OKLAHOMA HEALTH CARE AUTHORITY
REGULAR BOARD MEETING
November 17, 2021, at 3:00 P.M.
Oklahoma Health Care Authority
4345 N. Lincoln Blvd
Oklahoma City, OK. 73105

A G E N D A

Public access via Zoom:
https://okhca.zoom.us/webinar/register/WN_960nzgosRM6KSYw-Q0Qw8g
Telephone: 1-669-900-6833 Webinar ID: 981 9528 2450

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

1. Call to Order / Determination of Quorum……Stan Hupfeld, Chair

2. Consent Agenda……Stan Hupfeld, Chair

    a) Approval of the August 26, 2021 OHCA Board Meeting Minutes (Attachment "A")
    b) Discussion and Approval of State Plan Amendment Rate Committee Rates pursuant to 63 O.S. Section 5006(A)(2) under OAC 317:1-3-4 (Attachment "B")
    c) Discussion and Vote regarding the Authority's ability to withstand the procurement decision made by the CEO based on the Authority's budget and available funds pursuant to 63 O.S. Section 5006(A)(2) under OAC 317:10-1-16.

        i. Third Party Liability (Attachment "C")
        ii. MyHealth (Attachment "D")
        iii. Prior Authorization RFP (Attachment "E")
        iv. Pondera (Attachment "F")

3. Chief Executive Officer's Report ……..……Kevin Corbett, Chief Executive Officer

4. Chief of Staff's Report…….……..Ellen Buettner, Chief of Staff

5. Chief Operating Officer's Report (Attachment "G")……....Melody Anthony, Chief Operating Officer
   State Medicaid Director

    a) Member Moment

6. Comprehensive Quality Strategy Update (Attachment "H").....…….Nathan Valentine, MD, CPE, FAAFP
   Chief Quality Officer

7. Discussion of Report from the……..……..Phil Kennedy
   Compliance Advisory Committee Chair, Compliance Advisory Committee

8. Discussion of Report from the Pharmacy ……Randy Curry
   Advisory Committee and Possible Action Regarding Chair, Pharmacy Advisory Committee
   Drug Utilization Board Recommendations

    a) Consideration and Vote on Recommendations Made by the Drug Utilization Review Board Pursuant to 63 O.S. § 5030.1, § 5030.3 To Add the Following Drugs to the Utilization and Scope Prior Authorization Program under OAC 317:2-1-11 (Attachment "I"):

        i. Cabometyx® (Cabozantinib), Fotivda® (Tivozanib), Jelmyto® (Mitomycin), and Padcev® (Enfortumab Vedotin-ejfv)
        ii. Zilxi® (Minocycline 1.5% Topical Foam)
        iii. Kynmobi™ (Apomorphine) and Ongentys® (Opicapone)
        iv. Fetroja® (Cefiderocol) and Kimyrsa™ (Oritavancin)

v. Xywav® (Calcium/Magnesium/Potassium/ Sodium Oxybates)
vi. Alkindi® Sprinkle (Hydrocortisone Oral Granule), Eysuvis® (Loteprednol 0.25% Ophthalmic Suspension), Gimoti® (Metoclopramide Nasal Spray), Nextstellis® (Drospirenone/Estetrol Tablet), Ozobax® (Baclofen 5mg/5mL Oral Solution), Phexxi® (Lactic Acid/Citric Acid/Potassium Bitartrate Vaginal Gel), RediTrex® (Methotrexate Injection), Reltone™ (Ursodiol Capsule), and Thyquidity™ (Levothyroxine Oral Solution)
vii. Nulibry™ (Fosdenopterin)
viii. Danyelza® (Naxitamab-gqgk) and Truseltiq™ (Infigratinib)
ix. Feraheme® (Ferumoxytol), Injectafer® (Ferric Carboxymaltose), and Monoferric® (Ferric Derisomaltose)
x. Herceptin® (Trastuzumab) and Margenza® (Margetuximab-cmkb)
xi. Orgovyx™ (Relugolix)

9. Discussion of Report of Administrative Rules Advisory Committee and Possible Action Regarding Agency Rulemaking (Attachment "J") ……..……..…….....Susan Dell'Osso Chair, Administrative Rules Advisory Committee

a) Consideration and Vote on Agency Recommended Rulemaking Pursuant to Article I of the Administrative Procedures Act and in accordance with 75 O.S. § 253. OHCA Requests the Adoption of the Following Emergency Rules (see Attachment "J"):

i. APA WF #21-01 Reimbursing Federally Qualified Health Centers (FQHCs) for Long-Acting Reversible Contraceptive (LARCs) Devices Outside of the Encounter Rate
ii. APA WF #21-05 Medicaid Expansion and Durable Medical Equipment
iii. APA WF #21-10 Transitioning Developmental Disabilities Services Division (DDSD) Members back into the Money Follows the Person (MFP) Demonstration
iv. APA WF #21-11 Indian Health Service, Tribal and Urban Indian (I/T/U) Shared Savings Program
v. APA WF # 21-13 Grievance Procedures and Process Rule Revisions
vi. APA WF # 21-15 Ensuring Access to Medicaid Act
vii. APA WF #21-16 Hospital Presumptive Eligibility (HPE) for Expansion Adults
viii. APA WF #21-17 Adult Dental Benefit Revisions
ix. APA WF #21-19 Appeals to the Chief Executive Officer (CEO)/Administrative Law Judge (ALJ)
x. APA WF 21-20 Alternative Treatments for Pain Management
xi. APA WF #21-22 Title XXI Dental Revision for Pregnant Women
xii. APA WF #21-26 COFA Migrant Medicaid Extension and Afghan Refugees Eligibility

10. Discussion and Possible Action Regarding OHCA Board Meeting Dates and Times for Calendar Year 2022 (Attachment "K") ……Stan Hupfeld, Chair

11. Discussion and Possible Action Elections of the OHCA 2022 Board Officers ……Stan Hupfeld, Chair

12. Discussion and Possible Action on the Adoption of Robert's Rule of Order as Governing Parliamentary Procedure Where Such Does Not Conflict with the Open Meeting Act ……Stan Hupfeld, Chair

13. Adjournment……Stan Hupfeld, Chair

NEXT BOARD MEETING
TBD
Oklahoma Health Care Authority
4345 N. Lincoln Blvd
Oklahoma City, OK 73105

Attachment A

MINUTES OF A SPECIAL BOARD MEETING
OF THE HEALTH CARE AUTHORITY BOARD
August 26, 2021
Oklahoma Health Care Authority Boardroom
Oklahoma City, Oklahoma

Manner and Time of Notice of Meeting: A statutorily required public meeting notice was placed on the front door of the Oklahoma Health Care Authority on August 25, 2021 at 3:30 p.m. Advance public meeting notice was provided to the Oklahoma Secretary of State. In addition to the posting of the statutory public notice, the agency placed its agenda on its website on August 20, 2021 at 12:00 p.m.

Pursuant to a roll call of the members, a quorum was declared to be present, and Chairman Hupfeld called the meeting to order at 4:05 p.m.

BOARD MEMBERS PRESENT:	Chairman Hupfeld, Vice-Chairman Yaffe, Member Boyd, Member Case, Member Curry, Member Hausheer, Member Kennedy, Member Shamblin
BOARD MEMBERS ABSENT:	Member Nuttle

ITEM 2 / PUBLIC COMMENT ON THIS MEETING'S AGENDA ITEMS BY ATTENDEES WHO GAVE 24-HOUR PRIOR WRITTEN NOTICE
Stanley Hupfeld, OHCA Board Chairman

Member Hausheer requested that those making public comment be allowed more time to make their comment. Chairman Hupfeld allowed the extension of time.

- Dr. Daniel Joyce, Comanche County Memorial Hospital
- Sandra Harrison, Oklahoma Hospital Association
- Anthony Sykes
- Dr. Steven Crawford
- Allison Warren, Oklahoma Osteopathic Association
- Jennifer McCullum, Alliance of Mental Health Providers of Oklahoma

Chairman Hupfeld thanked those who signed up to make public for their comments and reminded the board that promulgation of rules is a clear statutory obligation of the board. He urged the board to keep their questions focused on the purpose of the rules, which is to come into compliance with existing law.

CEO Corbett added that the purpose for today's special meeting is to approve rules that OHCA has been directed to promulgate through statute and in response to the recent Supreme Court ruling. He stated that there has been no decision made on whether the agency pursue third-party Managed Care. However, any decision on major changes in how OHCA delivers services will be made after thoughtful discussion with board members, the legislature, the Governor's office, and other stakeholders. CEO Corbett also stated that the board must approve the rules, otherwise OHCA will be in violation of a statutory directive from the legislature and ruling from the Supreme Court.

ITEM 3 / DISCUSSION AND POSSIBLE VOTE ON APPROVAL OF THE JUNE 30, 2021 BOARD MEETING MINUTES:

MOTION:	Member Hausheer moved for approval of the June 30, 2021 meeting minutes, as published. The motion was seconded by Member Kennedy.
FOR THE MOTION:	Chairman Hupfeld, Vice-Chairman Yaffe, Member Case, Member Curry, Member Hausheer, Member Kennedy, Member Shamblin
ABSTAINED:	Member Boyd
BOARD MEMBERS ABSENT:	Member Nuttle

ITEM 4 / CHIEF EXECUTIVE OFFICER'S REPORT
Kevin Corbett, Chief Executive Officer

CEO provided an COVID and Expansion update.

COVID Update: About 67 OHCA employees have been infected since the pandemic began, of those only two were hospitalized and had a full recovery. In the last 30 days, only 7 OHCA staff members have been infected. Part of this is due to OHCA flexible work schedule. OHCA continues to encourage staff to get vaccinated, while also respecting personal choice. Over 75% of OHCA staff have been vaccinated.

Expansion Update: CEO Corbett provided an overview of Medicaid Expansion that included information on total enrollment, Members and Claims, and Categories of Service.

Since July 1st, about 167,000 have enrolled for Medicaid Expansion. OHCA surveyed new members and about 70% of those that responded said they had not been able to get medical care for a period of time. Of the 167,000 expansion members, about 70,000 have received care over the last two months. Dr. Valentine and his team are looking into Social Determinates and how outcomes will be driven. OHCA is trying to engage the Expansion group on different levels. CEO Corbett provided information on the different services that have been provided. CEO Corbett added that he will provide an update to the legislature on Monday afternoon.

ITEM 5 / CHIEF OPERATING OFFICER'S REPORT
Melody Anthony, State Medicaid Director/Chief Operating Officer

Ms. Anthony introduced Kim Downing, Supervisor in Population Care Management, who presented her in-person member moment.

Ms. Anthony provided a brief Expansion update. For the month of July and part of August, about 25,000 of services provided were with primary care physicians. The Operations team is in the process of polling all the contracted dental providers and will provide an update on that at the next board meeting.

Ms. Anthony also provided a Patient Centered Medical Home update. The next generation will allow changes to the program without seeking federal authority and waiting 120 days. The program was approved and will be fully funded. The Policy team will work with Dr. Valentine's team, will change the pay for performance program and will take the Sooner Excel money and turn it into a value-based reimbursement methodology based on changes in health outcomes. OHCA is in the process of developing the metrics with Dr. Valentine and his team. The program can be launched in January 2022. September through November will be spent seeking stakeholder input and making any modifications to the program. As part of outreach that OHCA is currently doing, a health screen has been added to the end of the SoonerCare application. The results are broken down by needs. After the survey is completed, a letter is mailed or emailed to the member as an introduction to the population care management nurse that has been assigned to that member. Responses to both the survey and letter have been great. Member Hausheer asked that Ms. Anthony provide an update on the results of the survey at the next board meeting.

ITEM 6 / DISCUSSION OF REPORT FROM THE COMPLIANCE ADVISORY COMMITTEE
Phil Kennedy, Chair of the Compliance Advisory Committee

Committee Chairman Kennedy provided an update on the August 11th Compliance Committee Meeting.

Financial Update: OHCA ended FY21 with a positive budget variance of $62.7 million. A significant variance remains for Administration and Program spend. The administration variance is due to staffing and low budgeted FTE limits and under spend in third-party contracts. The program variance is due to utilization decreases, primarily attributable to public health emergency. The ending cash balance in the program fund, 340b, is over $348 million and when accounted for funds and transfers, the amount is over $430 million.

Audit Update: Billy Swindell attended the Compliance meeting to present OHCA's FY 2020 audit findings. OHCA received six reportable findings related to eligibility, system edits, and claim payments. Of the six, three of the findings have already been corrected and the remaining three will be implemented in the next couple of months.

ITEM 7i-iv / DISCUSSION OF REPORT FROM THE ADMINISTRATIVE RULES ADVISORY COMMITTEE AND POSSIBLE ACTION REGARDING AGENCY RULEMAKING
Jean Hausheer, M.D., Chair, Administrative Rules Advisory Committee

CEO Corbett restated that the purpose for today's special meeting is to approve rules that OHCA has been directed to promulgate through statute and in response to the recent Supreme Court ruling.

Committee Chairwoman Hausheer stated that the rules being promulgated were presented at the Tribal Consultation and were subject to a public comment period, which received no public comment. Additionally, the rules were presented to the Medical Advisory Committee (MAC). The MAC Members did not suggest any changes to the language in the rules. Committee Chairwoman Hausheer noted that APA WF 21-12 and APA WF 21-14 were approved by the MAC; however,

APA WF 21-13 and APA WF 21-15 were not approved by the MAC due to SB131 not authorizing OHCA to proceed with any rulemaking related to Managed Care. Committee Chairwoman Hausheer respectfully disagreed with Chairman Hupfeld's characterization of his comment after public comment as having nothing to do with Managed Care. Chairwoman Hausheer provided the following statement as to why she disagreed:

"Recently, administrative rules committee members met and deliberated carefully and thoughtfully over every one of these rules. In your board packets you were each given the essence of the line of questioning and that we ask and that were discussed, as well as answers given to us by the agency. Our recommendation, that day, were that this board approve each of these four emergency rules with a vote of two yes and the third vote on our committee, that board member was not present that day. Those votes were based on in-depth conversations, as I said, and not taken lightly. Since the meeting, as your Chair of this administrative rules committee, I have reached out to key legislative leaders involved in the promulgation of SB 131. I did this because I needed to further understand its origin, as well as where it stands today. I am merely a physician, so this is why I did this. Specifically, I personally spoke, at length, with both the author of SB 131 which is Sen. McCortney, as well as Rep. Marcus McEntire who's here in the audience today. I involved both of them and talked with them at length for my own understanding. I wish I had done this before our rules committee meeting, but I didn't. Here's the essence of what I was told, and I think it's key and it's relevant to these four rules. SB, and this is from Sen. McCortney and Rep. McEntire both, SB 131was created to try and get control of the RFP that has now been nullified by the Supreme Court Ruling. In other words, SB 131 was created, at the time, in effort to try and get that RFP situation under better control. Per Sen. McCortney and Rep. McEntire, SB 131 IS now null and void because of the recent Supreme Court ruling. There is no reason, whatsoever, to promulgate today's rules dealing with MCOs. The key point being that SB 131 was based on the assumption that we, as an agency, have the power to proceed forward with MCOs and we do not have that authority as per the Supreme Court ruling. It also seems important to recall and appreciate Member Case's request to this agency, back in January, to solve this board's question of whether we are advisory or instead statutory by getting the opinion of the Oklahoma AG. This board has repeatedly heard Vice-Chairman Yaffe request the AG opinion since that January meeting."

General Counsel, Kara Smith, reminded Committee Chairwoman Hausheer that while she can comment on the rules on the agenda, anything outside of that is outside the scope of the agenda. She also added that this is a special meeting and discussion is limited to the items on the agenda. Ms. Smith stated that the items to which Chairwoman Hausheer was speaking to surrounding Managed Care, SB 131 and the Supreme Court ruling and fell outside the scope of the board agenda. Chairwoman Hausheer stated that she was speaking on the items of the agenda and continued her statement.

"So as I see it, this board still is contemplating these questions, whether we're advisory or statutory. And it's at the core of this very issue today, of what we're talking about. At times, I feel like this board we're called upon to be advisory. In times like right now we're called to be statutory in nature. And so, I think that is a pertinent thing to acknowledge, at least, and bring up. Per Sen. McCortney and Rep. McEntire, SB 131 is not a live vehicle at this time. It is not set to play into motion magically on September 1st, at all, as has been portrayed. Since the recent meeting of the administrative rules committee, I have come to know that I had incomplete information at the time I voted to pass each of these rules set before you today. So, at this time I am going to say I am acting in good faith, it is my recommendation to propose to separate motions to this board which I will give individually. The first, I move to table any and all of today's four proposed rules as presented in the board agenda to a time indefinitely, is there a second?" Vice-Chairman Yaffe seconded the motion. Ms. Smith stated that the items on the agenda could not be tabled, as the meeting was a special meeting and was not an appropriate motion due to the limited nature of the meeting. Vice-Chairman Yaffe stated that it was his understanding was that a valid motion would be a motion to approve, deny, to table and asked for clarification as to why tabling was an improper motion. Ms. Smith stated that because the rules were listed as action items and based on the limited nature of the agenda, the appropriate motion that could be taken would be to approve or deny.

Upon hearing that, Chairwoman Hausheer amended her motion and stated that she motions to deny the four rules as listed in the agenda to a time indefinitely. Vice-Chairman Yaffe seconded the amended motion. During the discussion of the motion, Member Shamblin stated that she felt the board had received conflicted statements regarding the timing. Based on the statement made by a public commenter regarding the law not going into effect until September 1st, led her to believe that OHCA would need to promulgate rules after September 1st. Member Shamblin added that she has been told by legal counsel and the agency that the rules must be promulgated by September 1st.

CEO Corbett stated that, from a board perspective, there has to be trust and confidence in the agency and staff. He added that the OHCA Policy team is exceptional and are experts at doing this. OHCA Policy has gone through the process to evaluate whether OHCA needs to pass rules or not. The law is clear, and the law is effective in the books on September 1st. It has been OHCA's convention and process to have rules in place on the effective date. It is the agency's interpretation and CEO Corbett's directive to the staff to develop the rules and put them in place on the effective date of September 1st. CEO Corbett made it clear that promulgating these rules is not signaling what OHCA is going to do with regard to Third-Party Managed Care. He added that he's making sure that the agency and board are in compliance with a law that has been passed by the state legislature, as well as honoring and respecting the Supreme Court ruling. He also added that he does not want to be in violation of a law and suggested that the board also not violate it.

Chairwoman Hausheer stated that she asked Sen. McCortney exactly what CEO Corbett was talking about, who quoted Sen. McCortney saying, “the agency is picking and choosing what they want to do. This is not something they have to do. Based on 131, it is null and void”.

Member Boyd stated that the issue surrounding the board’s authority needs to be settled, however, from his perspective, it is clear what the board’s authority is. Chairman Hupfeld restated the motion on the floor and ended discussion for roll call.

Ms. Smith clarified that the motion to deny all of the rules would also deny the rules required by the Supreme Court decision and the expansion related rules, including APA WF 21-12 and APA WF 21-14. Vice-Chairman Yaffe asked Ms. Smith to point the board to where it states tabling of an action item is inappropriate. Ms. Smith stated that tabling the item was not what was currently on the floor, and based on the agenda, the motion to table was not an appropriate motion because of the limited nature of the meeting. Vice-Chairman Yaffe stated that that was outside of Robert’s Rules of Order, to which Ms. Smith stated Robert’s Rules of Order did not dictate the Oklahoma Meeting Act. She reminded the board that due to the limited nature of the agenda, the appropriate action would be to either deny taking action or approve the items.

Vice-Chairman Yaffe suggested that Chairwoman Hausheer amend her motion to an up or down vote to table the rules against the advice of the board’s counsel.

Chairwoman Hausheer withdrew her motion to deny all four of the rules on the agenda. Member Shamblin reminded the board that they still needed to vote on the emergency nature of the rules. Vice-Chairman Yaffe asked that the rules be voted on separately.

Chairwoman Hausheer reminded the board the MAC approved APA WF 21-12 and APA WF 21-14 and motioned to approve APA WF 21-12 and APA WF 21-14.

a) Consideration and Vote on Agency Recommended Rulemaking Pursuant to Article I of the Administrative Procedures Act and in Accordance with 75 O.S. § 253. OHCA Requests the Adoption of the Following Emergency Rules (see attachment “B”):

   i. APA WF 21-12 Purchasing Rule Revisions
   iii. APA WF 21-14 Expansion Adults into SoonerCare Choice

MOTION: Member Hausheer motioned for approval of item 7a.i & iii as published. The motion was seconded by Member Shamblin.

FOR THE MOTION: Chairman Hupfeld, Vice-Chairman Yaffe, Member Boyd, Member Case, Member Curry, Member Hausheer, Member Kennedy, Member Shamblin

BOARD MEMBERS ABSENT: Member Nuttle

Committee Chairwoman Hausheer’s second motion was to table APA WF 21-13 and APA WF 21-15 for an undetermined amount of time.

   ii. APA WF 21-13 Grievance Procedures and Process Rule Revisions
   iv. APA WF 21-15 Ensuring Access to Medicaid Act

MOTION: Member Hausheer motioned to table item 7a.ii & iv for an undetermined amount of time. The motion was seconded by Member Curry.

FOR THE MOTION: Vice-Chairman Yaffe, Member Boyd, Member Case, Member Curry, Member Hausheer, Member Kennedy, Member Shamblin

AGAINST THE MOTION: Chairman Hupfeld

BOARD MEMBERS ABSENT: Member Nuttle

Committee Chairwoman’s Hausheer’s third motion was to determine that APA WF 21-12 and APA WF 21-14 as emergency in nature.

MOTION: Member Hausheer motioned for approval of item 7ai & iii as emergency. The motion was seconded by Member Case.

FOR THE MOTION: Chairman Hupfeld, Vice-Chairman Yaffe, Member Boyd, Member Case, Member Curry, Member Hausheer, Member Kennedy, Member Shamblin

BOARD MEMBERS ABSENT: Member Nuttle

Committee Chairwoman motioned to request an AG opinion, to which Ms. Smith stated that motion could not be voted on as it was not on the agenda. Committee Chairwoman Hausheer request that that item be added to the next board agenda.

ITEM 8 / ADJOURNMENT

MOTION: Member Hausheer moved for approval for adjournment. The motion was seconded by Member Boyd.

FOR THE MOTION: Chairman Hupfeld, Vice-Chairman Yaffe, Member Boyd, Member Case, Member Curry, Member Hausheer, Member Kennedy, Member Shamblin

BOARD MEMBERS ABSENT: Member Nuttle

Meeting adjourned at 5:23 p.m., 8/26/2021

NEXT BOARD MEETING
September 20, 2021
Oklahoma Health Care Authority
4345 N. Lincoln Blvd
Oklahoma City, OK 73105

Martina Ordonez
Board Secretary

Minutes Approved: _____

*Initials:*_____

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OKLAHOMA
Health Care Authority

STATE PLAN AMENDMENT RATE COMMITTEE

CCBHC PPS REBASING METHODOLOGY

1. **IS THIS A RATE CHANGE OR A METHOD CHANGE?**
   Method Change

2. **IS THIS CHANGE AN INCREASE, DECREASE, OR NO IMPACT?**
   No Impact

3. **PRESENTATION OF ISSUE – WHY IS THIS CHANGE BEING MADE?**
   The Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) seeks to update and clarify language regarding the reimbursement methodology for the Prospective Payment System (PPS) rates for Certified Community Behavioral Health (CCBH) services. Changes will update and clarify the method, timing, and frequency for the establishment of initial and subsequent provider-specific PPS rates. Language also clarifies that initial interim rates for new providers of CCBH services are based on both rural and urban existing rates.

4. **CURRENT METHODOLOGY AND/OR RATE STRUCTURE.**
   The current process is to review cost reports bi-annually to determine adequacy of rates and update annually to reflect inflation.

5. **NEW METHODOLOGY OR RATE STRUCTURE.**
   The new methodology will clarify that CCBHC PPS rates will be updated every two years and at 12 months following an initial provider-specific rate for new CCBHCs. Proposed language also allows anticipated costs, in addition to actual costs, to be included in the initial provider-specific rate for new CCBHCs, allowing for the rate to account for necessary growth of the CCBHC during the initial years. Proposed changes will also allow for change in scope updates for changes expected to impact the PPS rate by at least 5 percent, once per year subject to state approval. Language also clarifies that new CCBHC initial rates are based on both rural and urban existing CCBHC rates. Updates for inflation will remain.

6. **BUDGET ESTIMATE.**
   There is no estimated budget impact.

7. **AGENCY ESTIMATED IMPACT ON ACCESS TO CARE.**
   The ODMHSAS has determined that this change will likely not impact access to care.

8. **RATE OR METHOD CHANGE IN THE FORM OF A MOTION.**
   The ODMHSAS requests the SPARC to approve the proposed changes to the method for determining CCBHC PPS rates.

9. **EFFECTIVE DATE OF CHANGE.**
   October 1, 2021, dependent upon CMS approval.

INTENSIVE RESIDENTIAL SUBSTANCE USE DISORDER TREATMENT FOR ADOLESCENTS RATE

1. **IS THIS A RATE CHANGE OR A METHOD CHANGE?**
   Rate Change

2. **IS THIS CHANGE AN INCREASE, DECREASE, OR NO IMPACT?**
   Increase

3. **PRESENTATION OF ISSUE – WHY IS THIS CHANGE BEING MADE?**
   The Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) proposes a new rate for intensive residential substance use disorder treatment for adolescents (Clinically Managed Medium-Intensity Residential Services for Adolescents, Intensive). A rate currently exists for adults only.

4. **CURRENT METHODOLOGY AND/OR RATE STRUCTURE.**
   The current Medicaid rate for intensive residential substance use disorder for adults is $160.00 per day. A rate for this service does not currently exist for adolescents.

5. **NEW METHODOLOGY OR RATE STRUCTURE.**
   ODMHSAS proposes a new rate of $160.00 per day for intensive residential substance use disorder treatment for adolescents.

6. **BUDGET ESTIMATE.**
   The estimated budget impact for SFY2022 is $131,513 total/$35,101 state share (9 months). The estimated budget impact for SFY2023 is $164,575 total/$43,925 state share. ODMHSAS attests that it has adequate funds to cover the state share of the projected cost of services per fiscal year.

7. **AGENCY ESTIMATED IMPACT ON ACCESS TO CARE.**
   The ODMHSAS has determined that this change will have a positive impact in that it will support the provision of services for adolescents in need of more intensive residential substance use disorder treatment.

8. **RATE OR METHOD CHANGE IN THE FORM OF A MOTION.**
   The ODMHSAS requests the SPARC to approve the proposed per diem reimbursement rate for intensive residential substance use disorder treatment for adolescents.

9. **EFFECTIVE DATE OF CHANGE.**
   October 1, 2021 contingent upon CMS approval.

DEVELOPMENTAL DISABILITIES SERVICES INCREASES

1. **IS THIS A RATE CHANGE OR A METHOD CHANGE?**
   Rate Change

2. **IS THIS CHANGE AN INCREASE, DECREASE, OR NO IMPACT?**
   Increase

3. **PRESENTATION OF ISSUE – WHY IS THIS CHANGE BEING MADE?**
   Oklahoma Human Services (OHS) is seeking to implement a provider rate increase pursuant to 1915(C) HOME AND COMMUNITY-BASED SERVICES WAIVER INSTRUCTIONS AND TECHNICAL GUIDANCE APPENDIX K: EMERGENCY PREPAREDNESS AND RESPONSE.

   Oklahoma Human Services (OHS) is seeking a series of 20% retroactive rate increases to support organizations providing services to persons with disabilities. These organizations compete for employees to provide direct care services in a highly competitive labor market. Without this additional support, staffing shortages could result in adverse health and safety outcomes for the individuals served.

   Habilitation Specialists, categorized as Home Health & Personal Care Aides or Personal Care & Service, have a direct impact on the health, safety and quality of life for individuals in care. Many of the individuals receiving waivered services require 24 hour care. Unfortunately, rates paid by OHS are insufficient to support a provider agency's ability to compete in the current labor market. As a result of turnover and vacancies, staff are forced to work overtime and cover additional shifts because understaffing is not an option.

   [1] To better understand Oklahoma's labor market, OHS sought information from the U.S. Bureau of Labor & Statistics for Occupational Employment and Wage Statistics. According to the most recent data for May 2020, wage estimates for Oklahoma reflect the dire situation faced by OHS service providers. The report categorizes 712 different job classifications, of which 650 report a median hourly rate ranging from a low of $8.84 to a high of $97.92. Staff employed by providers were likely categorized as Home Health & Personal Care Aides or in Personal Care & Services.

The hourly median wage for a Home Health & Personal Care Aide is $9.80. This is the 19th lowest hourly wage of the 650 reported, equating to the 3rd percentile.

The hourly median wage for someone in the Personal Care & Service occupation is $11.24. This is the 39th lowest hourly wage of the 650 reported, equating to the 6th percentile.

At these rates, service providers are unable to compete for 94% to 97% of the Oklahoma labor market. To address this situation, OHS is seeking to provide temporary funding through a series of retroactive rate increases until a market rate study is completed and rates can be addressed on a permanent basis.

[1] HTTPS://WWW.BLS.GOV/OES/CURRENT/OES_OK.HTM

The retroactive payments will not exceed 20% of provider's current payment rate and will apply to services paid for the time periods of:

- January 1, 2021 through March 31, 2021, and;
- April 1, 2021 through June 30, 2021, and;
- July 1, 2021 through September 30, 2021.

OHS is proposing the increase for the following categories of services:

- Adult Day
- Agency Companion
- Daily Living Supports
- Extended Duty Nursing
- Group Home
- Habilitation Training Specialist
- Homemaker
- Intensive Personal Supports
- Nursing
- Prevocational
- Respite
- Specialized Foster Care
- Supported Employment

The services provided by these rates are available to recipients of services paid through the

In Home Supports Waiver for Children, In-Home Supports Waiver for Adults, Homeward Bound Waiver and Community Waiver.

4. CURRENT METHODOLOGY AND/OR RATE STRUCTURE.

The current rate structure for services provided in the proposed rate changes are fixed and uniform rates established through the State Plan Amendment Rate Committee process. The services, current service codes and rates are as follows:

SERVICE DESCRIPTION	SERVICE CODE	SERVICE UNIT	CURRENT RATE
ADULT DAY CARE	S5100	15 Min	$2.08
AGENCY COMPANION - CLOSE	S5126 U1	1 Day	$100.36
AGENCY COMPANION - CLOSE - THERAPEUTIC LEAVE	S5126 U1 TV	1 Day	$100.36
AGENCY COMPANION - ENHANCED	S5126	1 Day	$130.52
AGENCY COMPANION - ENHANCED - THERAPEUTIC LEAVE	S5126 TV	1 Day	$130.52
AGENCY COMPANION - Pervasive Level	S5126 TF	1 Day	$142.74
AGENCY COMPANION - Pervasive Level - THERAPEUTIC LEAVE	S5126 TF TV	1 Day	$142.74
DAILY LIVING SUPPORTS	T2033	1 Day	$160.16
DAILY LIVING SUPPORTS - Telehealth	T2033 GT	1 Day	$160.16
DAILY LIVING SUPPORTS - THER LEAVE	T2033 TV	1 Day	$160.16
ES - CENTER BASED PREVOCATIONAL SVS	T2015 U1	1 Hour	$5.20
ES - COMMUNITY BASED PREVOCATIONAL SERVICES	T2015 TF	1 Hour	$10.40
ES - COMMUNITY BASED INDIVIDUAL SERVICES	T2015 U4	1 Hour	$16.84
ES - EMPLOYMENT SPECIALIST	T2019	15 Min	$25.12
ES - ENHANCED COMMUNITY BASED PREVOCATIONAL	T2015	1 Hour	$13.85
ES - JOB COACHING - GROUP OF 4-5	T2019 TF	15 Min	$13.88
ES - JOB COACHING - GROUP OF 2-3	T2019 HQ	15 Min	$15.00
ES - ENHANCED JOB COACHING SERVICES - GROUP OF 4-5	T2019 TG	15 Min	$16.16
ES - ENHANCED JOB COACHING SERVICES - GROUP OF 2-3	T2019 TG-HQ	15 Min	$17.28
ES - JOB COACHING INDIVIDUAL SERVICES	T2019 U4	15 Min	$25.00
ES - JOB COACHING INDIVIDUAL SERVICES - Telehealth	T2019 U4 GT	15 Min	$25.00

ES - JOB STABILIZATION / EXTENDED SERVICES	T2019 U1	15 Min	$5.76
ES - PRE-VOC. HTS - SUPP. SUPPORTS	T2015 TG	1 Hour	$13.10
GROUP HOME ALT. LIVING HOME, 4 BED	T1020	1 Day	$303.68
GROUP HOME COMM. LIVING HOME, 6 BED	T1020	1 Day	$173.42
GROUP HOME COMM. LIVING HOME, 7 BED	T1020	1 Day	$148.72
GROUP HOME COMM. LIVING HOME, 8 BED	T1020	1 Day	$143.78
GROUP HOME COMM. LIVING HOME, 9 BED	T1020	1 Day	$127.66
GROUP HOME COMM. LIVING HOME, 10 BED	T1020	1 Day	$125.58
GROUP HOME COMM. LIVING HOME, 11 BED	T1020	1 Day	$114.14
GROUP HOME COMM. LIVING HOME, 12 BED	T1020	1 Day	$112.84
GROUP HOME, 6 BED	T1020	1 Day	$75.40
GROUP HOME, 7 BED	T1020	1 Day	$64.48
GROUP HOME, 8 BED	T1020	1 Day	$56.42
GROUP HOME, 9 BED	T1020	1 Day	$51.48
GROUP HOME, 10 BED	T1020	1 Day	$47.58
GROUP HOME, 11 BED	T1020	1 Day	$44.46
GROUP HOME, 12 BED	T1020	1 Day	$41.86
HOMEMAKER	S5130	15 Min	$16.00
HOMEMAKER - EVV	S5130 32	15 Min	$16.00
HOMEMAKER RESPITE	S5150	15 Min	$16.00
HOMEMAKER RESPITE - EVV	S5150 32	15 Min	$16.00
HTS - HABILITATION TRAINING SPECIALIST	T2017	15 Min	$16.84
HTS - HABILITATION TRAINING SPECIALIST - EVV	T2017 32	15 Min	$16.84
HTS - HABILITATION TRAINING SPECIALIST - Telehealth	T2017 GT	15 Min	$16.84
HTS - NO SUPV AGENCY - INDEPENDENT	T2017 U1	15 Min	$7.60
INTENSIVE PERSONAL SUPPORTS	T2017 TF	15 Min	$16.84
NURSING EXTENDED DUTY	T1000	15 Min	$13.52
NURSING INTERMITTENT SKILLED	T1001	1 Visit	$52.52
NURSING - REGISTERED NURSE	G0299	15 Min	$15.60
NURSING - LICENSED PRACTICAL NURSE	G0300	15 min	$14.56
NURSING - LICENSED PRACTICAL NURSE - Telehealth	G0300 GT	15 min	$14.56
RESPITE - MAXIMUM	S5151	1 Day	$79.04

RESPITE IN - AGENCY COMPANION - CLOSE	S5151	1 Day	$123.24
RESPITE IN - AGENCY COMPANION - ENHANCED	S5151	1 Day	$153.40
RESPITE IN - AGENCY COMPANION - Pervasive	S5151	1 Day	$165.62
RESPITE IN - GROUP HOME, 6 BED	S5151	1 Day	$98.70
RESPITE IN - GROUP HOME, 7 BED	S5151	1 Day	$87.36
RESPITE IN - GROUP HOME, 8 BED	S5151	1 Day	$79.70
RESPITE IN - GROUP HOME, 9 BED	S5151	1 Day	$74.36
RESPITE IN - GROUP HOME, 10 BED	S5151	1 Day	$70.46
RESPITE IN - GROUP HOME, 11 BED	S5151	1 Day	$67.34
RESPITE IN - GROUP HOME, 12 BED	S5151	1 Day	$64.74
RESPITE IN - COMMUNITY LIVING HOME, 6 BED	S5151	1 Day	$196.30
RESPITE IN - COMMUNITY LIVING HOME, 7 BED	S5151	1 Day	$171.60
RESPITE IN - COMMUNITY LIVING HOME, 8 BED	S5151	1 Day	$166.66
RESPITE IN - COMMUNITY LIVING HOME, 9 BED	S5151	1 Day	$150.54
RESPITE IN - COMMUNITY LIVING HOME, 10 BED	S5151	1 Day	$148.46
RESPITE IN - COMMUNITY LIVING HOME, 11 BED	S5151	1 Day	$137.02
RESPITE IN - COMMUNITY LIVING HOME, 12 BED	S5151	1 Day	$135.72
RESPITE, IN OWN HOME-CLOSE	S9125 TF	1 Day	$28.50
RESPITE, IN OWN HOME-INTERMITTENT	S9125 U1	1 Day	$19.00
RESPITE, IN OWN HOME-MAXIMUM	S9125	1 Day	$57.04
SPECIALIZED FOSTER CARE ADULT-CLOSE	S5140 U1	1 Day	$30.00
SPECIALIZED FOSTER CARE ADULT-MAX.	S5140	1 Day	$56.16
SPECIALIZED FOSTER CARE CHILD-CLOSE	S5145 U1	1 Day	$30.00
SPECIALIZED FOSTER CARE CHILD-MAX.	S5145	1 Day	$56.16

5. NEW METHODOLOGY OR RATE STRUCTURE.

The new rates are based on a 20% increase of existing rates

SERVICE DESCRIPTION	SERVICE CODE	SERVICE UNIT	PROPOSED RATE	TOTAL COST 3 MTHS
ADULT DAY CARE	S5100	15 Min	$ 2.50	$ 160,040.92
AGENCY COMPANION - CLOSE	S5126 U1	1 Day	$ 120.43	$ 42,095.33
AGENCY COMPANION - CLOSE - THERAPEUTIC LEAVE	S5126 U1 TV	1 Day	$ 120.43	$ 171.95
AGENCY COMPANION - ENHANCED	S5126	1 Day	$ 156.62	$ 156,458.64
AGENCY COMPANION - ENHANCED - THERAPEUTIC LEAVE	S5126 TV	1 Day	$ 156.62	$ 1,129.32
AGENCY COMPANION - Pervasive Level	S5126 TF	1 Day	$ 171.29	$ 110,083.55
AGENCY COMPANION - Pervasive Level - THERAPEUTIC LEAVE	S5126 TF TV	1 Day	$ 171.29	$ 1,027.17
DAILY LIVING SUPPORTS	T2033	1 Day	$ 192.19	$ 4,907,150.21
DAILY LIVING SUPPORTS - Telehealth	T2033 GT	1 Day	$ 192.19	$ -
DAILY LIVING SUPPORTS - THER LEAVE	T2033 TV	1 Day	$ 192.19	$ 16,526.43
ES - CENTER BASED PREVOCATIONAL SVS	T2015 U1	1 Hour	$ 6.24	$ 179,487.25
ES - COMMUNITY BASED PREVOCATIONAL SERVICES	T2015 TF	1 Hour	$ 12.48	$ 90,663.29
ES - COMMUNITY BASED INDIVIDUAL SERVICES	T2015 U4	1 Hour	$ 20.21	$ 162,960.92
ES - EMPLOYMENT SPECIALIST	T2019	15 Min	$ 7.54	$ 1,016.42
ES - ENHANCED COMMUNITY BASED PREVOCATIONAL	T2015	1 Hour	$ 16.62	$ 23,266.69
ES - JOB COACHING - GROUP OF 4-5	T2019 TF	15 Min	$ 4.16	$ 771,552.43
ES - JOB COACHING - GROUP OF 2-3	T2019 HQ	15 Min	$ 4.50	$ 13,017.88
ES - ENHANCED JOB COACHING SERVICES - GROUP OF 4-5	T2019 TG	15 Min	$ 4.85	$ 69,899.62
ES - ENHANCED JOB COACHING SERVICES - GROUP OF 2-3	T2019 TG-HQ	15 Min	$ 5.18	$ 6,309.59
ES - JOB COACHING INDIVIDUAL SERVICES	T2019 U4	15 Min	$ 7.50	$ 119,208.63
ES - JOB COACHING INDIVIDUAL SERVICES - Telehealth	T2019 U4 GT	15 Min	$ 7.50	$ 1,469.11
ES - JOB STABILIZATION / EXTENDED SERVICES	T2019 U1	15 Min	$ 1.73	$ 2,395.93

ES - PRE-VOC. HTS - SUPP. SUPPORTS	T2015 TG	1 Hour	$ 15.72	$ 111,820.62
GROUP HOME ALT. LIVING HOME, 4 BED	T1020	1 Day	$ 364.42	$ 411,332.20
GROUP HOME COMM. LIVING HOME, 6 BED	T1020	1 Day	$ 208.10	$ 355,747.06
GROUP HOME COMM. LIVING HOME, 7 BED	T1020	1 Day	$ 178.46	$ 11,727.66
GROUP HOME COMM. LIVING HOME, 8 BED	T1020	1 Day	$ 172.54	$ -
GROUP HOME COMM. LIVING HOME, 9 BED	T1020	1 Day	$ 153.19	$ -
GROUP HOME COMM. LIVING HOME, 10 BED	T1020	1 Day	$ 150.70	$ 3,932.11
GROUP HOME COMM. LIVING HOME, 11 BED	T1020	1 Day	$ 136.97	$ 7,802.95
GROUP HOME COMM. LIVING HOME, 12 BED	T1020	1 Day	$ 135.41	$ 8,946.59
GROUP HOME, 6 BED	T1020	1 Day	$ 90.48	$ 387,700.31
GROUP HOME, 7 BED	T1020	1 Day	$ 77.38	$ 8,393.52
GROUP HOME, 8 BED	T1020	1 Day	$ 67.70	$ 113.58
GROUP HOME, 9 BED	T1020	1 Day	$ 61.78	$ -
GROUP HOME, 10 BED	T1020	1 Day	$ 57.10	$ 13,342.73
GROUP HOME, 11 BED	T1020	1 Day	$ 53.35	$ 6,461.62
GROUP HOME, 12 BED	T1020	1 Day	$ 50.23	$ 22,895.19
HOMEMAKER	S5130	15 Min	$ 4.80	$ 20,052.89
HOMEMAKER - EVV	S5130 32	15 Min	$ 4.80	$ 33,682.23
HOMEMAKER RESPITE	S5150	15 Min	$ 4.80	$ 74,880.10
HOMEMAKER RESPITE - EVV	S5150 32	15 Min	$ 4.80	$ 9,994.71
HTS - HABILITATION TRAINING SPECIALIST	T2017	15 Min	$ 5.05	$ 5,020,392.07
HTS - HABILITATION TRAINING SPECIALIST - EVV	T2017 32	15 Min	$ 5.05	$ 870,282.69
HTS - HABILITATION TRAINING SPECIALIST - Telehealth	T2017 GT	15 Min	$ 5.05	$ -
HTS - NO SUPV AGENCY - INDEPENDENT	T2017 U1	15 Min	$ 2.28	$ -
INTENSIVE PERSONAL SUPPORTS	T2017 TF	15 Min	$ 5.05	$ 195,429.91
NURSING EXTENDED DUTY	T1000	15 Min	$ 8.11	$ 151,482.33
NURSING INTERMITTENT SKILLED	T1001	1 Visit	$ 63.02	$ 62,985.41

NURSING - REGISTERED NURSE	G0299	15 Min	$ 18.72	$ 12,391.95
NURSING - LICENSED PRACTICAL NURSE	G0300	15 min	$ 17.47	$ 3,678.98
NURSING - LICENSED PRACTICAL NURSE - Telehealth	G0300 GT	15 min	$ 17.47	$ 37.42
RESPITE - MAXIMUM	S5151	1 Day	$ 94.85	$ 71.10
RESPITE IN - AGENCY COMPANION - CLOSE	S5151	1 Day	$ 147.89	$ 52.79
RESPITE IN - AGENCY COMPANION - ENHANCED	S5151	1 Day	$ 184.08	$ 374.53
RESPITE IN - AGENCY COMPANION - Pervasive	S5151	1 Day	$ 198.74	$ 468.21
RESPITE IN - GROUP HOME, 6 BED	S5151	1 Day	$ 118.44	$ 105.69
RESPITE IN - GROUP HOME, 7 BED	S5151	1 Day	$ 104.83	$ -
RESPITE IN - GROUP HOME, 8 BED	S5151	1 Day	$ 95.64	$ -
RESPITE IN - GROUP HOME, 9 BED	S5151	1 Day	$ 89.23	$ -
RESPITE IN - GROUP HOME, 10 BED	S5151	1 Day	$ 84.55	$ -
RESPITE IN - GROUP HOME, 11 BED	S5151	1 Day	$ 80.81	$ -
RESPITE IN - GROUP HOME, 12 BED	S5151	1 Day	$ 77.69	$ -
RESPITE IN - COMMUNITY LIVING HOME, 6 BED	S5151	1 Day	$ 235.56	$ -
RESPITE IN - COMMUNITY LIVING HOME, 7 BED	S5151	1 Day	$ 205.92	$ -
RESPITE IN - COMMUNITY LIVING HOME, 8 BED	S5151	1 Day	$ 199.99	$ -
RESPITE IN - COMMUNITY LIVING HOME, 9 BED	S5151	1 Day	$ 180.65	$ -
RESPITE IN - COMMUNITY LIVING HOME, 10 BED	S5151	1 Day	$ 178.15	$ -
RESPITE IN - COMMUNITY LIVING HOME, 11 BED	S5151	1 Day	$ 164.42	$ -
RESPITE IN - COMMUNITY LIVING HOME, 12 BED	S5151	1 Day	$ 162.86	$ -
RESPITE, IN OWN HOME-CLOSE	S9125 TF	1 Day	$ 34.20	$ -
RESPITE, IN OWN HOME-INTERMITTENT	S9125 U1	1 Day	$ 22.80	$ -
RESPITE, IN OWN HOME-MAXIMUM	S9125	1 Day	$ 68.45	$ -
SPECIALIZED FOSTER CARE ADULT-CLOSE	S5140 U1	1 Day	$ 36.00	$ -
SPECIALIZED FOSTER CARE ADULT-MAX.	S5140	1 Day	$ 67.39	$ 90,482.55
SPECIALIZED FOSTER CARE CHILD-CLOSE	S5145 U1	1 Day	$ 36.00	$ -
SPECIALIZED FOSTER CARE CHILD-MAX.	S5145	1 Day	$ 67.39	$ 32,424.48

6. **BUDGET ESTIMATE.**

Oklahoma's FFY21 FMAP of 67.99% has been temporarily increased to 74.19% as a result of the FFCRA for the retroactive rate increase effective from January 1, 2021 through March 31, 2021. The total projected cost is $14,765,417, with $10,954,463 in federal funds and $3,810,954 in state funds.

