Oklahoma Health Care Authority
MEDICAL ADVISORY COMMITTEE
September 7, 2023
1:00 – 3:30 PM
Charles Ed McFall Board Room

AGENDA

Please access via zoom:
https://www.zoomgov.com/webinar/register/WN_1wkCUwRuTvWcOBYAgo-B0A
Telephone: 1-669-254-5252 Webinar ID: 161 731 9253

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

II. Action Item: Approval of Minutes of the July 13, 2023: **Medical Advisory Committee Meeting**

III. Public Comments (2 minute limit)

IV. MAC Member Comments/Discussion

V. Financial Report: **Josh Richards, Senior Director of Financial Services**

VI. Medicaid Directors Update: **Traylor Rains, State Medicaid Director**

- **A.** MAC Review of SoonerSelect CE Marketing Materials**: Christina Foss, Deputy Chief of Staff**
- **B.** SoonerSelect Update: **Sandra Puebla, Deputy State Medicaid Officer**
- **C.** HIE Strategic Planning Update: **Stephen Miller, State Coordinator for Health Information Exchange**

VII. Proposed Rule Changes: Presentation, Discussion, and Vote: **Kasie McCarty, Senior Director of Federal and State Authorities**

- **A. APA WF # 23-08 Non-Payment of Provider Preventable Conditions**
- **B. APA WF # 22-13 Secure Mental Health Transportation**
- **C. APA WF # 23-15 Biosimilar Reimbursement**
- **D. APA WF # 23-18 Twelve-months Continuous Eligibility for Children in Medicaid and CHIP**

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

IX. Future Meeting: **Chairman, Jason Rhynes, O.D.**

November 2, 2023

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

Oklahoma Health Care Authority
MEDICAL ADVISORY COMMITTEE
MINUTES of the July 13, 2023, 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 3:30 PM.

Delegates present were: Mr. Nick Barton, Ms. Joni Bruce, Dr. Steven Crawford, Ms. Wanda Felty, Dr. Arlen Foulks, Ms. Jennifer King, Ms. Melissa Miller, Dr. Daniel Post, and Dr. Jason Rhynes providing a quorum.

Alternates present were: Mr. Steven Buck, and Ms. Buffy Heater

***Delegates absent without an alternate were*:** Ms. Janet Cizek, Dr. Raymond Smith, Dr. Marny Dunlap and Dr. Whitney Yeates.

II. Approval of the May 4th, 2023 Minutes

Medical Advisory Committee

The motion to approve the minutes was by Dr. Daniel Post and seconded by Dr. Steven Crawford 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.

VIII. Proposed Rule Change: Presentation, Discussions, and Vote:

Kasie McCarty, Senior Director of Federal and State Authorities

APA WF # 23-17 Statewide Health Information Exchange (HIE) – Oklahoma Senate Bill 1369 of the 2022 Legislative Session implemented changes to the Statewide HIE resulting in the Agency adopting permanent rules on March 22, 2023 and the Governor subsequently disapproving those rules on June 23, 2023. The new proposed emergency revisions were written to align policy with feedback received from members, providers, and the Governor which allow the HIE Coordinator to grant exemptions from the HIE when requested by any provider. Additionally, the proposed revisions provide information about the availability of grant funds to help cover connection fees.

Budget Impact: The proposed rules are budget neutral for the agency; however, there will be a cost for providers to connect and subscribe to the statewide HIE as well as grant funds to help cover the connection costs.

The rule change motion to approve as by Ms. Joni Bruce and seconded by Dr. Arlen Foulks and passes unanimously.

IX. MAC Meeting Dates for Calendar 2023:

Chairman, Jason Rhynes, O.D.

September 7, 2023
November 2, 2023

X. **New Business:**

Chairman, Jason Rhynes, O.D.

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 3:05pm.

OKLAHOMA
Health Care Authority

FINANCIAL REPORT

For the Fiscal Year Ended June 30, 2023
Submitted to the CEO & Board

- Revenues for OHCA through June, accounting for receivables, were **$7,925,723,889** or **0.1% over** budget.
- Expenditures for OHCA, accounting for encumbrances, were **$7,628,184,917** or **0.6% under** budget.
- The state dollar budget variance through June is a positive **$47,410,064.**
- The budget variance is primarily attributable to the following (in millions):

Expenditures:		
Medicaid Program Variance		6.8
Administration		3.4
Revenues:		
Drug Rebate		5.9
Medical Refunds		1.4
Taxes and Fees		29.9
Total FY 23 Variance	**$**	**47.4**

ATTACHMENTS

OKLAHOMA HEALTH CARE AUTHORITY
Summary of Revenues & Expenditures: OHCA
SFY 2023, For the Fiscal Year Ended June 30, 2023

REVENUES	FY23 Budget YTD	FY23 Actual YTD	Variance	% Over/ (Under)
State Appropriations	$ 1,088,276,322	$ 1,089,494,387	$ 1,218,065	0.1%
Federal Funds	5,738,077,185	5,677,585,467	(60,491,718)	(1.1)%
Tobacco Tax Collections	46,716,500	42,365,844	(4,350,656)	(9.3)%
Quality of Care Collections	90,829,851	92,095,527	1,265,676	1.4%
Prior Year Carryover	17,057,261	17,057,261	-	0.0%
Federal Deferral - Interest	1,133,809	1,133,809	-	0.0%
Drug Rebates	650,620,656	678,255,610	27,634,954	4.2%
Medical Refunds	36,249,709	43,096,687	6,846,978	18.9%
Prior Year Carryover Supplemental Hospital Offset Payment Program	-	-	-	0.0%
Supplemental Hospital Offset Payment Program	242,398,354	275,468,523	33,070,169	13.6%
Other Revenues	9,194,026	9,170,774	(23,253)	(0.3)%
TOTAL REVENUES	**$ 7,920,553,673**	**$ 7,925,723,889**	**$ 5,170,216**	**0.1%**

EXPENDITURES	FY23 Budget YTD	FY23 Actual YTD	Variance	% (Over)/ Under
ADMINISTRATION - OPERATING	**$ 65,258,822**	**$ 59,485,541**	**$ 5,773,281**	**8.8%**
ADMINISTRATION - CONTRACTS	**$ 139,457,490**	**$ 132,947,117**	**$ 6,510,373**	**4.7%**
MEDICAID PROGRAMS				
Managed Care:				
SoonerCare Choice	57,832,535	58,745,297	(912,762)	(1.6)%
Acute Fee for Service Payments:				
Hospital Services	1,726,054,380	1,726,557,448	(503,068)	(0.0)%
Behavioral Health	34,206,437	33,249,408	957,029	2.8%
Physicians	629,200,389	621,287,393	7,912,996	1.3%
Dentists	256,047,226	252,815,665	3,231,561	1.3%
Other Practitioners	92,004,631	89,094,707	2,909,924	3.2%
Home Health Care	30,176,483	30,322,092	(145,609)	(0.5)%
Lab & Radiology	49,478,098	50,094,804	(616,706)	(1.2)%
Medical Supplies	101,759,058	104,302,133	(2,543,074)	(2.5)%
Ambulatory/Clinics	672,974,419	666,199,572	6,774,847	1.0%
Prescription Drugs	1,679,892,334	1,670,281,771	9,610,563	0.6%
OHCA Therapeutic Foster Care	402,748	404,977	(2,229)	(0.6)%
Other Payments:				
Nursing Facilities	834,287,396	833,632,554	654,843	0.1%
Intermediate Care Facilities for Individuals with Intellectual Disabilities Private	69,672,481	66,999,703	2,672,779	3.8%
Medicare Buy-In	245,608,802	244,741,481	867,321	0.4%
Transportation	137,774,825	139,589,278	(1,814,453)	(1.3)%
Money Follows the Person-OHCA	608,069	624,409	(16,340)	(2.7)%
Electronic Health Records-Incentive Payments	(17,880)	(17,880)	-	0.0%
Part D Phase-In Contribution	78,821,702	78,749,751	71,951	0.1%
Supplemental Hospital Offset Payment Program	756,274,913	756,270,749	4,164	0.0%
Telligen	12,560,024	11,806,950	753,074	6.0%
Total OHCA Medical Programs	**7,465,619,071**	**7,435,752,259**	**29,866,811**	**0.4%**
OHCA Non-Title XIX Medical Payments	89,382	-	89,382	0.0%
TOTAL OHCA	**$ 7,670,424,765**	**$ 7,628,184,917**	**$ 42,239,847**	**0.6%**
REVENUES OVER/(UNDER) EXPENDITURES	**$ 250,128,908**	**$ 297,538,972**	**$ 47,410,064**	

OKLAHOMA HEALTH CARE AUTHORITY

Total Medicaid Program Expenditures
by Source of State Funds
SFY 2023, For the Fiscal Year Ended June 30, 2023

Category of Service	Total	Health Care Authority	Quality of Care	Insure Oklahoma	SHOPP	BCC	Other State Agencies
SoonerCare Choice	$ 58,745,297	$ 58,740,447	$ -	$ -	$ -	$ 4,850	$ -
Inpatient Acute Care	1,933,959,902	951,322,640	486,687	(4,698)	534,936,669	838,323	446,380,281
Outpatient Acute Care	962,742,990	771,193,031	41,604	(4,374)	188,837,566	2,675,164	-
Behavioral Health - Inpatient	121,297,903	20,750,487	-	-	27,126,307	-	73,421,109
Behavioral Health - Psychiatrist	17,869,128	12,493,438	-	-	5,370,207	5,483	-
Behavioral Health - Outpatient	21,371,344	-	-	-	-	-	21,371,344
Behaviorial Health-Health Home	(2,398)	-	-	-	-	-	(2,398)
Behavioral Health Facility- Rehab	268,831,352	-	-	-	-	229,848	268,831,352
Behavioral Health - Case Management	6,644,489	-	-	-	-	-	6,644,489
Behavioral Health - PRTF	13,695,723	-	-	-	-	-	13,695,723
Behavioral Health - CCBHC	363,780,517	-					363,780,517
Residential Behavioral Management	19,952,168	-	-	-	-	-	19,952,168
Targeted Case Management	83,453,272	-	-	-	-	-	83,453,272
Therapeutic Foster Care	404,977	404,977	-	-	-	-	-
Physicians	759,802,480	620,000,021	58,101	(955)	-	1,229,271	138,516,041
Dentists	252,815,665	252,736,493	-	-	-	79,171	-
Mid Level Practitioners	1,499,795	1,498,416	-	-	-	1,379	-
Other Practitioners	87,594,928	87,088,596	446,364	16	-	59,952	-
Home Health Care	30,322,092	30,319,891	-	-	-	2,201	-
Lab & Radiology	50,094,804	50,021,795	-	-	-	73,009	-
Medical Supplies	104,302,133	101,551,275	2,711,532	-	-	39,326	-
Clinic Services	681,869,405	652,247,116	-	398	-	298,977	29,322,914
Ambulatory Surgery Centers	13,653,479	13,643,800	-	-	-	9,679	-
Personal Care Services	9,961,475	-	-	-	-	-	9,961,475
Nursing Facilities	833,632,554	425,081,661	408,550,401	-	-	491	-
Transportation	139,149,465	136,946,805	2,024,547	1,871	-	176,243	-
IME/DME	72,481,648	-	-	-	-	-	72,481,648
ICF/IID Private	66,999,703	45,441,489	21,558,214	-	-	-	-
ICF/IID Public	29,196,872	-	-	-	-	-	29,196,872
CMS Payments	323,491,232	323,053,510	437,722	-	-	-	-
Prescription Drugs	1,670,264,423	1,667,967,407	-	(17,348)	-	2,314,364	-
Miscellaneous Medical Payments	441,684	438,477	-	-	-	3,207	-
Home and Community Based Waiver	281,088,654	-	-	-	-	-	281,088,654
Homeward Bound Waiver	80,725,495	-	-	-	-	-	80,725,495
Money Follows the Person	3,469,856	624,409	-	-	-	-	2,845,448
In-Home Support Waiver	36,655,851	-	-	-	-	-	36,655,851
ADvantage Waiver	226,225,403	-	-	-	-	-	226,225,403
Family Planning/Family Planning Waiver	1,622,208	-	-	-	-	-	1,622,208
Premium Assistance*	41,481,110	-	-	41,481,110.09	-	-	-
Telligen	11,806,950	11,806,950	-	-	-	-	-
Electronic Health Records Incentive Payments	(17,880)	(17,880)	-	-	-	-	-
Total Medicaid Expenditures	**$ 9,683,378,145**	**$ 6,235,355,247**	**$ 436,315,171**	**$ 41,456,021**	**$ 756,270,749**	**$ 8,040,940**	**$ 2,206,169,866**

