routine patient costs provided under a qualifying clinical trial to an eligible member. The OHCA does not:

(1) Determine eligibility for participation in any research study; or

(2) Reimburse for any costs associated in the research study, other than for routine patient costs for clinical studies, as defined in this Section and in the Oklahoma Medicaid State Plan.

(b) **Qualifying clinical trials criteria.**

(1) Clinical trial, as adopted from the National Institute of Health (NIH) definition, means a research study in which one (1) or more human subjects are prospectively assigned to one (1) or more interventions, which may include placebo or other control, to evaluate the effects of those interventions on health-related biomedical or behavioral outcomes.

(2) Pursuant to Section 1905(a)(30) and 1905(gg) of the Act, as amended and added by Division CC, Title II, Section 210 of the Consolidated Appropriations Act, 2021 (Public Law 116-260, Section 210), qualifying clinical trial means a clinical trial, in any clinical phase of development, that is conducted in relation to the prevention, detection, or treatment of any serious or life-threatening disease or condition and is described in any of the following clauses:

(A) The clinical trial is approved, conducted, or supported (which may include funding through in-kind contributions) by one (1) or more of the following:

(i) The National Institutes of Health (NIH);

(ii) The Centers for Disease Control and Prevention (CDC);

(iii) The Agency for Healthcare Research and Quality (AHRC);

(iv) The Centers for Medicare and Medicaid Services (CMS);
(v) A cooperative group or center of any of the entities described above or of the Department of Defense or the Department of Veteran Affairs;
(vi) A qualified non-governmental research entity identified in guidelines issued by the National Institutes of Health for center support grants, including guidelines issued after the date of these rules; or
(vii) Any of the following if the clinical trial has been reviewed and approved through a system of peer review that the Secretary determines to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health and assures unbiased review of the highest scientific standards by qualified individuals with no interest in the outcome of the review:
(I) The Department of Veterans Affairs;
(II) The Department of Defense; or
(III) The Department of Energy.

(B) The clinical trial is conducted pursuant to an investigational new drug exemption under section 505(i) of the Federal Food, Drug, and Cosmetic Act or an exemption for a biological product undergoing investigation under section 351(a)(3) of the Public Health Service Act.
(C) The clinical trial is a drug trial that is exempt from being required to have an investigational new drug exemption or an exemption for a biological product undergoing investigation.

(3) Serious disease or condition, as adopted from 21 C.F.R. § 312.300, means a disease or condition associated with morbidity that has substantial impact on day-to-day functioning. Short-lived and self-limiting morbidity will usually not be sufficient, but the morbidity need not be irreversible, provided it is persistent or recurrent. Whether a disease or condition is serious is a matter of clinical judgment, based on its impact on such factors as survival, day-to-day functioning, or the likelihood that the disease, if left untreated, will progress from a less severe condition to a more serious one.
(4) Life-threatening disease or condition, as adopted from 21 C.F.R. § 312.300, means a stage of disease in which there is reasonable likelihood that death will occur within a matter of months or in which premature death is likely without early treatment.

(c) **Clinical trials determination standards.** Pursuant to Section 1905(a)(30) and 1905(gg) of the Act, as amended and added by Division CC, Title II, Section 210 of the Consolidated Appropriations Act, 2021 (Public Law 116-260, Section 210, the OHCA will expedite and complete a coverage determination for routine services under this Section within seventy-two (72) hours of receiving the required attestation as described below. The OHCA will maintain the following standards in any coverage determination under this section:

(1) **Attestation.** The health care provider and principal investigator for the qualifying clinical trial must submit a standardized form attestation to the OHCA regarding the appropriateness of the qualifying clinical trial for the individual member.
(2) **Expedited determination.** Upon receiving the completed required attestation, the OHCA will expedite and complete a coverage determination under this Section within seventy-two (72) hours. All documentation submitted to request services must demonstrate, through adequate objective medical records, evidence sufficient to meet at least one (1) definition in subsection (b)(3)-(4) above for the terms "serious disease or condition" or "life-threatening disease or condition".

(3) **Geographic and network allowance.** The OHCA will determine coverage under this Section without limitation on the geographic location or network affiliation of the health care provider treating the individual member or the principal investigator of the qualifying clinical trial.

(4) **Protocols and proprietary documentation.** The OHCA will determine coverage under this Section without requiring the submission of the protocols of the qualifying clinical trial or any other documentation that may be proprietary or determined by the Secretary to be burdensome to provide.