Oklahoma's FFY21 FMAP of 67.99% has been temporarily increased to 84.19% as a result of the FFCRA and ARPA for the retroactive rate increases effective from April 1, 2021 through June 30, 2021. The total projected cost is $14,765,417, with $12,431,005 in federal funds and $2,334,412 in state funds.

Oklahoma's FFY21 FMAP of 67.99% has been temporarily increased to 84.19% as a result of the FFCRA and ARPA for the retroactive rate increases effective from July 1, 2021 through September 30, 2021. The total projected cost is $14,765,417, with $12,431,005 in federal funds and $2,334,412 in state funds.

The total cost to fund the series of retroactive rate increases is $44,296,251, with $35,816,473 in federal funds and $8,479,778.

OHS attests it has adequate funding to pay the state share of the projected cost of services.

7. **AGENCY ESTIMATED IMPACT ON ACCESS TO CARE.**

The rate increase will have a positive impact on access to care.

8. **RATE OR METHOD CHANGE IN THE FORM OF A MOTION.**

Oklahoma Human Services requests the State Plan Amendment Rate Committee approve the proposed 20% three (3) quarterly retroactive rate increases for the periods January 1, 2021 through March 31, 2021; April 1, 2021 through June 30, 2021 and July 1, 2021 through September 30, 2021.

9. **EFFECTIVE DATE OF CHANGE.**

October 1, 2021 or upon CMS approval, whichever occurs first.

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ADVANTAGE WAIVER SERVICES RATE INCREASES

1. **IS THIS A RATE CHANGE OR A METHOD CHANGE?**
   Rate Change

2. **IS THIS CHANGE AN INCREASE, DECREASE, OR NO IMPACT?**
   Increase

3. **PRESENTATION OF ISSUE – WHY IS THIS CHANGE BEING MADE?**
   Oklahoma Human Services (OHS) is seeking to implement a provider rate increase pursuant to 1915(C) HOME AND COMMUNITY-BASED SERVICES WAIVER INSTRUCTIONS AND TECHNICAL GUIDANCE APPENDIX K: EMERGENCY PREPAREDNESS AND RESPONSE.

   Oklahoma Human Services (OHS) is seeking a series of quarterly 20% retroactive rate increases to support organizations providing services to persons over age 65 and adults over 21 with physical disabilities. These organizations compete for employees to provide direct care services in a highly competitive labor market. Without this additional support, staffing shortages could result in adverse health and safety outcomes for the individuals served.

   Personal care workers, categorized as Home Health & Personal Care Aides or Personal Care & Service Occupations, have a direct impact on the health, safety, and quality of life of individuals receiving care. Unfortunately, the rates paid by OHS are insufficient to support provider agencies' ability to compete in the current labor market. As a result of turnover and vacancies, remaining staff are forced to work overtime because of understaffing, often leaving vulnerable individuals without necessary care.

   [1] To better understand Oklahoma's labor market, OHS turned to the U.S. Bureau of Labor & Statistics for Occupational Employment and Wage Statistics. According to the most recent data for May 2020, The State Occupational Employment and Wage Estimates for Oklahoma quantifies the dire situation faced by OHS' provider partners. This report categorizes a total of 712 different job classifications, of which 650 reported a median hourly rate with a range from a low of $8.84 to a high of $97.92. Staff employed by providers were likely categorized as Home Health & Personal Care Aides or in the Personal Care & Services occupation.

The hourly median wage for a Home Health & Personal Care Aide is $9.80. This is the 19th lowest hourly wage of the 650 reported, which equates to the 2.92 percentile.

The hourly median wage for someone in the Personal Care & Service occupation is $11.24. This is the 39th lowest hourly wage of the 650 reported, which equates to the 6.00 percentile.

At these rates, service providers are unable to compete for 94% to 97% of the Oklahoma labor market. To address this situation, OHS is seeking to provide temporary funding through retroactive rate increases until a market rate study is completed and rates can be addressed on a permanent basis.

[1] HTTPS://WWW.BLS.GOV/OES/CURRENT/OES_OK.HTM

The retroactive payments will not exceed 20% of provider's current payment rate and will apply to services paid for the time periods of:

- January 1, 2021 through March 31, 2021, and;
- April 1, 2021 through June 30, 2021, and;
- July 1, 2021 through September 30, 2021.

OHS is proposing the increase for the following categories of services:

- Case Management / Transitional Case Management Services (Standard and Very Rural)
- Home Care Services
  - o Registered Nurse Skilled Nursing – Home Health Setting
  - o Registered Nurse Skilled Nursing – Extended State Plan
  - o Licensed Practical Nursing – Home Health Setting
  - o Licensed Practical Nursing – Extended State Plan
  - o Personal Care Services
  - o Advanced Supportive/Restorative
  - o In-home Respite (less than 8 hours)
  - o In-home Extended Respite (8+ hours)
- Adult Day Health Services
  - o Adult Day Health
  - o Personal Care in Adult Day Health

- Assisted Living Services
    - o Assisted Living Standard Tier
    - o Assisted Living Intermediate Tier
    - o Assisted Living High Tier
- Hospice Services
- Nursing Facility Respite Services

The services provided by these rates are available to recipients on the AD*vantage* home and community-based services waiver.

4. CURRENT METHODOLOGY AND/OR RATE STRUCTURE.

The current rate structure for services provided in the proposed rate changes are of two types:

- Utilizing the Medicaid Rate established for State Plan Services. Services of this type include:
    - Personal Care Services
    - Respite Services
    - Nursing Facility Respite Services
- Fixed and uniform rates established through the State Plan Amendment Rate Committee process. Services of this type include:
    - Case Management (Standard and Very Rural)
    - Transitional Case Management (Standard and Very Rural)
    - Nursing
    - Adult Day Health Care
    - Advanced Supportive/Restorative Assistance
    - Assisted Living Services
    - Hospice Services

All services are in 15-minute units except In-home Extended Respite, Personal Care in Adult Day Health, Assisted Living (all tier levels), Hospice, and Nursing Facility Respite, which are all per-diem services.

The services, current service codes and rates are as follows:

SERVICE DESCRIPTION	SERVICE CODE	Service Unit	Current Rate	Total Cost for 3 Months
Case Management – Standard	T1016	15 min	$15.29	$8,486,286
Case Management – Very Rural	T1016 TN	15 min	$21.89	$2,587,114
Transitional Case Management – Standard	T1016 U3	15 min	$15.29	$3,456
Transitional Case Management – Very Rural	T1016 TN U3	15 min	$21.89	$2,802
Registered Nurse Skilled Nursing – Home Health Setting	G0299	15 min	$15.60	$126,903
Registered Nurse Skilled Nursing – Extended State Plan	G0299 TF	15 min	$15.60	$0
Licensed Practical Nursing – Home Health Setting	G0300	15 min	$14.56	$170,454
Licensed Practical Nursing – Extended State Plan	G0300 TF	15 min	$14.56	$116
Personal Care Services	T1019	15 min	$4.21	$15,354,785
Advanced/Supportive Restorative Assistance	T1019 TF	15 min	$4.52	$179,747
In-home Respite (less than 8 hours)	T1005	15 min	$4.21	$29,104
In-home Extended Respite (8+ hours)	S9125	Per day	$175.55	$878
Adult Day Health Services	S5100 U1	15 min	$2.08	$284,339
Personal Care in Adult Day Health	S5105	Per day	$8.27	$1,530
Assisted Living Services – Standard Tier	T2031	Per day	$48.99	$441
Assisted Living Services – Intermediate Tier	T2031 TF	Per day	$66.11	$20,424
Assisted Living Services – High Tier	T2031 TG	Per day	$92.47	$2,723,827
Hospice Services	S9126	Per day	$123.80	$105,435
Nursing Facility Respite Services	120	Per day	$178.88	$7,003

5. NEW METHODOLOGY OR RATE STRUCTURE.

The proposed rates and costs are based on a 20% increase of existing rates.

SERVICE DESCRIPTION	SERVICE CODE	Service Unit	Current Rate	Proposed Rate	Total Cost for 3 Months
Case Management – Standard	T1016	15 min	$15.29	$18.35	$10,183,544

SERVICE DESCRIPTION	SERVICE CODE	Service Unit	Current Rate	Proposed Rate	Total Cost for 3 Months
Case Management – Very Rural	T1016 TN	15 min	$21.89	$26.27	$3,104,537
Transitional Case Management – Standard	T1016 U3	15 min	$15.29	$18.35	$4,147
Transitional Case Management – Very Rural	T1016 TN U3	15 min	$21.89	$26.27	$3,362
Registered Nurse Skilled Nursing – Home Health Setting	G0299	15 min	$15.60	$18.72	$152,284
Registered Nurse Skilled Nursing – Extended State Plan	G0299 TF	15 min	$15.60	$18.72	$0
Licensed Practical Nursing – Home Health Setting	G0300	15 min	$14.56	$17.47	$204,544
Licensed Practical Nursing – Extended State Plan	G0300 TF	15 min	$14.56	$17.47	$140
Personal Care Services	T1019	15 min	$4.21	$5.05	$18,425,742
Advanced/Supportive Restorative Assistance	T1019 TF	15 min	$4.52	$5.42	$215,696
In-home Respite (less than 8 hours)	T1005	15 min	$4.21	$5.05	$34,924
In-home Extended Respite (8+ hours)	S9125	Per day	$175.55	$210.66	$1,053
Adult Day Health Services	S5100 U1	15 min	$2.08	$2.50	$341,207
Personal Care in Adult Day Health	S5105	Per day	$8.27	$9.92	$1,836
Assisted Living Services – Standard Tier	T2031	Per day	$48.99	$58.79	$529
Assisted Living Services – Intermediate Tier	T2031 TF	Per day	$66.11	$79.33	$24,509
Assisted Living Services – High Tier	T2031 TG	Per day	$92.47	$110.96	$3,268,592
Hospice Services	S9126	Per day	$123.80	$148.56	$126,522
Nursing Facility Respite Services	120	Per day	$178.88	$214.66	$8,404

6. BUDGET ESTIMATE.

Oklahoma's FFY21 FMAP of 67.99% has been temporarily increased to 74.19% as a result of the FFCRA for the retroactive rate increase effective from January 1, 2021 through March 31, 2021. The 20% retroactive temporary rate adjustment results in a total increased cost of $36,101,572, which is an increase of $6,016,929 over the current base rate. Of this amount, $4,463,959 is Federal funding and $1,552,969 is State funding.

Oklahoma's FFY21 FMAP of 67.99% has been temporarily increased to 84.19% as a result of the FFCRA and ARPA for the retroactive rate increases effective from April 1, 2021 through June 30, 2021. The 20% retroactive temporary rate adjustment results in a total increased cost of $36,101,572, which is an increase of $6,016,929 over the current base rate. Of this amount, $5,065,653 is Federal funding and $951,276 is State funding.

Oklahoma's FFY21 FMAP of 67.99% has been temporarily increased to 84.19% as a result of the FFCRA and ARPA for the retroactive rate increases effective from July 1, 2021 through September 30, 2021. The 20% retroactive temporary rate adjustment results in a total increased cost of $36,101,572, which is an increase of $6,016,929 over the current base rate. Of this amount, $5,065,653 is Federal funding and $951,276 is State funding.

The total cost to fund the series of retroactive rate increases is $18,050,787 of which $14,595,265 is Federal funding and $3,455,522 is State funding.

OHS attests it has adequate funding to pay the state share of the projected increase in service costs.

7. **AGENCY ESTIMATED IMPACT ON ACCESS TO CARE.**
The rate increase will have a positive impact on access to care.

8. **RATE OR METHOD CHANGE IN THE FORM OF A MOTION.**
Oklahoma Human Services requests the State Plan Amendment Rate Committee approve the proposed 20% three (3) quarterly retroactive rate increases for the periods January 1, 2021 through March 31, 2021; April 1, 2021 through June 30, 2021 and July 1, 2021 through September 30, 2021.

9. **EFFECTIVE DATE OF CHANGE.**
October 1, 2021 or upon CMS approval, whichever occurs first.

Attachment C

SUBMITTED TO THE C.E.O. AND BOARD ON NOVEMBER 17, 2021
AUTHORITY FOR EXPENDITURE OF FUNDS

BACKGROUND

Services	**Third Party Liability Services**
Purpose and Scope	Oklahoma Health Care Authority is seeking to extend current contract for ninety (90) days with Health Management Systems for the services to perform Medicaid Third Party Liability (TPL) revenue collection services in accordance with 42 CRF 433.135 et. seq. Pending RFP. The Vendor is assisting OHCA in achieving the following goals: * Maximize revenues to OHCA; * Cost avoid claims before payments are generated; *Lessen the accounting and collection work required of OHCA; * Reduce call volume to onsite TPL staff
Mandate	42 CRF 433.135 et. seq.
Procurement Method	Amendment
Award	N/A
External Approvals	N/A
Incumbent Contractor Name & Contract Term	Health Management Systems 07/01/2015 through 6/30/2022
New Contract Term	January 1, 2022 through June 30, 2022

BUDGET

Total Contract Not-to-Exceed Requested for Approval.	**$2,250,000.00**
50% Federal Match	**$1,125,000.00**
State Share will be paid by OKHCA	**$1,125,000.00**

RECOMMENDATION

The Authority affirms its ability to withstand the procurement decision made by the CEO based on the budget and available funds. Board approval is requested to procure the Third Party Liability Services described above for six (6) month, for a total not-to-exceed $2,250,000.00

Additional Information

Contract Term, Including all Optional Renewal Years (Oklahoma law limits State Agencies from encumbering funds for more than a single State Fiscal Year. As a result, all State of Oklahoma contracts are entered into for an initial year period with subsequent optional renewal years. Every OHCA professional services contract includes standard contract termination language, including immediate, 30 day for cause, 60 day without cause, and non-renewal terminations.)
Total Contract Not-to-Exceed Requested for Approval. (Actual not-to-exceed amounts are established by the competitive bid process. If the not-to-exceed amount exceeds the amount previously approved by $1,000,000.00 or more, the contract increase shall require additional Board approval.)
Federal Match Percentage(s) (CMS authorizes Federal Match based upon specific criteria, for example, a single Information Technology contract may qualify for 50% administrative match, 75% operational match, and 90% implementation match.)

Attachment D

SUBMITTED TO THE C.E.O. AND BOARD ON NOVEMBER 17, 2021
AUTHORITY FOR EXPENDITURE OF FUNDS

BACKGROUND

Contractor	MyHealth
Services	MyHealth shall engage with OHCA for the purpose of providing consulting, project management, and administrative services in connection and support of the Statewide Health Information Exchange under the OHCA and Orion Health Contract.
Mandate	Not Applicable
Procurement Method	Sole Source
Award	Single Contractor
Contract Term	Date of contract signature, with nine (9) renewals

BUDGET

Total Contract Not-to-Exceed Requested for Approval.	$2,600,000.00
All state dollars	

RECOMMENDATION

The Authority affirms its ability to withstand the procurement decision made by the CEO based on the budget and available funds. Board approval is requested to procure sole sources service from MyHealth as described above for nine (9) years with a total not-to-exceed of $2,600,000.00. While the contract duration will be nine (9) years, the funds requested shall not be expended past the current state fiscal year.

Additional Information

Contract Term, Including all Optional Renewal Years (Oklahoma law limits State Agencies from encumbering funds for more than a single State Fiscal Year. As a result, all State of Oklahoma contracts are entered into for an initial year period with subsequent optional renewal years. Every OHCA professional services contract includes standard contract termination language, including immediate, 30 day for cause, 60 day without cause, and non-renewal terminations.)
Total Contract Not-to-Exceed Requested for Approval. (Actual not-to-exceed amounts are established by the competitive bid process. If the not-to-exceed amount exceeds the amount previously approved by $1,000,000.00 or more, the contract increase shall require additional Board approval.)
Federal Match Percentage(s) (CMS authorizes Federal Match based upon specific criteria, for example, a single Information Technology contract may qualify for 50% administrative match, 75% operational match, and 90% implementation match.)

Attachment E

SUBMITTED TO THE C.E.O. AND BOARD ON November 17, 2021
AUTHORITY FOR EXPENDITURE OF FUNDS

BACKGROUND

Services	Prior Authorization RFP
Purpose and Scope	OHCA is seeking a Contractor to perform prior authorization services for Occupational, Physical, Speech Therapy, and Dental services covered by SoonerCare. OHCA recognizes that many prior authorization vendors specialize in fields such as radiology or therapy. To the extent possible, it is OHCA's overarching goal to efficiently contract with the most qualified vendor(s) to perform the services and to reduce the administrative burden on SoonerCare contracted providers.
Procurement Method	Competitive Bid
Award	Multiple Contractors could receive awards
New Contract Term	Initial Contract effective date July 1, 2022 through June 30, 2023 with five (5) options to renew.

BUDGET

Total Contract Not-to-Exceed Requested for Approval.	$3,500,000.00/Year
50% Federal Match Costs within the Total Contract Not-to-Exceed	$1,750,000.00
50% State Share Costs within the Total Contract Not-to-Exceed	$1,750,000.00

RECOMMENDATION

The Authority affirms its ability to withstand the procurement decision made by the CEO based on the budget and available funds. Board approval is requested to procure prior authorization services as described above for six years with a total not-to-exceed of $21,000,000.00.

Additional Information

Contract Term, Including all Optional Renewal Years (Oklahoma law limits State Agencies from encumbering funds for more than a single State Fiscal Year. As a result, all State of Oklahoma contracts are entered into for an initial year period with subsequent optional renewal years. Every OHCA professional services contract includes standard contract termination language, including immediate, 30 day for cause, 60 day without cause, and non-renewal terminations.)
Total Contract Not-to-Exceed Requested for Approval. (Actual not-to-exceed amounts are established by the competitive bid process. If the not-to-exceed amount exceeds the amount previously approved by $125,000.00 or more, the contract increase shall require additional Board approval.)
Federal Match Percentage(s) (CMS authorizes Federal Match based upon specific criteria, for example, a single Information Technology contract may qualify for 50% administrative match, 75% operational match, and 90% implementation match.)

Attachment F

SUBMITTED TO THE C.E.O. AND BOARD ON NOVEMBER 17, 2021
AUTHORITY FOR EXPENDITURE OF FUNDS

BACKGROUND

Contractor Name	**Pondera Solutions Holdings LLC**
Purpose and Scope	Support OHCA in achieving the objectives of the "Act to restore Hope, Opportunity, and Prosperity to Everyone" or the "HOPE Act" (HB1270) through the provision of Medicaid Eligibility verification services and/or data sources. This is an increase of expenditures due to Pilot ending and the expansion population.
Mandate	HB1270
Procurement Method	Amendment
External Approvals	OMES and CMS
Contract Term	Initial contract effective date July 1, 2020 through June 30, 2021 with six (6) renewal options.

BUDGET

Not-to-Exceed Requested for Approval.	$2,997,112.26/Year
Not-to-Exceed considerations	
Federal Match Percentage(s) within the Total Contract Not-to-Exceed	
State Share Costs within the Total Contract Not-to-Exceed	90/50%
Pricing Methodology	Hourly Rate

RECOMMENDATION

The Authority affirms its ability to withstand the procurement decision made by the CEO based on the budget and available funds. Board approval is requested to increase the funded amount (now that the Pilot is ending and the expansion population is added) for the HOPE Act services described above for 6 years with a total not-to-exceed of $17,982,673.56.

Additional Information

Contract Term, Including all Optional Renewal Years Oklahoma law limits State Agencies from encumbering funds for more than a single State Fiscal Year. As a result, all State of Oklahoma contracts are entered into for an initial year period with subsequent optional renewal years. Every OHCA professional services contract includes standard contract termination language, including immediate, 30 day for cause, 60 day without cause, and non-renewal terminations.
Competitive Bid Total Contract Not-to-Exceed Requested for Approval. Actual not-to-exceed amounts are established by the competitive bid process. If the not-to-exceed amount exceeds the amount previously approved by $125,000.00 or more, the contract increase shall require additional Board approval.
Federal Match Percentage(s) CMS authorizes Federal Match based upon specific criteria, for example, a single Information Technology contract may qualify for 50% administrative match, 75% operational match, and 90% implementation match.
Pricing Methodologies: **Hourly Rate:** Hourly Rate contracts authorize payments based on the number of hours required to perform a service within an established not-to-exceed. Hourly rate contractors cannot bill for more hours than worked, and are not guaranteed to be able to bill for the entire not-to-exceed amount. **Fixed Rate:** Fixed rate professional services contracts establish fixed prices based on services performed based on volume estimates, such as completing a prior authorization is valued at X, and costs based on established deliverables. Deliverables may be billed as all-inclusive costs, such as a report, or may include milestones with associated payments, such as a payment for a report for the first draft and another payment upon OHCA approval for the final report. Contractors cannot bill until services are completed.

Attachment H

COMPREHENSIVE QUALITY STRATEGY

Nathan Valentine, MD, CPE, FAAFP

11/17/2021, OHCA Board

OVERVIEW

- The strategy
- Resultant tactics we are pursuing
- The Comprehensive Quality Strategy (CQS) process
- CQS Current Status

STRATEGY OVERVIEW

STRATEGY OVERVIEW-1

- Key Challenge
  - Quality Assurance → Pop Health Quality Improvement
  - Disease-focus → Wellness focus
  - Current payment model: (FFS → Global w/ cross-sector requirements)
    - Rewards low yield care
    - Upstream, it ties us to disease instead of wellness

STRATEGY OVERVIEW-2

- Key Tactics:
  - Invest in system updates and staff for more agile data mining, analysis and reporting
    - For Iterative proactive Quality Improvement processes
    - For ongoing identification of rising risk and healthy members
    - For broad engagement of providers and members
  - Engage our healthy members as much as our afflicted members
    - Including both short-term and long-term focused efforts to improve social needs status
  - Payment redesign to drive aligned action for
    - Outcome-linked performance indicators
    - Health equity
    - Social needs

STRATEGY OVERVIEW-3

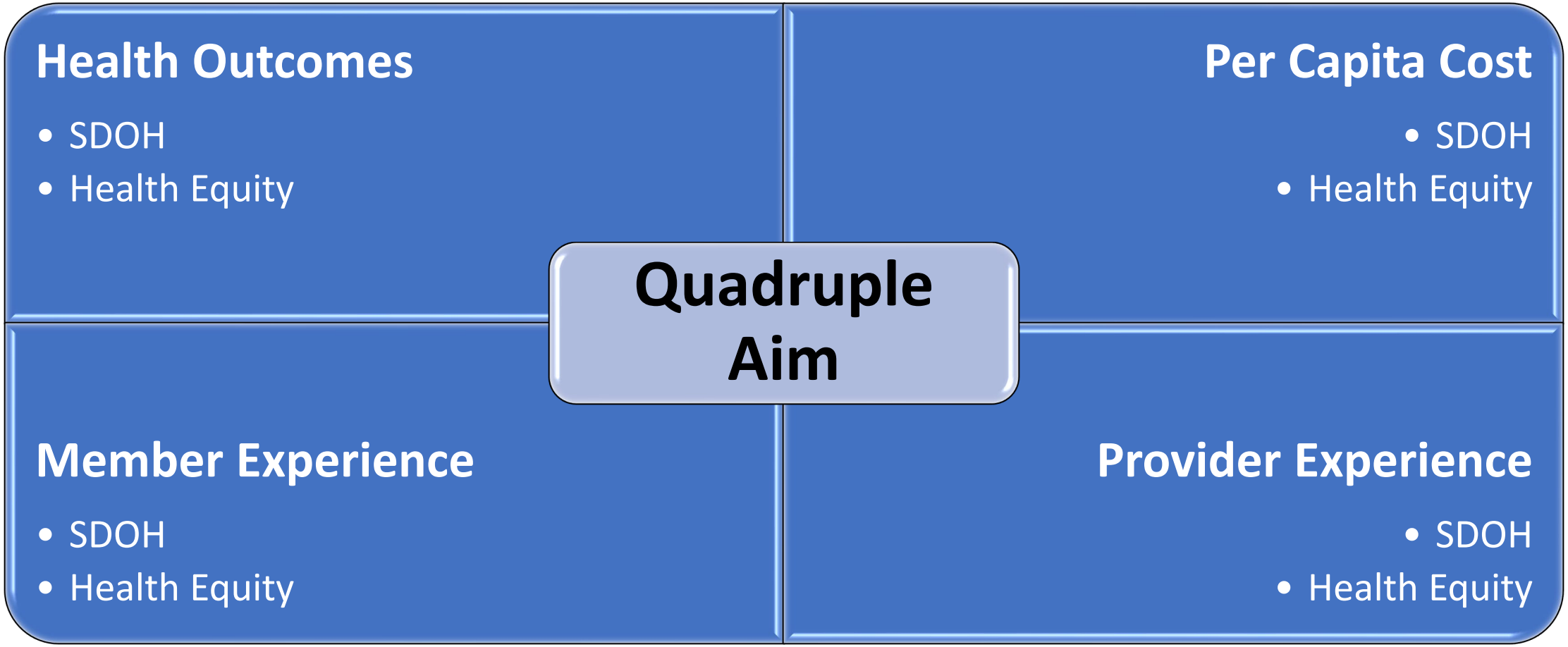
- The Top 3
  - Obesity: linked to top causes of U.S. mortality, poor mental health outcomes, decreased quality of life.
  - Smoking: leading cause of preventable death
  - Teen Pregnancy: linked to low birth weights and one important engine for generational poverty.
- Measures of Focus
  - Aligned with Governor's Dashboard, America's Health Rankings and OHCA strategic goals.

CQS DOCUMENT OVERVIEW

CQS DOCUMENT OVERVIEW

TN Division of TennCare

CQS DOCUMENT FRAMEWORK



CQS PROCESS OVERVIEW

CQS PROCESS OVERVIEW

Image Source: (CMS, 2021)

CQS ACTIVITIES

- 10/30/21: Virtual Member Stakeholder Event
- Document: drafting is on track.
- CQS workgroup: meets twice a week.
- Upcoming Virtual Stakeholder Feedback Events:
  - Tribal partners: 12/9/2021, 10a-12p.
  - Providers: 12/10/21, 9a-11a.
  - Other State Agencies: 12/16/21, 1p-3p.
- Future In-Person Events:
  - Member Session: 02/18/2021, West/SW OKC area
  - Provider Session: 04/14/2021, Tulsa area

OKLAHOMA
Health Care Authority

GET IN TOUCH

4345 N. Lincoln Blvd.
Oklahoma City, OK 73105

oklahoma.gov/ohca
mysoonercare.org

Agency: 405-522-7300
Helpline: 800-987-7767

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Drug Utilization Review Board Meeting – June 9, 2021, July 14, 2021, September 8, 2021, and October 13, 2021

Recommendation/ Vote	Drug	Used for	Cost*	Notes
1	Cabometyx® Fotivda® Jelmyto® Padcev®	• Bladder Cancer	• $21,662 per 30 days • $24,150 per 28 day cycle • $21,376 per dose • $30,739 per 28 days	• Advanced Renal Cell Carcinoma (RCC) • RCC; Not first line • Urothelial Cancer (UC) • UC; not first line
2	Zilxi®	• Rosacea	• $970 per package	• Cheaper options available
3	Kynmobi™ Ongentys®	• Parkinson's Disease	• $47,250 per year • $7,081 per year	• Sublingual film • Cheaper option available
4	Fetroja® Kimyrsa™	• Antibiotics	• $15,939 per 14 day course • $4884 per single dose/treatment	• Complicated urinary tract infection; pneumonia • Cellulitis
5	Xywav®	• Narcolepsy	• $10,220 per 30 days	• Cheaper options available
6	Alkindi® Sprinkle Eysuvis® Gimoti®	• Corticosteroid Replacement Therapy • Dry Eye Disease • Diabetic Gastroparesis	• $2,515.50 • $456.97 • $3,499.97 per 8 week course	• Cheaper options available • Cheaper options available • Cheaper options available

	Nextstellis® Ozobax® Phexxi® RediTrex® Reltone™ Thyquidity™	• Birth Control • Multiple Sclerosis • Birth Control • Rheumatoid Arthritis & Psoriasis • Gallstones • Thyroid hormone replacement	• $190.12 per month • $4,152 per 30 days • $267.60 per package • $300 per 4 weeks • $1,710 per 30 days • $110 per 30 days	• Cheaper options available • Cheaper options available • Cheaper options available • Cheaper options available • Cheaper options available • Cheaper options available
7	Nulibry™	• Molybdenum Cofactor Deficiency	• $499,998.90 per year	• Rare disease; only treatment option
8	Danyelza® Truseltiq™	• Neuroblastoma • Cholangiocarcinoma	• $244,416 every 4 weeks • $21,500 per 21 days	• Relapsed or Refractory disease • Previously treated, unresectable, locally advanced, or metastatic
9	Feraheme® Injectafer® Monoferric®	• Iron Deficiency Anemia	• $989.40 per course • $1,665 per course • $2,460 per course	• Cheaper options available
10	Herceptin® Margenza®	• Breast Cancer & Gastric Adenocarcinoma • Breast Cancer	• $6,233 per 4 weeks • $10,385 every 3 weeks	• Biosimilars available • 2 or more prior therapies
11	Orgovyx™	• Prostate Cancer	• $2313 per month	• Other treatment options available

*Costs do not reflect rebated prices or net costs. Costs based on National Average Drug Acquisition Costs (NADAC) or Wholesale Acquisition Costs (WAC) if NADAC unavailable. N/A = not available at the time of publication.

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Recommendation 1: Vote to Prior Authorize Cabometyx® (Cabozantinib), Fotivda® (Tivozanib), Jelmyto® (Mitomycin), and Padcev® (Enfortumab Vedotin-ejfv

The Drug Utilization Review Board recommends the prior authorization of Cabometyx® (Cabozantinib), Fotivda® (Tivozanib), Jelmyto® (Mitomycin), and Padcev® (Enfortumab Vedotin-ejfv) with the following criteria:

Cabometyx® (Cabozantinib) Approval Criteria:

1. For cabozantinib monotherapy:
    a. Diagnosis of advanced renal cell carcinoma (RCC); or
    b. Diagnosis of advanced hepatocellular carcinoma (HCC); and
        i. Member has previously received sorafenib.
2. For cabozantinib in combination with nivolumab:
    a. Diagnosis of relapsed or surgically unresectable stage 4 disease in the initial treatment of members with advanced RCC; and
    b. Nivolumab, when used in combination with cabozantinib for RCC, will be approved for a maximum duration of 2 years.

Fotivda® (Tivozanib) Approval Criteria [Renal Cell Carcinoma (RCC) Diagnosis]:

1. Diagnosis of relapsed or refractory advanced RCC; and
2. Member has received at least 2 prior systemic therapies; and
3. As a single-agent.

Jelmyto® (Mitomycin) Approval Criteria [Urothelial Cancer Diagnosis]:

1. Diagnosis of non-metastatic upper urinary tract tumor; and
2. Must be a single, residual, low-grade, low-volume (5 to 15mm) tumor; and
3. Member is not a candidate for nephroureterectomy; and
4. Initial approvals will be for the duration of 6 weeks. With documentation from the prescriber of complete response 3 months after initial treatment, subsequent approvals may be authorized for once monthly use for up to 11 additional instillations.

Padcev® (Enfortumab) Approval Criteria [Urothelial Cancer Diagnosis]:

1. Diagnosis of locally advanced or metastatic urothelial cancer; and
2. Previously received a programmed death 1 (PD-1) or programmed death ligand 1 (PD-L1) inhibitor and a platinum-containing chemotherapy in the neoadjuvant/adjuvant, locally advanced, or metastatic setting.

Recommendation 2: Vote to Prior Authorize Zilxi®

The Drug Utilization Review Board recommends the prior authorization Zilxi® (Minocycline 1.5% Topical Foam) with the following criteria:

Zilxi® (Minocycline 1.5% Topical Foam) Approval Criteria:

1. An FDA approved diagnosis of inflammatory lesions of rosacea in adults; and
2. Member must be 18 to 20 years of age; and
3. A patient-specific, clinically significant reason why the member cannot utilize clindamycin topical solution (generic), metronidazole topical gel and cream 0.75%, erythromycin topical 2% solution, oral isotretinoin medications, and other generically available preferred oral or topical antibiotic products must be provided; and
4. A quantity limit of 30 grams per 30 days will apply.

Recommendation 3: Vote to Prior Authorize Kynmobi™ and Ongentys®

The Drug Utilization Review Board recommends the prior authorization of Kynmobi™ (Apomorphine) and Ongentys® (Opicapone) with the following criteria:

Kynmobi™ [Apomorphine Sublingual (SL) Film] Approval Criteria:

1. An FDA approved indication of acute, intermittent treatment of “off” episodes in members with Parkinson’s disease (PD); and
2. Member must be taking carbidopa/levodopa in combination with Kynmobi™; and
3. Member should be experiencing at least 1 well defined “off” episode per day with a total daily “off” time duration of ≥2 hours during the waking day; and
4. Initial dose titration should occur in an “off” state and in a setting supervised by a health care provider to monitor blood pressure and heart rate; and
5. Member must not use apomorphine concomitantly with 5-HT3 antagonists (e.g., ondansetron, granisetron, dolasetron, palonosetron, alosetron); and
6. Prescriber must verify the member has been counseled on separating doses by at least 2 hours; and
7. The maximum single dose approvable is 30mg; and
8. A quantity limit of 5 doses per day will apply.

Ongentys® (Opicapone) Approval Criteria:

1. An FDA approved indication of adjunctive treatment to levodopa/carbidopa in members with Parkinson's disease (PD) experiencing "off" episodes; and
2. Member must be taking levodopa/carbidopa in combination with Ongentys®; and
3. Member must not use non-selective monoamine-oxidase inhibitors (MAOIs) concomitantly with Ongentys®; and
4. Member must not have a history of pheochromocytoma, paraganglioma, or other catecholamine secreting neoplasms; and
5. Prescriber must verify member has been counseled to avoid eating food 1 hour before and at least 1 hour after taking Ongentys®; and
6. For members with moderate hepatic impairment, the prescriber must verify the dose of Ongentys® will be reduced in accordance with package labeling; and
7. Prescriber must agree to monitor member for changes in heart rate, heart rhythm, and blood pressure in members concurrently taking medications known to be metabolized by catechol-O-methyltransferase (COMT); and
8. A patient-specific, clinically significant reason why the member cannot use entacapone must be provided; and
9. A quantity limit of 30 capsules per 30 days will apply.

Recommendation 4: Vote to Prior Authorize Fetroja® and Kimyrsa™

The Drug Utilization Review Board recommends the prior authorization of Fetroja® (Cefiderocol) and Kimyrsa™ (Oritavancin) with the following criteria:

Fetroja® (Cefiderocol) Approval Criteria:

1. An FDA approved diagnosis of 1 of the following infections caused by designated susceptible microorganisms:
    b. Complicated urinary tract infection (cUTI), including pyelonephritis; or
    c. Hospital-acquired bacterial pneumonia/ventilator-associated bacterial pneumonia (HABP/VABP); and
2. Member must be 18 years of age or older; and
3. The prescriber must verify that limited or no alternative treatment options are available; and
4. A patient-specific, clinically significant reason why the member cannot use an appropriate penicillin/beta-lactamase inhibitor combination (e.g., piperacillin/tazobactam), a carbapenem (e.g., ertapenem,

meropenem, imipenem/cilastatin), a cephalosporin (e.g., ceftriaxone, ceftazidime), or other cost-effective therapeutic equivalent alternative(s) must be provided; and
5. Approval quantity will be based on Fetroja® *Prescribing Information* and FDA approved dosing regimen(s).

Kimyrsa™ (Oritavancin) Approval Criteria:

1. An FDA approved indication for the treatment of acute bacterial skin and skin structure infections (ABSSSI) caused by or suspected to be caused by susceptible isolates of designated gram-positive microorganisms; and
2. Member must be 18 years of age or older; and
3. The prescriber must verify that limited or no alternative treatment options are available; and
4. A patient-specific, clinically significant reason (beyond convenience) why the member cannot use Orbactiv® (oritavancin) or other cost-effective therapeutic equivalent alternative(s) must be provided; and
5. Approval quantity will be based on Kimyrsa™ *Prescribing Information* and FDA approved dosing regimen(s).

Recommendation 5: Vote to Prior Authorize Xywav®

The Drug Utilization Review Board recommends the prior authorization of Xywav® (Calcium/Magnesium/Potassium/ Sodium Oxybates) with the following criteria:

Xywav® (Calcium/Magnesium/Potassium/ Sodium Oxybates) approval criteria:

1. An FDA approved diagnosis; and
2. Use of Xywav® (calcium/magnesium/potassium/sodium oxybates) requires previously failed trials (within the last 180 days) with Tier-1 and Tier-2 stimulants from different chemical categories, Provigil®, and Nuvigil®, unless contraindicated, that did not yield adequate results; and
3. Additionally, use of Xywav® (calcium/magnesium/potassium/sodium oxybates) requires a patient-specific, clinically significant reason why the member cannot use Xyrem®; and
    a. For members requesting Xywav® due to lower sodium content in comparison to Xyrem®, a patient-specific, clinically significant reason why the member requires a low-sodium product must be provided.

Recommendation 6: Vote to Prior Authorize Alkindi® Sprinkle, Eysuvis®, Gimoti®, Nextstellis®, Ozobax®, Phexxi®, RediTrex®, Reltone™, and Thyquidity™

OHCA Board Meeting November 17, 2021
Pharmacy Agenda Items

The Drug Utilization Review Board recommends the prior authorization of Alkindi® Sprinkle (Hydrocortisone Oral Granule), Eysuvis® (Loteprednol 0.25% Ophthalmic Suspension), Gimoti® (Metoclopramide Nasal Spray), Nextstellis® (Drospirenone/Estetrol Tablet), Ozobax® (Baclofen 5mg/5mL Oral Solution), Phexxi® (Lactic Acid/Citric Acid/Potassium Bitartrate Vaginal Gel), RediTrex® (Methotrexate Injection), Reltone™ (Ursodiol Capsule), and Thyquidity™ (Levothyroxine Oral Solution) with the following criteria:

Alkindi® Sprinkle (Hydrocortisone Oral Granule) Approval Criteria:

1. An FDA approved indication of replacement therapy in pediatric members with adrenocortical insufficiency; and
2. A patient-specific, clinically significant reason (beyond convenience) why the member cannot use hydrocortisone tablets, even when tablets are crushed, must be provided.