* Includes $41,108,373.96 paid out of Fund 245

OKLAHOMA HEALTH CARE AUTHORITY
Summary of Revenues & Expenditures:
Other State Agencies
SFY 2023, For the Fiscal Year Ended June 30, 2023

REVENUE		FY23 Actual YTD
Revenues from Other State Agencies		479,831,573
Federal Funds		1,779,620,429
TOTAL REVENUES	**$**	**2,259,452,002**

EXPENDITURES	Actual YTD
Oklahoma Human Services	
Home and Community Based Waiver	281,088,654
Money Follows the Person	2,845,448
Homeward Bound Waiver	80,725,495
In-Home Support Waivers	36,655,851
Advantage Waiver	226,225,403
Intermediate Care Facilities for Individuals with Intellectual Disabilities Public	29,196,872
Personal Care	9,961,475
Residential Behavioral Management	13,592,906
Targeted Case Management	70,332,585
Total Oklahoma Human Services	**750,624,688**
State Employees Physician Payment	
Physician Payments	138,516,041
Total State Employees Physician Payment	**138,516,041**
Education Payments	
Indirect Medical Education	39,124,998
Direct Medical Education	8,161,559
DSH	25,195,091
Total Education Payments	**72,481,648**
Office of Juvenile Affairs	
Targeted Case Management	2,124,527
Residential Behavioral Management	6,359,263
Total Office of Juvenile Affairs	**8,483,789**
Department of Mental Health & Substance Abuse Services	
Case Management	6,644,489
Inpatient Psychiatric Free-standing	73,421,109
Outpatient	21,371,344
Health Homes	(2,398)
Psychiatric Residential Treatment Facility	13,695,723
Certified Community Behavioral Health Clinics	363,780,517
Rehabilitation Centers	268,831,352
Total Department of Mental Health & Substance Abuse Services	**747,742,136**
State Department of Health	
Children's First	558,115
Sooner Start	834,367
Early Intervention	6,118,747
Early and Periodic Screening, Diagnosis, and Treatment Clinic	1,227,760
Family Planning	712,523
Family Planning Waiver	909,685
Maternity Clinic	34,317
Total Department of Health	**10,395,513**
County Health Departments	
EPSDT Clinic	499,399
Family Planning Waiver	-
Total County Health Departments	**499,399**
State Department of Education	**199,832**
Public Schools	**4,119,466**
Medicare DRG Limit	**425,300,986**
Native American Tribal Agreements	**26,727,072**
Department of Corrections	**6,103,439**
JD McCarty	**14,975,856**

Total OSA Medicaid Programs	**$**	**2,206,169,866**
OSA Non-Medicaid Programs	**$**	**79,987,694**
Accounts Receivable from OSA	**$**	**26,705,558**

OKLAHOMA HEALTH CARE AUTHORITY

SUMMARY OF REVENUES & EXPENDITURES:

Fund 205: Supplemental Hospital Offset Payment Program Fund

SFY 2023, For the Fiscal Year Ended June 30, 2023

REVENUES		FY 23 Revenue
SHOPP Assessment Fee		275,269,648
Federal Draws	$	633,875,625
Interest		198,875
Penalties		-
TOTAL REVENUES	$	909,344,148

EXPENDITURES	Quarter	Quarter	Quarter	Quarter		FY 23 Expenditures
Program Costs:	7/1/22 - 9/30/22	10/1/22 - 12/31/22	1/1/23 - 3/31/23	4/1/23 - 6/30/23		
Hospital - Inpatient Care	63,024,796	75,134,606	70,653,264	72,702,552	$	281,515,219
Hospital -Outpatient Care	17,328,429	37,624,389	25,238,768	25,759,110	$	105,950,696
Psychiatric Facilities-Inpatient	3,356,599	3,885,836	3,706,106	3,811,307	$	14,759,849
Rehabilitation Facilities-Inpatient	754,585	873,881	582,112	598,636	$	2,809,215
Hospital - Inpatient Care - Expansion	63,991,142	74,913,904	55,090,213	59,426,191	$	253,421,450
Hospital -Outpatient Care - Expansion	13,361,525	28,372,522	20,054,500	21,098,322	$	82,886,870
Psychiatric Facilities-Inpatient - Expansion	2,540,039	3,879,726	2,832,020	3,114,674	$	12,366,458
Rehabilitation Facilities-Inpatient - Expansion	754,446	872,507	444,821	489,217	$	2,560,992
Total OHCA Program Costs	165,111,562	225,557,371	178,601,805	187,000,010		756,270,749
Total Expenditures					$	756,270,749

SHOPP Revenue transferred to Fund 340 for Medicaid Program expense	$	153,073,400

*** 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 2023, For the Fiscal Year Ended June 30, 2023

REVENUES	Total Revenue	State Share
FY22 EFMAP Surplus	$ 7,740,157	$ 7,740,157
Quality of Care Assessment	$ 92,056,239	$ 92,056,239
*Quality of Care Penalties (*Non-Spendable Revenue)*	$ 227,813	$ 227,813
Interest Earned	$ 39,288	$ 39,288
TOTAL REVENUES	**$ 100,063,496**	**$ 100,063,496**

EXPENDITURES	FY 23 Total $ YTD	FY 23 State $ YTD	Total State $ Cost
Program Costs			
Nursing Facility Rate Adjustment	$ 238,068,521	$ 50,974,204	
Eyeglasses and Dentures	226,998	$ 48,604	
Personal Allowance Increase	2,837,880	$ 607,686	
Coverage for Durable Medical Equipment and Supplies	2,711,532	$ 583,047	
Coverage of Qualified Medicare Beneficiary	1,032,756	$ 222,068	
Part D Phase-In	437,722	$ 437,722	
ICF/IID Rate Adjustment	4,657,635	$ 996,642	
Acute Services ICF/IID	6,886,628	$ 1,474,284	
Non-emergency Transportation - Soonerride	2,024,547	$ 433,402	
NF Covid-19 Supplemental Payment	167,417,002	$ 35,950,457	
ICF Covid-19 Supplemental Payment	10,013,950	$ 2,149,637	
Ventilator NF DME Supplemental Payment		$ -	
Total Program Costs	**$ 436,315,171**	**$ 93,877,752**	**$ 93,877,752**
Administration			
OHCA Administration Costs	$ 297,175	$ 148,587	
OHS-Ombudsmen	288,622	288,622	
OSDH-Nursing Facility Inspectors	-	-	
Mike Fine, CPA	13,800	6,900	
Total Administration Costs	**$ 599,597**	**$ 444,109**	**$ 444,109**
Total Quality of Care Fee Costs	**$ 436,914,768**	**$ 94,321,862**	
TOTAL STATE SHARE OF COSTS			**$ 94,321,862**

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 2023, For the Fiscal Year Ended June 30, 2023

REVENUES	FY 22 Carryover	FY 23 Revenue	Total Revenue
Prior Year Balance	$ 14,187,453		
State Appropriations	-		
Federal Draws - Prior Year	265,676		
Total Prior Year Revenue			14,453,129
Transfer to 340 for Expansion-current year		-	-
Tobacco Tax Collections	-	34,844,514	34,844,514
Interest Income	-	339,838	339,838
Federal Draws	-	33,466,257	33,466,257
TOTAL REVENUES	$ 14,453,129	$ 68,650,609	$ 83,103,738

EXPENDITURES		FY 22 Expenditures	FY 23 Expenditures	Total State $ YTD
Program Costs:				
	Employer Sponsored Insurance		$ 41,108,374	$ 41,108,374
	College Students/ESI Dental		372,736	79,760
Individual Plan				
	SoonerCare Choice		$ -	$ -
	Inpatient Hospital		(4,553)	(968)
	Outpatient Hospital		(4,417)	(942)
	BH - Inpatient Services-DRG		-	-
	BH -Psychiatrist		-	-
	Physicians		(955)	(234)
	Dentists		-	-
	Mid Level Practitioner		-	-
	Other Practitioners		16	3
	Home Health		-	-
	Lab and Radiology		-	-
	Medical Supplies		-	-
	Clinic Services		398	82
	Ambulatory Surgery Center		-	-
	Skilled Nursing		-	-
	Prescription Drugs		(17,002)	(3,612)
	Transportation		1,871	383
	Premiums Collected			-
Total Individual Plan			$ (24,641)	$ (5,287)
	College Students-Service Costs		$ (449)	$ (98)
Total OHCA Program Costs			$ 41,456,021	$ 41,182,750
Administrative Costs				
	Salaries	$ -	$ 1,332,692	$ 1,332,692
	Operating Costs	323	1,175	1,498
	E&E Development Gainwell	-	-	-
	Contract - Gainwell	375,519	930,417	1,305,937
			-	
Total Administrative Costs		$ 375,842	$ 2,264,284	$ 2,640,126
Total Expenditures				$ 43,822,876
Transfer to Fund 340 for Expansion Costs				$ 35,202,148
NET CASH BALANCE		$ 14,077,287	$ (9,998,573)	$ 4,078,714