(5) **Documentation of serious or life-threatening disease or condition.** In determining coverage under this Section, the OHCA will consider existing or newly offered documentation that the individual member has been diagnosed with or is suffering from one (1) or more serious or life-threatening diseases or conditions that are the subject of the qualifying clinical trial as shown in the attestation.

(d) **Routine patient costs.**

(1) **Included items and services.** Routine patient costs include any item or service provided to Medicaid-eligible members under the qualifying clinical trial, including:

(A) Any item or service provided to prevent, diagnose, monitor, or treat complications resulting from participation in the qualifying clinical trial, to the extent that the provision of such items or services to the member would otherwise be covered outside the course of participation in the qualifying clinical trial under the Oklahoma Medicaid State Plan or waiver, including a demonstration project under section 1115 of the Act; and

(B) Any item or service required solely for the provision of the investigational item or services that is the subject of the qualifying clinical trial, including the administration of the investigational item or service.

(2) **Excluded items and services.** The following items and services are excluded from routine patient costs in qualifying clinical trials:

(A) Any investigational item or service that is:

(i) The subject of the qualifying clinical trial; and

(ii) Not otherwise covered outside of the clinical trial under the Oklahoma Medicaid State Plan or waiver, including a demonstration project under section 1115 of the Act; and

(B) Any item or service that is:

(i) Provided to the member solely to satisfy data collection and analysis for the qualifying clinical trial and is not used in the direct clinical management of the member; and

(ii) Not otherwise covered under the Oklahoma Medicaid State Plan or waiver, including a demonstration project under section 1115 of the Act.

PART 6. OUT-OF-STATE SERVICES

317:30-3-90. Out-of-state services

(a) Consistent with Section 431.52 of Title 42 of the Code of Federal Regulations (C.F.R.), an eligible SoonerCare member who is a resident of Oklahoma but who is temporarily out of state, may receive services from an out-of-state provider to the same extent that he or she would receive such services in Oklahoma, if:

(1) Medical services are needed for a medical emergency, as determined by the attending physician or other provider (M.D., D.O., P.A., or A.P.R.N), or a dentist [Doctor of Dental Surgery (DDS), or Doctor of Medicine in Dentistry (DMD)]. For any provider, who is not contracted at the time the services are provided, documentation as requested from the Oklahoma Health Care Authority (OHCA) of the emergency must be submitted, including, but not limited to, emergency room reports, medical histories, discharge summaries, and all other relevant medical reports.

(2) Medical services are needed and the member's health would be endangered if he or she were required to return to Oklahoma for medical care and treatment, as determined by the attending physician or other provider (M.D., D.O., P.A., or A.P.R.N), or a dentist [Doctor of Dental Surgery (DDS), or Doctor of Medicine in Dentistry (DMD)]. For any provider, who is not contracted at the time the services are provided, documentation of the nature and possible extent of the endangerment must be submitted as requested from the OHCA.

(3) The Oklahoma Health Care Authority's (OHCA) Chief Medical Officer (CMO), or his or her designee, determines, on the basis of medical advice, that the needed medical services, or necessary supplemental resources, are more readily available in the state where the member is located at the time of needing medical treatment. Prior authorization must be obtained from the OHCA's CMO, or his or her designee, before the services are rendered~~; or~~.

~~(4) The customary or general practice for members residing in a particular locality within Oklahoma is to use medical resources in another state, and the member is using a provider that is contracted with the OHCA.~~

(b) Per 42 C.F.R. § 431.52, if it is the customary or general practice for SoonerCare members who are residing in a particular locality within Oklahoma to use medical or dental resources in another state, reimbursement is available for services furnished in another State to the same extent that reimbursement for services is furnished within Oklahoma boundaries. The services being rendered must be provided by a provider who is contracted with the OHCA and must be appropriately licensed and in good standing with the state in which they practice.

~~(A)~~(1) Except for out-of-state inpatient psychiatric services, no prior authorization is necessary for services provided in accordance with paragraph ~~(a)~~(4)(b), above, if the member obtains them from an out-of-state provider that is:

~~(i)~~(A) Located in a border state (Arkansas, Colorado, Kansas, Missouri, New Mexico, or Texas) within fifty (50) miles of the Oklahoma border, with exceptions for dental services. The OHCA will allow the member to travel up to one hundred (100) miles of the Oklahoma border to receive dental services; and

~~(ii) Contracted with the OHCA;~~

~~(iii)~~(B) Provided, however, that nothing in this paragraph shall be interpreted to eliminate or otherwise affect a prior authorization requirement established by any other OHCA rule, including, but not limited to, Oklahoma Administrative Code (OAC) 317:30-3-31, that would have to be met if the health care-related good and/or service were provided in Oklahoma.