Eysuvis® (Loteprednol 0.25% Ophthalmic Suspension) Approval Criteria:

1. An FDA approved indication for the short-term (up to 2 weeks) treatment of the signs and symptoms of dry eye disease (DED); and
2. A documented trial of intermittent or regular artificial tear use within the past 3 months; and
3. A patient-specific, clinically significant reason why the member cannot use Restasis® (cyclosporine 0.05% ophthalmic emulsion), which is available without a prior authorization, must be provided; and
4. A patient-specific, clinically significant reason why the member cannot use Tier-1 ophthalmic corticosteroids including Lotemax® (loteprednol 0.5% suspension) must be provided; and
5. Member must not have any contraindications to Eysuvis®; and
6. A quantity limit of 8.3mL per 15 days will apply (Eysuvis® for the treatment of DED is not indicated for use beyond 15 days).

Gimoti® (Metoclopramide Nasal Spray) Approval Criteria:

1. An FDA approved indication of acute or recurrent diabetic gastroparesis in adult members; and
2. A patient-specific, clinically significant reason why the member cannot use metoclopramide oral tablets and metoclopramide oral solution must be provided; and
3. For members 65 years of age or older, approvals will not be granted for initiation of metoclopramide therapy; and
4. For members 65 years of age or older requesting to switch from an alternative metoclopramide product to Gimoti®:
    a. Member must be taking a stable dose of metoclopramide 10mg 4 times daily for at least 10 days; and
    b. Duration of current metoclopramide treatment must be provided; and

5. A maximum approval duration of 8 weeks total from all sources will apply; and
6. A quantity limit of 9.8mL per 28 days will apply.

Ozobax® (Baclofen 5mg/5mL Oral Solution) Approval Criteria:

1. An FDA approved diagnosis of spasticity resulting from multiple sclerosis (relief of flexor spasms and concomitant pain, clonus, and muscular rigidity) or spinal cord injuries/diseases; and
2. Members older than 10 years of age require a patient-specific, clinically significant reason (beyond convenience) why the member cannot use baclofen oral tablets, even when tablets are crushed.

Phexxi® (Lactic Acid/Citric Acid/Potassium Bitartrate Vaginal Gel) Approval Criteria:

1. A patient-specific, clinically significant reason why the member cannot use an over-the-counter (OTC) spermicide and all other forms of contraception (e.g., condoms, oral contraceptives) must be provided. Various OTC spermicides containing nonoxynol 9 are covered by SoonerCare without prior authorization.

Reltone™ (Ursodiol Capsule) Approval Criteria:

1. An FDA approved indication for the dissolution of radiolucent, noncalcified gallstones <20mm in greatest diameter or the prevention of gallstone formation in obese members experiencing rapid weight loss; and
2. For the indication of dissolution of radiolucent, noncalcified gallstones <20mm in greatest diameter:
    a. Prescriber must confirm member is not a candidate for elective cholecystectomy due to 1 or more of the following:
        i. Increased surgical risk due to systemic disease; or
        ii. Advanced age; or
        iii. Idiosyncratic reaction to general anesthesia; or
        iv. Member refuses surgery; and
    b. Prescriber must confirm the member does not have compelling reasons for cholecystectomy including unremitting acute cholecystitis, cholangitis, biliary obstruction, gallstone pancreatitis, or biliary-gastrointestinal fistula; and
3. For the indication of prevention of gallstone formation in obese members experiencing rapid weight loss:
    a. Member's baseline body mass index (BMI) and weight must be provided; and

   b. Member's current weight must be provided supporting rapid weight loss compared to baseline; and
4. For both FDA approved indications, a patient-specific, clinically significant reason why the member cannot use other generic formulations of ursodiol must be provided; and
5. Initial approvals for the indication of dissolution of gallstones will be for the duration of 6 months, after which time the prescriber must confirm (via ultrasound imaging) partial or complete dissolution of gallstone(s). Subsequent approvals will be for the duration of 12 months; and
6. Approvals for prevention of gallstone formation in obese members experiencing rapid weight loss will be for 6 months, after which time the member's current weight must be provided to justify continued rapid weight loss and need for preventative treatment; and
7. Treatment duration will be limited to a maximum of 24 months for all diagnoses.

Nextstellis® (Drospirenone/Estetrol Tablet) and Slynd® (Drospirenone Tablet) Approval Criteria:

1. A patient-specific, clinically significant reason why the member cannot use all alternative formulations of hormonal contraceptives available without a prior authorization must be provided.

RediTrex® (Methotrexate Injection) Approval Criteria:

1. An FDA approved diagnosis of 1 of the following:
   a. Adults with severe, active rheumatoid arthritis (RA); or
   b. Children with active polyarticular juvenile idiopathic arthritis (pJIA); or
   c. Severe, recalcitrant, disabling psoriasis confirmed by biopsy or dermatologic consultation; and
2. A patient-specific, clinically significant reason why the oral tablets or and the generic injectable formulation cannot be used must be provided; and

Thyquidity™ (Levothyroxine Oral Solution) Approval Criteria:

1. An FDA approved diagnosis of 1 of the following:
   a. Hypothyroidism: As replacement therapy in primary (thyroidal), secondary (pituitary), and tertiary (hypothalamic) congenital or acquired hypothyroidism; or
   b. Pituitary Thyrotropin (thyroid-stimulating hormone, TSH) Suppression: As an adjunct to surgery and radioiodine therapy in the management of thyrotropin-dependent well-differentiated thyroid cancer; and
2. A patient-specific, clinically significant reason why the member cannot use all other formulations of levothyroxine must be provided. For the

oral solutions, a reason why the member cannot use the levothyroxine tablet, even when the tablets are crushed, must be provided; and
3. Prescriber must verify member has been compliant with levothyroxine tablets at a greatly increased dose for at least 8 weeks; and
4. Prescriber must verify that member has not been able to achieve normal thyroid lab levels despite a greatly increased dose and compliance with levothyroxine tablets.

Recommendation 7: Vote to Prior Authorize Nulibry™

The Drug Utilization Review Board recommends the prior authorization of Nulibry™ (Fosdenopterin) with the following criteria:

Nulibry™ (Fosdenopterin) Approval Criteria:

1. An FDA approved indication to reduce the risk of mortality in members with molybdenum cofactor deficiency (MoCD) Type A; and
2. MoCD Type A must be confirmed by genetic testing; and
    a. If the member is presumed to have MoCD Type A, Nulibry™ can be approved for 1 month until genetic testing can be performed; and
    b. Nulibry™ will be discontinued if genetic testing results do not confirm MoCD Type A; and
3. Nulibry™ must be administered by a health care provider or the prescriber must verify the member or member's caregiver has been trained by a health care professional on proper storage, preparation, and intravenous (IV) administration of Nulibry™; and
4. Member's weight (kg) must be provided and must have been taken within the last 4 weeks to ensure accurate weight-based dosing according to package labeling; and
5. Approval quantities will be dependent on the member's age, weight, and dosing based on the Nulibry™ Prescribing Information.

Recommendation 8: Vote to Prior Authorize Danyelza® and Truseltiq™

The Drug Utilization Review Board recommends the prior authorization of Danyelza® (Naxitamab-gqgk) and Truseltiq™ (Infigratinib) with the following criteria:

Danyelza® (Naxitamab-gqgk) Approval Criteria [Neuroblastoma Diagnosis]:

1. Diagnosis of relapsed or refractory high-risk neuroblastoma in adult and pediatric members 1 year of age and older; and

2. Disease in the bone or bone marrow demonstrating a partial response, minor response, or stable disease to prior therapy (i.e., no progressive disease following most recent therapy); and
3. Must be given in combination with a granulocyte-macrophage colony-stimulating factor (GM-CSF) according to package labeling (GM-CSF dosed at 250mcg/m2/day daily starting 5 days prior to Danyelza® therapy and 500mcg/m2/day daily on days 1 to 5 of Danyelza® therapy); and
4. Prescriber must agree to provide the member appropriate premedication for pain management and neuropathic pain (e.g., oral opioids, gabapentin); and
5. Prescriber must agree to provide the member appropriate premedication for infusion-related reactions and nausea/vomiting including an intravenous (IV) corticosteroid, a histamine 1 (H1) antagonist, an H2 antagonist, acetaminophen, and an antiemetic.

Truseltiq™ (Infigratinib) Approval Criteria [Cholangiocarcinoma Diagnosis]:

1. Diagnosis of unresectable, locally advanced or metastatic cholangiocarcinoma; and
2. Presence of fibroblast growth factor receptor 2 (FGFR2) fusion or other rearrangement; and
3. Disease has progressed on at least 1 prior systemic therapy; and
4. As a single agent.

Recommendation 9: Vote to Prior Authorize Feraheme®, Injectafer®, and Monoferric®

The Drug Utilization Review Board recommends the prior authorization of Feraheme® (Ferumoxytol), Injectafer® (Ferric Carboxymaltose), and Monoferric® (Ferric Derisomaltose) with the following criteria:

Feraheme® (Ferumoxytol) Approval Criteria:

1. An FDA approved indication of 1 of the following:
    a. Iron deficiency anemia (IDA); or
    b. IDA with chronic kidney disease (CKD); and
2. Documented lab results verifying IDA; and
3. Documentation of intolerance or inadequate response to oral iron therapy after at least 3 months at recommended dosing; and
4. Prescriber must verify the member does not have a previous history of allergic reaction to any intravenous iron medications; and
5. A recent, failed trial of Infed® (iron dextran) or Venofer® (iron sucrose) or a patient-specific, clinically significant reason why the member cannot utilize Infed® and Venofer® must be provided.

Injectafer® (Ferric Carboxymaltose) Approval Criteria:

1. An FDA approved indication of 1 of the following:
    a. Iron deficiency anemia (IDA); or
    b. IDA in patients with non-dialysis dependent chronic kidney disease (CKD); and
2. Documented lab results verifying IDA; and
3. Documentation of intolerance or inadequate response to oral iron therapy after at least 3 months at recommended dosing; and
4. A recent, failed trial of Infed® (iron dextran) or Venofer® (iron sucrose) or a patient-specific, clinically significant reason why the member cannot utilize Infed® and Venofer® must be provided.

Monoferric® (Ferric Derisomaltose) Approval Criteria:

1. An FDA approved indication of 1 of the following:
    a. Iron deficiency anemia (IDA); or
    b. IDA in patients with non-dialysis dependent chronic kidney disease (CKD); and
2. Documented lab results verifying IDA; and
3. Documentation of intolerance or inadequate response to oral iron therapy after at least 3 months at recommended dosing; and
4. A recent, failed trial of Infed® (iron dextran) or Venofer® (iron sucrose) or a patient-specific, clinically significant reason why the member cannot utilize Infed® and Venofer® must be provided.

Recommendation 10: Vote to Prior Authorize Herceptin® and Margenza®

The Drug Utilization Review Board recommends the prior authorization of Herceptin® (Trastuzumab) and Margenza® (Margetuximab-cmkb) with the following criteria:

Herceptin® (Trastuzumab) Approval Criteria [Breast Cancer Diagnosis]:

1. Diagnosis of human epidermal growth factor receptor 2 (HER2)-positive breast cancer; and
2. Authorization of Herceptin® (trastuzumab) will also require a patient-specific, clinically significant reason why the member cannot use Ogivri® (trastuzumab-dkst), Ontruzant® (trastuzumab-dttb), or Trazimera™ (trastuzumab-qyyp). Biosimilars and/or reference products are preferred based on the lowest net cost product(s) and may be moved to either preferred or non-preferred if the net cost changes in comparison to the reference product and/or other available biosimilar products.

Herceptin® (Trastuzumab) Approval Criteria [Metastatic Gastric or Gastroesophageal Junction (GEJ) Adenocarcinoma Diagnosis]:

1. Diagnosis of human epidermal growth factor receptor 2 (HER2)-positive metastatic gastric or GEJ adenocarcinoma; and
2. Authorization of Herceptin® (will also require a patient-specific, clinically significant reason why the member cannot use Ogivri® (trastuzumab-dkst), Ontruzant® (trastuzumab-dttb), or Trazimera™ (trastuzumab-qyyp). Biosimilars and/or reference products are preferred based on the lowest net cost product(s) and may be moved to either preferred or non-preferred if the net cost changes in comparison to the reference product and/or other available biosimilar products.

Margenza® (Margetuximab-cmkb) Approval Criteria [Breast Cancer Diagnosis]:

1. Diagnosis of metastatic breast cancer; and
2. Human epidermal growth factor receptor 2 (HER2)-positive; and
3. Member has received 2 or more prior anti-HER2 regimens, at least 1 of which was for metastatic disease; and
4. Used in combination with chemotherapy (capecitabine, eribulin, gemcitabine, or vinorelbine).

Recommendation 11: Vote to Prior Authorize Orgovyx™

The Drug Utilization Review Board recommends the prior authorization of Orgovyx™ (Relugolix) with the following criteria:

Orgovyx™ (Relugolix) Approval Criteria [Prostate Cancer Diagnosis]:

1. Diagnosis of advanced prostate cancer; and
2. A patient-specific, clinically significant reason why the member cannot use Eligard® (leuprolide acetate), Firmagon® (degarelix), and Lupron Depot® (leuprolide acetate) must be provided [reason(s) must address each medication]; and
3. A quantity limit of 30 tablets per 30 days will apply. Upon meeting approval criteria, a quantity limit override will be approved for the day 1 loading dose of 360mg.

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Attachment J

November Board
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 # 21-01 Reimbursing Federally Qualified Health Centers (FQHCs) for Long-Acting Reversible Contraceptive (LARCs) Devices Outside of the Encounter Rate — The proposed revisions add language to clarify that reimbursement for LARC devices will be paid outside of the FQHC encounter rate.

Budget Impact: Budget neutral

Tribal Consultation: July 7, 2020

Medical Advisory Committee Meeting: September 9, 2021

APA WF # 21-05 Medicaid Expansion and Durable Medical Equipment — The proposed revisions will expand Medicaid eligibility for individuals defined by 42 C.F.R. § 435.119 (Expansion Adults). Additionally, the proposed revisions will define Expansion Adult benefits, prior authorization requirements, and/or medically necessary criteria. Additional rule revisions will be made to indicate that Expansion Adults will receive prosthetics and orthotics above the current limits to meet federal regulation requirements.

Furthermore, the revisions will comply with the Home Health rule and CURES Act requirements. The federal regulations change medical equipment, appliances, and supplies (formerly called DMEPOS) from an optional benefit to a mandatory benefit that must be provided to all SoonerCare members who meet medical necessity criteria. Additionally, the proposed revisions describe the new coverage criteria, renting versus purchasing equipment, and outlines prior authorization requirements.

The proposed revisions will also update organ transplant requirements and guidelines to reflect current practice; and add a definition for rehabilitation and habilitation.

Finally, revisions will align and better clarify policy with current practice and correct grammatical errors.

Please note, these rules were voted on and approved by this Board at the May Board meeting, in order to achieve an effective date of July 1, which is when expansion was implemented. However, to keep these rules from expiring, we must take them as emergency rules one more time so then we can take them through the permanent rulemaking process without any gaps.

Budget Impact: To add the new eligibility group, Expansion Adults, the estimated budget impact for SFY2022 will be an increase in the total amount of $1,339,830,140; $164,138,054 in state share and $1,175,692,086 in federal share.

To comply with the home health care final rule, the estimated budget impact for SFY2021 and SFY2022 will be an increase in the total amount of $2,615,007; $1,702,631 in federal share and $912,376 in state share. This budget impact was also reflected in the previous promulgate of this emergency rule WF# 21-05A.

Tribal Consultation: January 7, 2020 and March 2, 2021

Medical Advisory Committee Meeting: May 14, 2020 and May 13, 2021

APA WF # 21-10 Transitioning Developmental Disabilities Services Division (DDSD) Members back into the Money Follows (MFP) the Person Demonstration — The proposed revisions will add language that allows the DDSD to transition members, who have been a resident in a public or private Medicaid Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID), or qualified long-term care facility, into a community setting through the Living Choice MFP program. The proposed revisions also change the required amount of consecutive time an individual must be in the long-term care institution prior to being eligible for transition into the community setting from “at least ninety (90) consecutive days” to sixty (60) consecutive days. Additionally, proposed revisions will remove language that pertained to a pilot program involving the PRTF population, which was not successful and will no longer be implemented. Finally, revisions will remove outdated language to reflect current business practices.

Budget Impact: Budget neutral

Tribal Consultation: July 6, 2021

Medical Advisory Committee Meeting: September 9, 2021

APA WF # 21-11 Indian Health Service, Tribal and Urban Indian (I/T/U) Shared Savings Program — The proposed new rules comply with Oklahoma Senate Bill 434, which allows the Oklahoma Health Care Authority (OHCA) to create a shared savings program and shared savings revolving fund with the I/T/U.

Budget Impact: The impact is pending. There will be a shift from program to administrative budget. Currently, there is not enough savings to share savings with the tribal clinics; however, as the program grows over the next few years the tribes and OHCA could see savings from the program. This may take a year or two to grow to that level.

Tribal Consultation: July 6, 2021

Medical Advisory Committee Meeting: September 9, 2021

APA WF 21-13 Grievance Procedures and Process Rule Revisions — The proposed revisions will revise existing appeals rules to clarify appeals related to the aged, blind, and disabled populations. The proposed rules will also establish appeals rules related to Agency-level appeals for providers and beneficiaries whose initial grievance and/or appeal occurs with an Agency contractor. Additional revisions will clarify contract award protest process based on whether the OMES Director considers the appeal or assigns the appeal to an administrative law judge.

Budget Impact: Budget neutral

Tribal Consultation: July 6, 2021

Medical Advisory Committee Meeting: July 8, 2021

APA WF 21-15 Ensuring Access to Medicaid Act — The proposed policy changes will comply with Senate Bill 131 (SB131), otherwise known as the "Ensuring Access to Medicaid Act", by addressing the specific requirements that are outlined throughout the bill. These requirements

include, but are not limited to, enrollment and voluntary enrollment into an alternative delivery model, developing specific network adequacy standards, prior authorization requirements, and developing requirements for appeals and hearings.

Budget Impact: Budget neutral

Tribal Consultation: July 6, 2021

Medical Advisory Committee Meeting: July 8, 2021

APA WF # 21-16 Hospital Presumptive Eligibility (HPE) for Expansion Adults — The proposed policy will add expansion adults to the list of groups eligible to have a presumptive eligibility determination made by a qualified hospital participating in the Hospital Presumptive Eligibility (HPE) program. HPE is a limited period of SoonerCare eligibility for certain eligibility groups that can be determined by a qualified hospital on the basis of preliminary information provided by the applicant while the complete SoonerCare application is being processed.

Budget Impact: The estimated total cost for SFY 2022 is $841,781 ($757,603 in federal share and $84,178 in state share). The estimated total cost for SFY 2023 is $1,122,375 ($1,010,137 in federal share and $112,238 in state share).

Tribal Consultation: September 7, 2021

Medical Advisory Committee Meeting: September 9, 2021

APA WF 21-17 Adult Dental Benefit Revisions — The proposed revisions will comply with Oklahoma Senate Bill 1046, which directed the Oklahoma Health Care Authority to expand its adult dental benefit. The revisions will add dental examinations, x-rays, dental cleanings, fluoride, dental fillings, scaling and root planing, as well as dentures and partial dentures as covered services for SoonerCare adult members. The proposed revisions will delineate coverage as well as any applicable service limitation(s). Furthermore, the revisions will state that the new adult dental services will be reimbursed pursuant to the reimbursement methodology within the Oklahoma State Plan. Finally, revisions will involve minor cleanup to fix grammatical and formatting errors, as well as, align the policy with current business practice.

Budget Impact: The estimated budget impact, for SFY2022, will be an increase in the total amount of $68,653,438; with $14,124,398 state share. The estimated budget impact, for SFY2023, will be an increase in the total amount of $68,653,438; with $14,867,564 state share.

Tribal Consultation: June 8, 2021

Medical Advisory Committee Meeting: September 9, 2021

APA WF 21-19 Appeals to the Chief Executive Officer (CEO)/Administrative Law Judge (ALJ) — The proposed revisions will comply with Oklahoma Senate Bill 207 by revising policies regarding appeals to the Agency's chief executive officer (CEO) pursuant to 63 O.S. §5052(C). The revisions will note that the CEO may only designate an administrative law judge (ALJ) at another state agency, that is established in the State Medicaid Plan and approved by the Centers for Medicare and Medicaid Services (CMS), to hear and decide a CEO appeal. Further revisions will clarify that telephonic hearings are the preferred format for hearings and a request for an in-

person hearing will need to be submitted on the updated LD-4 form. Finally, revisions will add language regarding new appeals that are available to members and providers.

Budget Impact: Budget neutral

Tribal Consultation: July 6, 2021

Medical Advisory Committee Meeting: September 9, 2021

APA WF 21-20 Alternative Treatments for Pain Management — The proposed additions will establish limited coverage for chiropractor services and physical therapy services as a nonpharmacologic alternative for the treatment of spinal pain in SoonerCare adult members. Furthermore, the proposed additions will define provider participation, medical necessity, as well as coverage and service limitation guidelines. Furthermore, the proposed additions will state that reimbursement is established within the Oklahoma State Plan. Finally, grammatical and formatting errors will be fixed and references to the new sections will be added.

Budget Impact: The estimated budget impact for SFY2022 will be an increase in the total amount of $13,152,504; with $4,228,530 in state share. The estimated budget impact for SFY2023 will be an increase in the total amount of $26,305,009; with $8,457,060 in state share.

Tribal Consultation: July 6, 2021

Medical Advisory Committee Meeting: September 9, 2021

APA WF 21-22 Title XXI Dental Revision for Pregnant Women — The proposed revision will amend policy to provide certain dental benefits to pregnant women covered under the Title XXI State Plan. The revision is needed to comply with parity federal regulations which instruct the State to provide services that are medically necessary to the unborn child.

Budget Impact: The estimated budget impact for SFY2022 will be an increase in the total amount of $185,934; with $49,626 in state share. The estimated budget impact for SFY2023 will be an increase in the total amount of $371,869; with $98,731 in state share.

Tribal Consultation: September 7, 2021

Medical Advisory Committee Meeting: September 9, 2021

APA WF # 21-26 COFA Migrant Medicaid Extension and Afghan Refugees Eligibility Determinations - The proposed policy will update the citizenship/alien status section by adding eligibility determinations related to Compact of Free Association (COFA) migrants from the Republic of the Marshall Islands, the Republic of Palau, and Federated States of Micronesia, as well as Afghan nationals, entering the United States. These individuals are entitled to receive SoonerCare services, provided all other eligibility factors are met. Additionally, language and formatting were updated to align with federal law more closely.

Budget Impact for COFA Migrant Medicaid Extension: The estimated budget impact for SFY 2022 is $8,552,972 ($6,395,913 in federal share and $2,157,059 in state share). The estimated budget impact for SFY 2023 is $8,552,972 ($6,270,184 in federal share and $2,282,788 in state share).

Budget Impact for Afghan Refugee Eligibility Determinations: The estimated budget impact for SFY 2022 is $3,841,000 ($2,951,918 in federal share and $889,082 in state share). The estimated budget impact for SFY 2023 is $6,913,800 ($5,019,246 in federal share and $1,894,554 in state share).

Tribal Consultation: September 7, 2021 and November 2, 2021

Medical Advisory Committee Meeting: September 9, 2021 and November 4, 2021

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 75. FEDERALLY QUALIFIED HEALTH CENTERS

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

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

(b) Other medically necessary health services that will be reimbursed at the ~~FFS~~fee-for-service rate include, but are not limited to:

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

(2) Eyeglasses (refer to OAC 317:30-5-431, 317:30-5-432.1 and 317:30-5-451);

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

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

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

(6) Transportation by ambulance (refer to OAC 317:30-5-335);

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

(8) Prosthetic devices (other than dental) which replace all or part of an internal body organ (including colostomy bags) and supplies directly related to colostomy care and the replacement of such devices;

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

(10) Psychosocial rehabilitation services (refer to OAC 317:30-5-241.3);

(11) Behavioral health related case management services (refer to OAC 317:30-5-241.6); and

(12) Applied behavior analysis (ABA) (refer to OAC 317:30-3-65.12).

(13) Diabetes self-management education and support (DSMES) services (refer to OAC 317:30-5-1080 through 317:30-5-1084).

(14) Long-acting reversible contraceptive devices (devices are not considered part of the FQHC encounter rate and can be billed separately).

317:30-5-664.5. Federally Qualified Health Center (FQHC) encounter exclusions and limitations

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

(1) Services provided by an independently ~~CLIA~~Clinical Laboratory Improvement Amendments certified and enrolled laboratory~~.~~;

(2) Radiology services including nuclear medicine and diagnostic ultrasound services~~.~~;

(3) Venipuncture for lab tests is considered part of the encounter and cannot be billed separately. When a member is seen at the clinic for a lab test only, use the appropriate ~~CPT~~Current Procedural Terminology code. A visit for "lab test only" is not considered a Center encounter~~.~~;

(4) ~~Durable medical equipment or medical supplies~~Medical supplies, equipment, and appliances not generally provided during the course of a Center visit such as diabetic supplies. However, gauze, band-aids, or other disposable products used during an office visit are considered as part of the cost of an encounter and cannot be billed separately under SoonerCare~~.~~;

(5) Supplies and materials that are administered to the member are considered a part of the physician's or other health care practitioner's service~~.~~;

(6) Drugs or medication treatments provided during a clinic visit are included in the encounter rate. For example, a member has come into the Center with high blood pressure and is treated at the Center with a hypertensive drug or drug samples provided to the Center free of charge are not reimbursable services and are included in the cost of an encounter. Prescriptions are not included in the encounter rate and must be billed through the pharmacy program by a qualified enrolled pharmacy~~.~~;

(7) Administrative medical examinations and report services;

(8) Emergency services including delivery for pregnant members that are eligible under the Non-Qualified (ineligible) provisions of OAC 317:35-5-25;

(9) SoonerPlan family planning services;

(10) Long-acting reversible contraceptive devices (devices are not considered part of the FQHC encounter rate and can be billed separately);

~~(10)~~(11) Optometry and podiatric services other than for dual eligible for Part B of Medicare; ~~and~~

(12) Diabetes self-management education and support (DSMES) services (refer to OAC 317:30-5-1080 through 317:30-5-1084); and

~~(11)~~(13) Other services that are not defined in this rule or the Oklahoma Medicaid State Plan.

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

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

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

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

SUBCHAPTER 1. GENERAL PROVISIONS

317:30-1-4. Definitions

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

"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.

"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.

"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.

"Expansion Adult" means an individual defined by 42 Code of Federal Regulations § 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 categorically related to the aged, blind, and disabled.

"Habilitation" means health care services that are aimed at helping people gain certain new skills, abilities, knowledge and functioning for daily living.

"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.

"Rehabilitation" means health care services that help a person to re-gain skills, abilities or knowledge that may have been lost or compromised as a result of acquiring a disability, or due to a change in one's disability or circumstances.

SUBCHAPTER 3. GENERAL PROVIDER POLICIES

PART 1. GENERAL SCOPE AND ADMINISTRATION

317:30-3-1. Creation and implementation of rules; applicability

(a) Medical rules of the Oklahoma Health Care Authority (OHCA) are set by the ~~Oklahoma Health Care Authority~~OHCA Board. The rules are based upon the recommendations of the Chief Executive Officer of the Authority, ~~the Deputy Administrator for Health Policy~~the

Deputy State Medicaid Director, the ~~Medicaid Operations~~ State Medicaid Director, OHCA Tribal partners and the ~~Advisory Committee on Medical Care for Public Assistance Recipients~~OHCA Medical Advisory Committee. The ~~Medicaid Operations~~ State Medicaid Director is responsible for implementing medical policies and programs and directing the Fiscal Agent ~~with regard to~~regarding proper payment of claims.

(b) Payment to practitioners under Medicaid is made for services clearly identifiable as personally rendered services performed on behalf of a specific ~~patient~~member. There are no exceptions to personally rendered services unless specifically set out in coverage guidelines.

(c) Payment is made on behalf of Medicaid eligible individuals for services within the scope of the Authority medical programs. Services cannot be paid under Medicaid for ineligible individuals or for services not covered under the scope of medical programs or that do not meet documentation requirements. These claims will be denied, or in some instances upon post-payment review, payment will be recouped.

(d) Payment to practitioners on behalf of Medicaid eligible individuals is made only for services that are medically necessary and essential to the diagnosis and treatment of the patient's presenting problem. ~~Well patient~~Wellness examinations and diagnostic testing are not covered for adults unless specifically set out in coverage guidelines.

(e) The scope of the medical program for eligible children is the same as for adults except as further set out under ~~EPSDT~~Early and Periodic Screening, Diagnostic and Treatment (EPSDT) service guidelines.

(f) Services, provided within the scope of the Oklahoma Medicaid ~~Program~~program, shall meet medical necessity criteria. Requests by qualified providers for services 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. Some service limits listed within OAC 317:30 can be exceeded for expansion adults, upon meeting medical necessity as determined by OHCA and in alignment with the Oklahoma Medicaid State Plan. Physical therapy, occupational therapy and speech language pathology have hard limits, which are set at forty-five (45) visits for both habilitation and rehabilitation – a cumulative total of 90 visits [fifteen (15) visits of each therapy]. Members must meet medical necessity criteria, prior authorization, and all other documentation requirements. Medical necessity is established through consideration of the following standards:

(1) Services must be medical in nature and must be consistent with accepted health care practice standards and guidelines for

the prevention, diagnosis or treatment of symptoms of illness, disease or disability;

(2) Documentation submitted in order to request services or substantiate previously provided services must demonstrate through adequate objective medical records and other supporting records, evidence sufficient to justify the ~~client's~~member's need for the service;

(3) Treatment of the ~~client's~~member's condition, disease or injury must be based on reasonable and predictable health outcomes;

(4) Services must be necessary to alleviate a medical condition and must be required for reasons other than convenience for the member, family, or medical provider;

(5) Services must be delivered in the most cost-effective manner and most appropriate setting; and

(6) Services must be appropriate for the ~~client's~~member's age and health status and developed for the ~~client~~member to achieve, maintain, or promote functional capacity.

(g) Emergency medical condition means a medical condition including injury manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected, by a reasonable and prudent layperson, to result in placing the patient's health in serious jeopardy, serious impairment to bodily function, or serious dysfunction of any bodily organ or part.

(h) Verbal or written interpretations of policy and procedure in singular instances is made on a ~~case by case~~case-by-case basis and shall not be binding on this Agency or override its policy of general applicability.

(i) The rules and policies in this ~~part~~Part apply to all providers of service who participate in the program.

PART 3. GENERAL MEDICAL PROGRAM INFORMATION

317:30-3-40. Home and ~~Community-Based Services Waivers (HCBS)~~community-based services (HCBS) waivers for persons with intellectual disabilities or certain persons with related conditions

(a) **Introduction to HCBS waivers for persons with intellectual disabilities.** The Medicaid HCBS waiver programs are authorized per Section 1915(c) of the Social Security Act.

(1) The Oklahoma Department of Human Services (OKDHS) Developmental Disabilities Services Division (DDS) operates HCBS waiver programs for persons with intellectual disabilities and certain persons with related conditions. The Oklahoma Health Care Authority (OHCA), ~~is~~ the State's Medicaid agency, retains and exercises administrative authority over all HCBS

waiver programs.

(2) Each waiver allows for the provision of specific SoonerCare-compensable services that assist members to reside in the community and avoid institutionalization.

(3) HCBS waiver services:

(A) ~~complement~~Complement and supplement services available to members through the Medicaid State Plan or other federal, state, or local public programs, as well as informal supports provided by families and communities;

(B) ~~are~~Are only provided to persons who are Medicaid eligible, outside of a nursing facility, hospital, or institution;

(C) ~~are~~Are not intended to replace other services and supports available to members; and

(D) ~~are~~Are authorized based solely on current need.

(4) HCBS waiver services must be:

(A) ~~appropriate~~Appropriate to the member's needs; and

(B) ~~included~~Included in the member's ~~Individual Plan~~individual plan (IP).

(i) The IP:

(I) ~~is~~Is developed annually by the member's ~~Personal Support Team,~~personal support team, per Oklahoma Administrative Code (OAC) 340:100-5-52; and

(II) ~~contains~~Contains detailed descriptions of services provided, documentation of amount and frequency of services, and types of providers to provide services.

(ii) Services are authorized, per OAC 340:100-3-33 and 340:100-3-33.1.

(5) DDS furnishes case management, targeted case management, and services to members as ~~a~~ Medicaid State Plan services, per Section 1915(g)(1) of the Social Security Act and per OAC 317:30-5-1010 through 317:30-5-1012.

(b) **Eligible providers.** All providers must have entered into contractual agreements with OHCA to provide HCBS for persons with an intellectual disability or related conditions.

(1) All providers, except pharmacy~~, specialized medical supplies~~ and durable medical equipment (DME) providers must be reviewed by ~~DHS~~OKDHS DDS. The review process verifies that:

(A) ~~the~~The provider meets the licensure, certification or other standards specified in the approved HCBS waiver documents; and

(B) ~~organizations~~Organizations that do not require licensure wanting to provide HCBS services meet program standards, are financially stable and use sound business management practices.

(2) Providers who do not meet program standards in the review

process are not approved for a provider agreement.

(3) Provider agreements with providers that fail to meet programmatic or financial requirements may not be renewed.

(c) **Coverage.** All services must be included in the member's IP and arranged by the member's case manager.

317:30-3-57. General SoonerCare coverage - categorically needy

The following are general ~~SoonerCare coverage~~SoonerCare coverage guidelines for the categorically needy:

(1) ~~Inpatient hospital~~Inpatient hospital services ~~other than those provided in an institution for mental diseases~~.

(A) Adult coverage for ~~inpatient hospital~~inpatient hospital stays as described at ~~OAC~~Oklahoma Administrative Code (OAC) 317:30-5-41.

(B) Coverage for members under twenty-one (21) years of age is not limited. All admissions must be medically necessary. All psychiatric admissions require prior authorization for an approved length of stay.

(2) Emergency department services.

(3) Dialysis in an outpatient hospital or ~~free standing~~freestanding dialysis facility.

(4) Outpatient therapeutic radiology or chemotherapy for proven malignancies or opportunistic infections.

(5) Outpatient surgical services - facility payment for selected ~~outpatient surgical~~outpatient surgical procedures to hospitals which have a contract with the Oklahoma Health Care Authority (OHCA).

(6) Outpatient mental health services for medical and remedial care including services provided on an outpatient basis by certified ~~hospital based~~hospital-based facilities that are also qualified mental health clinics.

(7) Rural health clinic services and other ambulatory services furnished by rural health clinic.

(8) Optometrists' services - only as listed in Subchapter 5, Part 45, Optometrist specific rules of this Chapter.

(9) Maternity clinic services.

(10) Outpatient diagnostic x-rays and lab services. Other outpatient services provided to adults, not specifically addressed, are covered only when prior authorized by the ~~agency's~~Agency's Medical Authorization Unit.

(11) Medically necessary screening mammography. Additional follow-up mammograms are covered when medically necessary.

(12) ~~Nursing~~Long-term care facility services (other than services in an institution for tuberculosis or mental diseases).

(13) Early and Periodic Screening, ~~Diagnosis~~Diagnostic and Treatment Services (EPSDT) are available for members under

twenty-one (21) years of age to provide access to regularly scheduled examinations and evaluations of the general physical and mental health, growth, development, and nutritional status of infants, children, and youth. Federal regulations also require that diagnosis and treatment be provided for conditions identified during a screening whether or not they are covered under the State Plan, as long as federal funds are available for these services. These services must be necessary to ameliorate or correct defects and physical or mental illnesses or conditions and require prior authorization. EPSDT/OHCA ~~Child Health~~child-health services are outlined in OAC 317:30-3-65.2 through ~~317:30-3-65.4~~317:30-3-65.12.

(A) ~~Child health screening examinations~~EPSDT screening examinations for eligible children by a medical or osteopathic physician, physician assistant, or advanced practice nurse practitioner.

(B) Diagnostic x-rays, lab, and/or injections when prescribed by a provider.

(C) Immunizations.

(D) Outpatient care.

(E) Dental services as outlined in OAC 317:30-3-65.8.

(F) Optometrists' services. The EPSDT periodicity schedule provides for at least one (1) visual screening and glasses each twelve (12) months. In addition, payment is made for glasses for children with congenital aphakia or following cataract removal. Interperiodic screenings and glasses at intervals outside the periodicity schedule for optometrists are allowed when a visual condition is suspected. Payment is limited to two (2) glasses per year. Any glasses beyond this limit must be prior authorized and determined to be medically necessary.

(G) Hearing services as outlined in OAC 317:30-3-65.9.

(H) Prescribed drugs.

(I) Outpatient psychological services as outlined in OAC 317:30-5-275 through 317:30-5-278.

(J) Inpatient psychiatric services as outlined in OAC ~~317:30-5-95~~317:30-5-94 through 317:30-5-97.

(K) Transportation. Provided when necessary in connection with examination or treatment when not otherwise available.

(L) Inpatient hospital services.

(M) Medical supplies, equipment, appliances~~ and prosthetic devices beyond the normal scope of SoonerCare~~, orthotics and prosthetics.

(N) EPSDT services furnished in a qualified child health center.

(14) Family planning services and supplies for members of child-bearing age, including counseling, insertion of intrauterine

device, implantation of subdermal contraceptive device, and sterilization for members twenty-one (21) years of age and older who are legally competent, not institutionalized and have signed the "Consent Form" at least thirty (30) days prior to procedure. Reversal of sterilization procedures for the purposes of conception is not covered. Reversal of sterilization procedures are covered when medically indicated and substantiating documentation is attached to the claim.

(15) Physicians' services whether furnished in the office, the member's home, a hospital, a ~~nursing~~long-term care facility, ~~Intermediate Care Facilities for Individuals with Intellectual Disabilities~~intermediate care facilities for individuals with intellectual disabilities (ICF/IID), or elsewhere. For adults, payment is made for compensable hospital days described at OAC 317:30-5-41. Office visits for adults are limited to four (4) per month except when in connection with conditions as specified in OAC 317:30-5-9(b).

(16) Medical care and any other type of remedial care recognized under state law, furnished by licensed practitioners within the scope of their practice as defined by state law. See applicable provider section for limitations to covered services for:

(A) Podiatrists' services;

(B) Optometrists' services;

(C) Psychologists' services;

(D) Certified ~~Registered Nurse Anesthetists~~registered nurse anesthetists;

(E) Certified ~~Nurse Midwives~~nurse midwives;

(F) Advanced ~~Practice Nurses~~practice registered nurses; and

(G) Anesthesiologist ~~Assistants~~assistants.

(17) ~~Free-standing~~Freestanding ambulatory surgery centers.

(18) Prescribed drugs not to exceed a total of six (6) prescriptions with a limit of two (2) brand name prescriptions per month. Exceptions to the six (6) prescription limit are:

(A) ~~unlimited~~Unlimited medically necessary monthly prescriptions for:

(i) ~~members~~Members under the age of twenty-one (21) years; and

(ii) ~~residents~~Residents of ~~nursing~~long-term care facilities or ICF/IID.

(B) ~~seven~~Seven (7) medically necessary generic prescriptions per month in addition to the six (6) covered under the State Plan (including three (3) brand name prescriptions) are allowed for adults receiving services under the 1915(c) ~~Home and Community Based Services Waivers (HCBS)~~home and community-based services (HCBS) waivers. These additional medically necessary prescriptions beyond the three (3) brand name or thirteen (13) total prescriptions are covered with

prior authorization.
(19) Rental and/or purchase of ~~durable medical equipment.~~medical supplies, equipment, and appliances.
(20) Adaptive equipment, when prior authorized, for members residing in private ICF/IID's.
(21) Dental services for members residing in private ICF/IID's in accordance with the scope of dental services for members under age twenty-one (21).
(22) For non-expansion adults, prosthetic devices are limited to catheters and catheter accessories, colostomy and urostomy bags and accessories, tracheostomy accessories, nerve stimulators, hyperalimentation and accessories, home dialysis equipment and supplies, external breast prostheses and support accessories, oxygen/oxygen concentrator equipment and supplies, respirator or ventilator equipment and supplies, and those devices inserted during the course of a surgical procedure. There is no coverage for orthotic devices for adults.
(23) Orthotics and prosthetics are covered for expansion adult members, above the limitations within (22) of this Section, when prescribed by the treating provider (physician, physician assistant, or an advanced practice registered nurse) and medical necessity is documented in accordance with OAC 317:30-5-211.13.
~~(23)~~(24) Standard medical supplies.
~~(24)~~(25) Eyeglasses under EPSDT for members under age twenty-one (21). Payment is also made for glasses for children with congenital aphakia or following cataract removal. Payment is limited to two (2) glasses per year. Any glasses beyond this limit must be prior authorized and determined to be medically necessary.
~~(25)~~(26) Blood and blood fractions for members when administered on an outpatient basis.
~~(26)~~(27) Inpatient services for members age sixty-five (65) or older in institutions for mental diseases, limited to those members whose Medicare, Part A benefits are exhausted for this particular service and/or those members who are not eligible for Medicare services.
~~(27)Nursing~~(28) Long-term care facility services, limited to members preauthorized and approved by OHCA for such care.
~~(28)~~(29) Inpatient psychiatric facility admissions for members ~~under twenty-one (21)~~ are limited to an approved length of stay ~~effective July 1, 1992,~~ with provision for requests for extensions.
~~(29)~~(30) Transportation and subsistence (room and board) to and from providers of medical services to meet member's needs (ambulance or bus, etc.), to obtain medical treatment.
~~(30)~~(31) Extended services for pregnant women including all

pregnancy-related and postpartum services to continue to be provided, as though the women were pregnant, for sixty (60) days after the pregnancy ends, beginning on the last date of pregnancy.

~~(31) Nursing~~(32) Long-term care facility services for members under twenty-one (21) years of age.

~~(32)~~(33) Personal care in a member's home, prescribed in accordance with a plan of treatment and rendered by a qualified person under supervision of a ~~Registered Nurse~~registered nurse (RN).

~~(33) Part A deductible and Part B Medicare Coinsurance and/or deductible~~(34) Medicare Part A, Part B, and Part C deductibles, coinsurance, and copays.

~~(34)~~(35) HCBS for the intellectually disabled.

~~(35)~~(36) Home health services ~~limited to~~can be provided without a PA for the first thirty-six (36) visits ~~per year and standard supplies for one (1) month in a twelve (12) month period~~. A PA will be required beyond the 36th visit. The visits are limited to any combination of ~~Registered Nurse~~RN and nurse aide visits~~, not to exceed thirty-six (36) per year~~.