OKLAHOMA HEALTH CARE AUTHORITY

Combining Statement of Revenues, Expenditures and Changes in Fund Balance

SFY 2023, For the Fiscal Year Ended June 30, 2023

	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	Ambulance Service Provider Access Payment Program Fund 270	Medicaid Program Fund 340	Clearing Account 1807B	Total Cash Balance
June Beginning Fund Balance:												
Prior year	21,969,537	954,274	158,274	173,190,614	60,976,360	14,077,287	-	-	-	885,144,627	30,260,202	1,186,731,174
Current year	19,589,009	(888,560)	(129,207)	144,671,990	1,010,762	(7,784,175)	-	-	4,841,109	242,212,950	2,604,149	406,128,028
Total	41,558,546	65,715	29,067	317,862,604	61,987,122	6,293,112	-	-	4,841,109	1,127,357,578	32,864,350	1,592,859,202
June Revenues:												
Prior year	2,456,336	-	-	-	-	-	-	-	-	5,633	-	2,461,970
Current year	8,893,865	122	7,954,417	-	123,047	5,269,389	59,038	3,537,946	128,858	548,352,149	157,721,235	732,040,067
Total	11,350,201	122	7,954,417	-	123,047	5,269,389	59,038	3,537,946	128,858	548,357,782	157,721,235	734,502,036
June Expenditures:												
Prior year	-	-	-	-	-	-	-	-	-	-	-	-
Current year	20,120,215	-	-	-	-	2,909,412	-	-	-	745,183,841	-	768,213,468
Total	20,120,215	-	-	-	-	2,909,412	-	-	-	745,183,841		768,213,468
Operating Transfers In												
Prior year												
Current year	6,054,287	-	-	13,678,175	-	-	-	-	-	97,579,845	-	117,312,307
Total	6,054,287	-	-	13,678,175	-	-	-	-	-	97,579,845	-	117,312,307
Operating Transfers Out												
Prior year	1,236,334	-	-	-	-	-	-	-	-	-		1,236,334
Current year	-	-	6,992,055	-	-	4,500,000	59,038	3,537,946	4,920,778	-	30,260,202	50,270,019
Total	1,236,334	-	6,992,055	-	-	4,500,000	59,038	3,537,946	4,920,778	-	30,260,202	51,506,353
Change in CY Fund Balance	***14,416,946***	***(888,438)***	***833,155***	***158,350,165***	***1,133,809***	***(9,924,197)***	***-***	***-***	***49,189***	***142,961,103***	***130,065,182***	***436,996,915***
Ending Fund Balance	**37,606,485**	**65,837**	**991,429**	**331,540,779**	**62,110,169**	**4,153,089**	**-**	**-**	**49,189**	**1,028,111,364**	**160,325,383**	**1,624,953,724**

OKLAHOMA HEALTH CARE AUTHORITY
HEALTHY ADULT PROGRAM EXPENDITURES - OHCA
SFY 2023, For the Fiscal Year Ended June 30, 2023

PROGRAM / ACTIVITY	FY23 BUDGETED EXPENDITURES Full Year	FY23 BUDGETED EXPENDITURES Year to Date	FY23 ACTUAL EXPENDITURES YTD through June	BUDGET VARIANCE (Over)/ Under
OHCA MEDICAID PROGRAMS				
Managed Care				
SoonerCare Choice	4,516,290	4,516,290	4,598,802	(82,512)
Total Managed Care	**4,516,290**	**4,516,290**	**4,598,802**	**(82,512)**
Fee for Service				
Hospital Services:				
Inpatient Acute Care	260,882,958	260,882,958	255,054,665	5,828,292
SHOPP	324,314,903	324,314,903	349,657,155	(25,342,253)
Outpatient Acute Care	293,896,966	293,896,966	294,768,154	(871,188)
Total Hospitals	**879,094,826**	**879,094,826**	**899,479,975**	**(20,385,148)**
Behavioral Mental Health:				
Inpatient Services - DRG	22,151,542	22,151,542	25,551,993	(3,400,451)
Outpatient	-	-	-	-
Total Behavioral Mental Health	**22,151,542**	**22,151,542**	**25,551,993**	**(3,400,451)**
Physicians & Other Providers:				
Physicians	201,346,028	201,346,028	198,054,043	3,291,985
Dentists	65,984,397	65,984,397	64,861,010	1,123,387
Mid-Level Practitioner	471,847	471,847	465,280	6,568
Other Practitioners	24,095,810	24,095,810	24,447,355	(351,545)
Home Health Care	1,060,472	1,060,472	1,233,702	(173,230)
Lab & Radiology	22,794,960	22,794,960	22,900,357	(105,397)
Medical Supplies	19,021,752	19,021,752	19,792,815	(771,062)
Clinic Services	180,670,196	180,670,196	179,950,706	719,490
Ambulatory Clinics	5,565,503	5,565,503	5,572,119	(6,616)
Total Physicians & Other Providers	**521,010,967**	**521,010,967**	**517,277,387**	**3,733,579**
Misc Medical & Health Access Network	**82,094**	**82,094**	**146,949**	(64,855)
Transportation	**31,411,337**	**31,411,337**	**31,983,672**	(572,336)
Health Access Network	**-**	**-**	**20,350**	(20,350)
Prescription Drugs	**768,460,130**	**768,460,130**	**768,744,170**	(284,040)
Total OHCA Medicaid Programs	**2,226,727,185**	**2,226,727,185**	**2,247,803,298**	**(21,076,113)**

OKLAHOMA HEALTH CARE AUTHORITY
SUMMARY OF EXPENDITURES:
Healthy Adult Program - Medicaid Expansion
SFY 2023, For the Fiscal Year Ended June 30, 2023

REVENUES	FY 23 Total Revenue
Federal Draws	**2,364,952,485**
State Share from Other State Agencies	**37,992,169**
SHOPP Assessment Fee - Expansion	**34,965,716**
TOTAL REVENUES	**$ 2,437,910,369**

EXPENDITURES	FY 23 Total $ YTD	FY 23 State $ YTD	Total State $ Cost
OHCA Program Costs			
SoonerCare Choice	$ 4,598,802	$ 459,880	
Inpatient Hospital	$ 255,054,665	$ 25,505,467	
SHOPP	$ 349,657,155	$ 34,965,716	
Outpatient Hospital	$ 294,768,154	$ 29,476,815	
Inpatient Psychiatry	$ 25,551,993	$ 2,555,199	
Physicians	$ 198,054,043	$ 19,805,404	
Dentists	$ 64,861,010	$ 6,486,101	
Mid-level Practitioner	$ 465,280	$ 46,528	
Nursing Homes	$ 53,937	$ 5,394	
Other Practitioners	$ 24,447,355	$ 2,444,735	
Home Health	$ 1,233,702	$ 123,370	
Lab & Radiology	$ 22,900,357	$ 2,290,036	
Medical Supplies	$ 19,792,815	$ 1,979,281	
Clinic Services	$ 179,950,706	$ 17,995,071	
Ambulatory Surgery Center	$ 5,572,119	$ 557,212	
Prescription Drugs	$ 768,744,170	$ 76,874,417	
Transportation	$ 31,983,672	$ 3,198,367	
Health Access Network	$ 20,350	$ 2,035	
Miscellaneous Medical	$ 93,012	$ 9,301	
Total OHCA Program Costs	**$ 2,247,803,298**	**$ 224,780,330**	
Other State Agency Program Costs			
Department of Human Services	$ 6,154	$ 615	
Department of Mental Health	$ 207,203,230	$ 20,720,323	
State Health Department	$ 1,223,635	$ 122,364	
State Employees Physicians	$ 32,771,665	$ 3,277,167	
City/County Health Departments	$ 44,861	$ 4,486	
Department of Corrections	$ 5,037,197	$ 503,720	
Indian Health	$ 10,689,130	$ 1,068,913	
OU - UHA & UHT	$ 122,945,814	$ 12,294,581	
Total Other State Agency Program Costs	**$ 379,921,686**	**$ 37,992,169**	
Combined Total OHCA & Other Agency	**$ 2,627,724,984**	**$ 262,772,498**	
TOTAL STATE SHARE OF COSTS			**$ 262,772,498**

HIE UPDATE

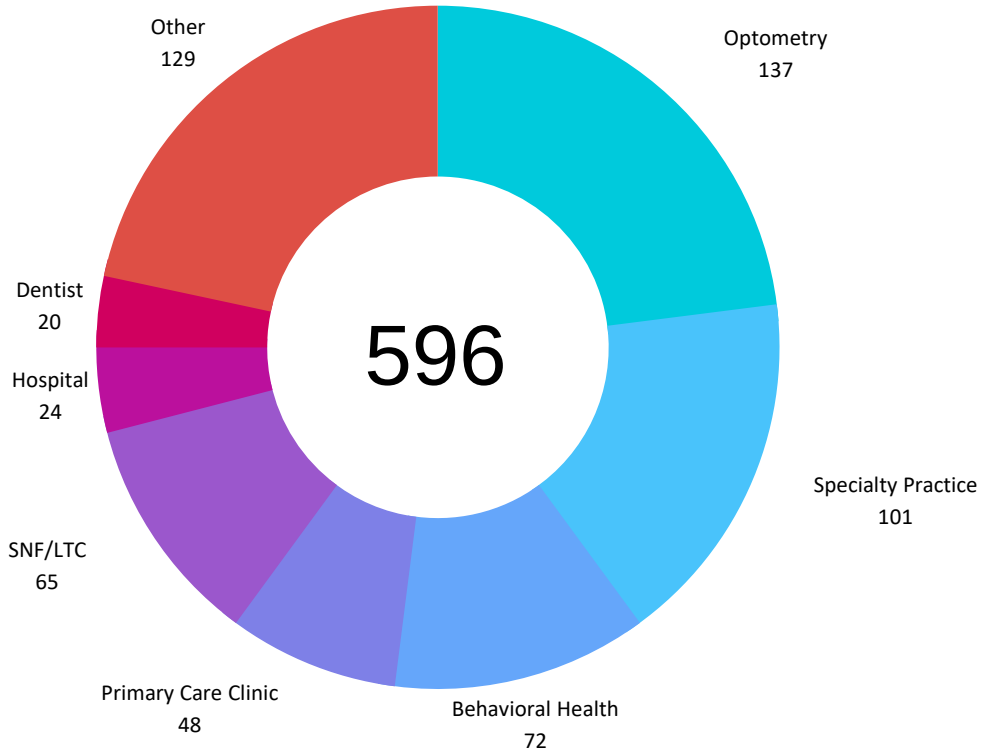
- EY engaged and RFP in Development for HIE Operations & Data Services – Projected Release – Fall 2023
- New Emergency rules developed that relax exemption eligibility, approved by Board and Governor.
- Opt-Out Policy Changes - All Break the Glass Capability has been removed – No Disclosure
- Exemption approvals have been released (3011 exemption)
- SB 32X $30M Appropriation for Provider Connections to the HIE
  - On-line form developed and set to release (pending final legal review).
  - Investigating Possible Incentives Program for Medicaid Providers who utilize the HIE (Directed Payments)
- MCE's Beginning Connection / Testing Efforts
- HIE Statistics
  - Over 130,000 Transactions Daily (patient data sent or updated in the HIE).
  - 35,000 Unique Patient Accesses Monthly
  - 15,000 – 25,000 Conditions of Participation Delivered Monthly

NEW PARTICIPANTS (37)