~~(B)~~(2) In all other instances, prior authorization must be obtained from the OHCA's CMO, or his or her designee, before the services are rendered.

(c) Clinical trials, either in-state or out-of-state, will need to adhere to any federal regulations which provides for certain exceptions to OHCA's out-of-state policy. For the full clinical trials policy, please refer to OAC 317:30-3-57.1.

~~(b)~~(d) Except as provided in subsections (a)(1),(a)(2) ~~and (a)(4)(A),~~(b)(1) and (c), above, SoonerCare will not pay for any services furnished by an out-of-state provider unless prior authorization has been obtained from the OHCA's CMO, or his or her designee, before the services are rendered. Prior authorization for out of state services must be obtained in all instances in which the member is located in Oklahoma at the time the services are determined to be medically necessary.

(1) As part of this authorization process, the following documents must be submitted to the OHCA's CMO, or his or her designee:

(A) Documents sufficient to establish the "medical necessity" of the services requested, as that term is defined by OAC 317:30-3-1(f). See also OAC 317:30-3-31, Prior authorization for health care-related goods and services. Examples of such documents may include, but are not limited to, Histories of Present Illnesses (HPIs), physical exams, laboratory reports, imaging reports, progress notes, hospital charts, and/or other relevant medical records; and

(B) Documents sufficient to establish that the health care needs of the member cannot be met in Oklahoma. Such documents shall include, but not be limited to, a letter from the referring provider that contains:

(i) A clear presentation of the member's medical condition and diagnosis for which out-of-state treatment is requested, including a summary of treatment to date that is supported by the documents in paragraph ~~(b)~~(c)(1)(A), above;

(ii) Names of physicians and/or facilities in Oklahoma that the member has previously been referred to for diagnosis and/or treatment;

(iii) Physicians consulted by the attending physician relative to diagnosis and/or availability of recommended treatment in Oklahoma;

(iv) Recommended treatment or further diagnostic work; and

(v) Reasons why medical care cannot be provided in Oklahoma or the next closest location outside Oklahoma.

(C) Except for emergency medical, behavioral health cases, and as provided in subsections (a)(1),(a)(2) and (b)(1), above, prior authorization requests for out-of-state services must be made in writing with all the necessary documents that show medical necessity and details of the services provided, including but not limited to, relevant medical history, description of services and procedures to be performed, Histories of Present Illnesses (HPIs), physical exams, laboratory reports, imaging reports, and received by the OHCA at least ten (10) calendar days prior to the date services are to be provided in another state or at the discretion of the CMO or his/her designee.

(i) Emergency medical, ~~or~~ behavioral health, and dental cases must be identified as such by the physician or provider in the prior authorization request.

(ii) Any telephone request for prior authorization of out-of-state services will only be accepted in emergency situations, and must be promptly followed by a written request.

(2) Prior authorization requirements for medically necessary lodging, transportation, and/or meals assistance associated with out-of-state services are established in other OHCA rules, including, but not limited to, OAC 317:30-3-92 and 317:30-5-327.1. In accordance with federal regulations, exceptions to prior authorization requirements will be made for members who are participating in a clinical trial that require out-of-state medically necessary services. For the full clinical trials policy, please refer to OAC 317:30-3-57.1.

~~(c)~~(e) The ~~restrictions~~limitations established in subsections (a) through ~~(b)~~(c), above, shall not apply to children who reside outside of Oklahoma and for whom the Oklahoma ~~Department of~~ Human Services (OKDHS) makes Title IV-E adoption assistance payments or Title IV-E foster care maintenance payments.

~~(d)~~(f) Denials of requests for prior authorization may be appealed in accordance with OAC 317:2-1-2(d)(1)(C).

~~(e)~~(g) Out-of-state providers shall, upon request by authorized OHCA representatives, make available fiscal and medical records as required by applicable federal regulations, OHCA rules, and the Provider Agreement. Such records shall be made available for review by authorized OHCA representatives at the OHCA's address in Oklahoma City, Oklahoma.