~~(36)~~(37) Medically necessary solid organ and bone marrow/stem cell transplantation services for children and adults are covered services based upon the conditions listed in (A)-(D) of this paragraph:

~~(A) Transplant procedures, except kidney and cornea, must be prior authorized to be compensable.~~

~~(B) To be prior authorized all procedures are reviewed based on appropriate medical criteria.~~

~~(C) To be compensable under the SoonerCare program, all transplants must be performed at a facility which meets the requirements contained in Section 1138 of the Social Security Act.~~

~~(D) Finally, procedures considered experimental or investigational are not covered.~~

(A) All transplantation services, except kidney and cornea, must be prior authorized;

(B) All transplant procedures are reviewed and prior authorization is based upon appropriate medical criteria;

(C) All organ transplants must be performed at a Medicare approved transplantation center;

(D) Procedures considered experimental or investigational are not covered. For more information regarding experimental or investigational including clinical trials, see OAC 317:30-3-57.1; and

(E) Donor search and procurement services are covered for transplants consistent with the methods used by the Medicare program for organ acquisition costs.

~~(37)~~(38) HCBS for intellectually disabled members who were determined to be inappropriately placed in a ~~nursing~~long-term care facility (Alternative Disposition Plan - ADP).
~~(38)~~(39) Case management services for the chronically and/or ~~severely~~seriously mentally ill.
~~(39)~~(40) Emergency medical services, including emergency labor and delivery for ~~illegal~~undocumented or ineligible aliens.
~~(40)~~(41) Services delivered in Federally Qualified Health Centers (FQHCs). Payment is made on an encounter basis.
~~(41)~~(42) Early intervention services for children ages zero (0) to three (3).
~~(42)~~(43) Residential behavior management in therapeutic foster care setting.
~~(43) Birthing center services.~~
(44) Case management services through the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS).
(45) HCBS for aged or physically disabled members.
(46) Outpatient ambulatory services for members infected with tuberculosis.
(47) Smoking and tobacco use cessation counseling for children and adults.
(48) Services delivered to American Indians/Alaskan Natives (AI/AN) in ~~I/T/Us~~Indian Health Services, Tribal Programs, and Urban Indian Clinics (I/T/Us). Payment is made on an encounter basis.
(49) OHCA contracts with designated agents to provide disease state management for individuals diagnosed with certain chronic conditions. Disease state management treatments are based on protocols developed using evidence-based guidelines.
(50) Residential substance use disorder (SUD) services.
(51) Medication-assisted treatment (MAT) services.
(52) Diabetes self-management education and support (DSMES).

317:30-3-59. General program exclusions - adults

The following are excluded from SoonerCare coverage for adults:
(1) Inpatient admission for diagnostic studies that could be performed on an outpatient basis.
(2) Services or any expense incurred for cosmetic surgery.
(3) Services of two (2) physicians for the same type of service to the same member on the same day, except when supplemental skills are required and different specialties are involved.
(4) Refractions and visual aids.
(5) Pre-operative care within ~~24~~twenty-four (24) hours of the day of admission for surgery and routine post-operative care as defined under the global surgery guidelines promulgated by Current Procedural Terminology (CPT) and the Centers for Medicare and Medicaid Services (CMS).

(6) Sterilization of members who are under ~~21~~twenty-one (21) years of age, mentally incompetent, or institutionalized or reversal of sterilization procedures for the purposes of conception.
(7) Non-therapeutic hysterectomies.
(8) Induced abortions, except when certified in writing by a physician that the abortion was necessary due to a physical disorder, injury or illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would place the woman in danger of death unless an abortion is performed, or that the pregnancy is the result of an act of rape or incest. ~~(Refer to OAC 317:30-5-6 or 317:30-5-50.)~~
(9) Medical services considered experimental or investigational. For more information regarding coverage of clinical trials, see Oklahoma Administrative Code (OAC) 317:30-3-57.1.
(10) Services of a ~~Certified Surgical Assistant.~~certified surgical assistant.
(11) Services of a ~~Chiropractor~~chiropractor. Payment is made for ~~Chiropractor~~chiropractor services on ~~Crossover~~crossover claims for coinsurance and/or deductible only.
(12) ~~Services of an independent licensed Physical and/or Occupational Therapist.~~Services of an independent licensed physical therapist and/or licensed physical therapist assistant. Per OAC 317:30-5-291.
(13) Services of an independent licensed occupational therapist and/or occupational therapist assistant. Per OAC 317:30-5-296.
~~(13)~~(14) Services of a ~~Psychologist.~~psychologist.
~~(14)~~(15) Services of an independent licensed ~~Speech and Hearing Therapist.~~speech-language pathologist, speech-language pathology assistant (SLPA), and/or speech-language clinical fellow. Per OAC 317:30-5-675.
~~(15)~~(16) Payment for more than four (4) outpatient visits per month (home or office) per member, except those visits in connection with family planning or related to emergency medical conditions.
~~(16)~~(17) Payment for more than ~~two nursing~~two (2) long-term care facility visits per month.
~~(17)~~(18) More than one (1) inpatient visit per day per physician.
~~(18)~~(19) Payment for removal of benign skin lesions.
~~(19)~~(20) Physician services which are administrative in nature and not a direct service to the member including such items as quality assurance, utilization review, treatment staffing, tumor board review or multidisciplinary opinion, dictation, and similar functions.

~~(20)~~(21) Charges for completion of insurance forms, abstracts, narrative reports or telephone calls.
~~(21)~~(22) Payment for the services of social workers, licensed family counselors, registered nurses or other ancillary staff, except as specifically set out in ~~OHCA~~the Oklahoma Health Care Authority (OHCA) rules.
~~(22)~~(23) Mileage.
~~(23)~~(24) A routine hospital visit on the date of discharge unless the member expired.
~~(24)~~(25) Direct payment to perfusionist as this is considered part of the hospital reimbursement.
~~(25) Inpatient chemical dependency treatment.~~
(26) Fertility treatment.
(27) Payment to the same physician for both an outpatient visit and admission to hospital on the same date.
~~(28) Sleep studies.~~

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 3. HOSPITALS

317:30-5-42.16. Related services

(a) **Ambulance.** Ambulance services furnished by the facility are covered separately if otherwise compensable under the ~~Authority's Medical Programs.~~SoonerCare program.

(b) **Home health care.** ~~Hospital based~~Hospital-based home health providers must be Medicare certified and have a current Home Health Agency contract with the ~~OHCA~~Oklahoma Health Care Authority (OHCA). For home health services, a qualified provider must conduct and document a face-to-face encounter with the member in accordance with provisions of ~~42 CFR §440.70.~~42 Code of Federal Regulations (C.F.R.) § 440.70. Refer to Oklahoma Administrative Code (OAC) 317:30-5-546 and OAC 317:30-5-547 for additional policy related to coverage and reimbursement for home health care services.

~~(1) Payment is made for home health services provided in a member's residence to all categorically needy individuals.~~
~~(2) Payment is made for a maximum of 36 visits per year for eligible members 21 years of age or older. Payment for any combination of skilled and home health aide visits can not exceed 36 visits per year.~~
~~(3) Payment is made for standard medical supplies.~~
~~(4) Payment is made on a rental or purchase basis for equipment and appliances suitable for use in the home.~~
~~(5) Non-covered items include sales tax, enteral therapy and nutritional supplies, and electro-spinal orthosis systems (ESO).~~
~~(6) Payment may be made to home health agencies for prosthetic~~

devices.

(A) Coverage of oxygen includes rental of liquid oxygen systems, gaseous oxygen systems and oxygen concentrators when prior authorized. Purchase of oxygen systems may be made where unusual circumstances exist and purchase is considered most appropriate.

(B) Payment is made for permanent indwelling catheters, drain bags, insert trays and irrigation trays. Male external catheters are also covered.

(C) Sterile tracheotomy trays are covered.

(D) Payment is made for colostomy and urostomy bags and accessories.

(E) Payment is made for hyperalimentation, including supplements, supplies and equipment rental on behalf of persons having permanently inoperative internal body organ dysfunction. Information regarding the member's medical condition that necessitates the hyperalimentation and the expected length of treatment, should be attached when requesting prior authorization.

(F) Payment is made for ventilator equipment and supplies when prior authorized.

(G) Payment for medical supplies, oxygen, and equipment is made when using appropriate HCPCS codes which are included in the HCPCS Level II Coding Manual.

(c) **Hospice Services.** Hospice is defined as palliative and/or comfort care provided to the member family when a physician certifies that the member has a terminal illness and has a life expectancy of six months or less. A hospice program offers palliative and supportive care to meet the special needs arising out of the physical, emotional and spiritual stresses which are experienced during the final stages of illness and death. 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.

(1) Payment is made for home based hospice services for terminally ill individuals under the age of 21 with a life expectancy of six months or less when the member and/or family has elected hospice benefits. Hospice services are available to eligible members without forgoing any other service to which the member is entitled under SoonerCare for curative treatment of the terminal illness. Once the member has elected hospice care, the hospice medical team assumes responsibility for the member's medical care for the terminal illness in the home environment. Hospice providers are not responsible for curative treatments for members that elect such services while on hospice. Hospice care includes nursing care, physician services, medical equipment and supplies, drugs for symptom

~~control and pain relief, home health aide and personal care, physical, occupational and/or speech therapy, medical social services, dietary counseling and grief and bereavement counseling to the member and/or family.~~

~~(2) Hospice care is available for two initial 90-day periods and an unlimited number of subsequent 60-day periods during the remainder of the member's lifetime. Beginning January 1, 2011, a hospice physician or nurse practitioner must have a face to face encounter with the member to determine if the member's terminal illness necessitates continuing hospice care services. The encounter must take place prior to the 180th day recertification and each subsequent recertification thereafter; and attests that such visit took place. The member and/or the family may voluntarily terminate hospice services.~~

~~(3) Hospice services must be reasonable and necessary for the palliation or management of a terminal illness or related conditions. A certification that the member is terminally ill must be completed by the member's attending physician or the Medical Director of an Interdisciplinary Group. Nurse practitioners serving as the attending physician may not certify the terminal illness; however, effective January 1, 2011, nurse practitioners may re-certify the terminal illness.~~

~~(4) Services must be prior authorized. A written plan of care must be established before services are provided. The plan of care should be submitted with the prior authorization request.~~

317:30-5-42.17. Non-covered services

In addition to the general program exclusions [~~OAC~~Oklahoma Administrative Code (OAC) 317:30-5-2(a)(2)] the following are excluded from coverage:

(1) Inpatient admission for diagnostic studies that could be performed on an outpatient basis.

(2) Procedures that result in sterilization which do not meet the guidelines set forth in this Chapter ~~of rules~~.

(3) Reversal of sterilization procedures for the purposes of conception are not covered.

(4) Medical services considered experimental or investigational. For more information regarding coverage of clinical trials, see OAC 317:30-3-57.1.

(5) Payment for removal of benign skin lesions for adults.

(6) Visual aids.

(7) Charges incurred while the member is in a skilled nursing or swing bed.

~~(8) Sleep studies for adults.~~

PART 9. LONG-TERM CARE FACILITIES

317:30-5-133.1. Routine services

(a) ~~Nursing~~Long-term care facility care includes routine items and services that must be provided directly or through appropriate arrangement by the facility when required by SoonerCare residents. Charges for routine services may not be made to resident's personal funds or to resident family members, guardians, or other parties who have responsibility for the resident. If reimbursement is available from Medicare or another public or private insurance or benefit program, those programs are billed by the facility. In the absence of other available reimbursement, the facility must provide routine services from the funds received from the regular SoonerCare vendor payment and the SoonerCare resident's applied income, or spend down amount.

(b) The ~~OHCA~~Oklahoma Health Care Authority (OHCA) will review the listing periodically for additions or deletions, as indicated. Routine services are member specific and provided in accordance with standard medical care. Routine services include, but are not limited to:

(1) Regular room.

(2) Dietary ~~Services~~services:

(A) ~~regular~~Regular diets;

(B) ~~special~~Special diets;

(C) ~~salt~~Salt and sugar substitutes;

(D) ~~supplemental~~Supplemental feedings;

(E) ~~special~~Special dietary preparations;

(F) ~~equipment~~Equipment required for preparing and dispensing tube and oral feedings; and

(G) ~~special~~Special feeding devices (furnished or arranged for).

(3) Medically related social services to attain or maintain the highest practicable physical, mental and psycho-social well-being of each resident, nursing care, and activities programs (costs for a private duty nurse or sitter are not allowed).

(4) Personal services - personal laundry services for residents (does not include dry cleaning).

(5) Personal hygiene items (personal care items required to be provided does not include electrical appliances such as shavers and hair dryers, or individual personal batteries), to include:

(A) ~~shampoo~~Shampoo, comb, and brush;

(B) ~~bath~~Bath soap;

(C) ~~disinfecting~~Disinfecting soaps or specialized cleansing agents when indicated to treat or prevent special skin problems or to fight infection;

(D) ~~razor~~Razor and/or shaving cream;

(E) ~~nail~~Nail hygiene services; and

(F) ~~sanitary~~Sanitary napkins, douche supplies, perineal irrigation equipment, solutions, and disposable douches.

(6) Routine oral hygiene items, including:

(A) ~~toothbrushes~~Toothbrushes;

(B) ~~toothpaste~~Toothpaste;

(C) ~~dental~~Dental floss;

(D) ~~lemon~~Lemon glycerin swabs or equivalent products; and

(E) ~~denture~~Denture cleaners, denture adhesives, and containers for dental prosthetic appliances such as dentures and partial dentures.

(7) Necessary items furnished routinely as needed to all members, e.g., water pitcher, cup and tray, towels, wash cloths, hospital gowns, emesis basin, bedpan, and urinal.

(8) The facility will furnish as needed items such as alcohol, applicators, cotton balls, tongue depressors and, first aid supplies, including small bandages, ointments and preparations for minor cuts and abrasions, and enema supplies, disposable enemas, gauze, 4 x 4's ABD pads, surgical and micropore tape, telfa gauze, ace bandages, etc.

(9) Over the counter drugs (non-legend) not covered by the prescription drug program (PRN or routine). In general, ~~nursing~~long-term care facilities are not required to provide any particular brand of non-legend drugs, only those items necessary to ensure appropriate care.

(A) If the physician orders a brand specific non-legend drug with no generic equivalent, the facility must provide the drug at no cost to the member. If the physician orders a brand specific non-legend drug that has a generic equivalent, the facility may choose a generic equivalent, upon approval of the ordering physician;

(B) If the physician does not order a specific type or brand of non-legend drug, the facility may choose the type or brand;

(C) If the member, family, or other responsible party (excluding the ~~nursing~~long-term care facility) prefers a specific type or brand of non-legend drug rather than the ones furnished by the facility, the member, family or responsible party may be charged the difference between the cost of the brand the resident requests and the cost of the brand generally provided by the facility. (Facilities are not required to provide an unlimited variety of brands of these items and services. It is the required assessment of resident needs, not resident preferences, that will dictate the variety of products facilities need to provide);

(D) Before purchasing or charging for the preferred items, the facility must secure written authorization from the member, family member, or responsible party indicating his or her desired preference, as well as the date and signature of the person requesting the preferred item. The signature

may not be that of an employee of the facility. The authorization is valid until rescinded by the maker of the instrument.

(10) The facility will furnish or obtain any necessary equipment to meet the needs of the member upon physician order. Examples include: trapeze bars and overhead frames, foot and arm boards, bed rails, cradles, wheelchairs and/or geriatric chairs, foot stools, adjustable crutches, canes, walkers, bedside commode chairs, hot water bottles or heating pads, ice bags, sand bags, traction equipment, IV stands, etc.

(11) Physician prescribed lotions, ointments, powders, medications and special dressings for the prevention and treatment of decubitus ulcers, skin tears and related conditions, when medications are not covered under the Vendor Drug Program or other ~~third party~~third-party payer.

(12) Supplies required for dispensing medications, including needles, syringes including insulin syringes, tubing for IVs, paper cups, medicine containers, etc.

(13) Equipment and supplies required for simple tests and examinations, including scales, sphygmomanometers, stethoscopes, clinitest, acetest, dextrostix, pulse oximeters, blood glucose meters and test strips, etc.

(14) Underpads and diapers, waterproof sheeting and pants, etc., as required for incontinence or other care.

(A) If the assessment and care planning process ~~determines~~determine that it is medically necessary for the resident to use diapers as part of a plan to achieve proper management of incontinence, and if the resident has a current physician order for adult diapers, then the facility must provide the diapers without charge;

(B) If the resident or the family requests the use of disposable diapers and they are not prescribed or consistent with the facility's methods for incontinent care, the resident/family would be responsible for the expense.

(15) ~~Oxygen for emergency use, or intermittent use as prescribed by the physician for medical necessity.~~Members in long-term care facilities requiring oxygen will be serviced by oxygen kept on hand by the long-term care facility as part of the per diem rate.

(16) Other physician ordered equipment to adequately care for the member and in accordance with standard patient care~~, including infusion pumps and supplies, and nebulizers and supplies, etc~~.

(17) Dentures and ~~Related Services~~related services. Payment for the cost of dentures and related services is included in the daily rate for routine services. The projected schedule for routine denture services must be documented on the ~~Admission~~

~~Plan of Care and on the Annual Plan of Care~~admission plan of care and on the annual plan of care. The medical records must also contain documentation of steps taken to obtain the services. When the provision of denture services is medically appropriate, the ~~nursing~~long-term care facility must make timely arrangements for the provision of these services by licensed dentists. In the event denture services are not medically appropriate, the treatment plan must reflect the reason the services are not considered appropriate, e.g., the member is unable to ingest solid nutrition or is comatose, etc. When the need for dentures is identified, one (1) set of complete dentures or partial dentures and one (1) dental examination is considered medically appropriate every three (3) years. One (1) rebase and/or one (1) reline is considered appropriate every three (3) years. It is the responsibility of the ~~nursing~~long-term care facility to ensure that the member has adequate assistance in the proper care, maintenance, identification and replacement of these items. The ~~nursing~~long-term care facility cannot set up payment limits which result in barriers to obtaining denture services. However, the ~~nursing~~long-term care facility may restrict the providers of denture services to providers who have entered into payment arrangements with the facility. The facility may also choose to purchase a private insurance dental coverage product for each SoonerCare member. At a minimum, the policy must cover all denture services included in routine services. The member cannot be expected to pay any co-payments and/or deductibles. If a difference of opinion occurs between the ~~nursing~~long-term care facility, member, and/or family regarding the provision of dentures services, the OHCA will be the final authority. All members and/or families must be informed of their right to appeal at the time of admission and yearly thereafter. The member cannot be denied admission to a facility because of the need for denture services.

(18) Vision ~~Services~~services. Routine eye examinations for the purpose of medical screening or prescribing or changing glasses and the cost of glasses are included in the daily rate for routine services. This does not include follow-up or treatment of known eye disease such as diabetic retinopathy, glaucoma, conjunctivitis, corneal ulcers, iritis, etc. Treatment of known eye disease is a benefit of the member's medical plan. The projected schedule for routine vision care must be documented on the ~~Admission Plan of Care and on the Annual Plan of Care~~admission plan of care and on the annual plan of care. The medical record must contain documentation of the steps that have been taken to access the service. When vision services are not appropriate, documentation of why vision services are not

medically appropriate must be included in the treatment plan. For example, the member is comatose, unresponsive, blind, etc. ~~Nursing Home~~Long-term care facility providers may contract with individual eye care providers, providers groups or a vision plan to provide routine vision services to their members. The member cannot be expected to pay any co-payments and/or deductibles.

(A) The following minimum level of services must be included:

(i) Individuals ~~21~~twenty-one (21) to ~~40~~forty (40) years of age are eligible for one (1) routine eye examination and one (1) pair of glasses every ~~36~~thirty-six (36) months ~~(~~[three (3) years~~)~~].

(ii) Individuals ~~41~~forty-one (41) to ~~64~~sixty-four (64) years of age are eligible for one (1) routine eye examination and one (1) pair of glasses every ~~24~~twenty-four (24) months ~~(2 years).~~[two (2) years].

(iii) Individuals ~~65~~sixty-five (65) years of age or older are eligible for one (1) routine eye examination and one (1) pair of glasses every ~~12~~twelve (12) months (yearly).

(B) It is the responsibility of the ~~nursing~~long-term care facility to ensure that the member has adequate assistance in the proper care, maintenance, identification and replacement of these items. When vision services have been identified as a needed service, ~~nursing~~long-term care facility staff will make timely arrangements for provision of these services by licensed ophthalmologists or optometrists. If a difference of opinion occurs between the ~~nursing~~long-term care facility, member, and/or family regarding the provision of vision services, the OHCA will be the final authority. All members and/or families must be informed of their right to appeal at admission and yearly thereafter. The member cannot be denied admission to the facility because of the need for vision services.

(19) An attendant to accompany SoonerCare eligible members during SoonerRide ~~Non-Emergency Transportation~~non-emergency transportation (NET). Please refer to ~~OAC~~Oklahoma Administrative Code (OAC) 317:30-5-326 through OAC 317:30-5-327.9 for SoonerRide rules regarding members residing in a ~~nursing~~long-term care facility~~. And~~; and

(20) Influenza and pneumococcal vaccinations.

317:30-5-133.2. Ancillary services [REVOKED]

~~(a) Ancillary services are those items which are not considered routine services. Ancillary services may be billed separately to the SoonerCare program, unless reimbursement is available from Medicare or other insurance or benefit programs. Coverage criteria, utilization controls and program limitations are~~

~~specified in Part 17 of OAC 317:30-5. Ancillary services are limited to the following services:~~

~~(1) Services requiring prior authorization:~~

~~(A) External breast prosthesis and support accessories.~~

~~(B) Ventilators and supplies.~~

~~(C) Total Parenteral Nutrition (TPN), and supplies.~~

~~(D) Custom seating for wheelchairs.~~

~~(2) Services not requiring prior authorization:~~

~~(A) Permanent indwelling or male external catheters and catheter accessories.~~

~~(B) Colostomy and urostomy supplies.~~

~~(C) Tracheostomy supplies.~~

~~(D) Catheters and catheter accessories.~~

~~(E) Oxygen and oxygen concentrators.~~

~~(i) PRN Oxygen. Members in nursing facilities requiring oxygen PRN will be serviced by oxygen kept on hand as part of the per diem rate.~~

~~(ii) Billing for Medicare eligible members. Oxygen supplied to Medicare eligible nursing home members may be billed directly to OHCA. It is not necessary to obtain a denial from Medicare prior to filing the claim with OHCA.~~

~~(b) Items not considered ancillary, but considered routine and covered as part of the routine rate include but are not limited to:~~

~~(1) Diapers.~~

~~(2) Underpads.~~

~~(3) Medicine cups.~~

~~(4) Eating utensils.~~

~~(5) Personal comfort items.~~

PART 17. MEDICAL SUPPLIERS

317:30-5-210. Eligible providers

All eligible medical suppliers must have a current contract with the Oklahoma Health Care Authority (OHCA). The supplier must comply with all applicable ~~State and Federal~~state and federal laws. ~~Effective January 1, 2011, all~~All suppliers of ~~durable medical equipment, prosthetics, orthotics and supplies (DMEPOS)~~medical supplies, equipment, and appliances must be accredited by a Medicare deemed accreditation organization for quality standards for ~~DMEPOS~~durable medical equipment (DME) suppliers in order to bill the SoonerCare program. OHCA may make exceptions to this standard based on the exemptions provided by the Centers for Medicare and Medicaid Services (CMS) for Medicare accreditation, if the provider is a government-owned entity, or at a provider's request and at the discretion of OHCA based on access issues and/or

agency needs for SoonerCare members. Additionally, unless an exception is granted from the OHCA, all ~~DMEPOS~~DME providers must meet the following criteria:

(1) ~~DMEPOS~~DME providers are required to have a physical location in the State of Oklahoma, or within a designated range of the Oklahoma State border, as determined by the OHCA. The OHCA may make exceptions to this requirement if a ~~DMEPOS~~DME provider provides a specialty item, product, or service, which is not otherwise available to SoonerCare members within the State of Oklahoma. Provider contracts for out-of-state ~~DMEPOS~~DME providers will be reviewed on a case-by-case basis for specialty items only. The OHCA has discretion and the final authority to approve or deny any provider contract.

(2) ~~DMEPOS~~DME providers are required to comply with Medicare ~~DMEPOS~~DME Supplier Standards for ~~DMEPOS~~medical supplies, equipment, and appliances provided to SoonerCare members, except the requirement to meet surety bond requirements, as specified in 42 ~~C.F.R.~~Code of Federal Regulations (C.F.R.) § 424.57(c).

(3) Complex ~~Rehabilitation Technology~~rehabilitation technology (CRT) suppliers are considered ~~DMEPOS~~DME providers. Only CRT suppliers may bill CRT procedure codes. A CRT supplier means a company or entity that:

(A) Is accredited by a recognized accrediting organization as a supplier of CRT;

(B) Is an enrolled Medicare supplier and meets the supplier and quality standards established for DME suppliers, including those for CRT, under the Medicare program;

(C) Employs as a W-2 employee at least one (1) qualified CRT professional, also known as assistive technology professional, for each location to:

(i) Analyze the needs and capacities of complex-needs patients in consultation with qualified health care professionals;

(ii) Participate in selecting appropriate CRT items for such needs and capacities; and

(iii) Provide the complex-needs patient technology related training in the proper use and maintenance of the CRT items.

(D) Requires a qualified CRT professional be physically present for the evaluation and determination of the appropriate CRT;

(E) Has the capability to provide service and repair by qualified technicians for all CRT items it sells; and

(F) Provides written information to the complex-needs patient prior to ordering CRT as to how to access service and repair.

317:30-5-210.1. Coverage for adults

~~Coverage of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) for adults is specified in OAC 317:30-5-211.1 through OAC 317:30-5-211.18.~~Coverage of medical supplies, equipment, and appliances for adults complies with 42 Code of Federal Regulations (C.F.R.) § 440.70 and is specified in Oklahoma Administrative Code (OAC) 317:30-5-211.1 through OAC 317:30-5-211.19.

317:30-5-210.2. Coverage for children

(a) **Coverage.** ~~Coverage of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) for children includes the specified coverage for adults found in OAC 317:30-5-211.1 through OAC 317:30-5-211.18. In addition the following are covered items for children only:~~Medical supplies, equipment, and appliances are covered for children.

~~(1) Orthotics and prosthetics.~~

~~(2) Enteral nutrition is considered medically necessary for certain conditions in which, without the products, the member's condition would deteriorate to the point of severe malnutrition.~~

~~(A) Enteral nutrition must be prior authorized. PA requests must include:~~

~~(i) the member's diagnosis;~~

~~(ii) the impairment that prevents adequate nutrition by conventional means;~~

~~(iii) the member's weight history before initiating enteral nutrition that demonstrates oral intake without enteral nutrition is inadequate;~~

~~(iv) the percentage of the member's average daily nutrition taken by mouth and by tube; and~~

~~(v) prescribed daily caloric intake.~~

~~(B) Enteral nutrition products that are administered orally and related supplies are not covered.~~

~~(3) Continuous positive airway pressure devices (CPAP).~~

(b) **~~EPSDT~~Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services.** ~~Services deemed medically necessary and allowable under federal regulations may be covered by the EPSDT Child Health program even though those services may not be part of the SoonerCare program. These services must be prior authorized.~~ EPSDT services, supplies, or equipment that are determined to be medically necessary for a child, and which are included within the categories of mandatory and optional services in Section 1905(a) of Title XIX, are covered regardless of whether such services, supplies, or equipment are listed as covered in the Oklahoma Medicaid State Plan.

(c) **Medical necessity.** Federal regulations require ~~OHCA~~the Oklahoma Health Care Authority (OHCA) to make the determination as to whether the service is medically necessary and do not require the provision of any items or services that the State determines are not safe and effective or that are considered experimental. For more information regarding clinical trials, see Oklahoma Administrative Code 317:30-3-57.1.

317:30-5-211.1. Definitions

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

"Activities of daily living-basic" means a series of activities performed on a day-to-day basis that are necessary to care for oneself (e.g., personal hygiene, dressing, eating, maintaining continence and transferring).

"Activities of daily living-instrumental" means activities that are not necessarily required on a daily basis but are important to being able to live independently (e.g., basic communication skills, transportation, meal preparation, shopping, housework, managing medication and managing personal finances).

~~**"Adaptive equipment"** means devices, aids, controls, appliances or supplies of either a communication or adaptive type, determined necessary to enable the person to increase his or her ability to function in a home and community based setting or private Intermediate Care Facilities for Individuals with Intellectual Disabilities (IFC/IID) with independence and safety.~~

~~**"Basic activities of daily living"** means a series of activities performed on a day-to-day basis that are necessary to care for oneself (e.g., personal hygiene, dressing, eating, maintaining continence and transferring).~~

"Capped rental" means monthly payments for the use of the ~~Durable Medical Equipment (DME)~~medical supplies, equipment, and appliances for a limited period of time not to exceed ~~13~~thirteen (13) months. Items are considered purchased and owned by the Oklahoma Health Care Authority (OHCA) after ~~13~~thirteen (13) months of continuous rental.

"Certificate of medical necessity (CMN)" means a certificate which is required to help document the medical necessity and other coverage criteria for selected items. Those items are defined in this Chapter. The ~~physician's certification~~CMN must include the member's diagnosis, the reason the equipment is required, and the physician's, non-physician provider's (NPP's), or dentist's estimate, in months, of the duration of its need.

~~**"Complex-needs patient"** means an individual with a diagnosis or medical condition that results in significant physical or functional needs and capacities.~~

"Complex rehabilitation technology" means medically necessary

durable medical equipment and items that are individually configured to meet specific and unique medical, physical, and functional needs and capacities for basic activities of daily living and instrumental activities of daily living of a ~~complex needs patient~~member with complex needs. Such equipment and items include, but are not limited to, individually configured power wheelchairs and accessories, individually configured manual wheelchairs and accessories, adaptive seating and positioning systems and accessories, and other specialized equipment such as standing frames and gait trainers.

"Customized ~~DME~~equipment and/or appliances" means items of ~~DME~~equipment and/or appliances which have been uniquely constructed or substantially modified for a specific member according to the description and orders of the member's treating physician or other qualified medical professional. For instance, a wheelchair would be considered "customized" if it has been:

(A) ~~measured~~Measured, fitted, or adapted in consideration of the member's body size, disability, period of need, or intended use;

(B) ~~assembled~~Assembled by a supplier or ordered from a manufacturer who makes available customized features, modifications, or components for wheelchairs; and

(C) ~~intended~~Intended for an individual member's use in accordance with instructions from the member's physician.

"~~Durable medical equipment (DME)~~Equipment and/or appliances" means ~~equipment that can withstand repeated use (e.g. a type of item that could normally be rented), is used to serve a medical purpose, is not useful to a person in the absence of an illness or injury, and is used in the most appropriate setting, including the home or workplace~~items that are primarily and customarily used to serve a medical purpose, generally are not useful to an individual in the absence of a disability, illness or injury, can withstand repeated use, can be reusable or removable, and are suitable for use in any setting in which normal life activities take place other than a hospital, long-term care facility, intermediate care facility for individuals with intellectual disabilities, or any setting in which payment is or could be made under Medicaid for inpatient services that include room and board. Refer to 42 Code of Federal Regulations (C.F.R.) 440.70(b).

"Face-to-face encounter" means a patient visit in which a practitioner, as defined by 42 C.F.R. 440.70(f), completes a face-to-face assessment related to the primary reason the beneficiary requires durable medical equipment. The face-to-face encounter must occur no more than six (6) months prior to the start of services. The ordering physician must document the face-to-face encounter, including the practitioner who conducted the encounter and the date of the encounter. Clinical findings must be

incorporated into a written or electronic document included in the beneficiary's medical record. The face-to-face encounter may occur through telehealth.

~~**"Instrumental activities of daily living"** means activities that are not necessarily required on a daily basis, but are important to being able to live independently (e.g., basic communication skills, transportation, meal preparation, shopping, housework, managing medication and managing personal finances).~~

"Invoice" means a document that provides the following information when applicable: the description of product, quantity, quantity in box, purchase price, NDC, strength, dosage, provider, seller's name and address, purchaser's name and address, and date of purchase. At times, visit notes will be required to determine how much of the supply was expended. When possible, the provider should identify the SoonerCare member receiving the equipment or supply on the invoice.

"Medical supplies" means ~~an article used in the cure, mitigation, treatment, prevention, or diagnosis of illnesses. Disposable medical supplies are medical supplies consumed in a single usage and do not include skin care creams or cleansers.~~ health care related items that are consumable or disposable, or cannot withstand repeated use by more than one (1) individual, that are required to address an individual medical disability, illness, or injury. Medical supplies do not include skin care creams, cleansers, surgical supplies, or medical or surgical equipment.

"OHCA CMN" means a certificate required to help document the medical necessity and other coverage criteria for selected items. Those items are defined in this ~~chapter~~Chapter. The ~~physician's certification~~CMN must include the member's diagnosis, the reason equipment is required, and the physician's, NPP's, or dentist's estimate, in months, of the duration of its need. This certificate is used when the OHCA requires a CMN and one (1) has not been established by CMS.

"Orthotics" means ~~an item used for the correction or prevention of skeletal deformities.~~a device used to support, align, prevent or correct deformities, protect a body function, improve the function of movable body parts or to assist a dysfunctional joint.

"Patient with complex needs" means an individual with a diagnosis or medical condition that results in significant loss of physical or functional needs and capacities.

~~**"Prosthetic devices"**~~**"Prosthetics"** means ~~a replacement, corrective, or supportive device (including repair and replacement parts of the same) worn on or in the body to artificially replace a missing portion of the body, prevent or correct physical deformity or malfunction, or support a weak or deformed portion of the body~~an artificial substitute which replaces all or part of a

body organ or replaces all or part of the function of a permanently inoperative, absent, or malfunctioning body part.

"Provider" refers to the treating provider and must be a physician [Medical Doctor (MD), or Doctor of Osteopathy, (DO)], a NPP [Physician Assistant (PA), or Advanced Practice Registered Nurse (APRN)], or a dentist [Doctor of Dental Surgery (DDS), or Doctor of Medicine in Dentistry (DMD)].

~~**"Qualified complex rehabilitation technology professional"** means an individual who is certified as an Assistive Technology Professional (ATP) by the Rehabilitation Engineering and Assistive Technology Society of North America (RESNA).~~

317:30-5-211.2. Medical necessity

(a) **Coverage.** Coverage is subject to the requirement that the equipment be necessary and reasonable for the treatment of an illness or injury, or to improve the functioning of a malformed body member, in accordance with state and federal Medicaid law, including, but not limited to, Oklahoma Administrative Code (OAC) 317:30-3-1(f). The member's diagnosis must warrant the type of equipment or supply being purchased or rented. Items that are used for the following are not a benefit to a member of any age:

(1) Routine personal hygiene;

(2) Education;

(3) Exercise;

(4) Convenience, safety, or restraint of the member, or his or her family or caregiver;

(5) Participation in sports; and/or

(6) Cosmetic purposes.

(b) **Ordering requirements.** All medical supplies, equipment, and appliances as defined by 42 Code of Federal Regulations (C.F.R.) § 440.70 (b)(3) and OAC 317:30-5-211.1, nursing services, and home health aide services provided by a home health agency, must be ordered by a physician, nurse practitioner, clinical nurse specialist or physician assistant, working in accordance with State law, as part of a written plan of care.

(1) The plan of care must be reviewed in accordance with 42 C.F.R. § 440.70. Medical supplies, equipment, and appliances must be reviewed annually by the ordering provider. Nursing services and home health aide services provided by a home health agency must be reviewed every sixty (60) days by the ordering provider.

(2) A face-to-face encounter must occur and be documented, in accordance with 42 C.F.R. § 440.70 and OAC 317:30-5-211.1.

~~(b)~~(c) **Prescription requirements.** All ~~DME,~~medical supplies, equipment, and appliances, as those terms are defined by 42 C.F.R. § 440.120 and OAC 317:30-5-211.1, except for hearing aid batteries and equipment repairs with a cost per item of less than

~~$250.00~~$1,000.00 total parts and labor~~ and hearing aid batteries~~, require a prescription signed by a physician, a physician assistant, or an advanced practice registered nurse. Except as otherwise stated in state or federal law, the prescription must be in writing, or given orally and later reduced to writing by the provider filling the order. Prescriptions are valid for no more than one (1) year from the date written. The prescription must include the following information:

~~(1) date of the order;~~
~~(2) name and address of the prescriber;~~
~~(3) name and address of the member;~~
~~(4) name or description and quantity of the prescribed item;~~
~~(5) diagnosis for the item requested;~~
~~(6) directions for use of the prescribed item; and~~
~~(7) prescriber's signature.~~

(1) The member's name;
(2) The prescribing practitioner's name;
(3) The date of the prescription;
(4) All items, options, or additional features that are separately billed. The description can be either a narrative description (e.g., lightweight wheelchair base), a Healthcare Common Procedure Coding System (HCPCS) code, a HCPCS code narrative, or a brand name/model number; and
(5) The prescribing practitioner's signature and signature date.

~~(c)~~(d) **Certificate of medical necessity (CMN)**. For certain items or services, the supplier must receive a signed CMN/OHCA CMN from the treating physician, non-physician practitioner, or dentist. The supplier must have a signed CMN/OHCA CMN in their records before they submit a claim for payment. The CMN/OHCA CMN may be ~~faxed, copied~~faxed copy, electronic copy, or the original hardcopy.

~~(d)~~(e) **Place of service.**

(1) ~~OHCA covers DMEPOS for use in the member's place of residence except if the member's place of residence is a nursing facility.~~The Oklahoma Health Care Authority (OHCA) covers medical supplies, equipment, and appliances for use in the member's place of residence and in any setting in which normal life activities take place except for a hospital, long-term care facility, intermediate care facility for individuals with intellectual disabilities, or any other setting in which payment is or could be made under Medicaid for inpatient services that include room and board.

(2) ~~For members residing in a nursing facility, most medical supplies and/or DME are considered part of the facility's per diem rate. Refer to coverage for nursing facility residents at OAC 317:30-5-211.16.~~For members residing in a hospital, long-

term care facility, intermediate care facility for individuals with intellectual disabilities, or any other setting in which payment is or could be made under Medicaid for inpatient services that include room and board, medical supplies, equipment, and appliances are considered part of the facility's per diem rate.

(f) **Contracting requirements.** Per 42 C.F.R. 455.410(b), medical supplies, equipment, and appliances may only be ordered or prescribed by a SoonerCare contracted provider.

317:30-5-211.3. Prior authorization (PA)

(a) **General.** ~~Prior authorization~~PA is the electronic or written authorization issued by ~~OHCA~~ the Oklahoma Health Care Authority (OHCA) to a provider prior to the provision of a service. Providers should obtain a PA before providing services.

(b) **Requirements.** Billing must follow correct coding guidelines as promulgated by ~~CMS~~the Centers for Medicare and Medicaid Services (CMS) or per uniquely and publicly promulgated OHCA guidelines. ~~DME~~Medical supplies, equipment, and appliances claims must include the most appropriate ~~HCPCS~~Healthcare Common Procedure Coding System (HCPCS) code as assigned by the Medicare Pricing, Data, Analysis, and Coding (PDAC) or its successor. Authorizations for services not properly coded will be denied. ~~**The following services require prior authorization (PA):**~~The following services require PA:

(1) ~~services~~Services that exceed quantity/frequency limits;

(2) ~~medical~~Medical need for an item that is beyond OHCA's standards of coverage;

(3) ~~use~~Use of a Not Otherwise Classified (NOC) code or miscellaneous codes;

(4) ~~services~~Services for which a less costly alternative may exist; and

(5) ~~procedures~~Procedures indicating that a PA is required on the OHCA fee schedule.

(c) ~~**Prior authorization (PA)**~~**PA requests.** ~~Refer to OAC 317:30-5-216.~~

(1) **PA requirements.** Requirements vary for different types of services. Providers should refer to the service-specific sections of policy or the OHCA website for services requiring a PA. Also refer to OAC 317:30-3-31.

(A) **Required forms.** All required forms are available on the OHCA website.

(B) **Certificate of medical necessity (CMN).** The prescribing physician, non-physician practitioner (NPP), or dentist must complete the medical necessity section of the CMN. This section cannot be completed by the supplier. The medical necessity section can be completed by any health care

clinician; however, only the member's physician, NPP, or dentist may sign the CMN. By signing the CMN, the physician, NPP, or dentist is validating the completeness and accuracy of the medical necessity section. The member's medical records must contain documentation substantiating that the member's condition meets the coverage criteria and the answers given in the medical necessity section of the CMN. These records may be requested by OHCA or its representatives to confirm concurrence between the medical records and the information submitted with the PA request.

(2) **Submitting PA requests.** Contact information for submitting PA requests may be found in the OHCA Provider Billing and Procedures Manual. An electronic version of this manual is located on the OHCA website.

(3) **PA review.** Upon verifying the completeness and accuracy of clerical items, the PA request is reviewed by OHCA staff to evaluate whether or not each service being requested meets SoonerCare's definition of "medical necessity" [see OAC 317:30-3-1 (f)] as well as other criteria.

(4) **PA decisions.** After the PA request is processed, a notice will be issued regarding the outcome of the review.

(5) **PA does not guarantee reimbursement.** Provider status, member eligibility, and medical status on the date of service, as well as all other SoonerCare requirements, must be met before the claim is reimbursed.

(6) **PA of manually-priced items.** Manually-priced items must be prior authorized. For reimbursement of manually priced items, see OAC 317:30-5-218.

317:30-5-211.5. Repairs, maintenance, replacement and delivery

(a) **Repairs.** Repairs to equipment that either the Oklahoma Health Care Authority (OHCA) or a member owns are covered when they are necessary to make the equipment usable. The repair charge includes the use of "loaner" equipment as required. If the expense for repairs exceeds the estimated expense of purchasing or renting another item of equipment for the remaining period of medical need, payment cannot be made for the amount in excess. Repairs of rented equipment are not covered.

(b) **Maintenance.** Routine periodic servicing, such as testing, cleaning, regulating, and checking the member's equipment is considered maintenance and not a separate covered service. ~~DMEPOS~~DME suppliers must provide equipment-related services consistent with the manufacturer's specifications and in accordance with all federal, state, and local laws and regulations. Equipment-related services may include, but are not limited to, checking oxygen system purity levels and flow rates, changing and cleaning filters, and assuring the integrity of equipment alarms

and back-up systems. However, more extensive maintenance, as recommended by the manufacturer and performed by authorized technicians, is considered repairs. This may include breaking down sealed components and performing tests that require specialized testing equipment not available to the member. The supplier of a capped rental item that supplied the item the ~~13th~~thirteenth (13th) month must provide maintenance and service for the item. In very rare circumstances of malicious damage, culpable neglect, or wrongful disposition, the supplier may document the circumstances and be relieved of the obligation to provide maintenance and service.

(c) **Replacement.**

(1) ~~If a capped rental item of equipment has been in continuous use~~If equipment that has met the capped rental period and has been in continued use by the member for the equipment's useful life or if the item is irreparably damaged, lost, or stolen, a prior authorization must be submitted to obtain new equipment. The reasonable useful lifetime for capped rental equipment cannot be less than five (5) years. Useful life is determined by the delivery of the equipment to the member, not the age of the equipment.