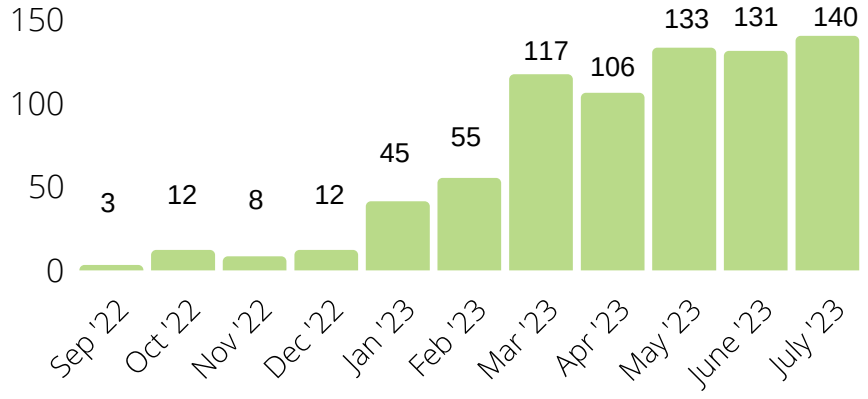
Account Name	City	Participant Type	Close Date
Moore Vision & Associates	Tulsa	Optometry	6/14/2023
Midtown Orthopedics and Sports Medicine LLC	Oklahoma City	Specialty Practice	6/14/2023
Absentee Shawnee Tribal Health System	Norman	Health System	6/15/2023
Bethany Eye Care	Bethany	Optometry	6/19/2023
Tariq Mahmood, MD	NORMAN	Specialty Practice	6/19/2023
New Hope Counseling & Guidance Center, llc	Poteau	Behavioral Health	6/23/2023
Baha aldeen Abuesheh MD.PC	Ardmore	Specialty Practice	6/26/2023
Advanced Pain Management Center of OK - Tulsa	Tulsa	Specialty Practice	6/26/2023
Joshua Powell MD PLLC	Norman	Specialty Practice	6/26/2023
Mark B. Privott, O.D. Inc	Bethany	Optometry	6/27/2023
Digestive Disease Specialists, Inc	Oklahoma City	Specialty Practice	6/28/2023
Ivanka A. Vassileva, M.D.	Lawton	Specialty Practice	6/29/2023
Seiling Municipal Hospital	Seiling	Hospital	7/3/2023
Robert V Blakeburn MD PC	Clinton	Specialty Practice	7/5/2023
The Eye Center	Okmulgee	Optometry	7/7/2023
The Eye and Vision Center	Owasso	Optometry	7/7/2023
Kids Therapy Connection	Thomas	Physical Therapy	7/10/2023
Southwest Medical Center OK Physician Clinics	Liberal	Specialty Practice	7/11/2023
Oklahoma Arthritis Center	Edmond	Specialty Practice	7/11/2023
Cordell Memorial Hospital	Cordell	Hospital	7/11/2023
Advanced Orthopedics of Oklahoma	Tulsa	Specialty Practice	7/12/2023
St. John Rehabilitation Hospital of Broken Arrow	Broken Arrow	Hospital	7/14/2023
Vision Source OKC South	Oklahoma City	Optometry	7/17/2023
Ascension St. John Rehabilitation of Owasso	Owasso	Hospital	7/17/2023
Keys Eye Care	Tahlequah	Optometry	7/19/2023
Advanced Pain Management of Oklahoma(OKC)	Oklahoma City	Specialty Practice	7/20/2023
DMNMDVIP, PLLC	Tulsa	Specialty Practice	7/20/2023
Orthopedic Solutions	Edmond	Specialty Practice	7/23/2023
Arbuckle Memorial Hospital	Sulphur	Hospital	7/26/2023
Oklahoma Pain Center	Oklahoma City	Specialty Practice	7/26/2023
James Russell, MD	Sapulpa	Primary Care Clinic	7/27/2023
Vitalis Metabolic Health, PLLC	Oklahoma City	Specialty Practice	7/31/2023
John E Stecklow, MD	Oklahoma City	Specialty Practice	8/1/2023
Wellspring Family Clinic, LLC	Broken Arrow	Primary Care Clinic	8/2/2023
Optique Vision Center PLLC	Edmond	Optometry	8/3/2023
Tulsa Retina Consultants	Tulsa	Specialty Practice	8/8/2023
ATLUS PREMIER HEALTH CLINIC	Altus	Primary Care Clinic	8/8/2023

HIE OUTREACH

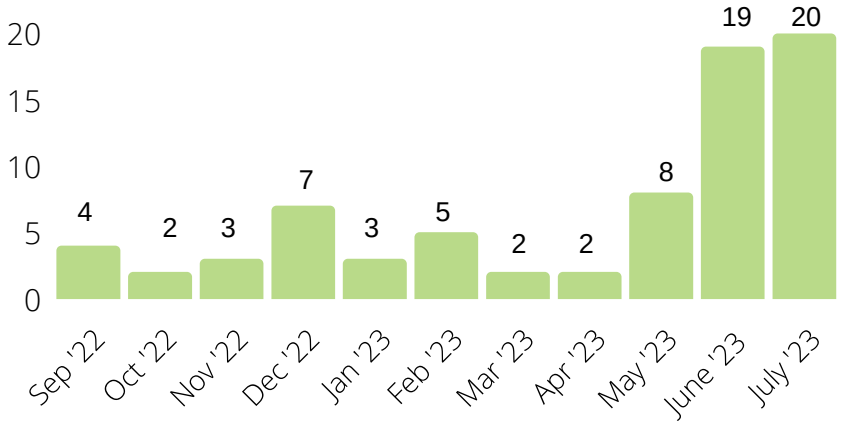
NEW PARTICIPANT OPPORTUNITIES



APPLICATIONS RECIEVED



NEW PARTICIPANTS



3011 Exemptions Registered
(30 Hospitals Requesting Exemptions)

THE HIE PROVIDES A PATH TO HEALTHIER OUTCOMES FOR OKLAHOMANS

September 2023 MAC
Proposed Rule Amendment Summaries

These proposed ***EMERGENCY*** rules were presented for Tribal Consultation and were subject to at least a 15-day public comment period. The Agency is requesting the effective date to be immediately upon Governor's approval or Jan. 1, 2024.

APA WF # 23-08 Non-Payment of Provider Preventable Conditions – The proposed rules update non-payment policies for provider preventable conditions (PPCs), including health care-acquired conditions (HCACs), and other provider-preventable conditions (OPPCs), for inpatient, outpatient, and long-term care services as required by Section 2702 of the Affordable Care Act of 2010. The rules will delineate the conditions that will be identified for non-payment and the requirements for provider to report the PPCs regardless of whether the provider seeks SoonerCare reimbursement for services to treat the conditions consistent with federal regulation.

Budget Impact: Budget neutral.

APA WF # 22-13 Secure Mental Health Transportation — The proposed additions implement secure mental health transportation as a covered benefit for SoonerCare members. Policy will define the service as secure transportation to a facility arranged by a Qualified Transportation Service Provider (QTSP) for the appropriate, medically necessary services to treat members experiencing a behavioral health crisis. Rules will include the specific contracted with the Oklahoma Department of Mental Health & Substance Abuse Services (ODMHSAS) requirements including for eligible providers (driver/contractor), member program eligibility, covered services, and the distance that will be taken into consideration when transporting members. Finally, additions will state that reimbursement for secure mental health transportation is outlined in the Oklahoma Medicaid State Plan.

Budget Impact: The estimated budget impact, for SFY2024, will be an increase in the total amount of $6,153,652; with $1,939,170 in state share. The estimated budget impact, for SFY2025 will be an increase in the total amount of $6,153,652; with $1,939,170 in state share.

APA WF # 23-15 Biosimilar Reimbursement — The proposed additions align reimbursement for certain biosimilar products with the Medicare Part B fee schedule. The Inflation Reduction Act (2022) included a provision directing Medicare Part B to increase reimbursement for certain biosimilar products from Average Sales Price (ASP) + 6% to ASP + 8%. Based on CMS guidance, policy will be amended to replace specific references to ASP + 6% with language indicating payment will match the Medicare Part B fee schedule.

Budget Impact: The estimated budget impact, for SFY2023, will be an increase in the total amount of $200,320; with $45,353 in state share. The estimated budget impact, for SFY2024 will be an increase in the total amount of $600,691; with $189,378 in state share.

APA WF # 23-18 Twelve-months Continuous Eligibility for Children in Medicaid and CHIP – The proposed revisions update eligibility policy for SoonerCare to implement 12-months continuous eligibility for children under age 19 receiving services through Medicaid and the Children's Health Insurance Plan (CHIP), effective January 1, 2024, in compliance with the Consolidated Appropriations Act of 2023.

Budget Impact: The estimated total cost for SFY 2024 is $4,463,262 ($3,056,776 in federal share and $1,406,485 in state share). The estimated total cost for SFY 2025 is $54,941,044 ($37,353,042 in federal share and $17,588,002 in state share).

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

SUBCHAPTER 3. GENERAL PROVIDER POLICIES

PART 3. GENERAL MEDICAL PROGRAM INFORMATION

317:30-3-62. ~~Serious reportable events - never events~~ Provider Preventable Conditions

~~(a) **Definitions.** The following words and terms, when used in this Section, have the following meaning, unless the context clearly indicates otherwise.~~

~~(1) "**Surgical and other invasive procedures**" are defined as operative procedures in which skin or mucous membranes and connective tissues are incised or an instrument is introduced through a natural body orifice. Invasive procedures include a range of procedures from minimally invasive dermatological procedures (biopsy, excision, and deep cryotherapy for malignant lesions) to extensive multi-organ transplantation. They include all procedures described by the codes in the surgery section of the Current Procedural Terminology (CPT) and other invasive procedures such as percutaneous transluminal angioplasty and cardiac catheterization. They include minimally invasive procedures involving biopsies or placement of probes or catheters requiring the entry into a body cavity through a needle or trocar. They do not include use of instruments such as otoscopes for examinations or very minor procedures such as drawing blood.~~

~~(2) A surgical or other invasive procedure is considered to be the wrong procedure if it is not consistent with the correctly documented informed consent for that member.~~

~~(3) A surgical or other invasive procedure is considered to have been performed on the wrong body part if it is not consistent with the correctly documented informed consent for that member including surgery on the right body part, but on the wrong location on the body; for example, left versus right (appendages and/or organs), or at the wrong level (spine).~~

~~(4) A surgical or other invasive procedure is considered to have been performed on the wrong member if that procedure is not consistent with the correctly documented informed consent for that member.~~

~~(b) **Coverage.** The Oklahoma Health Care Authority (OHCA) will no longer cover a particular surgical or other invasive procedure to treat a particular medical condition when the practitioner erroneously performs (1) a different procedure altogether; (2) the correct procedure but on the wrong body part; or (3) the correct procedure but on the wrong member. SoonerCare will not cover hospitalizations or any services related to these non-covered procedures. All services provided in the operating room when an error occurs are considered related and therefore not covered. All providers in the operating room when the error occurs, who could bill individually for their services, are also not eligible for payment. All related services provided during the same hospitalization in which the error occurred are not covered. A provider cannot shift financial liability or responsibility for the non-covered services to the member if the OHCA has determined that the service is related to one of the above erroneous surgical procedures.~~

~~(c) **Billing.** For inpatient claims, hospitals are required to bill two claims when the erroneous surgery is reported, one claim with covered services or procedures unrelated to the erroneous surgery, the other claim with the non-covered services or procedures as a no-payment claim. For outpatient and practitioner claims, providers are required to append the applicable HCPCS~~

~~modifiers to all lines related to the erroneous surgery. Claim lines submitted with one of the applicable HCPCS modifiers will be line-item denied.~~

~~(d) **Related claims.** Once a claim for the erroneous surgery(s) has been received, OHCA may review member history for related claims as appropriate. Incoming claims for the identified member may be reviewed for an 18-month period from the date of the surgical error. If such claims are identified to be related to the erroneous surgical procedure(s), OHCA may take appropriate action to deny such claims and recover any overpayments on claims already processed.~~

~~(e) **Dually eligible members.** SoonerCare will not act as a secondary payer for Medicare non-payment of the aforementioned erroneous surgery(s).~~

~~(f) **Hospital acquired conditions.** SoonerCare will not reimburse the extra cost of treating certain categories of conditions that occur while a member is in the hospital. See OAC 317:30-3-63 for specific information regarding hospital acquired conditions.~~

(a) **Definitions.** The following words and terms, when used in this Section, have the following meaning, unless the context clearly indicates otherwise.