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

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

317:30-5-1094. Behavioral health services provided at I/T/Us

(a) **Inpatient behavioral health.** Services are covered when provided in accordance with a documented individualized service plan developed to treat the identified behavioral health needs. ~~Inpatient psychiatric service providers must meet the requirements and applicable limitations, restrictions, or prior authorization requirements set forth in Oklahoma Administrative Code (OAC) 317:30-5-95 through 317:30-5-97.~~

~~(1) The provision of inpatient psychiatric services by Indian Health Services (IHS) facilities are reimbursed at the OMB inpatient encounter rate. Inpatient psychiatric services provided by non-IHS facilities are reimbursed at the established per diem or DRG rate.~~

~~(2) For the provision of residential substance use disorder (SUD) treatment services, I/T/U facilities must be contracted as residential SUD service providers and meet the requirements found at OAC 317:30-5-95.43 through 317:30-5-95.49. Residential SUD treatment services will be reimbursed at the OMB outpatient encounter rate.~~

(1) Inpatient psychiatric service providers must meet the requirements and applicable limitations, restrictions, or prior authorization requirements set forth in Oklahoma Administrative Code (OAC) 317:30-5-95 through 317:30-5-97.

(2) The provision of inpatient psychiatric services by Indian Health Services (IHS) facilities are reimbursed at the OMB inpatient encounter rate. Inpatient psychiatric services provided by non-IHS facilities are reimbursed at the established per diem or DRG rate.

(b) **Outpatient behavioral health**. Services are covered when provided in accordance with a documented individualized service plan developed to treat the identified mental health needs and/or SUD. Outpatient behavioral health services are reimbursed at the I/T/U outpatient encounter rate unless otherwise noted in the section.

(1) A full description of services may be found at OAC 317:30-5-241 and 317:30-5-241.5(d), 317:30-5-241.7. Services may include, but are not limited to:

(A) Mental health and/or substance use assessment/evaluation and testing;
(B) Service plan development;
(C) Crisis intervention services;
(D) Medication training and support;
(F) Individual/interactive psychotherapy;
(G) Group psychotherapy;
(H) Family psychotherapy;
(I) Medication-assisted treatment (MAT) services and/or medication; and
(J) Peer recovery support specialist (PRSS) services.

(2) In order to support access to behavioral health services, these services may be provided in settings outside of the I/T/U. Offsite services must take place in a confidential setting.

(3) For the provision of behavioral health related case management services, I/T/U facilities must be fully contracted with the Oklahoma Health Care Authority (OHCA) as an outpatient behavioral health agency. The provision of these services is considered to be outside of the

I/T/U encounter and will be paid at the current FFS rate. Contracted behavioral health case management providers must comply with the requirements found at OAC 317:30-5-241.6 and are responsible for obtaining all necessary prior authorizations, if needed.

(4) For the provision of psychosocial rehabilitation services, I/T/U facilities must be fully contracted with the OHCA as an outpatient behavioral health agency. The provision of these services is considered to be outside of the I/T/U encounter and will be paid at the current FFS rate. Contracted psychosocial rehabilitation service providers must comply with the requirements found at OAC 317:30-5-241.3 and are responsible for obtaining all necessary prior authorizations, if needed.

(5) Services provided by behavioral health practitioners, such as, licensed clinical social workers (LCSW), licensed marital and family therapists (LMFT), licensed professional counselors (LPC), licensed behavioral health practitioners (LBHP), licensed alcohol and drug counselors (LADC), and licensure candidates are not eligible for direct reimbursement as practitioners. Services provided by the aforementioned practitioners are compensable only when billed by their OHCA-contracted employer and when provided in those clinical settings in which they are currently approved to render services. Licensure candidates must meet the requirements contained in OAC 317:30-5-240.3.

(6) Behavioral health services must be billed on an appropriate claim form using the appropriate procedure code and guidelines. The time indicated on the claim form must be the time actually spent with the member.

(c) **Residential substance use disorder (SUD).** For the provision of residential SUD treatment services, I/T/U facilities must be contracted as SoonerCare providers and meet the requirements found at OAC 317:30-5-95.43 through 317:30-5-95.49. Residential SUD treatment services will be reimbursed at the OMB outpatient encounter rate.

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 58. ~~NON-HOSPITAL BASED~~ HOSPICE

317:30-5-530. Eligible providers

~~Non-Hospital Affiliated Hospice entities must be appropriately licensed and have a contract with the Oklahoma Health Care Authority to provide Hospice services.~~

(a) Providers of hospice services will meet applicable state and federal licensing requirements and meet Medicare certification requirements to provide hospice services.