(2) Replacement parts must be billed with the appropriate ~~HCPCS~~Healthcare Common Procedure Coding System (HCPCS) code that represents the item or part being ~~replacedalong~~replaced along with a pricing modifier and replacement modifier. If a part that has not been assigned a HCPCS code is being replaced, the provider should use a miscellaneous HCPCS code to bill each part. Each claim that contains miscellaneous codes for replacement parts must include a narrative description of the item, the brand name, model name/number of the item, and an invoice.

(d) **Delivery.** ~~DMEPOS~~Medical supplies, equipment, and appliance products are set with usual maximum quantities and frequency limits. Suppliers are not expected to provide these amounts routinely, nor are members required to accept ~~DMEPOS~~medical supplies, equipment, and appliance products at frequencies or in quantities that exceed the amount the member would typically use. Suppliers must not dispense a quantity of any ~~DMEPOS~~medical supplies, equipment, and appliance product exceeding a member's expected utilization. The reordering or refilling of ~~DMEPOS~~medical supplies, equipment, and appliance products should always be based on actual member usage. Suppliers should stay attuned to atypical utilization patterns on behalf of their members and verify with the ordering physician that the atypical utilization is warranted. Suppliers must exercise the following guidelines in regard to the delivery of ~~DMEPOS~~medical supplies, equipment, and appliance products:

(1) For ~~DMEPOS~~medical supplies, equipment, and appliance products that are supplied as refills to the original order, suppliers must contact the member prior to dispensing the refill. This shall be done to ensure that the refilled item is necessary and to confirm any changes/modifications to the order. Contact with the member regarding refills should take place no sooner than ~~7~~seven (7) days prior to the delivery/shipping date. For subsequent deliveries of refills, the supplier must deliver the ~~DMEPOS~~medical supplies, equipment, and appliance product no sooner than ~~5~~five (5) days prior to the end of the usage for the current product. This is regardless of which delivery method is utilized. A member must specifically request the refill before a supplier dispenses the product. Suppliers must not automatically dispense a quantity of supplies on a predetermined basis, even if the member has authorized this in advance. The supplier must have member contact documentation on file to substantiate that the ~~DMEPOS~~medical supplies, equipment, and appliance product was refilled in accordance with this section.

(2) For ~~DMEPOS~~medical supplies, equipment, and appliance products that are supplied via mail order, suppliers must bill using the appropriate modifier which indicates that the ~~DMEPOS~~medical supplies, equipment, and appliance product was delivered via the mail. Reimbursement for ~~DMEPOS~~medical supplies, equipment, and appliance products supplied and delivered via mail may be at a reduced rate.

(3) For ~~DMEPOS~~medical supplies, equipment, and appliance products that are covered in the scope of the SoonerCare program, the cost of delivery is always included in the rate for the covered item(s).

317:30-5-211.6. General documentation requirements

(a) Section 1833(e) of the Social Security Act precludes payment to any provider of service unless "there has been furnished such information as may be necessary in order to determine the amounts due such provider" ~~[42 U.S.S. Section 13951(e)]~~[42 United States Code (U.S.C.) Section 1395l(e)]. The member's medical records will reflect the need for the care provided. The member's medical records should include the physician's office records, hospital records, nursing home records, home health agency records, records from other health care professionals and test reports. This documentation must be provided for prior authorization requests and available to the ~~OHCA~~Oklahoma Health Care Authority (OHCA) or its designated agent upon request.

(b) Payment is made for durable medical equipment as set forth in this section when a face-to-face encounter has occurred in accordance with provisions of 42 Code of Federal Regulations

(C.F.R.) § 440.70 and Oklahoma Administrative Code (OAC) 317:30-5-211.1.

317:30-5-211.9. Adaptive equipment [REVOKED]

~~(a) **Residents of ICF/IID facilities.** Payment is made for customized adaptive equipment for persons residing in private Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID). This means customized equipment or devices to assist in ambulation. Standard wheelchairs, walkers, eyeglasses, etc., would not be considered customized adaptive equipment. All customized adaptive equipment must be prescribed by a physician and requires prior authorization.~~

~~(b) **Members in home and community-based waivers.** Refer to OAC 317:40-5-100.~~

317:30-5-211.10. ~~Durable medical equipment (DME)~~Medical supplies, equipment, and appliances

(a) ~~**DME**~~**Medical supplies, equipment, and appliances**. ~~DME includes, but is not limited to: medical supplies, orthotics and prosthetics, custom braces, therapeutic lenses, respiratory equipment, and other qualifying items when acquired from a contracted DME provider.~~See the definition for medical supplies, equipment, and appliances at Oklahoma Administrative Code (OAC) 317:30-5-211.1.

(b) **Certificate of medical necessity (CMN)**. Certain items of ~~DME~~medical supplies, equipment, and appliances require a CMN/OHCA CMN which should be submitted with the request for prior authorization. These items include, but are not limited to:

~~(1) hospital beds;~~
~~(2) support surfaces;~~
~~(3) patient lift devices;~~
~~(4) external infusions pumps;~~
~~(5) enteral and parenteral nutrition;~~
~~(6) Oxygen and oxygen related products; and~~
~~(7) pneumatic compression devices.~~
(1) External infusion pumps;
(2) Hospital beds;
(3) Oxygen and oxygen related products;
(4) Pneumatic compression devices;
(5) Support surfaces;
(6) Enteral and parenteral nutrition; and
(7) Osteogenesis stimulator.

(c) ~~**Prior authorization.**~~**Rental.** Several medical supplies, equipment, and appliance products are classified as either a capped rental or a continuous rental. Payment for a capped rental is capped at thirteen (13) months and a continuous rental is paid monthly for as long as it is medically necessary. Both require documentation showing that the product is medically necessary.

~~(1) **Rental.** Rental of hospital beds, support surfaces, oxygen and oxygen related products, continuous positive airway pressure devices (CPAP and BiPAP), pneumatic compression devices, and lifts require prior authorization and, except for CPAP and BiPAP devices, a completed CMN/OHCA CMN; medical necessity must be documented in the member's medical record, signed by the physician, and attached to the PA.~~

~~(2) **Purchase.** Equipment may be purchased when a member requires the equipment for an extended period of time. During the prior authorization review, the OHCA may change the authorization from a rental to a purchase or a purchase to a rental based on the documentation submitted. The provider must indicate whether the DME item provided is new or used.~~

(d) **Purchase.** Medical supplies, equipment, and appliances may be purchased when a member requires the product for an extended period of time. During the prior authorization review, the Oklahoma Health Care Authority (OHCA) may change the authorization from a rental to a purchase or a purchase to a rental based on the documentation submitted.

~~(d)~~(e) **Backup equipment.** Backup equipment is considered part of the rental cost and is not a covered service without prior authorization.

~~(e)~~(f) **Home modification.** ~~Equipment used for home modification is not a covered service.~~Home modifications that require permanent installation are not covered services as they are not removable and therefore do not meet the definition of medical supplies, equipment, and appliances per 42 Code of Federal Regulations (C.F.R.) § 440.70. Refer to Title 317, Chapters 40 and 50 for home modifications covered under Home and Community Based Services Waivers, including the ADvantage Waiver.

317:30-5-211.12. Oxygen rental

A monthly rental payment is made for rental of liquid oxygen systems, gaseous oxygen systems and oxygen concentrators. The rental payment for a stationary system includes all contents and supplies, such as, regulators, tubing, masks, etc., that are medically necessary. An additional monthly payment may be made for a portable liquid or gaseous oxygen system based on medical necessity.

(1) Stationary oxygen systems and portable oxygen systems are covered items for members residing in their home ~~or in a nursing facility~~and in any setting in which normal life activities take place except for a hospital, long-term care facility, intermediate care facility for individuals with intellectual disabilities, or any other setting in which payment is or could be made under Medicaid for inpatient services that include room and board.

(2) For members who meet medical necessity criteria, SoonerCare covers portable liquid or gaseous oxygen systems. ~~Portable oxygen contents are not covered for adults.~~Payment for both oxygen contents used with stationary oxygen equipment and oxygen contents used with portable oxygen equipment is included in the monthly payments for oxygen and oxygen equipment. The need for a portable oxygen system must be stated on the CMN. A portable system that is used as a backup system only is not a covered item.

(3) When four (4) or more liters of oxygen are medically necessary, an additional payment will be paid up to ~~150%~~one hundred and fifty percent (150%) of the allowable for a stationary system when billed with the appropriate modifier.

317:30-5-211.13. ~~Prosthetics and orthotics~~Orthotics and prosthetics

(a) Coverage of prosthetics for ~~adults~~non-expansion adults is limited to (1) home dialysis equipment and supplies, (2) nerve stimulators, (3) external breast prosthesis and support accessories, and (4) implantable devices inserted during the course of a surgical procedure. Prosthetics prescribed by an appropriate ~~medical~~qualified provider and as specified in this section are covered items for ~~adults~~non-expansion adults. There is no coverage of orthotics for ~~adults~~non-expansion adults.

(1) **Home dialysis.** Equipment and supplies are covered items for members receiving home dialysis treatments only.

(2) **Nerve stimulators.** Payment is made for transcutaneous nerve stimulators, implanted peripheral nerve stimulators, and neuromuscular stimulators.

(3) **Breast prosthesis, bras, and prosthetic garments.**

(A) Payment is limited to:

(i) ~~one~~One (1) prosthetic garment with mastectomy form every ~~12~~twelve (12) months for use in the postoperative period prior to a permanent breast prosthesis or as an alternative to a mastectomy bra and breast prosthesis;

(ii) ~~two~~Two (2) mastectomy bras per year; and

(iii) ~~one~~One (1) silicone or equal breast prosthetic per side every ~~24~~twenty-four (24) months; or

(iv) ~~one~~One (1) foam prosthetic per side every six (6) months.

(B) Payment will not be made for both a silicone and a foam prosthetic in the same ~~12~~twelve (12) month period.

(C) Breast prostheses, bras, and prosthetic garments must be purchased from a Board Certified Mastectomy Fitter.

(D) A breast prosthesis can be replaced if:

(i) ~~lost~~Lost;

(ii) ~~irreparably~~Irreparable damaged (other than ordinary

wear and tear); or

(iii) ~~the~~The member's medical condition necessitates a different type of item and the physician provides a new prescription explaining the need for a different type of prosthesis.

(E) External breast prostheses are not covered after breast reconstruction is performed except in instances where a woman with breast cancer receives reconstructive surgery following a mastectomy, but the breast implant fails or ruptures and circumstances are such that an implant replacement is not recommended by the surgeon and/or desired by the member.

(4) **Prosthetic devices inserted during surgery.** Separate payment is made for prosthetic devices inserted during the course of surgery when the prosthetic devices are not integral to the procedure and are not included in the reimbursement for the procedure itself.

(b) Orthotics and prosthetics are covered for expansion adults services when:

(1) Orthotics are medically necessary when required to correct or prevent skeletal deformities, to support or align movable body parts, or to preserve or improve physical function.

(2) Prosthetics are medically necessary as a replacement for all or part of the function of a permanently inoperative, absent, or malfunctioning body part. The member shall require the prosthesis for mobility, daily care, or rehabilitation purposes.

(3) In addition, orthotics and prosthetics must be:

(A) A reasonable and medically necessary part of the member's treatment plan;

(B) Consistent with the member's diagnosis and medical condition, particularly the functional limitations and symptoms exhibited by the member; and

(C) Of high quality, with replacement parts available and obtainable.

(c) Refer to Oklahoma Administrative Code (OAC) 317:30-5-211.1 for definitions of orthotics and prosthetics.

317:30-5-211.14. Nutritional support

(a) **Enteral nutrition.** Enteral nutrition administered only via gravity, syringe, or pump is covered for children and adults at home. Refer to pharmacy policy related to coverage of food supplements at Oklahoma Administrative Code (OAC) 317:30-5-72.1(2)(C). For enteral nutrition authorization guidelines, see OAC 317:30-5-211.20.

~~(a)~~(b) **Parenteral nutrition.** The member must require intravenous feedings to maintain weight and strength commensurate with the

member's overall health status. Adequate nutrition must not be possible by dietary adjustment and/or oral supplements.

(1) The member must have a permanent impairment. Permanence does not require a determination that there is no possibility that the member's condition may improve sometime in the future. If the judgment of the attending physician, substantiated in the medical record, is that the condition is of long and indefinite duration (ordinarily at least three (3) months), the test of permanence is met. Parenteral nutrition will be denied as a non-covered service in situations involving temporary impairments.

(2) The member must have a condition involving the small intestine, exocrine glands, or other conditions that significantly impair the absorption of nutrients. Coverage is also provided for a disease of the stomach and/or intestine that is a motility disorder and impairs the ability of nutrients to be transported through the GI system, and other conditions as deemed medically necessary. There must be objective medical evidence supporting the clinical diagnosis.

(3) Re-certification of parenteral nutrition will be required as medically necessary and determined by the ~~OHCA~~Oklahoma Health Care Authority (OHCA) medical staff.

(c) **Long-term care facility enteral and parenteral nutrition.** Enteral and parenteral nutrition products supplied to long-term care facility residents are included in the long-term care facility per diem rate.

~~(b)~~(d) ~~**Prior authorization**~~**Claim submission requirements**. A written signed and dated order must be received by the supplier before a claim is submitted to the OHCA. If the supplier bills an item addressed in this policy without first receiving the completed order, the item will be denied as not medically necessary. The ordering physician is expected to see the member within ~~30~~thirty (30) days prior to the initial certification or required re-certification. If the physician does not see the member within this time frame, the physician must document the reason why and describe what other monitoring methods were used to evaluate the member's parenteral nutrition needs.

~~(c) **Enteral formulas.** Enteral formulas are covered for children only. See OAC 317:30-5-210.2.~~

317:30-5-211.15. ~~Supplies~~Medical Supplies

The ~~OHCA~~Oklahoma Health Care Authority (OHCA) provides coverage for medically necessary supplies that are prescribed by the appropriate medical provider and meet the ~~special requirements below:~~member's specific needs. Medical supplies include, but are not limited to, IV therapy supplies, diabetic supplies, catheters, colostomy and urostomy supplies, and incontinence supplies.

~~(1) **Intravenous therapy.** Supplies for intravenous therapy are covered items. Drugs for IV therapy are covered items only as specified by the Vendor Drug program.~~

~~(2) **Diabetic supplies.** Glucose test strips and lancets are covered when medically necessary and prescribed by a physician, physician assistant, or an advanced practice nurse. Testing supplies may be limited based on insulin use or type of diabetes. Prior authorization may be required for supplies beyond the standard allowance.~~

~~(3) **Catheters.** Permanent indwelling catheters, male external catheters, drain bags and irrigation trays are covered items. Single use self catheters when the member has a history of urinary tract infections is a covered item. The prescription from the attending physician must indicate such documentation is available in the member's medical record.~~

~~(4) **Colostomy and urostomy supplies.** Colostomy and urostomy bags and accessories are covered items.~~

317:30-5-211.16. Coverage for ~~nursing~~long-term care facility residents

~~(a)~~ For residents in a ~~nursing~~long-term care facility, ~~most DMEPOS~~ medical supplies, equipment and appliances are ~~considered part of~~included in the facility's per diem rate. Orthotics and prosthetics are paid separately from the per diem rate in accordance with the Oklahoma Medicaid State Plan. Refer to Oklahoma Administrative Code (OAC) 317:30-5-211.13 for orthotics and prosthetics coverage. ~~The following are not included in the per diem rate and may be billed by the appropriate medical supplier:~~

~~(1) Services requiring prior authorization:~~

~~(A) ventilators and supplies;~~

~~(B) total parenteral nutrition (TPN), and supplies;~~

~~(C) custom seating for wheelchairs; and~~

~~(D) external breast prosthesis and support accessories.~~

~~(2) Services not requiring prior authorization:~~

~~(A) permanent indwelling or male external catheters and catheter accessories;~~

~~(B) colostomy and urostomy supplies;~~

~~(C) tracheostomy supplies;~~

~~(D) catheters and catheter accessories;~~

~~(E) oxygen and oxygen concentrators.~~

~~(i) **PRN oxygen.** Members in nursing facilities requiring oxygen PRN will be serviced by oxygen kept on hand as part of the per diem rate.~~

~~(ii) **Billing for Medicare eligible nursing home members.** Oxygen supplied to Medicare eligible nursing home members may be billed directly to OHCA. It is not necessary to obtain a denial from Medicare prior to filing the claim~~

~~with OHCA.~~

~~(b) Items not covered include but are not limited to:~~

~~(1) diapers;~~

~~(2) underpads;~~

~~(3) medicine cups;~~

~~(4) eating utensils; and~~

~~(5) personal comfort items.~~

317:30-5-211.17. Wheelchairs

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

(1) **"Assistive technology professional"** or **"ATP"** means a for-service provider who is involved in analysis of the needs and training of a consumer in the use of a particular assistive technology device or is involved in the sale and service of rehabilitation equipment or commercially available assistive technology products and devices. All ATPs are required to be credentialed by Rehabilitation Engineering and Assistive Technology Society of North America (RESNA).

(2) **"Custom seating system"** means a wheelchair seating system which is individually made for a member using a plaster model of the member, a ~~computer generated~~computer-generated model of the member (e.g., CAD-CAM technology), or the detailed measurements of the member to create either:

(A) ~~a~~A molded, contoured, or carved (foam or other suitable material) custom-fabricated seating system that is incorporated into the wheelchair base; or

(B) ~~a~~A custom seating system made from multiple pre-fabricated components or a combination of custom fabricated materials and pre-fabricated components which have been configured and attached to the wheelchair base or incorporated into a wheelchair seat and/or back in a manner that the wheelchair could not be easily re-adapted for use by another individual.

~~(3) **"RESNA"** means the Rehabilitation Engineering and Assistive Technology Society of North America.~~

~~(4)~~(3) **"Specialty evaluation"** means the determination and documentation of the consumer's pathology, history and prognosis, and the physiological, functional, and environmental factors that impact the selection of an appropriate wheeled mobility system.

(b) **Medical Necessity.** Medical necessity, pursuant to ~~OAC~~Oklahoma Administrative Code (OAC) 317:30-5-211.2, is required for a wheelchair to be covered and reimbursed by SoonerCare. Only one (1) wheelchair is covered as medically necessary during its reasonable useful lifetime, unless the member's documented medical

condition indicates the current wheelchair no longer meets the member's medical need. Backup wheelchairs are not covered items.

(c) **Prior authorization.** Prior authorization, pursuant to OAC 317:30-5-211.3, is required for selected wheelchairs to be covered and reimbursed by SoonerCare. All prior authorization requests for the purchase of a wheelchair must indicate the length of the warranty period and what is covered under the warranty.

(1) Wheelchairs, wheelchair parts and accessories, and wheelchair modifications that are beneficial primarily in allowing the member to perform leisure or recreational activities are not considered medically necessary and will not be authorized.

(2) Wheelchair parts, accessories, and/or modifications that are distinctly and separately requested and priced from the original wheelchair request may require prior authorization.

(3) The ~~OHCA~~Oklahoma Health Care Authority will deny prior authorization requests when the required forms have not been fully completed or the member's medical record does not provide sufficient information to establish medical necessity or to determine that the criteria for coverage has been met.

(d) **Coverage and limitations.**

~~(1) For a member who resides in a personal residence, assisted living facility, Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID), or long term care facility, the following criteria must be met for the authorization to purchase a wheelchair.~~

~~(A) The member must have a prescription signed by a physician, a physician assistant, or an advanced registered nurse practitioner.~~

~~(B) The member must meet the requirements for medical necessity as determined and approved by the OHCA.~~

~~(C) The member must either have:~~

~~(i) a specialty evaluation that was performed by a licensed or certified medical professional, such as a physical therapist, occupational therapist, or a physician who has specific training and experience in rehabilitation wheelchair evaluations, and that documents the medical necessity for the wheelchair and its special features; or~~

~~(ii) a wheelchair provided by a supplier that employs a RESNA certified assistive technology professional who specializes in wheelchairs and who has direct, in-person involvement in the wheelchair selection for the member.~~

~~(2) For members who reside in a long term care facility or ICF/IID, only custom seating systems for wheelchairs are eligible for direct reimbursement to DME providers.~~ For members who reside in a long-term care facility or intermediate care

facility for individuals with intellectual disabilities, ~~All~~all standard manual and power wheelchairs~~ are the responsibility of the facility and~~ are considered part of the facility's per diem rate. Repairs and maintenance~~, except for custom seating systems, are not covered items~~ for wheelchairs ~~and~~ are considered part of the facility's per diem rate.

(e) **Rental, repairs, maintenance, and delivery.** Refer to OAC 317:30-5-211.4 through 317:30-5-211.5.

(f) **Documentation.**

(1) The specialty evaluation or wheelchair selection documentation must be submitted with the prior authorization request.

(2) The specialty evaluation or wheelchair selection must be performed no longer than ~~90~~ninety (90) days prior to the submission of the prior authorization request.

(3) The results of the specialty evaluation or wheelchair selection documentation must be supported by the information submitted on the member's medical record.

(4) A copy of the dated and signed written specialty evaluation or wheelchair selection document must be maintained by the wheelchair provider. The results of the specialty evaluation or wheelchair selection must be written, signed, and dated by the medical professional who evaluated the member or the ATP who was involved in the wheelchair selection for the member.

317:30-5-211.20. Enteral nutrition

(a) **Enteral nutrition.** Enteral nutrition is the delivery of nutrients directly into the stomach, duodenum, or jejunum.

(b) **Medical necessity.** Enteral nutrition supplies must be determined by a provider to be medically necessary and documented in the member's plan of care as medically necessary and used for medical purposes. Requests by qualified providers for enteral nutrition supplies 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) 317:30-5-211.2 and 317:30-3-1(f) for policy on medical necessity.

(c) **Documentation.** 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). Documentation must include:

(1) Diagnosis;

(2) Certificate of medical necessity (CMN);

(3) Ratio data;

(4) Route;

(5) Caloric intake; and

(6) Prescription.
(7) For full guidelines, please refer to www.okhca.org/mau.

(d) **Reimbursement.**
(1) Extension sets and Farrell bags are not covered when requested separately from the supply kits;
(2) Enteral nutrition for individuals in long-term care facilities is not separately reimbursed as this is included in the per diem rate.

(e) **Non-covered items.** The following are non-covered items:
(1) Orally administered enteral products and/or related supplies;
(2) Formulas that do not require a prescription unless administered by tube;
(3) Food thickeners, human breast milk, and infant formula;
(4) Pudding and food bars; and
(5) Nursing services to administer or monitor the feedings of enteral nutrition.

317:30-5-211.21. Incontinence supplies

(a) **Incontinence supplies and services.** Incontinence supplies and services are those supplies that are used to alleviate or prevent skin breakdown or excoriation associated with incontinence.

(b) **Medical necessity.** Incontinence supplies must be determined by a provider to be medically necessary and documented in the member's plan of care as medically necessary and used for medical purposes. A request by a qualified provider for incontinence supplies 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) 317:30-5-211.2 and 317:30-3-1(f) for policy on medical necessity.

(c) **Documentation.** 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). Documentation must include:
(1) A signed prescription by a provider specifying the requested item;
(2) A documented diagnosis of an underlying chronic medical condition that involves loss of bladder or bowel control;
(3) Documentation must include the height and weight of the member, the type of incontinence (bowel/bladder/combined), and expected length of need;
(4) Requests submitted for underwear/pull-on(s) the member must be ambulatory or in toilet training;
(5) The member may qualify for incontinence supplies for a short period of time when the member has documented full-skin

thickness injuries;

(6) When requesting wipes as incontinence supplies, documentation must be submitted specific to the supply being requested. Disposable wipes are only allowed when diapers have been approved;

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

(d) **Quantity limits.** There is a quantity limit to the products allowed as well as product combinations. For a listing of quantity limits on specific products, refer to the OHCA website, under the Durable Medical Equipment page, "Incontinence Supplies". Requests for quantities or combinations outside of the limits published will require additional medical review for approval.

(e) **Non-covered items.** The following are non-covered items:

(1) Incontinence supplies for members under the age of four (4) years;

(2) Reusable underwear and/or reusable pull-ons;

(3) Reusable briefs and/or reusable diapers;

(4) Diaper service for reusable diapers;

(5) Feminine hygiene products;

(6) Disposable penile wraps; and

(7) Shipping costs.

317:30-5-211.22. Pulse oximeter

(a) **Pulse oximeter.** Pulse oximeter is a device used for measuring blood oxygen levels in a non-invasive manner.

(b) **Medical necessity.** Pulse oximeters must be determined by a provider to be medically necessary and documented in the member's plan of care as medically necessary and used for medical purposes. A request by a qualified provider for pulse oximeters 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) 317:30-5-211.2 and OAC 317:30-3-1(f) for policy on medical necessity.

(c) **Documentation.** 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). Documentation must include:

(1) A current oxygen order signed and dated by an OHCA-contracted provider, along with a certificate of medical necessity (CMN);

(2) Pertinent information relating to the member's underlying diagnosis and condition which results in the need for the oximeter and supplies, including documentation of unstable airway events and documentation of current monitor readings if available; and

(3) Documentation of an available trained caregiver in the home who is able to intervene and address changes in the member's oxygen saturation levels in a medically safe and appropriate manner.

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

(d) **Reimbursement.**

(1) Temporary probe covers are not reimbursed separately for rented oximeters as they are included in the price of the rental.

(2) Pulse oximeters are not reimbursed in conjunction with apnea monitors.

317:30-5-211.23. Continuous passive motion device for the knee

(a) **Continuous passive motion (CPM).** CPM is a postoperative treatment method designed to aid recovery of joint range of motion after joint surgery. CPM provides for early post-operative motion and is considered a substitute for active physical therapy (PT).

(b) **Medical necessity.** CPM must be determined by a provider to be medically necessary and documented in the member's plan of care as medically necessary and used for medical purposes. A request by a qualified provider for CPM 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) 317:30-5-211.2 and 317:30-3-1(f) for policy on medical necessity.

(1) A knee CPM device is covered for up to twenty-one (21) days and does not require a prior authorization (PA) for a patient in an early phase of rehabilitation.

(2) A knee CPM device required for more than twenty-one (21) days does require a PA of the additional days. These cases will be individually reviewed for medical necessity.

(c) **Documentation.** 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).

(1) Documentation must include:

(A) Type of surgery performed;

(B) Date of surgery;

(C) Date of application of CPM;

(D) Date of discharge from the hospital; and

(E) Written prescription issued by a licensed prescriber that is signed and dated no more than thirty (30) days prior to the first date of service and that defines the specific "from" and "to" dates that reflect the actual days the CPM device is to be utilized.

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

(d) **Reimbursement.**

(1) Separate reimbursement will not be made for use of device while member is hospitalized or in a long-term care facility.
(2) Billing for dates of service when the patient is no longer actively using the CPM device is not appropriate and is not reimbursable.

317:30-5-211.24. Parenteral nutrition

(a) **Parenteral nutrition (PN).** PN is the provision of nutritional requirements intravenously.

(b) **Medical necessity.** PN must be determined by a provider to be medically necessary and documented in the member's plan of care as medically necessary and used for medical purposes. A request by a qualified provider for PN 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) 317:30-5-211.2 and 317:30-3-1(f) for policy on medical necessity.

(c) **Documentation.** 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).

(1) Hospital records that have objective medical evidence supporting the clinical diagnosis; if applicable;
(2) A certificate of medical necessity;
(3) A prescription; and
(4) Caloric Intake.
(5) For full guidelines, please refer to www.okhca.org/mau.

(d) **Reimbursement.**

(1) Supply kits are all inclusive, unbundled supplies (e.g., gloves, tubing, etc.) are not reimbursable for PN.
(2) Pumps are rented as a capped rental.

317:30-5-211.25. Continuous glucose monitoring

(a) **Continuous glucose monitoring (CGM).** CGM means a minimally invasive system that measures glucose levels in subcutaneous or interstitial fluid. CGM provides blood glucose levels and can help members make more informed management decisions throughout the day.

(b) **Medical necessity.** CGM must be determined by a provider to be medically necessary and documented in the member's plan of care as medically necessary and used for medical purposes. A request by a qualified provider for CGM 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) 317:30-5-211.2 and 317:30-3-1(f) for policy on medical necessity. CGM devices must be approved by the U.S. Food and Drug

Administration (FDA) as non-adjunctive and must be used for therapeutic purposes. Devices may only be used for members within the age range for which the devices have been FDA approved.

(c) **Documentation.** 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). Requests for CGM must include all of the following documentation:

(1) Prescription by a qualified provider;

(2) Member diagnosis that correlates to the use of CGM;

(3) Documentation of the member testing to include the frequency each day;

(4) Documentation member is insulin-treated to include frequency of daily or is using insulin pump therapy;

(5) Documentation member's insulin treatment regimen requires frequent adjustment;

(6) The member and/or family member has participated in age appropriate diabetes education, training, and support prior to beginning CGM; and

(7) In-person or telehealth visit [within the last six (6) months] between the treating provider, member and/or family to evaluate their diabetes control.

(8) For full guidelines please refer to www.okhca.org/mau.

317:30-5-211.26. Bathroom equipment

(a) **Bathroom equipment.** Bathroom equipment is used for bathing and toileting and may be considered primarily medical in nature if used in the presence of an illness and/or injury and if it is necessary for activities of daily living that are considered to be essential to health and personal hygiene.

(b) **Medical necessity.** Bathroom equipment must be determined by a provider to be medically necessary and documented in the member's plan of care as medically necessary and used for medical purposes. A request by a qualified provider for bathroom equipment 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) 317:30-5-211.2 and 317:30-3-1(f) for policy on medical necessity.

(c) **Documentation.** 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).

(1) Current written prescription for specific medical supply, equipment, and appliance item;

(2) Letter of medical necessity;

(3) Product information;

(4) Manufacturer's suggested retail price (MSRP) for each item requested
(5) For full guidelines, please refer to www.okhca.org/mau.

317:30-5-211.27. Positive airway pressure (PAP) devices

(a) **PAP devices.** PAP devices are both a single level continuous positive airway pressure device (CPAP), and/or a bi-level respiratory assist device with or without back-up rate when it is used in the treatment of obstructive sleep apnea.

(b) **Medical Necessity.** PAP devices must be determined by a provider to be medically necessary and documented in the member's plan of care as medically necessary and used for medical purposes. A request by a qualified provider for PAP devices 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) 317:30-5-211.2 and 317:30-3-1(f) for policy on medical necessity.

(c) **Documentation.** 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).

(1) A face-to-face clinical evaluation by the treating qualified medical professional within six (6) months prior to receiving device;
(2) Qualifying polysomnogram that is dated within one (1) year of the prior authorization request submission;
(3) The patient and/or his or her caretaker have received instruction from the supplier of the device in the proper use and care of the equipment; and
(4) Medical records supporting the need for a PAP device.
(5) For full guidelines, please refer to www.okhca.org/mau.

317:30-5-211.28. Sleep studies

(a) **Sleep studies.** Sleep studies are the continuous and simultaneous monitoring and recording of specified physiological and pathophysiological parameters during a period of sleep for six (6) or more hours. The study is used to diagnose a variety of sleep disorders and to evaluate a patient's response to therapies such as continuous positive airway pressure (CPAP). A sleep study requires physician review, interpretation, and report.

(b) **Medical necessity.** Sleep studies must be determined by a provider to be medically necessary and documented in the member's plan of care as medically necessary and used for medical purposes. A request by a qualified provider for sleep studies 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) 317:30-5-211.2 and 317:30-3-1(f) for policy on medical necessity.

(c) **Documentation.** 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). Documentation requirements include:

(1) Legible signature of the qualified provider or non-physician practitioner responsible for and providing the care to the patient;

(2) All pages in the prior authorization request must be clear and legible;

(3) Face-to-face evaluation by the ordering provider, the supervising physician, or the interpreting physician; and

(4) Medical records to support the medical indication for the sleep study including results of sleep scale.

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

(d) **Reimbursement.**

(1) Sleep studies for children must be performed in a sleep diagnostic testing facility to be reimbursable.

(2) Sleep studies for adults age twenty-one (21) and older must be performed in a sleep diagnostic testing facility or as a home sleep study to be reimbursable.

(3) A split study beginning on a given date with the titration beginning after midnight on the subsequent date is one (1) study and may not be billed as two (2) consecutive studies.

317:30-5-216. Prior authorization requests [REVOKED]

~~(a) **Prior authorization requirements.** Requirements vary for different types of services. Providers should refer to the service-specific sections of policy or the OHCA website for services requiring PA.~~

~~(1) **Required forms.** All required forms are available on the OHCA web site at www.okhca.org.~~

~~(2) **Certificate of medical necessity.** The prescribing provider must complete the medical necessity section of the CMN. This section cannot be completed by the supplier. The medical necessity section can be completed by any health care clinician; however, only the member's treating provider may sign the CMN. By signing the CMN, the physician is validating the completeness and accuracy of the medical necessity section. The member's medical records must contain documentation substantiating that the member's condition meets the coverage criteria and the answers given in the medical necessity section of the CMN. These records may be requested by OHCA or its representatives to confirm concurrence between the medical records and the~~

~~information submitted with the prior authorization request.~~

~~(b) **Submitting prior authorization requests.** Contact information for submitting prior authorization requests may be found in the OHCA Provider Billing and Procedures Manual. An electronic version of this manual is located on the OHCA web site.~~

~~(c) **Prior authorization review.** Upon verifying the completeness and accuracy of clerical items, the PA request is reviewed by OHCA staff to evaluate whether or not each service being requested meets SoonerCare's definition of "medical necessity" [see OAC 317:30-3-1 (f)] as well as other criteria.~~

~~(d) **Prior authorization decisions.** After the PA request is processed, a notice will be issued regarding the outcome of the review. If the request is approved the notice will include an authorization number, the appropriate date span and procedure codes approved.~~

~~(e) **Prior authorization does not guarantee reimbursement.** Provider status, member eligibility, and medical status on the date of service, as well as all other SoonerCare requirements, must be met before the claim is reimbursed.~~

~~(f) **Prior authorization of manually-priced items.** Manually-priced items must be prior authorized. If manual pricing is used, the provider is reimbursed at the provider's documented Manufacturer's Suggested Retail Price (MSRP) minus 30% or invoice cost plus 30%, whichever is the lesser of two. OHCA may establish a fair market price through claims review and analysis.~~

317:30-5-218. Reimbursement

(a) **Medical ~~equipment and~~ supplies<u>, equipment and appliances</u>.**

<u>(1)</u> Reimbursement for ~~durable medical equipment and supplies~~<u>medical supplies, equipment, and appliances</u> will be made using an amount derived from the lesser of the ~~OHCA~~<u>Oklahoma Health Care Authority (OHCA)</u> 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. ~~The fee schedule will be reviewed annually and adjustments to the fee schedule may be made at any time based on efficiency, budget considerations, and quality of care as determined by the OHCA.~~

<u>(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.</u>

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

(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 Medicare Part B, average sales price (ASP) + six percent (6%). When ASP is not available, an equivalent price is calculated using 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).

~~(b)~~ (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 ~~pickup~~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. ~~Reimbursement for members who reside in a nursing facility may be at a reduced rate. The fee schedule will be reviewed annually and adjustments to the fee schedule may be made at any time based on efficiency, budget considerations, and quality of care~~

~~as determined by the OHCA.~~
(4) For residents in a long-term care facility, durable medical equipment products, including oxygen, are included in the facility's per diem rate.

PART 35. RURAL HEALTH CLINICS

317:30-5-356. Coverage for adults

Payment is made to rural health clinics (RHC) for adult services as set forth in this Section.

(1) **RHC services.** Payment is made for ~~one~~(1) encounter per member per day. Payment is also limited to four (4) visits per member per month. Refer to ~~OAC~~Oklahoma Administrative Code (OAC) 317:30-1, General Provisions, and OAC 317:30-3-65.2 for exceptions to the four (4) visit limit for children under the Early and Periodic Screening, ~~Diagnosis~~Diagnostic and Treatment Program (EPSDT). Additional preventive service exceptions include: obstetrical care and family planning.

(A) ~~**Obstetrical care.** A Rural Health Clinic~~An RHC should have a written contract with its physician, certified nurse midwife (CNM), advanced practice registered nurse (APRN), or physician assistant (PA) that specifically identifies how obstetrical care will be billed to SoonerCare, in order to avoid duplicative billing situations. The agreement should also specifically identify the physician's compensation for rural health and non-rural health clinic (other ambulatory) services. Obstetrical care is exempted from the four (4) visit limitation.

(i) If the clinic compensates the physician, ~~certified nurse midwife or advanced practice nurse~~CNM, or APRN to provide obstetrical care, then the clinic must bill the SoonerCare program for each prenatal visit using the appropriate CPT evaluation and management codes.

(ii) If the clinic does not compensate its practitioners to provide obstetrical care, then the independent practitioner must bill the OHCA for prenatal care according to the global method described in the SoonerCare provider specific rules for physicians, ~~certified nurse midwives, physician assistants, and advanced practice nurses~~CNMs, PAs, and APRNs (refer to OAC 317:30-5-22).

(iii) Under both billing methods, payment for prenatal care includes all routine or minor medical problems. No additional payment is made to the prenatal provider except in the case of a major illness distinctly unrelated to pregnancy.

(B) **Family planning services.** Family planning services are

available only to members with reproductive capability. Family planning visits~~ do not count as one of the four RHC visits per month.~~are exempted from the four (4) visit limitation.

(2) **Other ambulatory services.** Services defined as "other ambulatory" services are not considered a part of ~~a~~an RHC visit and are therefore billable to the SoonerCare program by the RHC or provider of service on the appropriate claim forms. Other ambulatory services are subject to the same scope of coverage as other SoonerCare services billed to the program, i.e., limited adult services and some services for ~~under 21~~individuals under twenty-one (21) are subject to the same prior authorization process. Refer to OAC 317:30-1, General Provisions, and OAC 317:30-3-57, 317:30-5-59, and 317:30-3-60 for general coverage and exclusions under the SoonerCare program. Some specific limitations are applicable to other ambulatory services as set forth in specific provider rules and excerpted as follows: Coverage under optometrists for adults is limited to treatment of eye disease not related to refractive errors. There is no coverage for eye exams for the purpose of prescribing eyeglasses, contact lenses or other visual aids. (See OAC 317:30-5-431.)

PART 61. HOME HEALTH AGENCIES

317:30-5-545. Eligible providers

All eligible home health service providers must be Medicare certified, ~~accredited by the Joint Commission on Accreditation of Health Care Organizations (JCAHO), ~~or have deemed status with Medicare, and have a current contract with the Oklahoma Health Care Authority (OHCA). Home ~~Health Agencies~~health agencies billing for ~~durable medical equipment (DME)~~medical supplies, equipment, and appliances must have a supplier contract and bill equipment on claim form CMS-1500. Additionally, home health services providers that did not participate in Medicaid prior to January 1, 1998, must meet the "Capitalization Requirements" set forth in ~~42 CFR 489.28~~42 Code of Federal Regulations (C.F.R.) § 489.28. Home health services providers that do not meet these requirements will not be permitted to participate in the Medicaid program.

317:30-5-546. Coverage by category

Payment is made for home health services as set forth in this section when a ~~face to face~~face-to-face encounter has occurred in accordance with provisions of ~~42 CFR 440.70.~~42 Code of Federal Regulations (C.F.R.) § 440.70. Payment is made for home health services provided by a home health agency in the member's residence and in any setting in which normal life activities take place

except for a hospital, long-term care facility, or intermediate care facility for individuals with intellectual disabilities. For individuals eligible for Part B of Medicare, payment is made utilizing the Medicaid allowable for comparable services.

~~(1) **Adults.** Payment is made for home health services provided in the member's residence to all categorically needy individuals. Coverage for adults is as follows.~~

~~(A) **Covered items.**~~

~~(i) Part-time or intermittent nursing services;~~

~~(ii) Home health aide services;~~

~~(iii) Standard medical supplies;~~

~~(iv) Durable medical equipment (DME) and appliances; and~~

~~(v) Items classified as prosthetic devices.~~

~~(B) **Non-covered items.** The following are not covered:~~

~~(i) Sales tax;~~

~~(ii) Enteral therapy and nutritional supplies;~~

~~(iii) Electro-spinal orthosis system (ESO); and~~

~~(iv) Physical therapy, occupational therapy, speech pathology, or audiological services.~~

~~(2) **Children.** Home Health Services are covered for persons under age 21.~~

~~(3) **Individuals eligible for Part B of Medicare.** Payment is made utilizing the Medicaid allowable for comparable services.~~

317:30-5-547. Reimbursement

(a) Nursing services and home health aide services are covered services on a per visit basis. ~~Reimbursement for any combination of nursing or home aid service shall not exceed 36 visits per calendar year per member. Additional visits for children must be prior authorized when medically necessary.~~Thirty-six (36) visits per calendar year of nursing and/or home health aide services for any member do not require prior authorization; however, any visit surpassing the thirty-sixth (36) visit will require prior authorization and medical review.

(b) Reimbursement for durable medical equipment and supplies will be made using the amount derived from the lesser of the ~~OHCA~~Oklahoma Health Care Authority (OHCA) fee schedule or the provider's usual and customary charge. ~~The maximum allowable fee is the maximum amount that OHCA will pay a provider for an allowable procedure code.~~ When a procedure code is not assigned a maximum allowable fee for a unit of service, a fee will be established. Once the service has been provided, the supplier is required to include a copy of the invoice documenting the supplier's cost of the item with the claim.

(c) Reimbursement for oxygen and oxygen supplies is as follows:

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

continuous monthly payment is made as long as it is medically necessary. The rental payment includes all contents and supplies, i.e., regulators, tubing, masks, etc. Portable oxygen systems are also 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 ~~pickup~~pick up the equipment when it is no longer medically necessary.

(3) Payment for oxygen and oxygen equipment and supplies will not exceed the Medicare fee for the same procedure code. ~~Reimbursement for members who reside in a nursing facility may be at a reduced rate.~~ The fee schedule will be reviewed annually and adjustments to the fee schedule may be made at any time based on efficiency, budget considerations, and quality of care as determined by the OHCA.

(4) Physical therapy, occupational therapy, and/or speech pathology and audiology services, are not covered when provided by a home health agency.

317:30-5-548. Procedure codes

~~Procedure codes for home health services are assigned HCPCS codes for supplies and durable medical equipment.~~All home health services are billed using Healthcare Common Procedure Coding System (HCPCS) codes.

317:30-5-549. Prosthetic devices [REVOKED]

~~Payment may be made to home health agencies for prosthetic devices. Refer to the Medical Suppliers Provider Rules for further information.~~

PART 75. FEDERALLY QUALIFIED HEALTH CENTERS

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

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

(1) Services provided by an independently ~~CLIA~~Clinical Laboratory Improvement Amendments (CLIA) certified and enrolled laboratory.