(1) "**Health care-acquired conditions (HCAC)**" means a condition occurring in any inpatient hospital setting, (identified as a hospital acquired condition by federal regulation and Medicare; other than deep vein thrombosis/pulmonary embolism as related to a total knee replacement or hip replacement surgery in pediatric and obstetric patients.) Medicare's list of hospital acquired conditions is also available at: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/Hospital-Acquired_Conditions.html.

(2) "**National Quality Forum (NQF)**" means the independent, nonpartisan organization tasked with devising a national strategy to set standards for quality improvement and reporting in the healthcare industry.

(3) "**Other provider preventable conditions (OPPC)**" means the list of serious reportable events in health care as identified by this Section and published by the NQF.

(4) "**Present on admission (POA) indicator"** means a status code the hospital uses on an inpatient claim that indicates if a condition was present at the time the order for inpatient admission occurs.

(5) "**Provider preventable condition (PPC)**" means a condition that meets the definition of a "health care-acquired condition" or an "other provider-preventable condition" as defined in this Section.

(b) **Health care-acquired conditions (HCAC).**

(1) **Payment policy**. In accordance with 42 C.F.R § 447.26, the Oklahoma Health Care Authority (OHCA) will not reimburse health care professionals and inpatient hospitals for the increased incremental cost of inpatient care services that result when a member is harmed by one (1) of the HCACs listed below.

(A) Foreign object retained after surgery;

(B) Air embolism;

(C) Blood incompatibility;

(D) Pressure ulcer stages III & IV;

(E) Falls and trauma; including:

(i) Fracture;

(ii) Dislocation;

(iii) Intracranial injury;

(iv) Crushing injury;

(v) Burn;

(vi) Electric shock;
(F) Catheter-associated urinary tract infection;
(G) Vascular catheter-associated infection;
(H) Manifestations of poor glycemic control; including:
(i) Diabetic ketoacidosis;
(ii) Nonketotic hyperosmolar coma;
(iii) Hypoglycemic coma;
(iv) Secondary diabetes with ketoacidosis;
(v) Secondary diabetes with hyperosmolarity;
(I) Surgical site infection following:
(i) Coronary artery bypass graft-mediastinitis;
(ii) Bariatric surgery; including:
(I) Laparoscopic gastric bypass;
(II) Gastroenterostomy;
(III) Laparoscopic gastric restrictive surgery;
(iii) Orthopedic procedures; including:
(I) Spine;
(II) Neck;
(III) Shoulder;
(IV) Elbow;
(iv) Cardiac implantable electronic device (CIED)
(J) Deep vein thrombosis and pulmonary embolism following:
(i) Total knee replacement with exceptions for pediatric and/or obstetric cases; or
(ii) Hip replacement with exceptions for pediatric and/or obstetric cases.
(K) Iatrogenic pneumothorax with venous catheterization

(2) **Billing.** Hospitals paid under the diagnosis related grouping (DRG) methodology are required to submit a POA indicator for the principal diagnosis code and every secondary diagnosis code for all discharges. A valid POA indicator is required on all inpatient hospital claims. Claims with no valid POA indicator will be denied. For all claims involving inpatient admissions, OHCA will group diagnoses into the proper DRG using the POA indicator. If a provider in either a fee-for-service or managed care delivery system receives SoonerCare reimbursement for the increased incremental cost of inpatient care services that result when a member is harmed by the HCACs identified in (b)(1) (A)-(K), the provider shall reimburse those costs to the Agency or Contracted Entity.

(3) **Dually eligible members.** SoonerCare will not act as a secondary payer for Medicare non-payment of HCACs.

(c) **Other provider preventable condition (OPPC)**

(1) **Payment policy.** In accordance with 42 C.F.R § 447.26, the Agency will not reimburse health care professionals and inpatient hospitals for care related to the treatment of consequences of an OPPC when the condition:
(A) Is identified in the Oklahoma Medicaid State Plan;
(B) Has been found by the State, based upon a review of medical literature by qualified professionals, to be reasonably preventable through the application of procedures supported by evidence-based guidelines;
(C) Is within the control of the hospital;
(D) Has a negative consequence for the member;

(E) Is auditable; and
(F) Is included on the list of serious reportable events in health care by the National Quality Forum (NQF). Providers are responsible for keeping abreast of any changes to the list of serious reportable events identified by the NQF. The list of serious reportable events in health care, as of the publishing of this rule, includes surgical or invasive procedure events:
(i) Surgical or other invasive procedure performed on the wrong site;
(ii) Surgical or other invasive procedure performed on the wrong patient;
(iii) Wrong surgical or other invasive procedure performed on a patient;

(2) **Billing.** For inpatient claims, hospitals are required to bill two (2) claims when the erroneous surgery is reported, one (1) claim with covered services or procedures unrelated to the erroneous surgery, the other claim with the non-covered services or procedures as a no-payment claim. For outpatient and practitioner claims, providers are required to append the applicable Healthcare Common Procedure Coding System (HCPCS) modifiers to all lines related to the erroneous surgery. Claim lines submitted with one (1) of the applicable HCPCS modifiers will be line-item denied. If a provider in either a fee-for-service or managed care delivery system receives SoonerCare reimbursement for patient care or treatment directly related to an identifiable provider-preventable condition that was not present when the individual initiated treatment with that provider, the provider shall reimburse those costs to the Agency or Contracted Entity.

(3) **Related claims.** Once a claim for the erroneous surgery(s) has been received, OHCA may review member history for related claims as appropriate. Incoming claims for the identified member may be reviewed for an eighteen-month (18-month) period from the date of the surgical error. If such claims are identified to be related to the erroneous surgical procedure(s), OHCA may take appropriate action to deny such claims and recover any overpayments on claims already processed.

(4) **Dually eligible members.** SoonerCare will not act as a secondary payer for Medicare non-payment of OPPCs.

(d) **Reporting.** Title 42 of the Code of Federal Regulations, Sections 447, 434 and 438 require providers, in both fee-for-service and managed care delivery systems, to report all PPCs that are associated with claims for SoonerCare payment or with courses of treatment furnished to a SoonerCare member for which Medicaid payment would otherwise be available. The report shall be made to the OHCA regardless of whether the provider seeks SoonerCare reimbursement for services to treat the PPCs. The Agency report form is available for download at https://oklahoma.gov/ohca. Providers must report the following information to the OHCA within 10 days of the occurrence of the event:

(1) Member name and member ID number.
(2) A description of the event.
(3) Dates of services and occurrence of the event.
(4) Attending physician(s).
(5) Facility.

(e) **Liability.** A provider cannot shift financial liability or responsibility for the non-covered services and treatment to the member if the OHCA has determined that the service is related to a PPC.

317:30-3-63. Hospital acquired conditions [REVOKED]

(a) **Coverage.** The Oklahoma Health Care Authority (OHCA) will no longer reimburse the extra cost of treating certain categories of conditions that occur while a member is in the hospital. For discharges, hospitals will not receive additional payment for cases in which one of the selected conditions was not present on admission. The claim will be grouped to a DRG as if the diagnosis was not present on the claim. The selected conditions that OHCA recognizes are those conditions identified as non-payable by Medicare. OHCA may revise through addition or deletion the selected conditions at any time during the fiscal year. The following is a complete list of the hospital acquired conditions (HACs) currently recognized by OHCA:

(1) Foreign Object Retained After Surgery
(2) Air Embolism
(3) Blood Incompatibility
(4) Pressure Ulcer Stages III & IV
(5) Falls and Trauma
    (A) Fracture
    (B) Dislocation
    (C) Intracranial Injury
    (D) Crushing Injury
    (E) Burn
    (F) Electric Shock
(6) Catheter-Associated Urinary Tract Infection
(7) Vascular Catheter-Associated Infection
(8) Manifestations of Poor Glycemic Control
    (A) Diabetic Ketoacidosis
    (B) Nonketotic Hyperosmolar Coma
    (C) Hypoglycemic Coma
    (D) Secondary Diabetes with Ketoacidosis
    (E) Secondary Diabetes with Hyperosmolarity
(9) Surgical Site Infection Following:
    (A) Coronary Artery Bypass Graft- Mediastinitis
    (B) Bariatric Surgery
        (i) Laparoscopic Gastric Bypass
        (ii) Gastroenterostomy
        (iii) Laparoscopic Gastric Restrictive Surgery
    (C) Orthopedic Procedures
        (i) Spine
        (ii) Neck
        (iii) Shoulder
        (iv) Elbow
(10) Deep Vein Thrombosis and Pulmonary Embolism
    (A) Total Knee Replacement
    (B) Hip Replacement

(b) **Billing.** Hospitals paid under the diagnosis related grouping (DRG) methodology are required to submit a present on admission (POA) indicator for the principal diagnosis code and every secondary diagnosis code for all discharges. A valid POA indicator is required on all inpatient hospital claims. Claims with no valid POA indicator will be denied. For all claims involving inpatient admissions, OHCA will group diagnoses into the proper DRG using the POA indicator.

~~(c) **Dually eligible members.** SoonerCare will not act as a secondary payer for Medicare non-payment of the aforementioned hospital acquired conditions.~~

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 34. SECURE BEHAVIORAL HEALTH TRANSPORTATION

317:30-5-350. Definitions

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

"Member/eligible member" means any person eligible for SoonerCare and individuals considered to be Medicare/SoonerCare dual eligible.

"Nearest appropriate facility" means a medical facility that is generally equipped and legally permitted to provide the needed care for the illness or injury involved that is the closest in geographical proximity to the member's pickup location.

"OAC" means Oklahoma Administrative Code.

"ODMHSAS" means the Oklahoma Department of Mental Health and Substance Abuse Services.