(b) Providers of hospice services will enter into a contractual agreement with the State Medicaid Agency, Oklahoma Health Care Authority (OHCA).

317:30-5-531. Coverage for adults

~~There is no coverage for hospice services provided Medicaid eligible adults except for the hospice provision provided through the ADvantage Waiver.~~

(a) **Definition.** Hospice care is a comprehensive, holistic program of palliative and/or comfort care and support provided to the member and his/her family when a physician certifies that the member has a terminal illness and has a life expectancy of six (6) months or less.

(1) Hospice services must be related to the palliation and management of the member's illness, symptom control, or to enable the individual to maintain activities of daily living and basic functional skills.

(2) Hospice care is performed under the direction of a physician as per the member's plan of care in an approved hospital hospice facility, in-home hospice program, or nursing facility.

(b) **Eligibility.** Coverage for hospice services is provided to Medicaid eligible expansion adults only.

(1) Expansion adults defined by 42 Code of Federal Regulations § 435.119 who are age nineteen (19) or older and under sixty-five (65), at or below one hundred thirty-three percent (133%) of the federal poverty level (FPL), and who are not categorically related to the aged, blind, or disabled eligibility group are eligible for hospice services.

(2) Hospice care eligibility requires physician certification that the member is terminally ill and includes a medical prognosis with a life expectancy of six (6) months or less if the illness runs its normal course. The terminal prognosis also must be supported by clinical documentation in the medical record.

(3) For information regarding hospice provision provided through waivers, refer to Oklahoma Administrative Code (OAC) 317:30-5-763, 317:30-5-1200, and 317:30-5-1202.

(c) **Covered services.** Hospice care services can include but not limited to:

(1) Nursing care;

(2) Physician services (e.g., physicians employed or working under arrangements made with the hospice);

(3) Medical equipment and supplies;

(4) Drugs for symptom control and pain relief;

(5) Home health aide services;

(6) Personal care services;

(7) Physical, occupational and/or speech therapy;

(8) Medical social services;

(9) Dietary counseling; and

(10) Grief and bereavement counseling to the member and/or family are required but are not reimbursable.

(d) **Prior authorization.** All services must be prior authorized, and a written plan of care must be established before services are rendered. For medical review purposes, all hospice services will be authenticated in accordance with OAC 317:30-3-30.

(e) **Service election.**

(1) The member or member's legal guardian or authorized representative must sign an election statement, choosing hospice care instead of routine medical care with the objective to treat and cure the member's terminal illness, and by doing so waives his or her right to other Medicaid benefits, except for care not related to the terminal illness and care provided by the attending physician.

(2) Once the member, legal guardian, or member's authorized representative has elected hospice care, the hospice medical team assumes responsibility for the member's medical care for the terminal illness.

(f) **Service revocation.**

(1) Hospice care services may be revoked by the member, legal guardian, or authorized representative at any time.

(2) Upon revoking the election of Medicaid coverage of hospice care for a particular election period, the member resumes Medicaid coverage of the benefits waived when hospice care was elected.

(3) The member may at any time elect to receive hospice coverage for any other hospice election periods for which he or she is eligible.

(g) **Service frequency.** Hospice care services:

(1) Are available for an initial two (2) ninety-day (90-day) certification periods. After the two (2) initial ninety-day (90-day) periods, a member is allowed an unlimited number of sixty-day (60-day) certification periods during the remainder of the member's lifetime. Each certification period requires a new prior authorization.

(2) Require a hospice physician or nurse practitioner to have a face-to-face encounter with the member to determine if the member's terminal illness necessitates continuing hospice care services. The encounter should take place prior to the one hundred eightieth (180^{th}) day recertification and each subsequent recertification thereafter; and attest that such visit took place.

(h) **Documentation.** Initial documentation requirements for requesting services, documentation requirements for continuation of services, and the full hospice guidelines can be found at OHCA's website, https://oklahoma.gov/ohca.

(i) **Reimbursement.**

(1) SoonerCare shall provide hospice care reimbursement:

(A) For each day that an individual is under the care of a hospice, the hospice will be reimbursed an amount applicable to the level, type and intensity of the services furnished to the individual for that day in accordance with the Oklahoma Medicaid State Plan.

(B) For independent physician direct services in accordance with the Oklahoma Medicaid State Plan.