(2) Radiology services including nuclear medicine and diagnostic ultrasound services.

(3) Venipuncture for lab tests is considered part of the encounter and cannot be billed separately. When a member is seen at the clinic for a lab test only, use the appropriate CPT code. A visit for "lab test only" is not considered a Center encounter.

(4) ~~Durable medical equipment or medical supplies~~Medical supplies, equipment and appliances are not generally provided during the course of a Center visit such as diabetic supplies. However, gauze, band-aids, or other disposable products used during an office visit are considered as part of the cost of an encounter and cannot be billed separately under SoonerCare.

(5) Supplies and materials that are administered to the member are considered a part of the physician's or other health care practitioner's service.

(6) Drugs or medication treatments provided during a clinic visit are included in the encounter rate. For example, a member has come into the Center with high blood pressure and is treated at the Center with a hypertensive drug or drug samples provided to the Center free of charge are not reimbursable services and are included in the cost of an encounter. Prescriptions are not included in the encounter rate and must be billed through the pharmacy program by a qualified enrolled pharmacy.

(7) Administrative medical examinations and report services;

(8) Emergency services including delivery for pregnant members that are eligible under the ~~Non-Qualified~~non-qualified (ineligible) provisions of OAC 317:35-5-25;

(9) ~~SoonerPlan family planning services;~~Family planning services;

(10) Optometry and podiatric services other than for dual eligible for Part B of Medicare; and

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

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

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

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

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY

CHAPTER 35. MEDICAL ASSISTANCE FOR ADULTS AND CHILDREN-ELIGIBILITY

SUBCHAPTER 23. LIVING CHOICE PROGRAM

317:35-23-2. Eligibility criteria

(a) Adults with disabilities or long-term illnesses, members with intellectual disabilities and members with physical disabilities are eligible to transition into the community through the Living Choice program if they meet all of the criteria in paragraphs (1) through (7) of this subsection.

(1) He/she must be at least nineteen (19) years of age.

(2) He/she must reside in a nursing facility or a qualified long term care facility, or a public or private Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) for at least ~~ninety (90)~~sixty (60) consecutive days prior to the proposed transition date. If any portion of the ~~ninety (90)~~sixty (60) days includes time in a skilled nursing facility, those days cannot be counted toward the ~~ninety (90)~~sixty (60) day requirement, if the member received Medicare post-hospital extended care rehabilitative services.

(3) He/she must have at least one (1) day of Medicaid paid long-term care services prior to transition.

(4) If transitioning from an out of state institution, he/she must be SoonerCare eligible.

(5) He/she requires at least the same level of care that necessitated admission to the institution.

(6) He/she must reside in a qualified residence after leaving the institution. A qualified residence is defined in (A) through (C) of this paragraph.

(A) a home owned or leased by the individual or the individual's family member;

(B) an apartment with an individual lease, with a locking entrance/exit, and which includes living, sleeping, bathing, and cooking areas over which the individual or the individual's family has domain and control; and

(C) a residence, in a community-based residential setting, in which no more than four (4) unrelated individuals reside.

(7) His/her needs can be met by the Living Choice program while living in the community.

(8) He/she must not be a resident of a nursing facility or ICF/IID in lieu of incarceration.

~~(b) Youth ages sixteen (16) through eighteen (18) are eligible to transition back into the community from a psychiatric residential treatment facility (PRTF) through the Living Choice program if~~

~~they meet the following criteria:~~

~~(1) Have been in a PRTF facility for ninety (90) or more days during an episode of care; and~~

~~(2) Meet Level 3 criteria on the Individual Client Assessment Record; or~~

~~(3) Meet the criteria for Serious Emotional Disturbance as defined in OAC 317:30-5-240.1; or~~

~~(4) Show critical impairment on a caregiver rated Ohio Scales (score of 25 and above on the Problems Subscale or a score of 44 and below on the Functioning Subscales).~~

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)

317:30-5-1101. I/T/U Shared Savings Program

(a) **Description.** In accordance with state and federal law, the I/T/U Shared Savings Program is a program that direct the reinvestment of any savings to the Oklahoma Health Care Authority (OHCA) generated by enhanced federal matching authorized under Section 1905(b) of the Social Security Act at a rate of one hundred percent (100%) for covered services received through participating Indian Health Service, Tribal and Urban Indian (I/T/U) facilities.

(1) **Eligibility.** Authorized services provided by a non-I/T/U Medicaid provider to an American Indian or Alaska Native (AI/AN) Medicaid member as a result of a referral from an I/T/U facility provider may be eligible for the enhanced federal matching rate of one hundred percent (100%).

(2) **Distribution criteria.** OHCA will distribute up to fifty percent (50%) of any savings that result from the I/T/U Shared Savings Program to the referring I/T/U, but only after administrative costs incurred by OHCA in implementing the program have been fully satisfied. Distributions issued will ensure the following:

(A) Distributions to participating I/T/U facilities will be used to increase care coordination and to support health care initiatives for AI/AN populations;

(B) OHCA will deposit any shared savings that remain after administrative costs have been fully paid, and after distributions have been made to participating I/T/U facilities, into the I/T/U Shared Savings Revolving Fund for the purpose of increasing Medicaid provider rates;

(C) Monies in the fund will not be used to replace other general revenues appropriated and funded by the Oklahoma Legislature or other revenues used to support Medicaid; or

(D) OHCA will make distributions on a quarterly basis to participating I/T/U facilities based on claims data. The calculation will include the paid claims from the non-I/T/U provider that a member was referred to by an I/T/U. The referring ITU provider will need to be listed on the claim, and there must be an active Care Coordination Agreement (CCA) on file with OHCA. A CCA must be executed between the I/T/U facility and the non-I/T/U provider. A CCA must include, but not limited to the following:

(i) The I/T/U facility provider providing a request for specific services by electronic or other verifiable means and relevant information about the practitioner's member to the non-I/T/U provider;

(ii) The non-I/T/U provider sending information about the care the non-I/T/U provider provides to the patient including the results of any screening, diagnostic or treatment procedures, to the I/T/U facility provider;

(iii) The I/T/U facility provider continuing to assume responsibility for the member's care by assessing the information and taking appropriate action including, when necessary, furnishing or requesting additional services; and

(iv) The I/T/U facility incorporating the member's information in the medical record through the statewide health information exchange or other agreed-upon means.

(b) **I/T/U Shared Savings Revolving Fund.** A revolving fund for OHCA will be designated as the "I/T/U Shared Savings Revolving Fund". All monies accruing to the credit of the fund will be budgeted and expended by OHCA and will consist of:

(1) All monies received by OHCA as pursuant to Title 63 Section 5061.2 of the Oklahoma Statutes, and as otherwise specified or authorized by other state and federal laws;

(2) All monies accruing to the credit of the fund are appropriated and will be budgeted and expended by OHCA to increase Medicaid provider rates, unless otherwise provided by state and federal law; and

(3) Expenditures from the fund will be made upon warrants issued by the State Treasurer against claims filed as prescribed by law with the Director of the Office of Management and Enterprise Services (OMES) for approval and payment.

(c) **Report Criteria.** An annual report will be prepared by the OHCA's Chief Financial Officer (CFO) and will be submitted to the Governor, the President Pro Tempore of the Senate, and the Speaker of the House of Representatives no later than thirty (30) days following the end of each state fiscal year. The annual report will account for:

(1) The savings realized by the OHCA as a result of the I/T/U Shared Savings Program;

(2) The administrative costs incurred by the OHCA as a result of the I/T/U Shared Savings Program;

(3) The monies distributed to participating I/T/U facilities as a result of I/T/U Shared Savings Program including, but not limited to, a summary of all specific distributions;

(4) The balance of savings realized by the OHCA as a result of the I/T/U Shared Savings Program and accruing to the credit of

the fund after payment of administrative costs and distributions to participating I/T/U facilities; and

(5) The monies expended on increasing Medicaid provider rates including, but not limited to, identification of the types of providers affected and the percentage by which the providers' rates were increased.

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TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 2. GRIEVANCE PROCEDURES AND PROCESS

SUBCHAPTER ONE. ADMINISTRATIVE APPEALS

317:2-1-1. Purpose

The purpose of this Chapter is to describe the different types of ~~grievances~~administrative appeals addressed by the Oklahoma Health Care Authority (OHCA), consistent with the State fair hearing requirements set out in 42 Code of Federal Regulations (C.F.R.) Part 431, Subpart E. The rules explain the ~~step by step~~step-by-step processes that must be followed by a party seeking redress from the OHCA. The majority of hearings on eligibility issues for members are conducted by the Oklahoma Department of Human Services~~,~~ and are not contained in this Chapter. Hearings will not be granted when the sole issue to be determined is a Federal or State law requiring an automatic change adversely affecting some or all members.

317:2-1-14. Contract award protest process

~~Suppliers who respond to a solicitation issued and awarded by the Authority pursuant to 74 Oklahoma Statutes (O.S.) ' 85.5 (N) may protest the award of a contract under such solicitation.~~

~~(1) A supplier shall submit written notice to the OHCA Legal Division of a protest of an award of a contract by OHCA within ten (10) business days of contract award. The protest shall state supplier facts and reasons for protest.~~

~~(2) The OHCA Legal Division shall review the supplier's protest and contract award documents. Written notice of the decision to sustain or deny the supplier's protest will be sent to the supplier within ten (10) business days of receipt of supplier's written notice.~~

~~(3) If the OHCA Legal Division denies the supplier's protest, the supplier may request a hearing to administratively resolve the matter within thirty (30) calendar days of receipt of the written denial by filing a form LD-3 with the Docket Clerk.~~

~~(4) The process afforded the supplier will be the process found at Oklahoma Administrative Code 317:2-1-2(c).~~

~~(5) The Administrative Law Judge's decision will constitute the final administrative decision of the Oklahoma Health Care Authority.~~

(a) **Protest process.** Suppliers who respond to a solicitation issued and awarded by the Authority pursuant to 74 Oklahoma Statutes (O.S.) § 85.5 (N) may protest the award of a contract under such solicitation to the State Purchasing Director. All remedies available to suppliers through the sealed bid process pursuant to

the Oklahoma Central Purchasing Act are also available to online bidders in an online bidding process.

(b) **State Purchasing Director review and determination.** The State Purchasing Director will review the supplier's protest and contract award documents.

(1) The State Purchasing Director may determine to respond to the protest or delegate the responsibility to OHCA by written notice to OHCA.

(2) The State Purchasing Director or OHCA, as applicable, will send to the supplier written notice of the decision to deny or sustain the protest within ten (10) business days of receipt of the protest.

(c) **Supplier appeal of decision to deny protest.** The supplier may appeal a denial of protest by the State Purchasing Director or OHCA to the Office of Management and Enterprise Services (OMES) Director.

(1) The supplier will file such appeal, if at all, within ten (10) business days of the date of the State Purchasing Director's or OHCA's notice of denial pursuant to 75 O.S. § 309 et seq.

(2) The OMES Director may enter an order staying contract performance upon such terms and conditions as the OMES Director determines to be proper. Any request for stay of contract performance must be made in writing and filed during the ten (10) business-day time period in which an appeal may be commenced to the OMES director. The OMES Director shall have continuing jurisdiction to modify any such orders made in connection with a stay during the pendency of the appeal as appropriate under the circumstances presented.

(3) The OMES Director may hear the appeal or assign the supplier's appeal to an administrative law judge (ALJ) retained by OHCA.

(4) Administrative hearings conducted by OMES will be conducted in accordance with the Administrative Procedures Act at 75 O.S. §§ 309 et seq., and the OMES director shall have all powers granted by law, including any powers delegated to an ALJ by this Section.

(5) Whenever the appeal is assigned to an ALJ retained by OHCA, the ALJ will review the appeal for legal authority and jurisdiction. If legal authority and jurisdictional requirements are met, the ALJ shall conduct an administrative hearing according to the hearing practices of OAC 317:2-1-5 and provide proposed findings of fact and conclusions of law to the OMES director.

(6) The OMES director or the ALJ, as applicable, will send written notice to the parties of the final order sustaining or denying the supplier's appeal.

(7) The cost of actions necessary to process a supplier's appeal, together with any other expenses incurred due to the appeal, will be paid by OHCA.
(8) Whenever the appeal is assigned to the ALJ retained by OHCA, the ALJ will:
(A) Establish a scheduling order;
(B) Establish reasonable procedures such as authorizing pleadings to be filed by facsimile or electronic mail;
(C) Rule on all interlocutory motions;
(D) Require briefing of any or all issues;
(E) Conduct hearings in a forum and manner as determined by the ALJ;
(F) Rule on the admissibility of all evidence;
(G) Question witnesses;
(H) Impose appropriate sanctions against any person failing to obey an order of the ALJ or authorized under the rules in this Chapter which will include:
(i) Refusing to allow the person to assert or oppose designated claims or defenses, or prohibiting that person from introducing designated matters in evidence;
(ii) Excluding all testimony of an unresponsive or evasive witness; or
(iii) Expelling the person from further participation in the hearing;
(I) Take official notice of any material fact not appearing as evidence in the record, if the fact is among traditional matters of judicial notice;
(J) Administer oaths or affirmations;
(K) Determine the location of the hearing and manner in which it will be conducted;
(L) Allow either party to request that the hearing be recorded by a court reporter with costs to be borne by the requesting party. The original of such transcription, if ordered, will be given to the ALJ with a copy to be given to the requesting party;
(M) Recess and reconvene the hearing;
(N) Set and/or limit the time frame of the hearing;
(O) Make proposed findings of facts and conclusions of law to the OMES Director; and
(P) Recommend that the OMES Director deny the supplier's appeal or that the contract award be cancelled and rebid.
(d) **Supplier appeal of OMES Director decision to deny appeal.** If the OMES Director denies a supplier's appeal, the supplier may appeal pursuant to provisions of 75 O.S. §§ 309 et seq.

SUBCHAPTER 3. MEMBER GRIEVANCES AND APPEALS, PROVIDER COMPLAINTS, AND STATE FAIR HEARINGS IN MANAGED CARE

317:2-3-1. Definitions

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

"**Adverse benefit determination**" means a determination by a health carrier or its designee utilization review organization that an admission, availability of care, continued stay, or other health care service that is a covered benefit has been reviewed and, based upon the information provided, does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness, and the requested service or payment for the service is therefore denied, reduced or terminated and in accordance with Title 36 of Oklahoma Statute (O.S.) § 6475.3.

"**Appeal**" means a review of an adverse benefit determination performed by a managed care entity or according to managed care law, regulations, and contracts.

"**Exigent circumstances**" means a situation in which a reasonable person applying the appropriate standard would consider a member's health condition to be urgent with identifiable harm that could reasonably be expected to occur if the requested health care service is not provided promptly. The appropriate standard requires the assessment of a member's health condition through application, at minimum, of established, accepted standards of medical practice. Evidence of the member's condition may be demonstrated by indications from the treating provider or from the member's medical record, including but not limited to such information as the member's diagnosis, symptoms, or test results.

"**Grievance**" means a member's expression of dissatisfaction about any managed care program matter other than an adverse benefit determination and may include, but is not limited to, the quality of care or services provided, aspects of interpersonal relationships such as rudeness of a managed care entity employee or contracted provider, or failure to respect the member's rights regardless of whether remedial action is requested. A grievance includes a member's right to dispute an extension of time to make an authorization decision when proposed by the managed care entity.

"**Health plan**" means any person or entity that is licensed as a health maintenance organization (HMO) by the State of Oklahoma to provide or arrange for the delivery of basic health care services to enrollees on a prepaid basis, except for copayments or deductibles for which the enrollee is responsible, or both, that meets the definition of an HMO as delineated in the Oklahoma State Medicaid Plan and that contracts with the State to provide services to enrollees. "Health plan" is synonymous with "health carrier".

"Managed care entity" or **"MCE"** means any entity permitted under 42 C.F.R. Part 438 to contract with a state for services provided under a risk contract or a nonrisk contract within the state's Medicaid managed care program, including but not limited to managed care organization (MCO), primary care case management (PCCM), primary care case management entity (PCCM entity), prepaid ambulatory health plan (PAHP), and prepaid inpatient health plan (PIHP).

"Managed care organization" or **"MCO"** means the same in these rules as defined at 42 Code of Federal Regulations (C.F.R.) § 438.2.

"Managed care program" or **"managed care"** or **"MCP"** means a health care delivery system organized to manage cost, utilization, and quality that is operated by a state as authorized under sections 1915(a), 1915(b), 1932(a), or 1115(a) of the Social Security Act and relevant state law.

"Member" means an individual eligible for Medicaid in the State of Oklahoma, eligible for a managed care program, and enrolled in a managed care entity. "Member" is synonymous with "health plan enrollee".

"Prepaid ambulatory health plan" or **"PAHP"** means the same in these rules as defined at 42 C.F.R. § 438.2.

"Prepaid inpatient health plan" or **"PIHP"** means the same in these rules as defined at 42 C.F.R. § 438.2.

"Primary care case management" or **"PCCM"** means the same in these rules as defined at 42 C.F.R. § 438.2.

"Primary care case management entity" or **"PCCM entity"** means the same in these rules as defined at 42 C.F.R. § 438.2.

"Prior authorization (PA)" means a requirement that a member, through a provider, obtain the managed care entity's approval before a requested medical service is provided or before services by a non-participating provider are received. Prior authorization is not a guarantee of claims payment; however, failure to obtain prior authorization may result in denial of the claim or reduction in payment of the claim. For purposes of these rules, "prior authorization" is included as a determination of health care services within the term "adverse benefit determination".

"Provider" means a health care or dental provider licensed or certified in this state.

317:2-3-2. Timeframes

(a) For the purpose of calculating a timeframe in this Subchapter, the date on the written notice is not included. The last day of the timeframe is included, unless the last day is a legal holiday, as defined by 25 Oklahoma Statutes (O.S.) § 82.1, or any other day OHCA is closed or closes early, in which case, the timeframe runs until the close of the next full business day.

(b) A grievance or appeal a member sends via mail is deemed filed on the date the MCE receives request.
(c) A request for reconsideration or appeal a provider sends via mail is deemed filed on the date the MCE receives the request.
(d) A request for State fair hearing by a member or provider is deemed filed on the date the OHCA receives the request.

317:2-3-3. Grievance and appeals system

In accordance with state and federal law, including but not limited to 63 Oklahoma Statutes (O.S.) § 7310 and 42 Code of Federal Regulations (C.F.R.) §§ 438.210, 431.213-14, 438.402, 438.404, 438.408, and 438.410, each MCE will have an established grievance and appeals system by which to receive, process, and resolve grievances and appeals, including requests for extensions of relevant timeframes, and by which to afford parties proper notice.

317:2-3-4. Member grievances

(a) **Filing.**

(1) **Filing with managed care entity.** Except as described in this section, when the member is enrolled in a managed care program, the member initially files a grievance with the managed care entity in which the member is enrolled.

(2) **Exception: Filing with OHCA.** When the member is enrolled in a managed care program and the grievance deals with direct interaction with OHCA or its employees or officers, the member first files the grievance with OHCA as an administrative appeal pursuant to applicable rules set forth at Oklahoma Administrative Code (OAC) 317:2-1-2 et seq.

(b) **Timing.** A member may file a grievance, orally or in writing, at any time.

(c) **Provider's and authorized representative's right to file a grievance.** A provider or an authorized representative may file a grievance on behalf of a member, provided that the provider or authorized representative has obtained the member's written consent to do so. The authorized representative of a deceased member's estate may also be a party to the litigation of a grievance, as applicable.

(d) **Clinical expertise in a grievance decision.** When a grievance involves clinical issues or is related to a denial of an expedited resolution of an appeal, the decision maker(s) of such a grievance will have clinical expertise as discussed at OAC 317:2-3-6.

(e) **Consideration of information in an appeal decision.** The decision maker(s) for any appeal will take into account all comments, documents, records, and other information submitted without regard to whether such information was submitted or considered in the initial determination.

(f) **OHCA-established timeframes for grievance decisions.** A grievance related in any way to the member's health condition will be resolved, with notice provided, as expeditiously as the member's health condition requires.

(1) Per 42 Code of Federal Regulations (C.F.R.) § 438.408, the standard resolution of a grievance will occur within ninety (90) calendar days after the managed care entity receives the grievance.

(2) OHCA sets the standard resolution of a grievance to occur within sixty (60) calendar days, inclusive of any extensions, after the MCE receives the grievance.

(3) The MCE may extend the timeframe in (f)(2) up to fourteen (14) days if:

(A) The member requests the extension; or

(B) The MCE shows (to the OHCA's satisfaction upon OHCA's request) that there is need for additional information and how the delay is in the member's interest.

(4) If the MCE extends the timeframes not at the request of the member, it must complete all of the following:

(A) Make reasonable efforts to give the member prompt oral notice of the delay; and

(B) Within two (2) calendar days give the member written notice of the reason for the decision to extend the timeframe and inform the enrollee of the right to file a grievance if he or she disagrees with that decision; and

(5) The MCE will adhere to all OHCA rules related to grievances, including but not limited to:

(A) Observing the timeframe for standard resolution of a grievance;

(B) Sending acknowledgement of receiving the grievance in writing to the member or the member's authorized representative within ten (10) calendar days of receipt; and

(C) Sending written notice conforming with this subchapter to the affected parties within three (3) calendar days following resolution of the grievance.

317:2-3-5. Member appeals

(a) **Filing.**

(1) **Filing with managed care entity.** Except as described in this Section, when the member is enrolled in a managed care program, the member initially files an appeal with the managed care entity in which the member is enrolled.

(2) **Exception: Filing with OHCA.** When the member is enrolled in a managed care program, the member initially files administrative appeals with OHCA and follows the appeals rules set forth at Oklahoma Administrative Code (OAC) 317:2-1-2 et

seq. whenever the appeal concerns a decision the Oklahoma Health Care Authority (OHCA) made regarding:

(A) Eligibility for Oklahoma Medicaid;

(B) Eligibility for a managed care program;

(C) Enrollment into Oklahoma Medicaid;

(D) Enrollment, including use of an auto-assignment algorithm, into a managed care entity;

(E) Disenrollment from a managed care entity; or

(F) Any other matter, so long as OHCA made the decision in the matter.

(b) **Timing.** A member may file an appeal, orally or in writing, at any time. An administrative appeal or State fair hearing request made to OHCA shall conform with the requirements of OAC 317:2-1-2 et seq. in terms of the manner and timing of any such filing.

(c) **Levels of appeals.** The managed care entity will use only one level of appeals, in accordance with 42 Code of Federal Regulations (C.F.R.) § 438.402.

(d) **Provider's and authorized representative's right to file an appeal.** A provider or an authorized representative may file an appeal on behalf of a member, provided that the provider or authorized representative has obtained the member's written consent to do so. The authorized representative of a deceased member's estate may also be a party to the litigation of an appeal, as applicable.

(e) **Clinical expertise in an appeal decision.** When an appeal involves clinical issues or is related to a denial based on lack of medical necessity, the decision maker(s) of such an appeal will have clinical expertise as discussed at OAC 317:2-3-6.

(f) **Consideration of information in an appeal decision.** The decision maker(s) for any appeal will take into account all comments, documents, records, and other information submitted without regard to whether such information was submitted or considered in the initial determination.

(g) **OHCA-established timeframes for appeals decisions.** An appeal related in any way to the member's health condition will be resolved, with notice provided, as expeditiously as the member's health condition requires.

(1) Per 42 C.F.R. § 438.408, the standard resolution of an appeal will occur within thirty (30) calendar days after the managed care entity receives the appeal.

(2) OHCA establishes the following timeframes for appeals:

(A) Standard resolution of an appeal will occur within thirty (30) calendar days, excluding any extensions, after the managed care entity receives the appeal;

(B) Expedited resolution of an appeal will occur within seventy-two (72) clock-hours after the MCE receives the appeal;

(C) In exigent circumstances, resolution of a step therapy request appeal will occur within twenty-four (24) clock-hours after the MCE receives the appeal; and

(D) In all other circumstances, resolution of a step therapy request appeal will occur within seventy-two (72) clock-hours after the MCE receives the appeal.

(3) The MCE may extend the timeframes in (g)(2)(A) or (B) up to fourteen (14) days if:

(A) The member requests the extension; or

(B) The MCE shows (to the OHCA's satisfaction upon OHCA's request) that there is need for additional information and how the delay is in the member's interest.

(4) If the MCE extends the timeframes not at the request of the member, it must complete all of the following:

(A) Make reasonable efforts to give the member prompt oral notice of the delay;

(B) Within two (2) calendar days give the member written notice of the reason for the decision to extend the timeframe and inform the enrollee of the right to file a grievance if he or she disagrees with that decision; and

(C) Resolve the appeal as expeditiously as the member's health condition requires and no later than the date the extension expires.

(5) The MCE will adhere to all OHCA policies related to appeals, including but not limited to:

(A) Observing the timeframes for resolving appeals, including standard resolution, expedited resolution, and resolution of step therapy appeals (in both exigent and other circumstances);

(B) Sending acknowledgement of receiving the appeal in writing to the member or the member's authorized representative within five (5) calendar days of receipt;

(C) Sending written notice conforming with this subchapter to the affected parties within three (3) calendar days following resolution of the appeal; and

(D) Sending documentation, in conformance with OAC 317:2-3-12(d) and any established OHCA forms or processes, to OHCA within fifteen (15) calendar days after a request for State fair hearing.

317:2-3-6. External medical review and clinical expertise

(a) **No external medical review.** The Oklahoma Health Care Authority (OHCA) will not offer an external medical review for the purposes of grievances or appeals.

(b) **Clinical expertise standards.** Individuals making the decision for a grievance or appeal regarding an adverse benefit

determination will be unbiased with appropriate clinical expertise in treating the member's condition or disease.

(1) Medical review staff of the MCE will be licensed or credentialed health care clinicians with relevant clinical training and/or experience.

(2) All MCEs will use medical review staff for such appeals and shall not use any automated claim review software or other automated functionality for such appeals.

(3) Bias is deemed to exist if an individual making a decision on a grievance or appeal was involved in, or a subordinate of any individual involved in, any previous level of review or decision regarding the subject matter of the grievance or appeal.

(4) Clinical expertise is deemed necessary for decisions makers whenever:

(A) The denial is based on a lack of medical necessity;

(B) The grievance is regarding a denial of an expedited resolution an appeal; and

(C) The grievance or appeal involves clinical issues.

317:2-3-7. Obligation to pay costs of services

(a) In accordance with 42 Code of Federal Regulations (C.F.R.) § 438.420(d), the MCE may recover from the member the costs of services provided to the member while an appeal or State fair hearing is pending:

(1) To the extent the services were continued solely due to the requirements set forth in 42 C.F.R. §§ 438.420 or 431.230(b); and

(2) The final resolution of the appeal or State fair hearing upholds the MCE's adverse benefit determination.

(b) If OHCA or the MCE reverses a decision to deny, limit, or delay services and these services were not furnished while the appeal or State fair hearing was pending, the MCE will authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires.

(c) If OHCA or the MCE reverses a decision to deny, limit, or delay services and the member received the disputed services while the appeal or State fair hearing was pending, the MCE will pay for these services.

317:2-3-8. Grievances and appeals notice

(a) The MCE will provide timely written notices per OAC 317:2-3-4 and 317:2-3-5.

(b) Each notice will conform to the provisions of 42 Code of Federal Regulations (C.F.R.) § 438.10 related to information provided from an MCE to a member.

(c) At minimum, each notice will:

(1) Be written in a manner and format that may be easily understood and is readily accessible by members;
(2) Use OHCA-developed definitions for terms as those terms are defined in the Model Member Handbook related to the contract;
(3) Use a font size no smaller than twelve-point (12-point);
(4) Be made available in alternative formats and through the provision of auxiliary aids and services in an appropriate manner that takes into consideration the special needs of members with disabilities or limited English proficiency; and
(5) Include a large-print tagline, in minimum eighteen-point (18-point) font, and information on how to request auxiliary aids and services, including the provision of materials in alternative formats.

(d) Per the delegation choice of 42 C.F.R. § 438.228, OHCA does not delegate responsibility to the MCE for timely notices of action under 42 C.F.R. Part 431, Subpart E.

(1) OHCA retains all responsibility for timely notices of action under 42 C.F.R. Part 431, Subpart E, including:

(A) A termination, suspension of, or reduction in covered benefits or services, when termination, suspension, or reduction is determined by OHCA;
(B) A termination, suspension of, or reduction in Medicaid eligibility, when termination, suspension, or reduction is determined by OHCA; and
(C) An increase in beneficiary liability, including determination that a beneficiary will incur a greater amount of medical expenses in order to establish income eligibility or is subject to an increase in premiums or cost sharing charges, when such increase is determined by OHCA.

(2) The foregoing (d)(1) does not apply to:

(A) Any grievance notice required to be sent by the MCE by contract or 42 C.F.R. § 438.408;
(B) Any adverse benefit determination notice based on the termination, suspension, or reduction of authorized covered services, payment denial, or standard, expedited, or untimely service authorization denial or limitation as required to be sent by the MCE by contract or 42 C.F.R. 438.404;
(C) Any appeal resolution notice required to be sent by the MCE by contract or 42 C.F.R. § 438.404 or 438.408; or
(D) Any other notice required to be sent by the MCE by contract or any state or federal law or regulation.

(3) OHCA's decision not to delegate the notices of action required by 42 C.F.R. Part 431 Subpart E applies to any managed care entity under any managed care contract for professional services unless and until this section is revoked.

(4) The random review system required of a state by 42 C.F.R. § 438.228 does not apply to OHCA, because OHCA has not delegated responsibility for the relevant notices of action.

(5) For any notices of action for which OHCA retains responsibility under this section, OHCA will ensure the notice conforms to federal regulations at 42 C.F.R. Part 431, Subpart E, and any applicable requirements under 42 C.F.R. § 438.228. OHCA will send such notices of action by electronic or postal means at least ten (10) days before the date of action, except as permitted when:

(A) OHCA has factual information confirming the death of a beneficiary;

(B) OHCA receives a clear written statement signed by a member that they no longer wish to receive services or that gives information that requires termination or reduction of services and indicates that the member understands that supplying the information will result in termination or reduction of services;

(C) The member has been admitted to an institution where they are ineligible for further services;

(D) The member's whereabouts are unknown and the post office returns, indicating no forwarding address, OHCA mail sent directly to the member; and

(E) The MCE establishes the fact that the member has been accepted for Medicaid services by another local jurisdiction, state, territory, or commonwealth.

(6) For any notices of action for which OHCA retains responsibility under this Section, OHCA will ensure the notice contains:

(A) A statement of the action OHCA intends to take and the effective date of such action;

(B) A clear statement of the specific reasons supporting the intended action, the specific regulations that support or require the action, and an explanation of the member's rights to request a hearing; and

(C) An explanation of the circumstances under which benefits continue if a hearing is requested.

(7) For any notices of action for which OHCA retains responsibility under this section, OHCA will allow the member a reasonable time, not to exceed ninety (90) days from the date the notice is mailed, to request a State fair hearing.

317:2-3-9. Exhaustion of managed care entity appeals

(a) **Deemed exhaustion of MCE appeals.** If the MCE fails to adhere to any timing or notice requirements as detailed in 42 C.F.R. § 438.408, the member is deemed to have exhausted the MCE's appeal

process, and the member or the member's authorized representative may request a State fair hearing.

(b) **Actual exhaustion of MCE appeals.** Except as allowed in (a), a member or the member's authorized representative may request a State fair hearing only after receiving notice from the MCE upholding an adverse benefit determination and only within one hundred twenty (120) days after the date of the notice of appeal resolution.

(c) **Exhaustion of MCE appeals, determination.** OHCA has sole authority to decide whether MCE appeals have been exhausted for any member. Documentation, as submitted to OHCA by the MCE within fifteen (15) calendar days of the request for State fair hearing, will serve as evidence to deemed exhaustion, actual exhaustion, or no exhaustion of the MCE appeals process.

317:2-3-10. Provider complaint system

(a) A participating provider or nonparticipating provider may file a complaint whenever:

(1) The provider is not satisfied with the MCE's policies and procedures; or

(2) The provider is not satisfied with a decision made by the MCE that does not impact the provision of services to members.

(b) The MCE will establish and operate a provider complaint system. Such system will:

(1) Use written policies and procedures for receiving, tracking, dating, storing, responding to, reviewing, reporting, and resolving provider complaints;

(2) Track receipt and resolution of provider complaints, including requests for reconsideration or appeals;

(3) Demonstrate sufficient ability to receive provider complaints by telephone, in writing, or in person;

(4) Designate staff to receive, process, and resolve provider complaints;

(5) Thoroughly investigate each provider complaint;

(6) Ensure an escalation process for provider complaints;

(7) Furnish the provider timely written notification of resolution or results; and

(8) Maintain a tracking system capable of generating reports to OHCA on provider complaint volume and resolution.

(c) The MCE will operate a reconsideration process whereby providers may request the MCE reconsider a decision the MCE has made or intends to make that is adverse to the provider, including, at minimum, reconsiderations of provider audit findings, reconsiderations of provider agreement termination, and reconsiderations of denied claims.

(1) **Request for reconsideration, denied claims.** The MCE will ask that the provider submits a request for reconsideration of

a denied claim within six (6) months after the provider receives notice of the denied claim.

(2) **Request for reconsideration, all other reasons.** The MCE will ask that the provider submits a request for reconsideration within fifteen (15) days after the date the provider receives notice of audit findings, termination of provider agreement, or other actions the MCE permits for reconsideration requests.

(3) **Desk review.** The MCE will conduct the reconsideration through a desk review of the request and all related and available documents.

(4) **Reconsideration resolution.** The MCE will resolve all requests for reconsideration within twenty (20) calendar days of the date the MCE receives the request for reconsideration. The MCE will send a reconsideration resolution notice to the provider within three (3) business days of the MCE finalizing the resolution.

(5) **Notice of Reconsideration Resolution.** The MCE will send a reconsideration resolution notice that contains, at a minimum:

(A) The date of the notice;

(B) The action the MCE has made or intends to make;

(C) The reasons for the action;

(D) The date the action was made or will be made;

(E) The citation to statute, regulation, policy, or procedure, if any, upon which the action was based;

(F) An explanation of the provider's ability to submit an appeal request to the MCE within thirty (30) calendar days of the date recorded on the notice;

(G) The address and contact information for submitting an appeal;

(H) The procedures by which the provider may request an appeal regarding the MCE's action;

(I) The specific change in federal or state law, if any, that requires the action;

(J) The provider's ability to submit a State fair hearing request following completion of the provider appeal process, or, in cases of an action based on a change in law, the circumstances under which a State fair hearing will be granted; and

(K) Any other information required by state or federal statute or regulation, by contract, or by contract-related manual.

(d) The MCE will operate an appeals process whereby a provider may request an appeal of a reconsideration resolution when the underlying matter is based on the MCE's provider audit findings, for-cause or immediate termination of the provider agreement, or a denied claim.

(1) **Request for appeal.** The MCE will require the provider to submit a request for appeal in writing within thirty (30) calendar days after the provider receives notice reconsideration resolution.

(2) **Panel review.** The MCE will conduct the appeal through a panel review including a hearing and review of the request, all related and available documents, and all documents created for or used in connection with the request for reconsideration.

(A) The panel will consist of three (3) or five (5) reviewers, who are employees or officers of the MCE.

(B) Panel members will not have been directly involved with the reconsideration desk review and will not be a subordinate of someone involved directly with the reconsideration desk review.

(C) The panel review hearing will provide the provider or an authorized representative of the provider with a reasonable opportunity to be heard in person or by telecommunications.

(D) The review panel will accept and document any exhibit offered prior to the hearing or during the hearing, so long as the exhibit directly relates to the matter of the appeal.

(E) When the appeal is based on a claim denied on the basis of medical necessity, the following requirements apply:

(i) Medical review staff of the MCE will be licensed or credentialed health care clinicians with relevant clinical training or experience; and

(ii) All MCEs will use medical review staff for such appeals and will not use any automated claim review software or other automated functionality for such appeals.

(3) **Appeal resolution.** The MCE will resolve all appeals within forty-five (45) calendar days of the date the MCE receives the request for appeal. The MCE will send an appeal resolution notice to the provider within three (3) business days of the MCE finalizing the resolution.

(4) **Notice of Appeal Resolution.** The MCE will send an appeal resolution notice that contains, at a minimum:

(A) The date of the notice;

(B) The date of the appeal resolution; and

(C) For decisions not wholly in the provider's favor:

(i) An explanation of the provider's ability to request a State fair hearing within thirty (30) calendar days of the date recorded on the notice;

(ii) How to request a State fair hearing, including the OHCA address and contact information for submitting a request;

(iii) Details on the right to be represented by counsel at the State fair hearing; and

(iv) Any other information required by state or federal statute or regulation, by contract, or by contract-related manual.

(5) **Documentation.** The MCE will furnish to OHCA documentation including all information specified at OAC 317:2-3-13(c)(2) within fifteen (15) calendar days of a provider's request for a State fair hearing.

317:2-3-11. Recordkeeping

In compliance with 42 C.F.R. § 438.3(h) and (u), the MCE will maintain records of each grievance and appeal for ten (10) years after the later of the final date of the contract period or the date of completion of any MCE audit by the State, the Centers for Medicare and Medicaid Services (CMS), the Office of the Inspector General, or the Comptroller General. Such records will be part of OHCA's ongoing monitoring and will be used to update and revise OHCA's managed care quality strategy. The record will conform with the content requirements at 42 C.F.R. § 438.416.

317:2-3-12. State fair hearing for members

(a) **Right to State fair hearing.** With regard to grievances or appeals first filed with the MCE, a member may request a State fair hearing under 42 C.F.R. 431 Subpart E only after receiving notice from the MCE upholding an adverse benefit determination. The member will have one-hundred twenty (120) days from the date of the adverse benefit determination notice to request a State fair hearing. Refer to 42 C.F.R. §§ 438.402(c)(1)(i) and 438.408(f)(1).

(b) **MCE policies and procedures.** The MCE will implement established policies and procedures that allow a member described in (a) to initiate a State fair hearing process after having exhausted the MCE's appeals process or after the member is deemed to have exhausted the process due to the MCE's failure to adhere to notice and timing requirements.

(c) **Member's request for a State fair hearing.** The MCE will allow the member to request a State fair hearing either through an established MCE process or through an established OHCA process. Any MCE process will ensure that notice of the request for State fair hearing is communicated in writing to the OHCA contracting officer within twenty-four (24) clock-hours of receiving the request.

(d) **MCE documentation obligation.** The MCE will provide documentation to the member, the member's authorized representative, OHCA, and the Office of Administrative Hearings.

(1) **Timing.** The MCE will provide the documentation described in this subsection:

(A) Within twenty-four (24) clock-hours after receiving notification of the request for State fair hearing relating to a step therapy request; or

(B) Within fifteen (15) calendar days after notification of the request for State fair hearing in all other circumstances.

(2) **Information.** Documentation will include, at minimum, the following information:

(A) The name and address of the member and, if applicable, the member's authorized representative;

(B) A summary statement concerning why the member has filed a request for State fair hearing;

(C) A brief chronological summary of the MCE's action in relationship to the matter underlying the member's request for State fair hearing;

(D) The member's appeal request, along with any supporting documentation, if received by the MCE;

(E) Any applicable correspondence between the MCE and the member, including system notes entered by one or more MCE employees based on one or more telephone conversations with the member;

(F) All exhibits offered at any hearing held with the MCE;

(G) All documents the MCE used to reach its decision;

(H) A statement of the legal basis for the MCE's decision;

(I) A citation of the applicable policies and/or legal authorities relied upon by the MCE in making its decision;

(J) A copy of the notice which notified the member of the decision in question;

(K) The names and titles of any MCE employees who will serve as witnesses at the State fair hearing; and

(L) Any other information requested by the member, the member's authorized representative, OHCA, or the Office of Administrative Hearings when the information relates to the State fair hearing or any matter giving rise to the State fair hearing.

(e) **MCE staffing.** The MCE will maintain a sufficient level of staffing to competently perform the functions, requirements, roles, and duties involved in State fair hearing support, including but not limited to documentation, summarization of the arguments presented, and ensuring timely notice and delivery of documents to all parties.

(f) **Performance targets.** OHCA may set performance targets related to State fair hearing requests that are resolved upholding the MCE's original determination when and as OHCA deems necessary or appropriate.

(g) **Post-transition obligations.** After termination or expiration of the managed care contract, the MCE will remain responsible for

State fair hearings related to dates of service prior to the contract termination or expiration, including but not limited to the provision of records and representation at State fair hearings.
(h) **Cost of services.** If the State fair hearing officer reverses the MCE's decision to deny authorization of services and the member received the disputed services while the State fair hearing was pending, the MCE will pay for those disputed services.

317:2-3-13. State fair hearing for providers
(a) **Right to State fair hearing.** With regard to provider audit findings, for-cause and immediate termination of the provider's agreement, and claims denial, a provider may request a State fair hearing within thirty (30) calendar days of the MCE's notice of appeal resolution when that resolution does not favor the provider.
(b) **Information for providers.** As a part of the MCE's provider complaint system, the MCE will provide information to providers on how to request a State fair hearing via filing the appropriate form with the OHCA Docket Clerk.
(c) **MCE documentation obligation.** The MCE will provide documentation to the provider, OHCA, and the Office of Administrative Hearings.

(1) **Timing.** The MCE will provide the documentation described in this subsection within fifteen (15) calendar days after notification of the request for State fair hearing.
(2) **Information.** Documentation will include, at minimum, the following information:

(A) The name and address of the provider;
(B) A summary statement concerning why the provider has filed a request for State fair hearing;
(C) A brief chronological summary of the MCE's action in relationship to the matter underlying the provider's request for State fair hearing;
(D) The provider's appeal request, along with any supporting documentation, if received by the MCE;
(E) Any applicable correspondence between the MCE and the provider, including system notes entered by one or more MCE employees based on one or more telephone conversations with the provider;
(F) All exhibits offered at any hearing held with the MCE;
(G) All documents the MCE used to reach its decision;
(H) A statement of the legal basis for the MCE's decision;
(I) A citation of the applicable policies and/or legal authorities relied upon by the MCE in making its decision;
(J) A copy of the notice which notified the provider of the decision in question;
(K) The names and titles of any MCE employees who will serve as witnesses at the State fair hearing; and

(L) Any other information requested by the provider, OHCA, or the Office of Administrative Hearings when the information relates to the State fair hearing or any matter giving rise to the State fair hearing.

317:2-3-14. Administrative Law Judge (ALJ) jurisdiction

The ALJ has jurisdiction of the following matters:

(1) **Member State fair hearing.** The ALJ has jurisdiction to hear any State fair hearing arising from a member's MCE appeal of an adverse benefit determination.