"O.S." means Oklahoma Statutes.

"Qualified Transportation Service Provider" or **"QTSP"** means an ODMHSAS-contracted transportation provider for members requiring transportation to a treatment facility for the purpose of examination, emergency detention, protective custody, or inpatient services in accordance with 43A O.S. § 1-110.

317:30-5-350.1. Program overview

(a) ODMHSAS-contracted Qualified Transportation Service Providers (QTSPs) are required to transport SoonerCare members reasonably believed to be experiencing a behavioral health crisis to and from designated sites/facilities for the purpose of examination, emergency detention, protective custody, or inpatient services in accordance with 43A O.S. § 1-110.

(b) SoonerCare members being transported shall be afforded all rights and privileges guaranteed by the laws and Constitution of the State of Oklahoma and the United States of America. SoonerCare members have the right to be transported in a way that protects their dignity and safety.

(c) Mechanical restraints may only be used in the transportation of members when needed in accordance with 43A O.S. § 1-110 and as defined in the QTSP's contract with ODMHSAS.

317:30-5-350.2. Program eligibility and covered services

(a) SoonerCare members, both children and adults, are eligible for services when medically necessary.

(b) A member must be reasonably believed to be experiencing a behavioral health crisis as evidenced by extreme emotional distress that includes, but is not limited to, an acute episode of mental illness and/or suicidal thoughts and/or behavior that may occur with substance use and other disorders.

(c) Secure behavioral health transportation may be provided when medically necessary for the following:

(1) Transportation to a facility arranged by individuals authorized by ODMHSAS, including but not limited to, hospitals and other mental health facilities;

(2) Facility-to-facility transports; and

(3) Transport of a member seeking voluntary admission to a facility.

(d) Members must be transported to the nearest appropriate facility.
(e) Out-of-state transports are allowable when medically necessary and may require prior approval or authorization by ODMHSAS.

317:30-5-350.3. Service requirements

(a) **Eligible providers.** Service providers must be ODMHSAS-contracted Qualified Transportation Service Providers (QTSPs) and meet the Uniform Transportation Standards for QTSPs described in this Section.

(b) **Driver requirements.** Drivers must:

(1) Be twenty-one (21) years of age or older;
(2) Hold a valid driver's license issued by the State of Oklahoma;
(3) Undergo a criminal background check and not have been convicted of or received a deferred or probated sentence related to any felony crime, a crime involving moral turpitude or a crime of domestic violence; and not have any criminal charges pending in ay court in the State of Oklahoma, another state, in tribal court or pursuant to the United States Code;
(4) Be able to ensure that SoonerCare members who are transported are protected by harm and injuries due to abuse, self-abuse, neglect, sexual incidents, serious injuries and other sources of immediate danger;
(5) Be able to provide emergency care or have an established plan to access emergency care;
(6) Be trained in effective communication skills with persons with mental illness, consumer rights, CPR/First Aid, and confidentiality as prescribed by ODMHSAS prior to completing transports;
(7) Be able to recognize and plan for problematic behaviors in a therapeutic and safe manner and complete a 16-hour Therapeutic Options Course or similar curriculum approved by ODMHSAS prior to completing transports; and
(8) Be familiar with the statutes and standards related to transporting members.

(c) **Vehicle requirements.** Vehicles must:

(1) Be well maintained and in good mechanical condition;
(2) Have the following equipment operational:
(A) Air conditioner;
(B) Heater; and
(C) Chemical-type fire extinguisher, of at least a one-quart capacity, located in the same compartment of the vehicle as the driver.
(3) Have a safety partition between the driver's area and passenger's area;
(4) Have safety locks to prevent a member from exiting a car that is in motion;
(5) Be equipped with, either in the car or on the driver, a two-way radio or cellular telephone that is operational during the entire period of transport; and
(6) If transporting members in wheelchairs, be equipped with the following:
(A) An electrical or hydraulically-operated lift mechanism or a ramp with a non-skid surface;
(B) A means of securing a wheelchair to the inside of the vehicle to prevent any lateral, forward, backward, or vertical motion of the wheelchair within the vehicle;
(C) A rear-view mirror that enables the driver to view any passenger in a wheelchair; and
(D) A door at the rear of the vehicle for an emergency exit.

317:30-5-350.4. Authorization and reimbursement

(a) Secure behavioral health transportation does not require a prior authorization, with the exception of out-of-state transports, which may require prior approval or authorization by ODMHSAS.
(b) Secure behavioral health transportation is reimbursed per the methodology described in the Oklahoma Medicaid State Plan.

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 5. PHARMACIES

317:30-5-78. Reimbursement

(a) **Reimbursement.** Reimbursement for pharmacy claims is based on the sum of the ingredient cost plus a professional dispensing fee for brand and generic drugs dispensed by a retail community pharmacy or for a member residing in a long term care facility**.**

(b) **Ingredient Cost.** Ingredient cost is determined by one of the following methods:

(1) **Maximum Allowable Cost.** The State Maximum Allowable Cost (SMAC) is established for certain products which have a Food and Drug Administration (FDA) approved generic equivalent. The SMAC will be calculated using prices from pharmaceutical wholesalers who supply these products to pharmacy providers in Oklahoma. Pharmacies may challenge a specific product's SMAC price by providing information from their wholesaler(s) to certify a net cost higher than the calculated SMAC price and that there is not another product available to them which is generically equivalent to the higher priced product.

(2) **Actual Acquisition Cost.** The Actual Acquisition Cost (AAC) means the cost of a particular drug product to the pharmacy based on a review of invoices or the Wholesale Acquisition Cost (WAC), whichever is lower. The National Average Drug Acquisition Cost (NADAC) is based on a review of invoices and published by Centers for Medicare and Medicaid Services (CMS) and will be used in the determination of AAC.

(3) **Specialty Pharmaceutical Allowable Cost.** Reimbursement for specialty drugs not typically dispensed by a retail community pharmacy and dispensed primarily by delivery, including clotting factor for hemophilia, shall be set as a Specialty Pharmaceutical Allowable Cost (SPAC). The Medicare Part B allowed charge, ~~defined as Average Sales Price (ASP) plus 6%,~~ WAC, and NADAC when available, will be considered in setting the SPAC rate. For the purpose of this section, a drug may be classified as a specialty drug when it has one or more of the following characteristics:

(A) Covered by Medicare Part B;
(B) "5i drug" B Injected, infused, instilled, inhaled, or implanted;
(C) Cost greater than $1,000.00 per claim;
(D) Licensed by the FDA under a Biological License Application;
(E) Special storage, shipping, or handling requirements;
(F) Available only through a limited distribution network; and/or
(G) Does not have a NADAC price from CMS.

(4) **Exceptions.**

(A) Physician administered drugs shall be priced based on a formula equivalent to the Medicare Part B allowed charge~~, defined as ASP plus 6%~~. If a price equivalent to the Medicare Part B allowed charge cannot be determined, a purchase invoice may be supplied by the provider and will be considered in setting the reimbursement.

(B) I/T/U pharmacies shall be reimbursed at the OMB encounter rate as a per member per facility per day fee regardless of the number of prescriptions filled on that day. I/T/U pharmacies should not split prescriptions into quantities less than a one month

supply for maintenance medications. For this purpose a maintenance medication is one that the member uses consistently month to month.

(C) Pharmacies other than I/T/U facilities that acquire drugs via the Federal Supply Schedule (FSS) or at nominal price outside the 340B program or FSS shall notify OHCA and submit claims at their actual invoice price plus a professional dispensing fee.

(c) **Professional dispensing fee.** The professional dispensing fee for prescribed medication is established by review of surveys. A recommendation is made by the State Plan Amendment Rate Committee and presented to the Oklahoma Health Care Authority Board for their approval. There may be more than one level or type of dispensing fee if approved by the OHCA Board and CMS. A contracted pharmacy agrees to participate in any survey conducted by the OHCA with regard to dispensing fees. The pharmacy shall furnish all necessary information to determine the cost of dispensing drug products. Failure to participate may result in administrative sanctions by the OHCA which may include but are not limited to a reduction in the dispensing fee.

(d) **Reimbursement for prescription claims.** Prescription claims will be reimbursed using the lower of the following calculation methods:

(1) the lower of Actual Acquisition Cost (AAC), State Maximum Allowable Cost (SMAC), or Specialty Pharmaceutical Allowable Cost (SPAC) plus a professional dispensing fee, or

(2) usual and customary charge to the general public. The pharmacy is responsible to determine its usual and customary charge to the general public and submit it to OHCA on each pharmacy claim. The OHCA may conduct periodic reviews within its audit guidelines to verify the pharmacy's usual and customary charge to the general public and the pharmacy agrees to make available to the OHCA's reviewers prescription and pricing records deemed necessary by the reviewers. The OHCA defines general public as the patient group accounting for the largest number of non-SoonerCare prescriptions from the individual pharmacy, but does not include patients who purchase or receive their prescriptions through other third-party payers. If a pharmacy offers discount prices to a portion of its customers (i.e. -10% discount to senior citizens), these lower prices would be excluded from the usual and customary calculations unless the patients receiving the favorable prices represent more than 50% of the pharmacy's prescription volume. The usual and customary charge will be a single price which includes both the product price and the dispensing fee. For routine usual and customary reviews, the pharmacy may provide prescription records for non-SoonerCare customers in a manner which does not identify the customer by name so long as the customer's identity may be determined later if a subsequent audit is initiated. The OHCA will provide the pharmacy notice of its intent to conduct a review of usual and customary charges at least ten days in advance of its planned date of review.

(e) **Payment of Claims.** In order for an eligible provider to be paid for filling a prescription drug, the pharmacy must complete all of the following:

(1) have an existing provider agreement with OHCA,

(2) submit the claim in a format acceptable to OHCA,

(3) have a prior authorization before filling the prescription, if a prior authorization is necessary,

(4) have a proper brand name certification for the drug, if necessary, and

(5) include the usual and customary charges to the general public as well as the actual acquisition cost and professional dispensing fee.

(f) **Claims.** Prescription reimbursement may be made only for individuals who are eligible for coverage at the time a prescription is filled. Member eligibility information may be accessed by swiping a SoonerCare identification card through a commercial card swipe machine which is connected to the eligibility database or via the Point of Sale (POS) system when a prescription claim is submitted for payment. Persons who do not contract with commercial vendors can use the Member Eligibility Verification System (EVS) at no additional cost.

PART 5. MEDICAL SUPPLIERS

317:30-5-218. Reimbursement

(a) **Medical supplies, equipment and appliances.**

(1) Reimbursement for medical supplies, equipment, and appliances will be made using an amount derived from the lesser of the Oklahoma Health Care Authority (OHCA) maximum allowable fee or the provider's usual and customary charge. The maximum allowable fee is the maximum amount that the OHCA will pay a provider for an allowable procedure. When a code is not assigned a maximum allowable fee for a unit of service, a fee will be established.

(2) The fee schedule will be reviewed annually. Adjustments to the fee schedule may be possible at any time based on efficiency, budget considerations, federal regulations, and quality of care as determined by the OHCA.