(2) Through the Oklahoma Medicaid State Plan, the OHCA established payment amounts for the following categories:

(A) **Routine hospice care.** Member is at home and not receiving hospice continuous

care.

(B) **Continuous home care.** Member is not in an inpatient facility and receives hospice on a continuous basis at home; primarily consisting of nursing care to achieve palliation and management of acute medical symptoms during a brief period of crisis only as necessary to maintain the terminally ill patient at home. If less skilled care is needed on a continuous basis to enable the person to remain at home, this is covered as routine hospice care.

(C) **Inpatient respite care.** Member receives care in an approved inpatient facility on a short-term basis for respite.

(D) **General inpatient care.** Member receives general inpatient care in an inpatient facility for pain control or acute or chronic symptom management that cannot be managed at home.

(E) **Nursing facility (NF)/intermediate care facilities for individuals with intellectual disabilities (ICF/IID) care**. Member receives hospice care in a NF or ICF/IID. Hospice nursing facility or ICF/IID room and board per diem rates are reimbursed to the in-home hospice provider at a rate equal to 95% of the skilled nursing facility rate. The hospice provider is responsible for passing the room and board payment through to the NF or ICF/IID. If Medicare is the primary payer of hospice benefits, OHCA will only reimburse the hospice provider for coinsurance and deductible amounts per the Oklahoma Medicaid State Plan and will continue to pay the room and board to the nursing facility.

(F) **Service intensity add-on**. Member receives care by a registered nurse (RN) or social worker when provided in the last seven (7) days of his/her life.

(G) **Other general reimbursement items.**

(i) **Date of discharge**. For the day of discharge from an inpatient unit, the appropriate home care rate is to be paid unless the patient dies as an inpatient. When the patient is discharged as deceased, the inpatient rate, either general or respite, is to be paid for the discharge date.

(ii) **Inpatient day cap**. Payments to a hospice for inpatient care must be limited according to the number of days of inpatient care furnished to Medicaid patients. During the twelve-month (12-month) period beginning October 1 of each year and ending September 30, the aggregate number of inpatient days (both for general inpatient care and inpatient respite care) may not exceed twenty percent (20%) of the aggregate total number of days of hospice care provided to all Medicaid recipients during that same period. This limitation is applied once each year, at the end of the hospices' cap period.

(iii) **Obligation of continuing care**. After the member's Medicare hospice benefit expires, the patient's Medicaid hospice benefits do not expire. The hospice must continue to provide the recipient's care until the patient expires or until the member revokes the election of hospice care.

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

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

I/T/U covered services provided off-site or outside of the I/T/U setting, including but not limited to hospice services, mobile clinics, or places of residence, are compensable at the OMB rate when billed by an I/T/U that has been designated as a Federally Qualified Health Center. The

I/T/U must meet provider participation requirements listed in OAC 317:30-5-1088. I/T/U off-site services may be covered if the services rendered were within the provider's scope of practice and are of the same integrity of services rendered at the I/T/U facility.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 35. MEDICAL ASSISTANCE FOR ADULTS AND CHILDREN-ELIGIBILITY

SUBCHAPTER 5. ELIGIBILITY AND COUNTABLE INCOME

PART 1. DETERMINATION OF QUALIFYING CATEGORICAL RELATIONSHIP

317:35-5-8. Determining categorical relationship for the SoonerPlan Family Planning Program [REVOKED]

~~All non-pregnant women and men ages 19 and older, regardless of pregnancy or paternity history, who are otherwise ineligible for SoonerCare are categorically related to the SoonerPlan Family Planning Program. If eligible for SoonerCare benefits, the individual can choose to enroll only in SoonerPlan with the option of applying for SoonerCare at any time.~~

317:35-7-48. Eligibility for the SoonerPlan Family Planning Program [REVOKED]

~~(a) Non-pregnant women and men ages 19 and above are eligible to receive family planning services if they meet all of the conditions of eligibility in paragraphs (1), (2), (3), and (4) of this Subsection. This is regardless of pregnancy or paternity history and includes women who gain eligibility for SoonerCare family planning services due to a pregnancy, but whose eligibility ends 60 days postpartum.~~

~~(1) MAGI financial eligibility rules are used to determine eligibility for SoonerPlan.~~

~~(2) MAGI household composition rules are used to determine eligibility for SoonerPlan.~~