(2) **Provider State fair hearing.** The ALJ has jurisdiction to hear any State fair hearing arising from a provider's appeal of audit findings, for-cause or immediate termination of the provider's contract with the MCE, or claims denial.

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TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 55. MANAGED CARE

SUBCHAPTER 1. GENERAL PROVISIONS

317:55-1-1. Purpose; use of manuals

The purpose of this Chapter is to provide detailed rules which govern the delivery of health care services provided by managed care organizations or dental benefits managers as required by the "Ensuring Access to Medicaid Act", 2021 Okla. Sess. Law Serv. Ch. 542 (S.B. 131), Title 56 of the Oklahoma Statutes, Sections 4002-4004 and 42 Code of Federal Regulations (C.F.R.), Part 438. The Oklahoma Health Care Authority may also develop manuals and medical guidelines that formalize terms, conditions, and applicable policy of awarded contracts.

317:55-1-2. Monitoring system for all managed care programs

In accordance with 42 C.F.R. § 438.66, the Oklahoma Health Care Authority will monitor each managed care organization or dental benefits manager to assess its ability and capacity to comply with program- and contract-specific requirements and to assess its ability to perform satisfactorily in all major operational areas.

317:55-1-3. Definitions

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

"1115 waiver" means the demonstration waiver, as amended and including all active special terms and conditions (STCs) at a specific point in time, that authorizes Oklahoma Health Care Authority (OHCA) to operate a program in which one or more requirements of Title XIX of the Social Security Act (Act) are waived based on the waiver authority of section 1115 of the Act.

"1915(c) waiver" means any waiver, authorized by section 1915(c) of the Act, that allows specific coverage of home- and community-based services to a limited group of Medicaid-eligible individuals as an alternative to institutional care.

"Accountable care organization" or **"ACO"** means a group of clinicians, hospitals, or other health care providers who come together voluntarily to give coordinated high-quality care to a designated group of patients.

"Act" means the Social Security Act.

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

"Adverse determination" means a determination by a health carrier, including an managed care organization (MCO) or dental benefits manager (DBM), or its designee that an admission,

availability of care, continued stay or other health care service that is a covered benefit has been reviewed and, based upon the information provided, does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness, and the requested service or payment for services is therefore denied, reduced or terminated.

"Alternative benefit plan" means the benefit package delivered to expansion adults which is developed by OHCA and approved by the Centers for Medicare and Medicaid Services (CMS) in accordance with the requirements of Subpart C of 42 C.F.R. Part 440.

"American Indian/Alaska Native" or **"AI/AN"** means any individual as defined in 25 U.S.C. §§ 1603(13), 1603(28) or 1679(a) or who has been determined eligible as an Indian under 42 C.F.R. § 136.12.

"Appeal" means a review by an MCO or DBM of an adverse benefit determination.

"Authorized representative" means a competent adult who has the managed care enrollee's signed, written authorization to act on the managed care enrollee's behalf during the grievance, appeal, and State fair hearing process. The written authority to act will specify any limits of the representation.

"Capitation payment" means a payment, based on an actuarially sound capitation rate for the provision of Oklahoma Medicaid State Plan services under a managed care contract, that OHCA makes periodically to the MCO or DBM behalf of each enrollee enrolled in that MCO or DBM, regardless of whether the enrollee actually receives services during the period covered by the payment.

"Capitation rate" means the actuarially sound per-enrollee, per-month amount, including any adjustments, that OHCA agrees to pay an MCO or DBM for the provision of State Plan services.

"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.

"Children's Health Insurance Program" or **"CHIP"** means a federal Medicaid program authorized under Title XXI of the Social Security Act.

"Choice counseling" means the provision of information and services designed to assist eligibles in making enrollment decisions related to the managed care program. Choice counseling includes answering questions and identifying factors to consider when choosing among MCOs or DBMs, as well as when choosing a patient-centered medical home provider or dental home provider. Choice counseling does not include making recommendations for or against enrollment into a specific MCO or DBM.

"Chronic condition" means a condition that is expected to last one (1) year or more and requires ongoing medical attention and/or limits activities of daily living (ADL).

"Civil monetary damage" means a damage imposed by OHCA which the MCO must pay for acting or failing to act in accordance with 42 C.F.R. § 438.700 et seq. Amounts may not exceed those specified in

42 C.F.R. § 438.704.

"Claims denial error rate" means the rate of claims denials that are overturned on appeal.

"Clean claim" means a properly completed billing form with coding based on Current Procedural Terminology (CPT), 4th Edition or a more recent edition, the Tenth Revision of the International Classification of Diseases or a more recent revision, or Healthcare Common Procedure Coding System (HCPCS), where applicable, to provide information specifically required in the OHCA Provider Billing and Procedure Manual.

"C.F.R." means the Code of Federal Regulations.

"Contract" means the risk contract or the written and executed agreement between OHCA and a health plan or managed care organization or dental benefit manager for health plan or managed care services and includes the solicitation, the bid, the contract addenda, appendices, attachments, and amendments, and any documents incorporated into the contract by reference or otherwise, as well as any document or information subject to the rules on legally binding procurement in Chapter 10 of these rules.

"Copayment" means a fixed amount that an enrollee pays for a covered health care service when the enrollee receives the service.

"Cost sharing" means the State's requirement that an enrollee bear some of the cost of their care through mechanisms such as copayments, deductibles, and other similar charges.

"Deemed newborn" means children born to SoonerCare enrolled mothers and determined eligible under 42 C.F.R. § 435.117.

"Dental benefits manager" or **"DBM"** means a health plan under contract with the OHCA to manage and deliver dental benefits and services to enrollees and designated as a pre-paid ambulatory health plan (PAHP) under 42 C.F.R. Part 438.

"Dental home" or **"DH"** means the care coordinated delivery system as defined within the contract between OHCA and a DBM.

"Disenrollment" means OHCA's removal of an enrollee from participation in a specific MCO or DBM or from participation in the managed care program.

"Dual eligible individuals" means individuals eligible for both Medicaid and Medicare.

"Eligible" means an individual who has been deemed eligible for Medicaid in the State of Oklahoma and is eligible for participation in the managed care program but who is not yet enrolled in an MCO or DBM.

"Emergency services" means medical services provided for a medical condition, including injury, manifesting itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in placing the individual's health, or the health of an unborn child, in serious jeopardy, serious impairment to bodily functions or serious dysfunction of any bodily organs or parts.

"Enrollee" means an individual who has been deemed eligible for Medicaid in the State of Oklahoma, who has been deemed eligible for enrollment in a managed care program, and who is currently enrolled in a managed care program.

"Enrollee handbook" means a guidebook prepared as a model by OHCA and modified and distributed by the MCO or DBM to its enrollees. The enrollee handbook is designed to help the enrollee understand the MCO or DBM, the managed care program, and the rights and responsibilities that come with enrollment in the program.

"Enrollment" means the OHCA process by which an eligible becomes an enrollee with an MCO or DBM.

"Enrollment activities" means activities that OHCA performs or conducts related to distributing, collecting, or processing enrollment materials, taking enrollments by technological device or in person, or enrolling or disenrolling eligibles into any MCO or DBM.

"Essential community provider" means a provider defined by 45 C.F.R. § 156.235.

"Essential hospital services" means tertiary care hospital services to which the MCO must provide access, including but not limited to neonatal, perinatal, pediatric, trauma and burn services.

"Expansion adult" means an individual nineteen (19) or older and under age sixty-five (65), with income at or below one hundred thirty-eight percent (138%) of the federal poverty level (FPL) determined eligible in accordance with 42 C.F.R. § 435.119), and who are not categorically related to the aged, blind, and disabled.

"Former foster children" or **"FFC"** means individuals under age twenty-six (26) determined eligible in accordance with 42 C.F.R. § 435.150 who were in foster care under the responsibility of the State or an Indian Tribe within Oklahoma and enrolled in SoonerCare on the date of attaining age eighteen (18) or aging out of foster care.

"Foster children (FC)" means children in foster care under the responsibility of the State, including children and youth who are in State custody due to abuse or neglect.

"Fraud" means intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable federal or State law.

"Grievance" means an enrollee's expression of dissatisfaction about any matter other than an adverse benefit determination. Grievances may include, but are not limited to, the quality of care or services provided, aspects of interpersonal relationships such as rudeness of a provider or employee or failure to respect the enrollee's rights regardless of whether remedial action is requested. A grievance includes an enrollee's right to dispute an extension of time to make an authorization decision when proposed by the MCO or DBM.

"Grievance and appeal system" means the processes the MCO or DBM must implement in accordance with 42 C.F.R. Part 438, Subpart F, to handle enrollee grievances and appeals, as well as the processes to collect and track information about them.

"Health care services" means all Medicaid State Plan services provided, according to contract, by the MCO or DBM in any setting. Health care services may include but are not limited to medical care, behavioral health care, dental care, and pharmacy services.

"Health plan" means the same in these rules as at 36 O.S. § 4405.1.

"Implementation" means the process by which OHCA and the MCO or DBM performs actions and responsibilities to actively implement a managed care program or contract for the first time. Implementation also means, depending on its use, the moment in time that such actions and responsibilities are fully completed.

"Implementation period" means the period of time, as defined in contract, during which implementation occurs.

"Indian health care provider" or **"IHCP"** means a health care program operated by the Indian Health Service (IHS) or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (otherwise known as an I/T/U) as those terms are defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. § 1603).

"Initial enrollment" means an eligible's enrollment in an MCO or DBM during the initial enrollment period.

"Initial enrollment period" means the first period of time, as defined in contract, prior to or immediately following managed care program or contract implementation, when eligibles can first enroll in an MCO or DBM for the managed care program.

"Managed care organization" or **"MCO"** means a health plan designated as a managed care organization pursuant to 42 C.F.R. 438.2 and under contract with OHCA to participate in the managed care program and to deliver health care services to enrollees.

"Managed care program" or **"managed care"** or **"MCP"** means a health care delivery system organized to manage cost, utilization, and quality that is operated by a state as authorized under sections 1915(a), 1915(b), 1932(a), or 1115(a) of the Social Security Act and relevant state law.

"Manual" or **"guide"** means any document, outside of the Medicaid State Plan, any Medicaid waiver, and the rules, that is created by or for OHCA for use in interpreting or implementing contractual terms. "Manual" is synonymous with guide, guidebook, companion guide, manual, reference book, dictionary, handbook, model, instructions, primer, workbook, or any other words denoting a document that is handled as a matter of convenience.

"Material change" means, but not limited to, any change in the overall business operations such as policy, process or protocol which affects, or can reasonably be expected to affect, more than five percent (5%) of enrollees or participating providers of the MCO or DBM.

"Medical necessity" means a standard for evaluating the

appropriateness of services as established under OAC 317:30-3-1.

"National Provider Identifier (NPI)" means a unique identification number for covered health care providers. Covered health care providers and all MCOs, DBMs, and health care clearinghouses must use an NPI in the administrative and financial transactions adopted under the Health Insurance Portability and Accountability Act (HIPAA). The NPI is a ten-position, intelligence-free numeric identifier (ten-digit number). This means that the numbers do not carry other information about healthcare providers, such as the state in which they live or their medical specialty. The NPI must be used in lieu of legacy provider identifiers in the HIPAA standards transactions.

"Non-participating provider" means a physician or other provider who has not contracted with or is not employed by the MCO or DBM to deliver services under the managed care program.

"Non-urgent sick visit" means medical care given for an acute onset of symptoms which is not emergent or urgent in nature but which requires face-to-face medical attention within seventy-two (72) hours of enrollee notification of a non-urgent condition, as clinically indicated. Examples of non-urgent sick visits include cold symptoms, sore throat, and nasal congestion.

"Open enrollment" means an eligible's selection of and enrollment in an MCO or DBM during the open enrollment period.

"Open enrollment period" means the annual period of time, as defined by contract, when managed care enrollees and eligibles can enroll in and select an MCO or DBM for the managed care program.

"Parent and caretaker relative" means an individual determined eligible under 42 C.F.R. § 435.110.

"Participating provider" means a physician or other provider who has a contract with or is employed by an MCO or DBM to provide health care services to enrollees under the capitated managed care delivery model of the managed care program.

"Patient-centered medical home" or **"PCMH"** means, in this chapter, the care coordinated delivery system as defined within the contract between OHCA and an MCO.

"Pregnant women" means women determined eligible for SoonerCare under 42 C.F.R. § 435.116.

"Presumptive eligibility" means limited period of managed care program eligibility for individuals who are categorically related to certain eligibility groups listed in OAC 317:35-6-38(a)(1)(A)(i) through (vi) and are also determined by a qualified hospital, on the basis of preliminary information provided by the applicant on a completed HPE application, to be eligible for managed care program services.

"Primary care dentist" or **"PCD"** means a provider under contract with a DBM to provide primary health care services, as contracted, and case management, including all medically necessary referrals for specialty services and prior authorizations. In these rules, "dental home provider" or "DH provider" bears the same meaning as "primary care dentist" or "PCD".

"Primary care provider" or **"PCP"** means a provider under contract with an MCO to provide primary health care services, as contracted, and case management, including securing all medically necessary referrals for specialty services and prior authorizations. In these rules, "patient-centered medical home provider" or "PCMH provider" bears the same meaning as "primary care provider" or "PCP".

"Prior authorization" or **"PA"** means a requirement that an enrollee, through the enrollee's provider, obtain the MCO's or DBM's approval before a requested medical service is provided or before services by a non-participating provider are received. Prior authorization is not a guarantee of claims payment; however, failure to obtain prior authorization may result in denial of the claim or reduction in payment of the claim.

"Provider" means a health care services provider licensed or certified in this State.

"Provider agreement" means an agreement between the MCO or DBM and a participating provider that describes the conditions under which the participating provider agrees to furnish covered health care services to enrollees.

"Risk contract" means a contract between OHCA and an MCO, prepaid inpatient health plan (PIHP), or prepaid ambulatory health plan (PAHP), as those terms are defined at 42 C.F.R. § 438.2, under which the contractor assumes risk for the cost of the services covered under the contract and incurs loss if the cost of furnishing the services exceeds the payments under the contract.

"SoonerCare" means the Oklahoma Medicaid program.

"Soon-To-Be-Sooner" means Oklahoma's separate CHIP providing coverage to unborn children of families earning up to and including one hundred eighty-five percent (185%) of the FPL.

"Specialty Children's Plan" means the single statewide managed care plan, as contracted with a single MCO, that will coordinate and deliver health care services, as defined by contract, in a highly coordinated manner to the specialty population. The specialty population includes Medicaid eligibles who are FFC, select juvenile justice involved Office of Juvenile Affairs (OJA), in foster care (FC), children with an open prevention services case (PSC) through case workers or receiving adoption assistance (AA).

"State Plan" means an agreement between OHCA and CMS describing how Oklahoma administers its Medicaid and CHIP programs.

"Steady state enrollment" means the period of time, as defined by contract, when an individual, who first became an eligible during steady state operations or who became eligible again during steady state operations after more than two (2) months lapse of eligibility, can first enroll in and select an MCO or DBM for the managed care program.

"Steady state operations" or **"steady state"** means the period of time, as defined by contract, after initial implementation and prior to contract termination, during which all managed care program elements are expected to be operational.

"Third party liability" or **"TPL"** means all or part of the

expenditures for a managed care enrollee's medical assistance furnished under the Oklahoma Medicaid State Plan that may be the liability of a third-party individual, entity or program.

"Value-added benefit" means any benefit or service offered by an MCO or DBM when that benefit or service is not a covered benefit per the State Plan. These benefits are subject to change annually as determined by the MCO or DBM and OHCA.

"Value-based payment arrangement" means a payment arrangement between an MCO or DBM and its participating providers when payment is intentionally aligned with quality measures OHCA applies to the MCO or DBM.

"Value-based purchasing" means the provisions of a contract for managed care services when those provisions intentionally align OHCA payments to the MCO or DBM under contract with quality measures or other performance factors OHCA may apply to the MCO or DBM.

SUBCHAPTER 3. GENERAL PROGRAM INFORMATION

PART 1. ELIGIBILITY

317:55-3-1. Mandatory populations

(a) **Mandatory MCO enrollment.** Per 56 O.S. § 4002.3, eligibles in the following categories will be mandatorily enrolled in the MCP and with an MCO:

(1) Expansion adults;

(2) Parents and caretaker relatives;

(3) Pregnant women;

(4) Deemed newborns;

(5) Children; and

(6) All other populations requiring mandatory coverage pursuant to in 42 C.F.R. Part 435, Subpart B (§§ 435.100 435.172), unless otherwise covered by SoonerCare.

(b) **Mandatory Specialty Children's Plan enrollment.** Per 56 O.S. § 4002.3, eligibles in the following categories, upon entering custody of the State, will be mandatorily enrolled in the MCP and with the MCO under contract to provide the Specialty Children's Plan:

(1) Foster children (FC); and

(2) Certain children in the custody of OJA.

(c) **Mandatory Specialty Children's Plan enrollment, opt out.** Per 56 O.S. § 4002.3, eligibles in the following categories will be mandatorily enrolled in the MCP and with the MCO under contract to provide the Specialty Children's Plan, if they do not select a different MCO during initial enrollment, open enrollment, or steady state enrollment:

(1) Former foster care (FFC); and

(2) Children receiving adoption assistance (AA).

(d) **Mandatory DBM enrollment.** Per 56 O.S. § 4002.3, the following eligibles will be mandatorily enrolled in the MCP and with a DBM:

(1) Expansion adults;
(2) Parents and caretaker relatives;
(3) Pregnant women;
(4) Deemed newborns;
(5) Former foster children;
(6) Certain children in the custody of OJA;
(7) Foster care children;
(8) Children receiving adoption assistance; and
(9) Children.

317:55-3-2. Excluded populations

(a) Per 56 O.S. § 4002.3, individuals in the following categories will be excluded from enrollment in a MCP contracted with one (1) or more MCOs:

(1) Dual eligible individuals;
(2) Individuals enrolled in the Medicare Savings Program, including Qualified Medicare Beneficiaries (QMB), Specified Low Income Medicare Beneficiaries (SLMB), Qualified Disabled Workers (QDW) and Qualified Individuals (QI);
(3) Persons with a nursing facility or intermediate care facility for individuals with intellectual disabilities (ICF/IID) level of care, except that enrollees who are transitioning into long-term care will remain enrolled in any MCO for up to sixty (60) days while the enrollee's level of care determination is pending. Prior to disenrollment from an MCO, such excepted enrollees will receive a facility's pre-admission screening and resident review (PASRR) process. If OHCA approves the PASRR and designates the nursing facility or ICF/IID level of care, reimbursement will be made to the facility and the enrollee will be disenrolled from their MCO;
(4) Individuals during a period of presumptive eligibility;
(5) Individuals infected with tuberculosis eligible for tuberculosis-related services under 42 C.F.R. § 435.215;
(6) Individuals determined eligible for SoonerCare on the basis of needing treatment for breast or cervical cancer under 42 C.F.R. § 435.213;
(7) Individuals enrolled in a 1915(c) waiver;
(8) Undocumented persons eligible for emergency services only in accordance with 42 C.F.R. § 435.139;
(9) Insure Oklahoma employee sponsored insurance (ESI) dependent children in accordance with the Oklahoma Title XXI State Plan;
(10) Coverage of pregnancy-related services under Title XXI for the benefit of unborn children (Soon- to-be-Sooners), as allowed by 42 C.F.R. § 457.10; and
(11) Individuals determined eligible for Medicaid on the basis of age, blindness or disability.

(b) Per 56 O.S. § 4002.3, eligibles in the following categories will be excluded from enrollment in a MCP contracted with one (1) or more DBMs:

(1) Dual eligible individuals;

(2) Individuals enrolled in the Medicare Savings Program, including QMB, SLMB, QDW and QI;
(3) Persons with a nursing facility or ICF-IID level of care, except that enrollees who are transitioning into long-term care will remain enrolled in any DBM for up to sixty (60) days while the enrollee's level of care determination is pending. Prior to disenrollment from a DBM, such excepted enrollees will receive a facility's PASRR process. If OHCA approves the PASRR and designates the nursing facility or ICF/IID level of care, reimbursement will be made to the facility and the enrollee will be disenrolled from the DBM.
(4) Individuals during a period of presumptive eligibility;
(5) Individuals infected with tuberculosis eligible for tuberculosis-related services under 42 C.F.R. § 435.215;
(6) Individuals determined eligible for SoonerCare on the basis of needing treatment for breast or cervical cancer under 42 C.F.R. § 435.213;
(7) Individuals enrolled in a §1915(c) waiver;
(8) Undocumented persons eligible only for emergency services in accordance with 42 C.F.R. § 435.139;
(9) Insure Oklahoma Employee Sponsored Insurance (ESI) dependent children in accordance with the Oklahoma Title XXI State Plan;
(10) Coverage of Pregnancy-related services under Title XXI for the benefit of unborn children (Soon-to-be-Sooners), as allowed by 42 C.F.R. § 457.10; and
(11) Individuals determined eligible for Medicaid on the basis of age, blindness or disability.

317:55-3-3. Voluntary enrollment and disenrollment

(a) Per 56 O.S. § 4002.3, AI/AN populations that are eligible for SoonerCare will have the option to:
(1) Voluntarily enroll in the MCP through an opt-in process;
(2) Enroll in an MCO or DBM at each open enrollment period, regardless of initial selection or past disenrollment from the MCP;
(3) Receive services from an IHCP;
(4) Choose the IHCP as the enrollee's PCMH provider or DH provider, if the provider has the capacity to provide such services;
(5) Obtain services covered under the contract from out-of-network IHCPs when the enrollee is otherwise eligible to receive the IHCP's services;
(6) Self-refer for services provided by IHCPs to AI/AN enrollees;
(7) Obtain services covered under the contract from out-of-network IHCPs when the AI/AN enrollee is otherwise eligible to receive the IHCP's services; and
(8) Disenroll from any MCO or DBM at any time without cause.
(b) Children receiving prevention services from child welfare

services have the option to enroll in the MCO contract to provide health care services under the Specialty Children's Plan.

PART 3. SCOPE AND ADMINISTRATION

317:55-3-10. Grievances and appeals

(a) **Filing.** Grievances and appeals are to be initially filed with each enrollee's MCO or DBM. Grievances may be filed with the enrollee's MCO or DBM at any time, either orally or in writing. A provider or an authorized representative may file an appeal, grievance, or request for a State fair hearing on behalf of an enrollee, provided that the provider or authorized representative has obtained the enrollee's written consent.

(b) **Levels of appeal.** Pursuant to 42 C.F.R. § 438.402, MCOs and DBMs will only have one (1) level of appeal. Enrollees and providers may file an appeal to OHCA seeking the review of a final adverse benefit determination rendered by an MCO or DBM.

(c) **Governing rules.** The provisions at OAC 317:2-1-1 et seq. will govern any enrollee or provider right to file a grievance, complaint, appeal or request for a State fair hearing pursuant to 56 O.S. § 4002-4004, 42 C.F.R. Parts 431 or 438, or the managed care contract.

317:55-3-11. Intermediate sanctions

(a) **Intermediate sanctions obligation.** OHCA will establish intermediate sanctions that it may impose on an MCO if OHCA makes any of the determinations specified in 42 C.F.R. § 438.700(b)—(d).

(b) **Adoption of intermediate sanctions.** OHCA adopts the intermediate sanctions as provided at 42 C.F.R. § 438.702.

(c) **Imposition of sanctions.** If OHCA makes a determination per 42 C.F.R. §§ 438.700 or 438.706 and thereby imposes intermediate sanctions as listed at 42 C.F.R. §§ 438.702 or 438.706, OHCA will consider the totality of and follow all relevant regulations at 42 C.F.R. Part 438, Subpart I.

(d) **Required imposition of temporary management.** In accordance with 42 C.F.R. § 438.706(b), OHCA will impose the intermediate sanction of temporary management, regardless of any other sanction that may be imposed, if OHCA finds that an MCO has repeatedly failed to meet substantive requirements in sections 1903(m) or 1932 of the Act or 42 C.F.R. Part 438. In this situation, OHCA will also grant enrollees the right to terminate enrollment without cause, as described in 42 C.F.R. § 438.702(a)(3), and must notify the affected enrollees of their right to terminate enrollment. Notwithstanding any other Section of these rules, OHCA will not delay imposition of temporary management to provide a hearing before imposing this sanction. OHCA will continue this sanction until the MCO can ensure that the sanctioned behavior will not recur.

(e) **Retained authority.** OHCA retains authority to impose additional sanctions under State statutes or State regulations that address

areas of noncompliance specified in 42 C.F.R. § 438.700, as well as additional areas of noncompliance. Nothing in 42 C.F.R. Part 438, Subpart I, prevents OHCA from exercising that authority.

(f) **Notice.** Before imposing an intermediate sanction, OHCA will give the affected MCO timely written notice that explains the basis and nature of the sanction and any other appeal rights that OHCA elects to provide.

(g) **Right to request fair hearing.** Though not required under federal regulation, OHCA provides each MCO the right, upon notice of a sanction other than optional or required temporary management, to request a fair hearing before an administrative law judge (ALJ) retained by OHCA. The cost of actions necessary to process an MCO's request will be paid by OHCA.

(1) An MCO must file any request for fair hearing within thirty (30) days after receiving the notice.

(2) The ALJ has jurisdiction to hear any request under this section. The ALJ will review the appeal for legal authority and jurisdiction. If legal authority and jurisdictional requirements are met, the ALJ will conduct an administrative hearing according to the hearing practices of OAC 317:2-1-5, provide proposed findings of fact and conclusions of law to the parties, and send written notice to the parties of the final order sustaining or denying imposition of the sanction.

(3) At the ALJ's discretion, the ALJ will:

(A) Establish a scheduling order;

(B) Establish reasonable procedures such as authorizing pleadings to be filed by facsimile or electronic mail;

(C) Rule on all interlocutory motions;

(D) Require briefing of any or all issues;

(E) Conduct hearings in a forum and manner as determined by the ALJ;

(F) Rule on the admissibility of all evidence;

(G) Question witnesses;

(H) Impose appropriate sanctions against any person failing to obey an order of the ALJ or authorized under the rules in this section which will include:

(i) Refusing to allow the person to assert or oppose designated claims or defenses, or prohibiting that person from introducing designated matters in evidence;

(ii) Excluding all testimony of an unresponsive or evasive witness; or

(iii) Expelling the person from further participation in the hearing;

(I) Take official notice of any material fact not appearing as evidence in the record, if the fact is among traditional matters of judicial notice;

(J) Administer oaths or affirmations;

(K) Determine the location of the hearing and manner in which it will be conducted;

(L) Allow either party to request that the hearing be recorded by a court reporter with costs to be borne by the requesting party. The original of such transcription, if ordered, will be given to the ALJ with a copy to be given to the requesting party;
(M) Recess and reconvene the hearing;
(N) Set and/or limit the time frame of the hearing;
(O) Make proposed findings of facts and conclusions of law; and
(P) Sustain or deny OHCA's imposition of the sanction(s).

317:55-3-12. Non-compliance damages and remedies

If OHCA finds an MCO or DBM to be in violation of the provisions of 56 O.S. §§ 4002-4004, rules promulgated thereto, or the terms and conditions of the contract, OHCA may enforce any damages or remedies for non-compliance as required by CMS, as provided for in the contract, or as permitted by State or Federal law.

317:55-3-13. Termination of managed care contract

(a) **Termination of an MCO, permitted by 42 C.F.R. § 438.708.** Members impacted by the contract termination of an MCO will be enrolled with a different MCO or be provided Medicaid benefits through options as prescribed in the Oklahoma Medicaid State Plan. OHCA may terminate a contract with an MCO if OHCA determines that the MCO:

(1) Failed to carry out the substantive terms of the contract; or

(2) Failed to meet applicable requirements of sections 1903(m), 1905(t), or 1932 of the Act.

(b) **Termination permitted by contract, MCO or DBM.** Grounds for termination include:

(1) **Mutual consent.** OHCA and the MCO or DBM may terminate the contract by a mutually written agreement. The MCO or DBM does not have the right to appeal the termination. Enrollees impacted by the contract termination will be enrolled with a different MCO or DBM of their choosing or, if no choice is made, a default MCO or DBM.

(2) **Termination for convenience.** OHCA may terminate a contract for convenience, in whole or part, with a sixty (60) day written notice to the MCO or DBM if the State determines that termination is in the State's best interest. Any partial termination of the contract will not be construed as a waiver of, and will not affect, the rights and obligations of any party regarding portions of the contract that remain in effect. Upon receipt of notice of such termination, the MCO or DBM will immediately comply with the notice terms and take all necessary steps to minimize the incurrence of costs allocable to the work affected by the notice.

(3) **Termination for unavailability of funds.** OHCA may terminate a contract for lack of the availability of funds with written

notice to the managed care. OHCA will give written notice to the MCO or DBM, effective the close of business on the day specified. OHCA is the final authority on the availability of funds, and the MCO or DBM does not have the right to appeal this termination.

(4) **Termination for lack of authority.** In the event that the State is determined, in whole or part, to lack Federal or State approval or authority to contract with an MCO or DBM, OHCA may terminate the contract immediately, effective on the close of business on the day specified. The MCO or DBM does not have the right to appeal this termination.

(5) **Termination for default.** OHCA may terminate the contract, in whole or in part, whenever the MCO has failed to carry out the terms of the contract or meet the applicable readiness requirements of §§ 1932, 1903(m) or 1905(t) of the Act.

(6) **Termination for financial instability.** In the event that OHCA, in its sole discretion, deems an MCO or DBM to be financially unstable to the point of threatening the ability of OHCA to obtain the services provided for under this contract, or to conduct business in the normal course, makes a general assignment for the benefit of creditors or suffers or permits the appointment of a receiver for its business or its assets, then OHCA may, at its option, immediately terminate the contract effective on the close of business on the date specified. In the event OHCA elects to terminate the contract under this provision, the MCO or DBM will be notified in writing specifying the date of termination. In the event of the filing of a petition in bankruptcy court by or against a principal subcontractor, the MCO or DBM will immediately advise OHCA. The MCO or DBM will ensure that all tasks related to the subcontract are performed in accordance with the terms of the contract.

(7) **Termination for debarment.** Section 1932(d)(1) of the Act prohibits affiliations with individuals debarred by federal agencies. The MCO will not knowingly have an individual or affiliate, as defined in Section 1932(d)(1)(C), who has been debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.

(c) **Notice and pre-termination hearing.** Prior to terminating an MCO's contract for default, financial instability, or debarment, OHCA will provide the MCO a pre-termination hearing. OHCA will:

(1) Give the MCO written notice of the intent to terminate, the reason for termination, and the time and place of the hearing. The notice will detail how the MCO has failed to carry out the terms of the contract and/or failed to comply with the requirements of 1932, 1903(m) and 1905(t) of the Act. A time period will be provided, if applicable, in which the MCO is allowed to cure the default prior to the pre-termination

hearing. If the MCO cures the default within the specified timeframe, no further action is required;

(2) After the hearing, the MCO will receive written notice of the decision affirming or reversing the proposed termination of the contract. In the event the decision is affirmed the notice is to include the effective date of the termination; and

(3) Upon affirmation of a decision, OHCA will give enrollees of the MCO written notice, comporting with the content requirements of 42 C.F.R § 438.10, of the termination and information identifying options for receiving Medicaid services following the effective date of termination. This notice will be provided within five (5) business days of the affirming decision.

(d) **Hearing timing.** Though not required under federal regulation, OHCA provides each MCO the right, upon notice of a termination, to request a fair hearing before an administrative law judge (ALJ) retained by OHCA. The cost of actions necessary to process an MCO's request will be paid by OHCA.

(1) An MCO will file any request for fair hearing within thirty (30) days after receiving the notice.

(2) The ALJ has jurisdiction to hear any request under this section. The ALJ will review the appeal for legal authority and jurisdiction. If legal authority and jurisdictional requirements are met, the ALJ will conduct an administrative hearing according to the hearing practices of OAC 317:2-1-5, provide proposed findings of fact and conclusions of law to the parties, and send written notice to the parties of the final order sustaining or denying imposition of the sanction.

(3) At the ALJ's discretion, the ALJ will:

(A) Establish a scheduling order;

(B) Establish reasonable procedures such as authorizing pleadings to be filed by facsimile or electronic mail;

(C) Rule on all interlocutory motions;

(D) Require briefing of any or all issues;

(E) Conduct hearings in a forum and manner as determined by the ALJ;

(F) Rule on the admissibility of all evidence;

(G) Question witnesses;

(H) Impose appropriate sanctions against any person failing to obey an order of the ALJ or authorized under the rules in this section which will include:

(i) Refusing to allow the person to assert or oppose designated claims or defenses, or prohibiting that person from introducing designated matters in evidence;

(ii) Excluding all testimony of an unresponsive or evasive witness; or

(iii) Expelling the person from further participation in the hearing;

(I) Take official notice of any material fact not appearing as evidence in the record, if the fact is among traditional matters of judicial notice;

(J) Administer oaths or affirmations;
(K) Determine the location of the hearing and manner in which it will be conducted;
(L) Allow either party to request that the hearing be recorded by a court reporter with costs to be borne by the requesting party. The original of such transcription, if ordered, will be given to the ALJ with a copy to be given to the requesting party;
(M) Recess and reconvene the hearing;
(N) Set and/or limit the time frame of the hearing;
(O) Make proposed findings of facts and conclusions of law; and
(P) Sustain or deny OHCA's imposition of the termination(s).

317:55-3-14. Record retention

In addition to the requirements found at OAC 317:30-3-15 and 317:30-5-70.2, the MCO or DBM and its affiliates, subcontractors, and employees must retain records in compliance with the provisions and spirit of 42 C.F.R. §§ 438.3(h) and (u), to the extent applicable.

PART 5. REQUIRED FEDERAL AUTHORIZATIONS

317:55-3-20. Authorizations

Prior to the implementation of any MCP authorized under 42 C.F.R. Part 438, OHCA will receive the following authorizations:
(1) Federal authority through a State Plan Amendment or waiver of the Act;
(2) CMS approval of each contract in relation to the MCP;
(3) CMS approval of all contract rates authorized under the MCP; and
(4) CMS approval of direct payment arrangements authorized under the MCP.

317:55-3-21. Timing

OHCA may only execute transition to a managed care delivery system ninety (90) days after CMS has approved all contracts entered into between OHCA and all MCOs or DBMs following OHCA's submission of readiness review results to CMS, pursuant to 42 C.F.R. § 438.66.

SUBCHAPTER 5. REQUIREMENTS FOR MANAGED CARE ORGANIZATIONS AND DENTAL BENEFITS MANAGERS

PART 1. ACCREDITATION AND READINESS

317:55-5-1. MCO or DBM accreditation

All MCOs and DBMs will be accredited in accordance with 45 C.F.R. § 165.275 by an accrediting entity recognized by the United States Department of Health and Human Services.

317:55-5-2. MCO or DBM readiness

(a) According to 42 C.F.R. § 438.66, during implementation and prior to enrollment effective dates, the MCO or DBM will participate in a readiness review process. To be deemed eligible to effect enrollments, the MCO or DBM will complete all readiness review activities to the satisfaction of OHCA and CMS. The readiness reviews will be conducted through one (1) or more desk reviews and one or more on-site reviews. The MCO or DBM must satisfactorily demonstrate readiness for MCP operations, including but not limited to focus areas identified at 42 C.F.R. § 438.66(b). At any stage(s) of the readiness review process, OHCA may but is not required to provide an MCO or DBM with notice(s) of deficiency and reasonable opportunity(ies) to cure the deficiency. As between the parties to the managed care contract, OHCA has sole authority to determine the readiness of any MCO or DBM.

(b) As a part of any readiness review, OHCA will ensure the MCO or DBM meets the requirements at 56 O.S. § 4002.10.

PART 3. PROVIDER REQUIREMENTS

317:55-5-10. Provider contracts and credentialing standards

(a) All MCOs and DBMs will formally credential and recredential network providers at a frequency required by a single, consolidated provider enrollment and credentialing process established by OHCA in accordance with 42 C.F.R. § 438.214 and in coordination with MCOs and DBMs.

(b) All MCOs and DBMs will contract to the extent possible and practicable with all essential community providers who receive directed payments in accordance with 42 C.F.R. Part 438 and any other providers as specified by OHCA through contract.

(c) Every MCO and DBM will contract with every participating provider through a written provider agreement that:

(1) Identifies the contractual obligations between the MCO or DBM and the participating provider; and

(2) Incorporates any provision required by the contract between OHCA and the MCO or DBM for inclusion in the provider agreement.

(d) An MCO or DBM or any subcontractor thereof will not enforce with any provider a policy or contract term that requires the provider to contract for all products currently offered or that may be offered in the future by the MCO, DBM, or subcontractor.

317:55-5-11. Network adequacy standards

In accordance with 42 C.F.R. § 438.604, the MCO or DBM will submit documentation for which OHCA will base its certification to CMS that the MCO or DBM has complied with requirements for availability and accessibility of services, including health professional shortage areas and adequacy of the MCO's or DBM's network, as set forth in 42 C.F.R. §§ 438.206, 438.14 and 438.68.

317:55-5-12. Prior authorization requirements, generally

The OHCA will establish prior authorization requirements that are consistent with 56 O.S. §§ 4002-4004. MCOs and DBMs may establish prior authorization of benefits to the extent these are consistent with OHCA's policies and rules. The MCO or DBM may propose to impose additional prior authorization requirements, subject to OHCA's review and approval, except for those benefits identified in the Oklahoma Medicaid State Plan, rules, or practices as exempt from prior authorization. The MCO or DBM may be less restrictive on the requirements of a prior authorization than OHCA but may not impose greater restrictions.

317:55-5-13. Notification of material change

An MCO or DBM will promptly, within one (1) business day, notify OHCA of all changes materially affecting the delivery of care or the administration of the MCP.

317:55-5-14. Patient data

An MCO or DBM will provide patient data to a provider upon request to the extent allowed under federal or State laws, rules, or regulations, including but not limited to the Health Insurance Portability and Accountability Act of 1996.

PART 5. FINANCE

317:55-5-20. Capitation rates

OHCA will contract with an actuary, as defined at 42 C.F.R. § 438.2, to establish actuarially sound capitation rates, as described at 42 C.F.R. §§ 438.3(c), 438.4, and 438.5, for OHCA to pay to MCOs and DBMs.

317:55-5-21. Medical loss ratio

An MCO or DBM will have a medical loss ratio that, at minimum, meets the standards provided by 42 C.F.R. § 438.8.

317:55-5-22. Value-based purchasing

In any contract for managed care services, OHCA may include provisions in which payments OHCA makes to an MCO or DBM are based in whole or in part on quality measures and/or any other performance metric as defined in the contract.

317:55-5-23. Special contract provisions related to payment

(a) **Federal regulation.** Any special contract provision related to payment, as described at 42 C.F.R. § 438.6, will meet all related standards within the federal regulation.

(b) **Provider payments.**

(1) OHCA will establish minimum rates of reimbursement paid by MCOs and DBPs to providers who choose not to enter into value-based payment arrangements for health care items and services furnished by such providers to enrollees.

(A) For participating providers, the reimbursement rate until July 1, 2026, will be equal to or greater than one hundred percent (100%) of the reimbursement rate for the applicable item or service per the applicable OHCA fee schedule.

(B) For non-participating providers and subject to CMS approval as a directed payment or otherwise, the reimbursement rate, until July 1, 2026, will be equal to or greater than ninety percent (90%) of the reimbursement rate for the applicable item or service provided by a non-participating provider per the applicable OHCA fee schedule as of January 1, 2021.

(2) Notwithstanding any other provision of this section, OHCA will comply with payment methodologies required by federal law or regulation for specific types of providers including, but not limited to, Federally Qualified Health Centers (FQHCs), rural health clinics (RHCs), pharmacies, Indian Health Care Providers (IHCPs), and emergency services.

(c) **Optional value-based payments.** The MCO or DBM will offer optional value-based payment arrangements to all providers. Reimbursement amounts to providers in value-based payment arrangements align with the quality measures OHCA applies to MCOs or DBMs, respectively.

317:55-5-24. Hospital readmission damages

The OHCA will establish a hospital readmission damage program to reduce potentially preventable readmissions. The program will use a nationally recognized tool to establish a base measurement year and a performance year and will provide for risk-adjustment based on the population of the state Medicaid program covered by the MCOs or DBMs. The program will be fully described in the managed care contract so that the program will be founded on contract-current tools, populations, and other factors.

317:55-5-25. Claims processing and methodology; post payment audits

(a) **Claims payment systems.** The MCO or DBM will maintain a claims payment system capable of processing and adjudicating claims for payment in an accurate and timely manner and in full compliance with all State and Federal laws.

(b) **Claim filing.** A claim that is filed by a provider within six (6) months of the date the item or service was furnished will be considered timely, per Oklahoma Administrative Code (OAC) 317:30-3-11.

(c) **Clean claims.** The MCO or DBM will process a clean claim within the time frame outlined in 36 O.S. § 1219.

(1) The MCO or DBM will ensure that at least ninety percent (90%) of clean claims received from all providers are paid within fourteen (14) days of receipt.

(2) A clean claim that is not processed within the time frame will bear simple interest at the monthly rate of one and one-

half percent (1.5%), which is payable to the provider.

(d) **Additional documentation.** After a claim has been paid but not prior to payment, the MCO or DBM may request medical records, if additional documentation is needed to review the claim for medical necessity.

(e) **Claim denials.**

(1) A claim denial will include the following information:

(A) Detailed explanation of the basis for the denial; and

(B) Detailed description of the additional information necessary to substantiate the claim.

(2) The MCO or DBM will establish a process for all claim denials by which the provider may identify and provide additional information to substantiate the claim.

(3) A provider will have six (6) months from the receipt of a claim denial to file an appeal per OAC 317:2-3-10.

(f) **Post payment audits.**

(1) In accordance with OAC 317:30-5-70.2, the MCO or DBM will comply with the post payment audit process established by OHCA.

(2) The MCO or DBM will adhere to limits set forth by OHCA regarding the percentage of claims that can be subjected to post payment audits.

(3) An MCO or DBM who has a claims denial error rate of greater than five percent (5%) will be subject to damages as set forth by OHCA in the managed care contract.

PART 7. THE MANAGED CARE QUALITY ADVISORY COMMITTEE

317:55-5-30. Managed care quality advisory committee

(a) The Chief Executive Officer (CEO) of OHCA will establish and appoint members to the MC Quality Advisory Committee (Committee). Committee members serve without compensation and at the pleasure of the CEO. The Committee will consist of:

(1) Participating providers as a majority of the Committee members;

(2) Representatives of hospitals and health systems;

(3) Members of the health care community; and

(4) Members of the academic community with an expertise in health care or other applicable field.