(3) Payment for medical supplies, equipment, and appliances will be calculated using the rate methodologies found in the Oklahoma Medicaid State Plan.

(4) Payment is not made for medical supplies, equipment, and appliances that are not deemed as medically necessary or considered over-the-counter.

(5) OHCA does not reimburse medical supplies, equipment, and appliances providers separately for services that are included as part of the payment for another treatment program. For example, all items required during inpatient stays are paid through the inpatient payment structure.

(6) Medical supplies, equipment, and appliance products purchased at a pharmacy are paid the equivalent to the Medicare Part B allowed charge~~, average sales price (ASP) + six percent (6%)~~. When ~~ASP~~ the Medicare Part B allowed charge is not available, an equivalent price is calculated using ASP or wholesale acquisition cost (WAC). If no Medicare, ASP, or WAC pricing is available, then the price will be calculated based on invoice cost.

(b) **Manually-priced medical equipment and supplies.** There may be instances when manual pricing is required. When it is, the following pricing methods will be used:

(1) **Invoice pricing.** Reimbursement is at the provider's documented manufacturer's suggested retail price (MSRP) minus thirty percent (30%) or at the provider's invoice cost plus thirty percent (30%), whichever is the lesser of the two.

(2) **Fair market pricing.** OHCA may establish a fair market price through claims review and analysis. For a list of medical equipment and supplies that are fair market-priced, refer to the OHCA website at www.okhca.org for the fair market value list (Selected medical supplies, equipment, and appliance items priced at fair market price).

(c) **Oxygen equipment and supplies.**

(1) Payment for stationary oxygen systems (liquid oxygen systems, gaseous oxygen systems, and oxygen concentrators) is based on continuous rental, i.e., a continuous monthly payment

that is made as long as it is medically necessary. The rental payment includes all contents and supplies, e.g., regulators, tubing, masks, etc. Portable oxygen systems are considered continuous rental. Ownership of the equipment remains with the supplier.
(2) Separate payment will not be made for maintenance, servicing, delivery, or for the supplier to pick up the equipment when it is no longer medically necessary. In addition, the provider/supplier will not be reimbursed for mileage.
(3) Payment for oxygen and oxygen equipment and supplies will not exceed the Medicare fee for the same procedure code.
(4) For residents in a long-term care facility, durable medical equipment products, including oxygen, are included in the facility's per diem rate.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY

CHAPTER 35. MEDICAL ASSISTANCE FOR ADULTS AND CHILDREN-ELIGIBILITY

SUBCHAPTER 1. GENERAL PROVISIONS

317:35-1-2. Definitions

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

"Acute Care Hospital" means an institution that meets the requirements defined in Section (§) 440.10 of Title 42 of the Code of Federal Regulations (C.F.R.) and:

(A) Is maintained primarily for the care and treatment of patients with disorders other than mental diseases;

(B) Is formally licensed or formally approved as a hospital by an officially designated authority for state standard setting; and

(C) Meets the requirements for participation in Medicare as a hospital.

"Adult" means an individual twenty-one (21) years of age or older, unless otherwise specified by statute, regulation, and/or policy adopted by the Oklahoma Health Care Authority (OHCA). For eligibility criteria policy for children and adults, please refer to Oklahoma Administrative Code (OAC) 317:35-5-2.

"ADvantage Administration (AA)" means the Oklahoma Department of Human Services (OKDHS) which performs certain administrative functions related to the ADvantage Waiver.

"Aged" means an individual whose age is established as sixty-five (65) years or older.

"Agency partner" means an agency or organization contracted with the OHCA that will assist those applying for services.

"Aid to Families with Dependent Children (AFDC)" means the group of low-income families with children described in Section 1931 of the Social Security Act. The Personal Responsibility and Work Opportunity Act of 1996 established the new eligibility group of low-income families with children and linked eligibility income and resource standards and methodologies and the requirement for deprivation for the new group to the State plan for AFDC in effect on July 16, 1996. Oklahoma has elected to be less restrictive for all SoonerCare members related to AFDC. Children covered under Section 1931 are related to the children's group, and adults covered under Section 1931 are related to the parent and caretaker relative group. The Modified Adjusted Gross Income (MAGI) methodology is used to determine eligibility for these groups.

"Alien" is synonymous with the word "noncitizen" and means an individual who does not have United States citizenship and is not a United States national.

"Area nurse" means a registered nurse in the OKDHS Aging Services Division, designated according to geographic areas who evaluates the Uniform Comprehensive Assessment Tool (UCAT) and determines medical eligibility for Personal Care, ADvantage Waiver, and Nursing Facility services. The area nurse also approves care plan and service plan implementation for Personal Care services.

"Area nurse designee" means a registered nurse selected by the area nurse who evaluates the UCAT and determines medical eligibility for Personal Care, ADvantage Waiver, and Nursing Facility services.

"Authority" means the OHCA.

"Blind" means an individual who has central visual acuity of 20/200 or less in the better eye with the use of a correcting lens.

"Board" means the OHCA Board.

"Buy-in" means the procedure whereby the OHCA pays the member's Medicare premium.

(A) **"Part A Buy-in"** means the procedure whereby the OHCA pays the Medicare Part A premium for individuals determined eligible as Qualified Medicare Beneficiaries Plus (QMBP) who are enrolled in Part A and are not eligible for premium free enrollment as explained under Medicare Part A. This also includes individuals determined to be eligible as Qualified Disabled and Working Individuals (QDWI).

(B) **"Part B Buy-in"** means the procedure whereby the OHCA pays the Medicare Part B premium for categorically needy individuals who are eligible for Part B Medicare. This includes individuals who receive TANF or the State Supplemental Payment to the Aged, Blind or Disabled, and those determined to be Qualified Medicare Beneficiary Plus (QMBP), Specified Low Income Medicare Beneficiaries (SLMB) or Qualifying Individual-1 (QI-1). Also included are individuals who continue to be categorically needy under the PICKLE amendment and those who retain eligibility after becoming employed.

"Caretaker relative" means a person other than the biological or adoptive parent with whom the child resides who meets the specified degree of relationship within the fifth degree of kinship.

"Case management" means the activities performed for members to assist them in accessing services, advocacy and problem solving related to service delivery.

"Categorically needy" means that income and, when applicable, resources are within the standards for the category to which the individual is related.

"Categorically related" or **"related"** means the individual meets basic eligibility requirements for an eligibility group.

"Certification period" means the period of eligibility extending from the effective date of certification to the date of termination of eligibility or the date of the next periodic redetermination of eligibility.

"Child" means an individual under twenty-one (21) years of age, unless otherwise specified by statute, regulation, and/or policy adopted by the OHCA. For eligibility criteria policy for children and adults, please refer to OAC 317:35-5-2.

"Continuous eligibility" means uninterrupted eligibility for the extent of the certification period regardless of any changes in circumstances, unless:

(A) The child turns age nineteen (19);

(B) The child dies;

(C) The child is no longer an Oklahoma resident;

(D) The child becomes incarcerated (per OAC 317:35-6-45 the eligibility is suspended for the duration of the incarceration period for individuals under the age of twenty-one (21) except for periods of time that inpatient services are provided per OAC 317:35-5-26);

(E) The adult parent or caretaker relative on the case requests that the medical benefits are closed;

(F) The state has erred in the eligibility determination;

(G) The child or the adult parent or caretaker relative on the case has committed fraud or perjury in order to become eligible; or

(H) The child becomes categorically related to either the pregnancy eligibility group or the former foster care eligibility groups, thereby receiving eligibility based on such category, which is not considered an interruption in continuous eligibility.

"County" means the Oklahoma OKDHS' office or offices located in each county within the State.

"Custody" means the custodial status, as reported by OKDHS.

"Deductible/Coinsurance" means the payment that must be made by or on behalf of an individual eligible for Medicare before Medicare payment is made. The coinsurance is that part of the allowable medical expense not met by Medicare, which must be paid by or on behalf of an individual after the deductible has been met.

(A) For Medicare Part A (Hospital Insurance), the deductible relates to benefits for inpatient services while the patient is in a hospital or nursing facility. After the deductible is met, Medicare pays the remainder of the allowable cost.

(B) For Medicare Part B (Medical Insurance), the deductible is an annual payment that must be made before Medicare payment for medical services. After the deductible is met, Medicare pays eighty percent (80%) of the allowable charge. The remaining twenty percent (20%) is the coinsurance.

"Disabled" means an individual who is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death, or which has lasted (or can be expected to last) for a continuous period of not less than twelve (12) months.

"Disabled child" means for purposes of Medicaid Recovery a child of any age who is blind, or permanently and totally disabled according to standards set by the Social Security Administration.

"Estate" means all real and personal property and other assets included in the member's estate as defined in Title 58 of the Oklahoma Statutes.

"Expansion adult" means an individual defined by 42 Code of Federal Regulations (C.F.R.) ' 435.119 who is age nineteen (19) or older and under sixty-five (65), at or below 133 percent of the federal poverty level (FPL), and who are not related to the aged, blind, or disabled.

"Gatekeeping" means the performance of a comprehensive assessment by the OKDHS nurse utilizing the UCAT for the determination of medical eligibility, care plan development, and the determination of Level of Care for Personal Care, ADvantage Waiver and Nursing Facility services.

"Ineligible Spouse" means an individual who is not eligible for Supplemental Security Income (SSI) but is the husband or wife of someone who is receiving SSI.

"Lawfully present" means a noncitizen in the United States who is considered to be in lawful immigration status or class.

"Lawfully residing" means the individual is lawfully present in the United States and also meets Medicaid residency requirements.

"Local office" means the Oklahoma OKDHS' office or offices located in each county within the State.

"LOCEU" means the Oklahoma Health Care Authority's Level of Care Evaluation Unit.

"MAGI eligibility group" means an eligibility group whose financial eligibility is determined through the Modified Adjusted Gross Income (MAGI) methodology. The groups subject to MAGI are defined in 42 C.F.R. _ 436.603 and listed in OAC 317:35-6-1.

"Modified Adjusted Gross Income (MAGI)" means the financial eligibility determination methodology established by the Patient Protection and Affordable Care Act (PPACA) in 2009.

"Medicare" means the federally funded health insurance program also known as Title XVIII of the Social Security Act. It consists of four (4) separate programs. Part A is Hospital Insurance, Part B is Medical Insurance, Part C is Medicare Advantage Plans, and Part D is Prescription Drug

Coverage.

(A) **"Part A Medicare"** means Hospital Insurance that covers services for inpatient services while the patient is in a hospital or nursing facility. Premium free enrollment is provided for all persons receiving Old Age, Survivors, and Disability Insurance (OASDI) or Railroad Retirement income who are age sixty-five (65) or older and for those under age sixty-five (65) who have been receiving disability benefits under these programs for at least twenty-four (24) months.

(i) Persons with end-stage renal disease who require dialysis treatment or a kidney transplant may also be covered.