~~(3) SoonerPlan members with minor dependent children and a parent absent from the home are required to cooperate with the Oklahoma Department of Human Services, Child Support Services Division (OCSS) in the collection of child support payments. Federal regulations provide a waiver of this requirement when cooperation is not in the best interest of the child.~~

~~(4) Individuals eligible for SoonerCare can choose to enroll only in the SoonerPlan Family Planning Program with the option of applying for SoonerCare at any time.~~

~~(5) Persons who have Medicare or creditable health insurance coverage are not precluded from applying for the SoonerPlan Family Planning program.~~

~~(b) All health insurance is listed on applicable systems in order for OHCA Third Party Liability Unit to verify insurance coverage. The OHCA is the payer of last resort.~~

~~(c) Income for the SoonerPlan Family Planning Program does not require verification, unless questionable. If the income is questionable the worker must verify the income.~~

~~(d) There is not an asset test for the SoonerPlan Family Planning Program.~~

317:35-7-60.1. Certification for the SoonerPlan Family Planning Program. [REVOKED]

~~The effective date of certification for the SoonerPlan Family Planning Program is the date of application or later. The period of certification may not be for a retroactive period. An individual determined eligible for the SoonerPlan Family Planning Program is assigned a certification period of 12 months. At any time during the certification period the individual becomes ineligible, the case is closed using standard negative action procedures. At the end of the certification period, a redetermination of eligibility is required.~~

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 9. LONG-TERM CARE FACILITIES

317:30-5-136.1. Pay-for-Performance (PFP) program

(a) **Purpose.** The PFP program was established through Oklahoma State Statute, Title 56, Section 56-1011.5 as amended. PFP's mission is to enhance the quality of life for target citizens by delivering effective programs and facilitating partnerships with providers and the community they serve. The program has a full commitment to the very best in quality, service and value which will lead to measurably improved quality outcomes, healthier lifestyles, greater satisfaction and confidence for our members.

(b) **Eligible providers.** Any Oklahoma long-term care nursing facility that is licensed and certified by the Oklahoma State Department of Health (OSDH) as defined in Oklahoma Administrative Code (OAC) 317:30-5-120.

(c) **Quality measure care criteria.** To maintain status in the PFP program, each nursing facility shall submit documentation as it relates to program metrics quarterly or upon the request of the Oklahoma Health Care Authority (OHCA). The program metrics can be found on the OHCA's PFP website or on PFP/Quality of Care (QOC) data collection portal. If any quality metric, listed below, is substituted or removed by Centers of Medicare and Medicaid Services (CMS), an alternative quality metric may be chosen with the support of participating partners. For the period beginning October 1, 2019 and until changed by amendment, qualifying facilities participating in the PFP program have the potential to earn an average of the five dollars ($5.00) quality incentive per Medicaid patient per day. Facility(s) baseline is calculated annually and will remain the same for the twelve (12) month period. Facility(s) will meet or exceed five-percent (5%) relative improvement or the CMS' national average each quarter for the following metrics:

(1) Decrease percent of high risk/unstageable pressure ulcers for long-stay residents.

(2) Decrease percent of unnecessary weight loss for long-stay residents.

(3) Decrease percent of use of anti-psychotic medications for long-stay residents.

(4) Decrease percent of urinary tract infection for long-stay residents.

(d) **Payment.** Payment to long-term care facilities for meeting the metrics will be awarded quarterly. A facility may earn a minimum of one dollar and twenty-five cents ($1.25) per Medicaid patient per day for each qualifying metric. A facility receiving a scope and severity tag deficiency of "I" or greater ~~related to a targeted quality measure in the program is disqualified from receiving an award related to that measure for that quarter.~~from the Oklahoma State Department of Health will forfeit the PFP incentive for being out of compliance.

(1) **Distribution of payment.** OHCA will notify the PFP facility of the quality reimbursement amount on a quarterly basis.

(2) **Penalties.** Facilities shall have performance review(s) and provide documentation upon request from OHCA to maintain program compliance. Program payments will be withheld from facilities that fail to submit the requested documentation within fifteen (15) business days of the request.

(3) **Timeframe.** To qualify for program reimbursement by meeting a specific quality measure, facilities are required to provide metric documentation within thirty (30) days after the end of

each quarter to the OHCA.

(e) **Appeals.** Facilities can file an appeal with the Quality Review Committee and in accordance, with the grievance procedures found at OAC 317:2-1-2(c) and 317:2-1-17.