(ii) Those who do not receive OASDI or Railroad Retirement income must be age sixty-five (65) or over and pay a large premium for this coverage. Under Authority rules, these individuals are not required to enroll for Part A to be eligible for SoonerCare benefits as categorically needy. They must, however, enroll for Medicare Part B. Individuals eligible as a QMBP or as a QDWI under Medicaid are required to enroll for Medicare Part A. The Authority will pay Part A premiums for QMBP individuals who do not qualify for premium free Part A and for all QDWI's.

(B) **"Part B Medicare"** means Supplemental Medical Insurance that covers physician and related medical services other than inpatient or nursing facility care. Individuals eligible to enroll in Medicare Part B are required to do so under OHCA policy. A monthly premium is required to keep this coverage in effect.

"Minor child" means a child under the age of eighteen (18).

"Noncitizen" is synonymous with the word "alien" and means an individual who does not have United States citizenship and is not a United States national.

"Nursing Care" for the purpose of Medicaid Recovery is care received in a nursing facility, an intermediate care facility for individuals with intellectual disabilities (ICF/IIDs) or other medical institution providing nursing and convalescent care, on a continuing basis, by professional personnel who are responsible to the institution for professional medical services.

"OCSS" means the OKDHS' Oklahoma Child Support Services (formerly Child Support Enforcement Division).

"OHCA" means the Oklahoma Health Care Authority.

"OHCA Eligibility Unit" means the group within the OHCA that assists with the eligibility determination process.

"OKDHS" means the Oklahoma Department of Human Services which is also referenced in rules as Department of Human Services (DHS) and Office of Human Services (OHS).

"OKDHS nurse" means a registered nurse in the OKDHS Aging Services Division who meets the certification requirements for UCAT Assessor and case manager, and who conducts the uniform assessment of individuals utilizing the UCAT for the purpose of medical eligibility determination. The OKDHS nurse also develops care plans and service plans for Personal Care services based on the UCAT.

"Qualified Disabled and Working Individual (QDWI)" means individuals who have lost their Title II OASDI benefits due to excess earnings but have been allowed to retain Medicare coverage.

"Qualified Medicare Beneficiary Plus (QMBP)" means certain aged, blind or disabled individuals who may or may not be enrolled in Medicare Part A, meet the Medicaid QMBP income and resource standards and meet all other Medicaid eligibility requirements.

"Qualifying Individual" means certain aged, blind or disabled individuals who are enrolled in Medicare Part A, meet the Medicaid Qualifying Individual income and resource standards and

meet all other Medicaid eligibility requirements.

"Qualifying Individual-1" means a Qualified Individual who meets the Qualifying Individual-1 income and resource standards.

"Reasonably compatible" means that there is no significant discrepancy between information declared by a member or applicant and other information available to the agency. More specific policies and procedures for determining whether a declaration is reasonably compatible are detailed in Oklahoma's Verification Plan.

"Recipient lock-in" means when a member is restricted to one primary physician and/or one pharmacy. It occurs when the OHCA determines that a SoonerCare member has used multiple physicians and/or pharmacies in an excessive manner over a twelve (12) month period.

"Scope" means the covered medical services for which payment is made to providers on behalf of eligible individuals. The OHCA Provider Manual (OAC 317:30) contains information on covered medical services.

"Specified Low Income Medicare Beneficiaries (SLMB)" means individuals who, except for income, meet all of the eligibility requirements for QMBP eligibility and are enrolled in Medicare Part A.

"TEFRA" means the Tax Equity and Fiscal Responsibility Act of 1982 (Public Law 97-248). TEFRA provides coverage to certain disabled children living in the home who would qualify for SoonerCare if residents of nursing facilities, Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IIDs), or inpatient acute care hospital stays are expected to last not less than sixty (60) days.

"Worker" means the OHCA or OKDHS worker responsible for assisting in eligibility determinations.

SUBCHAPTER 6. SOONERCARE FOR PREGNANT WOMEN AND FAMILIES WITH CHILDREN

PART 7. CERTIFICATION, REDETERMINATION AND NOTIFICATION

317:35-6-60. Certification for SoonerCare for pregnant women and families with children

(a) **General rules of certification.**

(1) An individual determined eligible for SoonerCare may be certified for a prospective period of coverage on or after the date of certification.

(2) In accordance with 42 Code of Federal Regulations (C.F.R.) § 435.915 and Oklahoma Administrative Code (OAC) 317:35-6-60.2, an individual may also be determined eligible and certified for a retroactive period of coverage during the three (3) month period directly prior to the date of application. This only applies if the individual received covered medical services at any time during that period, and would have been eligible for SoonerCare at the time he or she received the services, regardless of whether the individual is alive when application for Medicaid is made. An individual may be eligible for the retroactive period even though ineligible for the prospective period.

(3) The individual who is categorically needy and related to pregnancy-related services retains eligibility for the period covering prenatal, delivery, and postpartum periods without regard to eligibility for other household members in the case. Eligibility during the postpartum period does not apply to women receiving pregnancy-related coverage under Title XXI.

(b) **Certification as a TANF (cash assistance) recipient.** A categorically needy individual who is determined eligible for ~~TANF~~Temporary Assistance for Needy Families (TANF) is certified

effective the first day of the month of TANF eligibility.

(c) **Certification of non-cash assistance individuals related to the children and parent and caretaker relative groups.** The certification period for the individual related to the children or parent and caretaker relative groups is twelve (12) months. The certification period can be less than twelve (12) months if the individual:

(1) Is certified as eligible in a money payment case during the twelve-month (12-month) period;

(2) Is certified for long-term care during the twelve-month (12-month) period;

(3) Becomes ineligible for SoonerCare after the initial month, except for children who are eligible for twelve months continuous coverage; or

(4) Becomes financially ineligible.

(A) If an income change after certification causes the case to exceed the income standard, the case is closed.

(B) Individuals, however, who are determined pregnant and financially eligible continue to be eligible for pregnancy-related services through the prenatal, delivery and postpartum period, regardless of income changes. A pregnant individual included in a TANF case which closes continues to be eligible for pregnancy-related services through the postpartum period.

(d) **Certification of individuals related to pregnancy-related services.** The certification period for the individual related to pregnancy-related services will cover the prenatal, delivery and postpartum periods. The postpartum period is defined as the two (2) months following the month the pregnancy ends. Financial eligibility is based on the income received in the first month of the certification period. No consideration is given to changes in income after certification.

(e) **Certification of newborn child deemed eligible.**

(1) Every newborn child is deemed eligible on the date of birth for SoonerCare when the child is born to a woman who is eligible for and enrolled in pregnancy-related services as categorically needy. The newborn child is deemed eligible through the last day of the month the newborn child attains the age of one (1) year. The newborn child's eligibility is not dependent on the mother's continued eligibility. The mother's coverage may expire at the end of the postpartum period; however, the newborn child is deemed eligible until age one (1). The newborn child's eligibility is based on the original eligibility determination of the mother for pregnancy-related services, and consideration is not given to any income or resource changes that occur during the deemed eligibility period.

(2) The newborn child is deemed eligible for SoonerCare as long as he/she continues to live in Oklahoma. In accordance with 42 C.F.R. § 435.117, no other conditions of eligibility are applicable, including social security number enumeration, child support referral, and citizenship and identity verification. However, it is recommended that social security number enumeration be completed as soon as possible after the newborn child's birth. It is also recommended that a child support referral be completed, if needed, as soon as possible and sent to the Oklahoma Child Support Services (OCSS) division at DHS. The referral enables child support services to be initiated.

(3) When a categorically needy newborn child is deemed eligible for SoonerCare, he/she remains eligible through the end of the month that the newborn child reaches age one (1). If the child's eligibility is moved from the case where initial eligibility was established, it is required that the newborn receive the full deeming period. The certification period is shortened only in the event the child:

(A) loses Oklahoma residence; or

(B) expires.

(4) A newborn child cannot be deemed eligible when the mother's only coverage was presumptive eligibility, and continued eligibility was not established.

317:35-6-60.1 Changes in circumstances

(a) **Reporting changes.** Members are required to report changes in their circumstances within ~~10~~ten (10) days of the date the member is aware of the change.

(b) **Agency action on changes in circumstances**. When the agency responsible for determining eligibility for the member becomes aware of a change in the member's circumstances, the agency will promptly redetermine eligibility for all household members whose eligibility is affected by the change.

(c) **Changes reported by third parties.** When the agency receives information regarding a change in the member's circumstances from a third party, such as the Oklahoma Employment Security Commission (OESC) or the Social Security Administration (SSA), the agency will determine whether the information received is reasonably compatible with the most recent information provided by the member.

(1) If the information received is reasonably compatible with the information provided by the member, the agency will use the information provided by the member for determinations and redeterminations of eligibility.

(2) If the information received is not reasonably compatible with the information provided by the member, the agency will determine whether the information received will have an effect on the eligibility of any member of the household.

(A) If the information received has no effect on the eligibility of any member of the household, including the benefit package the member is enrolled in, the agency will take no action.

(B) If the information received has an effect on the eligibility of a member of the household, the agency will request more information from the member, including, but not limited to, an explanation of the discrepancy or verification documenting the correct information regarding the factor of eligibility affected by the information received from a third party.

(C) The agency will give the member proper notice of at least 10 days to respond to the agency's request for information.

(D) If the member does not cooperate in resolving the discrepancy within the timeframe established by the notice, benefits will be terminated.

~~(d) **Exception January to March, 2014.** During the period January to March, 2014, redeterminations due to changes in circumstances will be processed, but the effective date of any termination action taken as a result of changes in household composition or income for individuals in MAGI eligibility groups will be April 1, 2014, or later.~~

(d) **Changes in a continuous eligibility period for children.** During a continuous eligibility period for children, a member must report:

(1) A change of address for the child; or

(2) If a certified child leaves the home, is institutionalized, or dies.

317:35-6-61. Redetermination of eligibility for persons receiving SoonerCare

(a) A periodic redetermination of eligibility for SoonerCare is required for all members. The redetermination is made prior to the end of the initial certification period and each ~~12~~twelve (12) months thereafter. A deemed newborn is eligible through the last day of the month the newborn

child attains the age of one year, without regard to eligibility of other household members in the case.

(b) Effective January 1, 2014, when the agency has sufficient information available electronically to redetermine eligibility, eligibility will be redetermined on that basis and a notice will be sent to the household explaining the action taken by the agency. The member is responsible for notifying the agency if any information used to redetermine eligibility is incorrect. If the agency does not have sufficient information to redetermine eligibility, the agency will send notice to that effect, and the member is responsible for providing the necessary information to redetermine eligibility.

(c) A member's case is closed if he/she does not return the form(s) and any verification necessary for redetermination timely. If the member submits the form(s) and verification necessary for redetermination within ~~90~~ninety (90) days after closure of the case, benefits are reopened effective the date of the closure, provided the member is eligible and benefits were closed because the redetermination process was not completed.

~~(d) Periodic redeterminations scheduled for January to March, 2014 will be rescheduled for April, 2014.~~

(d) SoonerCare does not redetermine the SoonerCare eligibility of a child under 19 years of age whose coverage began on or after January 1, 2024, regardless of changes in income, until the earlier of:

(1) Twelve (12) months; or

(2) The child's nineteenth (19^{th}) birthday.