(b) The primary power and duty of the Committee is set forth at 56 O.S. § 4002.13.

(c) Committee meetings will be subject to the Oklahoma Open Meeting Act.

(d) The Committee will select from among its membership a chair and vice chair.

(e) The Committee may meet as often as may be required in order to perform the duties imposed on it.

(f) A quorum of the Committee will be required to approve any final action of the Committee. A majority of the members of the Committee will constitute a quorum.

317:55-5-31. Quality scorecard

(a) Within one (1) year of beginning steady state operations of any MCP, OHCA will create a quality scorecard, in accordance with 56 O.S. § 4002.11, that compares MCOs to one another and DBMs to one another.

(b) OHCA will provide the most recent quarterly scorecard for initial enrollees during choice counseling.

(c) OHCA will provide the most recent quarterly scorecard to all enrollees at the beginning of each open enrollment period.

(d) OHCA will publish each quarterly scorecard on its website.

PART 9. ACCOUNTABLE CARE ORGANIZATIONS

317:55-5-40. Accountable care organization, no prohibition

OHCA will not contract with or otherwise prohibit an MCO or DBM from contracting with a statewide or regional ACO to implement the capitated managed care delivery model of the State Medicaid program.

317:55-5-41. Accountable care organization, duties

(a) Any MCO or DBM that contracts with an ACO will retain full responsibility as to all terms of the MCO's or DBM's managed care contract with OHCA.

(b) The MCO or DBM will track and report quality metrics of any contracted ACO in accordance with the terms of the MCO's or DBM's managed care contract with OHCA.

(c) The MCO or DBM will timely and accurately collect and analyze data related to patient utilization and costs. All such data and analysis will be shared with OHCA.

(d) The MCO or DBM in coordination with the ACO must use collected data to improve quality and target patients for care management interventions and program.

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

SUBCHAPTER 6. SOONERCARE FOR PREGNANT WOMEN AND FAMILIES WITH CHILDREN

PART 5. DETERMINATION OF ELIGIBILITY FOR SOONERCARE HEALTH BENEFITS FOR PREGNANT WOMEN AND FAMILIES WITH CHILDREN

317:35-6-38. Hospital ~~Presumptive Eligibility~~presumptive eligibility (HPE)

(a) **General.** ~~Hospital Presumptive Eligibility (HPE)~~HPE is a limited period of SoonerCare eligibility for individuals who are categorically related to certain ~~MAGI~~Modified Adjusted Gross Income (MAGI) eligibility groups listed in OAC 317:35-6-38(a)(1)(A)(i) through (vi) and are also determined by a qualified hospital ~~(see OAC 317:35-6-38(a)(2)(A) through (L)) for the conditions of a qualified hospital)~~[see OAC 317:35-6-38(a)(2)(A) through (L) for the conditions of a qualified hospital], on the basis of preliminary information provided by the applicant on a completed HPE application, to be eligible for SoonerCare services. The rules in this ~~section~~Section apply only to those individuals applying for, or qualified hospitals determining eligibility under, the HPE program.

(1) **Individuals eligible to participate in the HPE program.** To be eligible to participate in the HPE program, an individual must be categorically related to a MAGI eligibility group (see OAC 317:35-5-2 for categorical relationship criteria) and also meet the income standard and non-medical eligibility specified in this ~~section~~Section.

(A) **MAGI ~~Eligibility Groups~~eligibility groups.** The following MAGI eligibility groups are eligible to have a presumptive eligibility (PE) determination made by a qualified hospital participating in the HPE program:

(i) ~~children~~Children;
(ii) ~~pregnant~~Pregnant women;
(iii) ~~parents and caretaker relatives~~Parent/caretaker relatives;
(iv) Expansion adults;
~~(iv)~~(v) ~~former~~Former foster care children;
~~(v)~~(vi) Breast and Cervical Cancer~~ Treatment~~ (BCC) treatment program; and
~~(vi)~~(vii) SoonerPlan ~~Family planning~~family planning program.

(B) **Income standard.** The income that is counted in determining PE for an individual is that individual's household income. The income limit for the MAGI eligibility groups covered under the HPE program is the same as defined in OAC 317:35-6-39(b)(8) and is listed on the HPE

application. The calculation of countable household income for an individual covered under the HPE program is the same as OAC 317:35-6-39, except that, in determining the individual's household composition, only the MAGI household composition non-filer rules listed under OAC 317:35-6-43 apply for all individuals applying for the HPE program regardless of whether or not the individual is a tax filer, plans on filing taxes, or is a tax dependent.

(C) **Non-medical eligibility requirements.** Individuals covered under the HPE program must also meet the non-medical eligibility requirements described in OAC 317:35-5-25.

(D) **Pregnant women covered under the HPE program.** Coverage for pregnant women who are covered under the HPE program is limited to ambulatory prenatal care only, and the number of PE periods that may be authorized for pregnant women is one (1) per pregnancy. Pregnant women who may be covered for the benefit of the unborn child(ren) under Title XXI are not eligible for the HPE program.

(E) **Other individuals covered under the HPE program.** Coverage for other individuals listed under OAC 317:35-6-38(a)(1)(A)(i) through (vi) who are covered under the HPE program, except for pregnant women, is the same as covered under the State Plan. The number of PE periods that may be authorized is one (1) period every ~~365~~three hundred sixty-five (365) days beginning on the date the individual is enrolled in HPE.

(2) **Qualified hospital.** The decision that a hospital is qualified to make PE determinations is made by the ~~OHCA~~Oklahoma Health Care Authority. In order to participate in the HPE program and make PE determinations, a qualified hospital must:

(A) Meet all the conditions of an eligible provider under OAC 317:30-5-40;

(B) Elect to participate in the HPE program by:

(i) Completing and submitting a HPE Statement of Intent and Memorandum of Understanding to the OHCA and agreeing to all the terms and conditions of the HPE program;

(ii) Amending its current contract with the OHCA to include participation in the HPE program;

(C) Assign and designate a hospital employee to serve as the HPE program administrator and point of contact;

(D) Assign and designate hospital employees to make PE determinations. The term ~~Authorized Hospital Employee(s) (AHE)~~"authorized hospital employee(s) (AHE)" means all individuals making PE determinations on behalf of a hospital participating in the HPE program. The AHE must meet the following conditions:

(i) Be an employee of the hospital (i.e. the AHE may not be a third party contractor);

(ii) Attend, complete, and pass the HPE program training course provided and assessed by the OHCA;

(iii) The AHE certificate of HPE course completion must be kept in the worker's file at the hospital and must be made available to the OHCA upon request;
(iv) Follow state and federal privacy and security requirements regarding patient confidentiality;
(v) Agree to abide by all the rules and guidelines of the HPE program established by the OHCA under this ~~section~~Section.
(E) Notify the OHCA of any changes in the AHE's employment status or in the designation of that individual as the hospital's AHE;
(F) Abide by the rules and regulations of the Uniform Electronic Transaction Act as outlined in OAC 317:30-3-4.1;
(G) Keep internal records of all individuals for whom a PE determination was made and make those records available to the OHCA upon request;
(H) Agree to submit all completed HPE applications and PE determinations to the OHCA within ~~5~~five (5) days of the PE determination;
(I) Notify the applicant in writing, or in cases where the HPE application was made on behalf of a child, notify the child's parent or caretaker of the PE determination outcome and provide and explain to eligible members the "HPE Program Policy and Enrollment" form;
(J) Assist HPE applicants with the completion of a full SoonerCare application within ~~15~~fifteen (15) days of the HPE application submission to the OHCA;
(K) Agree to adhere to the processes and procedures established by the OHCA regarding the operation and oversight of the HPE program; and
(L) Cooperate with the OHCA regarding audit and quality control reviews on PE determinations the hospital makes. The agency may terminate the HPE agreement with the hospital if the hospital does not meet the standards and quality requirements set by the OHCA.

(3) **Limited hospital PE determinations.** The agency limits the PE determinations that a hospital may make to only those eligibility groups described in OAC 317:35-6-38(a)(1)(A) using the MAGI methodology rules established for the HPE program. Additionally, PE determinations made for individuals categorically related to the Breast and Cervical Cancer ~~Treatment~~(BCC) treatment program are limited to qualified hospitals that are also qualified entities through the ~~NBCCEDP~~National Breast and Cervical Cancer Early Detection Program (NBCCEDP).

(b) **General provisions of the HPE program.** The agency provides SoonerCare coverage to eligible individuals covered during a period of PE.

(1) **PE period.** The PE period begins on the date a qualified hospital determines an individual to be eligible under the HPE

program. A qualified hospital has ~~5~~five (5) days to notify the agency of its PE determination. The PE period ends with the earlier of:

(A) The day the agency receives the SoonerCare application form as described in OAC 317:35-5-60 and an eligibility determination is made by the agency; or

(B) If a SoonerCare application is not received, the last day of the month following the month in which the PE determination was made.

(2) **Agency approval of PE.** When the OHCA receives a timely and completed HPE application, a case number and, if needed, SoonerCare member ID is assigned to the member by the agency. Qualified hospitals will be able to review member enrollment and eligibility, once those members have been entered into the system by the OHCA, for claims billing and member eligibility verification.

(3) **Incomplete HPE applications.** Upon receiving a HPE ~~Application~~application, the OHCA reviews it for completeness and correctness. The HPE application is considered incomplete if it is not filled out in its entirety (e.g., the applicant's first or last name is not provided on the application) or if the application is not filed timely with the OHCA. When the HPE application is determined to be incomplete, the HPE application is returned to the AHE or the HPE program administrator at the qualified hospital to correct the application errors or amend the HPE application. To maintain the original PE certification period, the qualified hospital must return the completed or corrected HPE application to the agency within five (5) working days.

(4) **Applicant appeal.** The HPE applicant cannot appeal the PE determination made by a qualified hospital or the expiration date of the PE period.

(5) **Applicant ineligibility.** Applicants ineligible for the HPE program are individuals who do not meet the HPE criteria, individuals who have previously been enrolled in the HPE program within the last ~~365~~three hundred sixty-five (365) days, and individuals currently enrolled in SoonerCare. Individuals currently enrolled in SoonerPlan ~~Family Planning~~family planning are not eligible for HPE family planning services, but may be eligible for other programs under HPE. When the OHCA receives a HPE application from a qualified hospital for an ineligible applicant ~~(e.g., the applicant has been previously enrolled in the HPE program within the last 365 days)~~[e.g., the applicant has been previously enrolled in the HPE program within the last three hundred sixty-five (365) days], the OHCA will disenroll the individual from the HPE program immediately and notify the hospital of the error. The hospital will be responsible for following up with that individual to notify them of their disenrollment from the HPE program. If the applicant is not currently enrolled into SoonerCare, the applicant may submit a

full SoonerCare application and receive a full eligibility determination by the OHCA. HPE services provided to ineligible applicants, other than persons currently enrolled into SoonerCare or SoonerPlan ~~Family Planning~~family planning program, may not be eligible for reimbursement by the OHCA.

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 79. DENTISTS

317:30-5-696. Coverage by category

Payment is made for dental services as set forth in this Section.

(1) **Adults.** The OHCA Dental Program provides basic medically necessary treatment. The services listed below are compensable for members twenty-one (21) years of age and over without prior authorization.

(A) ~~Dental coverage for adults is limited to:~~**Comprehensive oral evaluation.** The comprehensive oral evaluation may be performed when a member has not been seen by the same dentist for more than thirty-six (36) months. The comprehensive oral evaluation must precede any images, and chart documentation must include image interpretations, six-point periodontal charting, and both medical and dental health history of member. The comprehensive treatment plan should be the final result of this procedure.

(B) **Periodic oral evaluation.** This procedure may be provided for a member once every six (6) months. An examination must precede any images, and chart documentation must include image interpretations, and both medical and dental health history of member. The comprehensive treatment plan should be the final result of this procedure.

(C) **Limited oral evaluation.** This procedure is only compensable to the same dentist or practice for two (2) visits prior to a comprehensive or periodic evaluation examination being completed.

(D) **Images.** To be SoonerCare compensable, images must be of diagnostic quality and medically necessary. A clinical examination must precede any images. Documentation must indicate medical necessity and diagnostic findings. Images must be properly labeled with date and member name. Periapical images must include at least three (3) millimeters beyond the apex of the tooth being imaged. Panoramic films are only compensable when chart documentation clearly indicates reasons for the exposure based on clinical findings. This type of panoramic film exposure is not to rule out or evaluate caries. Prior authorization and a detailed medical need narrative are required for additional panoramic films taken within three (3) years of the original set.

(E) **Dental prophylaxis.** Dental prophylaxis is provided once

every one hundred eighty-four (184) days along with topical application of fluoride.

(F) **Smoking and tobacco use cessation counseling.** Smoking and tobacco use cessation counseling is covered per Oklahoma Administrative Code (OAC) 317:30-5-2 (DD) (i) through (iv).

(G) **Medically necessary extractions.** Medically necessary extractions, as defined in OAC 317:30-5-695. Tooth extraction must have medical need documented.

(H) **Medical and surgical services.** Medical and surgical services performed by a dentist or physician to the extent such services may be performed under State law when those services would be covered if performed by a physician.

(I) **Additional services.** Additional covered services, which require a prior authorization, are outlined in OAC 317:30-5-698.

~~(i) Medically necessary extractions, as defined in Oklahoma Administrative Code (OAC) 317:30-5-695. Tooth extraction must have medical need documented;~~

~~(ii) Limited oral examinations and medically necessary images, as defined in OAC 317:30-5-695, associated with the extraction or with a clinical presentation with reasonable expectation that an extraction will be needed;~~

~~(iii) Smoking and tobacco use cessation counseling; and~~

~~(iv) Medical and surgical services performed by a dentist or physician to the extent such services may be performed under State law when those services would be covered if performed by a physician.~~

~~(B) Payment is made for dental care for adults residing in private intermediate care facilities for individuals with intellectual disabilities (ICF/IID) and who have been approved for ICF/IID level of care, similar to the scope of services available to individuals under age twenty-one (21).~~

~~(C) Limited dental services are available for members who meet all medical criteria, but need dental clearance to obtain organ transplant approval. Providers must obtain prior authorization before delivery of dental service, with the exception of evaluation and extractions. All requests must be filed on the currently approved American Dental Association (ADA) form and must include diagnostic images, six-point periodontal charting, narratives and comprehensive treatment plans. The Oklahoma Health Care Authority (OHCA) will notify the provider of determination using OHCA Prior Authorization Request Decision form. Prior authorized services must be billed exactly as they appear on the prior authorization request. The following dental services are available:~~

~~(i) Comprehensive oral evaluation;~~

~~(ii) Two (2) bitewing images;~~

~~(iii) Prophylaxis;~~
~~(iv) Fluoride application;~~
~~(v) Limited restorative procedures; and~~
~~(vi) Periodontal scaling/root planing.~~

~~(2) **Home and community-based services (HCBS) waiver for the intellectually disabled.** All providers participating in the HCBS must have a separate contract with the OHCA to provide services under the HCBS. Dental services are defined in each waiver and must be prior authorized.~~

~~(3)~~(2) **Children.** The OHCA Dental Program for children provides ~~the basic~~ medically necessary treatment. For services rendered to a minor, the minor's parent or legal guardian must provide a signed, written consent prior to the service being rendered, unless there is an explicit state or federal exception to this requirement. The services listed below are compensable for members under twenty-one (21) years of age without prior authorization. All other dental services must be prior authorized. Anesthesia services are covered for children in the same manner as adults per OAC 317:30-5-696.1. All providers performing preventive services must be available to perform needed restorative services for those members receiving any evaluation and preventive services.

(A) **Comprehensive oral evaluation.** ~~This procedure should precede any images, and chart documentation must include image interpretations, caries risk assessment, six-point periodontal charting (as applicable), and both medical and dental health history of member. The comprehensive treatment plan should be the final result of this procedure.~~A comprehensive oral evaluation may be performed when a member has not been seen by the same dentist for more than thirty-six (36) months. The comprehensive oral evaluation must precede any images, and chart documentation must include image interpretations, caries risk assessment, six-point periodontal charting, and both medical and dental health history of member. The comprehensive treatment plan should be the final result of this procedure.

(B) **Periodic oral evaluation.** This procedure may be provided for a member ~~of record~~ once every six (6) months. An examination ~~should~~must precede any images, and chart documentation must include image interpretations~~, caries risk assessment~~, and both medical and dental health history of member. The comprehensive treatment plan should be the final result of this procedure.

(C) **Limited oral evaluation.** This procedure is only compensable to the same dentist or practice for two (2) visits prior to a comprehensive or periodic evaluation examination being completed.

(D) **Images.** To be SoonerCare compensable, images must be of

diagnostic quality and medically necessary. ~~A clinical examination must precede any images, and chart documentation must include member history, prior images, caries risk assessment, the six-point periodontal charting (as applicable), and both dental and general health needs of the member. The referring dentist is responsible for providing properly identified images of acceptable quality with a referral, if that provider chooses to expose and submit for reimbursement prior to referral.~~A clinical examination must precede any images, and chart documentation must indicate medical necessity and diagnostic findings. Images must be properly labeled with date and member name. Periapical images must include at least three (3) millimeters beyond the apex of the tooth being imaged. Panoramic films and two (2) bitewings are considered full mouth images. Full mouth images as noted above or traditional [minimum of twelve (12) periapical films and two (2) posterior bitewings] are allowable once in a three (3) year period and must be of diagnostic quality. Prior authorization is required for full mouth images. Individually listed intraoral images by the same dentist/dental office are considered a complete series if the number of individual images equals or exceeds the traditional number for a complete series. Panoramic films are only compensable when chart documentation clearly indicates reasons for the exposure based on clinical findings. This type of exposure is not to rule out or evaluate caries. Prior authorization and a detailed medical need narrative are required for additional panoramic films taken within three (3) years of the original set.

(E) **Dental sealants.** Tooth numbers 2, 3, 14, 15, 18, 19, 30 and 31 must be caries free on the interproximal and occlusal surfaces to be eligible for this service. This service is available through eighteen (18) years of age and is compensable once every thirty-six (36) months if medical necessity is documented.

(F) **Interim caries arresting medicament application.** This service is available for primary and permanent teeth once every one hundred eighty-four (184) days for two (2) occurrences per tooth in a lifetime. The following criteria must be met for reimbursement:

(i) A member is documented to be unable to receive restorative services in the typical office environment within a reasonable amount of time;

(ii) A tooth that has been treated should not have any non-carious structure removed;

(iii) A tooth that has been treated should not receive any other definitive restorative care for three (3) months following an application;

(iv) Reimbursement for extraction of a tooth that has been treated will not be allowed for three (3) months following an application; and

(v) The specific teeth treated and number and location of lesions must be documented.

(G) **Dental prophylaxis.** This procedure is provided once every one hundred eighty-four (184) days along with topical application of fluoride.

(H) **Stainless steel crowns for primary teeth.** The use of any stainless steel crowns is allowed as follows:

(i) Stainless steel crowns are allowed if:

(I) The child is five (5) years of age or under;

(II) Seventy percent (70%) or more of the root structure remains; or

(III) The procedure is provided more than twelve (12) months prior to normal exfoliation.

(ii) Stainless steel crowns are treatment of choice for:

(I) Primary teeth treated with pulpal therapy, if the above conditions exist;

(II) Primary teeth where three (3) surfaces of extensive decay exist; or

(III) Primary teeth where cuspal occlusion is lost due to decay or accident.

(iii) Preoperative periapical images and/or written documentation explaining the extent of decay must be available for review, if requested.

(iv) Placement of a stainless steel crown is allowed once for a minimum period of twenty-four (24) months. No other restoration on that tooth is compensable during that period of time. A stainless steel crown is not a temporizing treatment to be used while a permanent crown is being fabricated.

(I) **Stainless steel crowns for permanent teeth.** The use of any stainless steel crowns is allowed as follows:

(i) Stainless steel crowns are the treatment of choice for:

(I) Posterior permanent teeth that have completed endodontic therapy if three (3) or more surfaces of tooth is destroyed;

(II) Posterior permanent teeth that have three (3) or more surfaces of extensive decay; or

(III) Where cuspal occlusion is lost due to decay prior to age sixteen (16) years.

(ii) Preoperative periapical images and/or written documentation explaining the extent of decay must be available for review, if requested.

(iii) Placement of a stainless steel crown excludes placement of any other type of crown for a period of

twenty-four (24) months. No other restoration on that tooth is compensable during that period of time.

(J) **Pulpotomies and pulpectomies.**

(i) Therapeutic pulpotomies and pulpal debridement are allowable once per lifetime. Pre-and post-operative periapical images must be available for review, if requested. Therapeutic pulpotomies and pulpal debridement is available for the following:

(I) Primary molars having at least seventy percent (70%) or more of their root structure remaining or more than twelve (12) months prior to normal exfoliation;

(II) Tooth numbers O and P before age five (5) years;

(III) Tooth numbers E and F before six (6) years;

(IV) Tooth numbers N and Q before five (5) years;

(V) Tooth numbers D and G before five (5) years.

(ii) Therapeutic pulpotomies and pulpal debridement are allowed for primary teeth if exfoliation of the teeth is not expected to occur for at least one (1) year or if seventy percent (70%) or more of root structure is remaining.

~~(K) **Endodontics.** Payment is made for the services provided in accordance with the following:~~

~~(i) This procedure is allowed when there are no other missing anterior teeth in the same arch requiring replacement.~~

~~(ii) The provider documents history of member's improved oral hygiene and flossing ability in records.~~

~~(iii) Prior authorization is required for members who have a treatment plan requiring more than two (2) anterior and/or any posterior root canals.~~

~~(iv) Pre and post-operative periapical images must be available for review.~~

~~(v) Pulpal debridement may be performed for the relief of pain while waiting for the decision from the OHCA.~~

~~(vi) Providers are responsible for any follow-up treatment required due to a failed root canal therapy for twenty-four (24) month post completion.~~

~~(vii) Endodontically treated teeth should be restored to limited occlusal function and all contours should be replaced. These teeth are not automatically approved for any type of crown.~~

~~(L)~~ (K) **Space maintainers.** Certain limitations apply with regard to this procedure. Providers are responsible for recementation of any maintainer placed by them for six (6) months post insertion.

(i) **Band and loop type space maintenance.** This procedure must be provided in accordance with the following

guidelines:

(I) This procedure is compensable for all primary molars where permanent successor is missing or where succedaneous tooth is more than five (5) millimeters below the crest of the alveolar ridge.

(II) First primary molars are not allowed space maintenance if the second primary and first permanent molars are present and in cuspal interlocking occlusion regardless of the presence or absence of normal relationship.

(III) If there are missing posterior teeth bilaterally in the same arch, under the above guidelines, bilateral space maintainer is the treatment of choice.

(IV) The teeth numbers shown on the claim ~~should~~must be those of the missing teeth.

(V) Post-operative bitewing images must be available for review.

(VI) Bilateral band and loop space maintainer is allowed if member does not have eruption of the four (4) mandibular anterior teeth in position or if sedation case that presents limitations to fabricate other space maintenance appliances.

(ii) **Lingual arch bar.** Payment is made for the services provided in accordance with the following:

(I) Lingual arch bar is used when permanent incisors are erupted and the second primary molar (K or T) is missing in the same arch.

(II) The requirements are the same as for band and loop space maintainer.

(III) Pre and post-operative images must be available.

~~(M)~~ (L) **Analgesia.** Analgesia services are reimbursable in accordance with the following:

(i) **Inhalation of nitrous oxide.** Use of nitrous oxide is compensable for four (4) occurrences per year and is not separately reimbursable, if provided on the same date as IV sedation, non-intravenous conscious sedation, or general anesthesia. The medical need for this service must be documented in the member's record.

(ii) **Non-intravenous conscious sedation.** Non-intravenous conscious sedation is not separately reimbursable, if provided on the same date ~~by the same provider~~ as analgesia, anxiolysis, inhalation of nitrous oxide, IV sedation, or general anesthesia. Non-intravenous conscious sedation is reimbursable when determined to be medically necessary for documented handicapped members, uncontrollable members or justifiable medical or dental conditions. The report must detail the member's condition. No services are reimbursable when provided

primarily for the convenience of the member and/or the dentist, it must be medically necessary.

~~(N)~~(M) **Pulp caps.** Indirect and direct pulp cap must be ADA accepted calcium hydroxide or mineral trioxide aggregate (MTA) materials, not a cavity liner or chemical used for dentinal hypersensitivity. Indirect and direct pulp cap codes require specific narrative support addressing materials used, intent and reasons for use. Application of chemicals used for dentinal hypersensitivity is not allowed as indirect pulp cap. Utilization of these codes is verified by post payment review.

~~(O)~~(N) **Protective restorations.** This restoration includes removal of decay, if present, and is reimbursable for the same tooth on the same date of service with a direct or indirect pulp cap, if needed. Permanent restoration of the tooth is allowed after sixty (60) days unless the tooth becomes symptomatic and requires pain relieving treatment.

~~(P)~~(O) **Smoking and tobacco use cessation counseling.** ~~Smoking and tobacco use cessation counseling is covered when performed utilizing the five (5) intervention steps of asking the member to describe his/her smoking, advising the member to quit, assessing the willingness of the member to quit, assisting with referrals and plans to quit, and arranging for follow-up. Up to eight (8) sessions are covered per year per individual who has documented tobacco use. It is a covered service when provided by physicians, physician assistants, nurse practitioners, certified nurse midwives, Oklahoma State Health Department (OSDH) and Federally Qualified Health Center (FQHC) nurses, and maternal/child health licensed clinical social workers with a Tobacco Treatment Specialist Certification (TTS-C). Chart documentation must include a separate note that addresses the 5A's, separate signature, and the member specific information addressed in the five (5) steps and the time spent by the practitioner performing the counseling. Anything under three (3) minutes is considered part of a routine visit.~~Smoking and tobacco use cessation counseling is covered per OAC 317:30-5-2 (DD) (i) through (iv).

~~(Q) **Diagnostic casts and/or oral/facial images.** Diagnostic casts and/or oral/facial images may be requested by OHCA or representatives of OHCA. If cast and/or images are received they will be considered supporting documentation and may be used to make a determination for authorization of services. Submitted documentation used to base a decision will not be returned. Providers will be reimbursed for either the study model or images.~~

~~(i) Documentation of photographic images must be kept in the client's medical record and medical necessity~~

~~identified on the submitted electronic or paper claim.~~
~~(ii) Oral/facial photographic images are allowed under the following conditions:~~
~~(I) When radiographic images do not adequately support the necessity for requested treatment.~~
~~(II) When photo images better support medical necessity for the requested treatment rather than diagnostic models.~~
~~(III) If a comprehensive orthodontic workup has not been performed.~~
~~(iii) For photographic images, the oral/facial portfolio must include a view of the complete lower arch, complete upper arch, and left and right maximum intercuspation of teeth.~~
~~(I) Maximum intercuspation refers to the occlusal position of the mandible in which the cusps of the teeth of both arches fully interpose themselves with the cusps of the teeth of the opposing arch.~~
~~(II) Intercuspation defines both the anterior-posterior and lateral relationships of the mandible and the maxilla, as well as the superior-inferior relationship known as the vertical dimension of occlusion.~~
~~(iv) Study models or photographic images not in compliance with the above described diagnostic guidelines will not be compensable. The provider may be allowed to resubmit new images that adhere to the diagnostic guidelines. If the provider does not provide appropriate documentation, the request for treatment will be denied.~~

(P) **Additional services.** Additional covered services, which require a prior authorization, are outlined in OAC 317:30-5-698.

(3) **1915(c) home and community-based services (HCBS) waivers.** Dental services are defined in each waiver and must be prior authorized.

317:30-5-698. Services requiring prior authorization

(a) **Prior authorizations.** Providers must have prior authorization for certain specified services before delivery of that service, unless the service is provided on an emergency basis [See Oklahoma Administrative Code (OAC) 317:30-5-695(d)(2)]. Requests for dental services requiring prior authorization must be accompanied by sufficient documentation.

(b) **Requests for prior authorization.** ~~Requests for prior authorization are filed on the currently approved American Dental Association (ADA) form.~~Requests for prior authorization, and any related documents, must be submitted electronically through the OHCA secure provider portal. Prior authorized services must be

billed exactly as they appear on the prior authorization. Payment is not made for any services provided prior to receiving authorization except for the relief of pain.

(c) **Prosthodontic services.** Prosthodontic services provided to members who have become ineligible mid-treatment are covered if the member was eligible for SoonerCare on the date the final impressions were made.

(d) **Adults.** Listed below are examples of services requiring prior authorization for members twenty-one (21) years of age and over/older. Minimum required records to be submitted with each request are right and left mounted bitewings and periapical films or images of tooth/teeth involved or the edentulous areas if not visible in the bitewings. Images must be of diagnostic quality. Images must be identified by the tooth number and include date of exposure, member name, member ID, provider name, and provider ID. All images, regardless of the media, must be submitted together with a completed and signed comprehensive treatment plan that details all needed treatment at the time of examination, with the prior authorization requesting all needed treatment. The images, digital media, and photographs must be of sufficient quality to clearly demonstrate for the reviewer, the pathology which is the basis for the authorization request. If radiographs are not taken, provider must include in narrative sufficient information to confirm diagnosis and treatment plan. Documentation of a periodontal evaluation with six (6) point measurements for teeth to remain must be included with requests.

(1) **Removable prosthetics.**

(A) This includes full and partial dentures.

(i) One (1) per every five (5) years is available for adults under twenty-five (25) years of age.

(ii) One (1) per every seven (7) years is available for adults twenty-five (25) years of age and over.

(iii) Provider is responsible for any needed follow up for a period of two (2) years post insertion.

(B) Partial dentures are allowed for replacement of missing anterior permanent teeth or two (2) or more missing posterior teeth in the same arch. Provider must indicate which teeth will be replaced.

(2) **Periodontal scaling and root planing.** Procedure involves instrumentation of the crown and root surfaces of the teeth to remove plaque and calculus from these surfaces. This procedure requires that each tooth involved have three (3) or more of the six-point measurements (probing pocket depths) equivalent to four (4) millimeters or greater, and image supported alveolar bone loss. Image supported subgingival calculus, and bleeding on probing, must be demonstrated on multiple teeth for consideration of scaling and root planing. A minimum of two (2) teeth per quadrant must be involved, with the appropriate CDT

code usage for fewer than four (4) teeth per quadrant. This procedure is not allowed in conjunction with any other periodontal surgery. Four quadrants of scaling and root planing will not be approved in conjunction with recent oral prophylaxis.

(3) **Scaling in the presence of generalized moderate or severe gingival inflammation.** Procedure is designed for removal of plaque, calculus and stain from supra- and sub-gingival tooth surfaces when there is generalized moderate or severe gingival inflammation as indicated by generalized suprabony pockets and bleeding on probing, in the absence of periodontitis (alveolar bone loss). Generalized supra- and sub-gingival calculus, and moderate to severe inflammation must be demonstrated, with probing pocket depths of five (5) mm or greater. This procedure is intended for scaling of the entire mouth in lieu of oral prophylaxis, and is only performed after a comprehensive evaluation has been completed.

~~(d)~~(e) **Children.** Listed below are examples of services requiring prior authorization for members under twenty-one (21) and eligible intermediate care facilities for individuals with intellectual disabilities (ICF/IID) residents. Minimum required records to be submitted with each request are right and left mounted bitewings and periapical films or images of tooth/teeth involved or the edentulous areas if not visible in the bitewings. Images must be of diagnostic quality. Images must be identified by the tooth number and include date of exposure, member name, member ID, provider name, and provider ID. All images, regardless of the media, must be submitted together with a completed and signed comprehensive treatment plan that details all needed treatment at the time of examination, and a completed ~~current ADA form requesting all treatments requiring prior authorization~~prior authorization requesting all needed treatments. ~~The images, digital media, photographs, or printouts must be of sufficient quality to clearly demonstrate for the reviewer, the pathology which is the basis for the authorization request.~~The images, digital media, and photographs must be of sufficient quality to clearly demonstrate for the reviewer, the pathology which is the basis for the authorization request. If radiographs are not taken, provider must include in narrative sufficient information to confirm diagnosis and treatment plan.

~~(1) **Endodontics.** Root canal therapy is not considered an emergency procedure unless due to trauma to an anterior tooth. The provider must document the member's oral hygiene and flossing ability in the member's records. Pulpal debridement may be performed for the relief of pain while waiting for the decision from the Oklahoma Health Care Authority (OHCA) on request for endodontics.~~

~~(A) **Anterior endodontics.** Prior authorization is required~~

~~for members who have a treatment plan requiring more than two (2) anterior root canals. All rampant, active caries should be removed prior to requesting anterior endodontics. Payment is made for services provided in accordance with the following:~~

~~(i) Permanent teeth only;~~

~~(ii) Accepted ADA materials must be used;~~

~~(iii) Pre and post-operative periapical images must be available for review;~~

~~(iv) Providers are responsible for any follow-up treatment required by a failed endodontically treated tooth within twenty-four (24) months post completion;~~

~~(v) A tooth will not be approved if it appears there is not adequate natural tooth structure remaining to establish good tooth/restorative margins or if crown to root ratio is poor; and~~

~~(vi) An endodontic procedure may not be approved if the tooth requires a post and core to retain a crown.~~

~~(B) **Posterior endodontics.** The guidelines for this procedure are as follows:~~

~~(i) The provider must document the member's oral hygiene and flossing ability in the member's records.~~

~~(ii) Teeth that require pre-fabricated post and cores to retain a restoration due to lack of natural tooth structure may not be approved for root canal therapy.~~

~~(iii) Pre and post-operative periapical images must be available for review.~~

~~(iv) Providers are responsible for any follow-up treatment required by a failed endodontically treated tooth within twenty-four (24) months post completion.~~

~~(v) A tooth will not be approved if it appears there is not adequate natural tooth structure remaining to establish good tooth/restorative margins or if there is a poor crown to root ratio or weakened root furcation area. Approval of second molars is contingent upon proof of medical necessity.~~

~~(vi) Only ADA accepted materials are acceptable under the OHCA policy.~~

~~(vii) Posterior endodontic procedure may not be approved if the tooth requires a post and core in order to present adequate structure to retain a crown.~~

~~(viii) Endodontics will not be considered if:~~

~~(I) An opposing tooth has super erupted;~~

~~(II) Loss of tooth space is one third or greater;~~

~~(III) Opposing second molars are involved unless prior authorized;~~

~~(IV) The member has multiple teeth failing due to previous inadequate root canal therapy or follow-up; or~~

~~(V) All rampant, active caries must be removed prior to requesting posterior endodontics.~~

~~(ix) Endodontically treated teeth must be restored to limited occlusal function and all contours must be replaced. Core build-up code is only available for use if other restorative codes are not sufficient. These teeth will not be approved for a crown if it appears the apex is not adequately sealed.~~

(1) **Endodontics.** Root canal therapy is not considered an emergency procedure unless due to trauma to an anterior tooth. The provider must document the member's improved oral hygiene and flossing ability and submit it with the prior authorization request to be considered when requesting endodontic therapy for multiple teeth. Pulpal debridement may be performed for the relief of pain while waiting for the decision from the Oklahoma Health Care Authority (OHCA) on request for endodontics.

(A) Payment is made for services provided in accordance with the following guidelines:

(i) Permanent teeth only;

(ii) Only ADA accepted materials are acceptable under the OHCA policy;

(iii) Pre and post-operative periapical images must be available for review;

(iv) Providers are responsible for any follow-up treatment required by a failed endodontically treated tooth within twenty-four (24) months post completion;

(v) A tooth will not be approved if it appears there is not adequate natural tooth structure remaining to establish good tooth/restorative margins or if crown to root ratio is poor. Approval of second molars is contingent upon proof of medical necessity; and

(vi) An endodontic procedure may not be approved if the tooth requires a post and core to retain a crown due to lack of tooth structure.

(B) Endodontics will not be considered if:

(i) An opposing tooth has super erupted;

(ii) The tooth impinges upon space of adjacent tooth space by one third or greater;

(iii) Fully restored tooth will not be in functional occlusion with opposing tooth;

(iv) Opposing second molars are involved unless prior authorized;

(v) The member has multiple teeth failing due to previous inadequate root canal therapy or follow-up.

(C) All rampant, active caries must be removed prior to

requesting endodontics.

(D) Endodontically treated teeth must be restored to limited occlusal function and all contours must be replaced. Core build-up code is only available for use if other restorative codes are not sufficient. These teeth will not be approved for a crown if it appears the apex is not adequately sealed.

(2) **Crowns for permanent teeth.** Crowns are compensable for restoration of natural teeth for members who are ~~sixteen (16) years of age or older~~through twenty (20) years of age and adults residing in private ICF/IID and who have been approved for ICF/IID level of care. Certain criteria and limitations apply.

(A) The following conditions must exist for approval of this procedure:

(i) All rampant, active caries must be removed prior to requesting any type of crown;

(ii) The tooth must be decayed to such an extent to prevent proper cuspal or incisal function;

(iii) The clinical crown is fractured or destroyed by one-half or more; and

(iv) Endodontically treated teeth must have three (3) or more surfaces restored or lost due to carious activity to be considered for a crown.

(B) The conditions listed above in (A)(i) through (iv) ~~should~~must be clearly visible on the submitted images when a request is made for any type of crown.

(C) Routine build-up(s) for authorized crowns are included in the fee for the crown, except when in conjunction with endodontic therapy. Non authorized restorative codes may be used if available.

(D) A crown will not be approved if adequate tooth structure does not remain to establish cleanable margins, there is invasion of the biologic width, poor crown to root ratio, or the tooth appears to retain insufficient amounts of natural tooth structure. Cast dowel cores are not allowed for molar or pre-molar teeth.

(E) Preformed post(s) and core build-up(s) are not routinely provided with crowns for endodontically treated teeth.

(F) Chart documentation must include the OHCA caries risk assessment form demonstrating member is at a low to moderate risk and be submitted with the prior authorization request for crowns for permanent teeth.

(G) Provider is responsible for replacement or repair of all crowns if failure is caused by poor laboratory processes or procedure by provider for forty-eight (48) months post insertion.

(3) **~~Cast frame partial~~Partial dentures.** ~~This appliance is the treatment of choice for replacement of missing anterior permanent teeth or two (2) or more missing posterior teeth in~~

~~the same arch for members sixteen (16) through twenty (20) years of age. Provider must indicate which teeth will be replaced. Members must have improved oral hygiene documented for at least twelve (12) months in the provider's records and submitted with prior authorization request to be considered. Provider is responsible for any needed follow up for a period of two (2) years post insertion.~~

(A) This appliance is the treatment of choice for replacement of missing anterior permanent teeth or two (2) or more missing posterior teeth in the same arch for members sixteen (16) years of age and older.

(B) Interim partial dentures are available for children five (5) years of age and older.

(C) Provider must indicate which teeth will be replaced.

(D) Members must have improved oral hygiene documented for at least twelve (12) months in the provider's records and submitted with prior authorization request to be considered.

(E) Provider is responsible for any needed follow up for a period of two (2) years post insertion.

(F) This appliance includes all necessary clasps and rests.

~~(4) **Acrylic partial.** This appliance is the treatment of choice for replacement of three (3) or more missing teeth in the same arch for members twelve (12) through sixteen (16) years of age. Provider must indicate tooth numbers to be replaced. This appliance includes all necessary clasps and rests.~~

~~(5)~~(4) **Occlusal guard.** Narrative of medical necessity must be sent with prior authorization. ~~Model should not be made or sent unless requested.~~

~~(6)~~(5) **Fixed cast non-precious metal or porcelain/metal bridges.** Only members seventeen (17) through twenty (20) years of age will be considered for this treatment. Destruction of healthy teeth to replace a single missing tooth is not considered medically necessary. Members must have excellent oral hygiene documented for at least eighteen (18) months in the requesting provider's records and submitted with prior authorization request to be considered. Provider is responsible for any needed follow up until member loses eligibility.

~~(7)~~(6) **Periodontal scaling and root planing.** ~~Procedure is designed for the removal of calculus or tissue that is contaminated and may require anesthesia and some soft tissue removal. This procedure requires that each tooth have three (3) or more of the six point measurements four (4) millimeters or greater, and have multiple areas of image supported bone loss, subgingival calculus and must involve two (2) or more teeth per quadrant for consideration. This procedure is not allowed in conjunction with any other periodontal surgery.~~Procedure involves instrumentation of the crown and root surfaces of the teeth to remove plaque and calculus from these surfaces. This

procedure requires that each tooth involved have three (3) or more of the six-point measurements (probing pocket depths) equivalent to four (4) millimeters or greater, and image supported alveolar bone loss. Image supported subgingival calculus, and bleeding on probing, must be demonstrated on multiple teeth for consideration of scaling and root planing. A minimum of two (2) teeth per quadrant must be involved, with the appropriate CDT code usage for fewer than four (4) teeth per quadrant. This procedure is not allowed in conjunction with any other periodontal surgery. Four quadrants of scaling and root planing will not be approved in conjunction with recent oral prophylaxis.

~~(8)~~(7) **Scaling in the presence of generalized moderate or severe gingival inflammation.** ~~Procedure is designed for removal of plaque, calculus and stain from supra- and sub-gingival tooth surfaces when there is generalized moderate or severe gingival inflammation, as indicated by generalized suprabony pockets and bleeding on probing, in the absence of periodontitis (bone loss). This procedure is only performed after a comprehensive evaluation has been completed and is not performed in conjunction with a prophylaxis.~~Procedure is designed for removal of plaque, calculus and stain from supra- and sub-gingival tooth surfaces when there is generalized moderate or severe gingival inflammation as indicated by generalized suprabony pockets and bleeding on probing, in the absence of periodontitis (alveolar bone loss). Generalized supra- and sub-gingival calculus, and moderate to severe inflammation must be demonstrated, with probing pocket depths of and five (5) mm or greater. This procedure is intended for scaling of the entire mouth in lieu of oral prophylaxis, and is only performed after a comprehensive evaluation has been completed.

317:30-5-699. Restorations

(a) **Utilization parameters.** ~~The Oklahoma Health Care Authority utilization parameters allow only one permanent restorative service to be provided per tooth per 24 months. Additional restorations may be authorized upon approval of OHCA in cases of trauma. Teeth receiving a restoration are eligible within three months for consideration of single crown if endodontically treated. Providers must document type of isolation used in treatment progress notes. The provider is responsible for follow-up or any required replacement of a failed restoration, if the member is currently SoonerCare eligible.~~

(1) The Oklahoma Health Care Authority utilization parameters allow only one (1) permanent restorative service to be provided per tooth per twenty-four (24) months.

(2) Additional restorations may be authorized upon approval of OHCA in cases of trauma.

(3) The provider is responsible for follow-up or any required replacement of a failed restoration, if the member is currently SoonerCare eligible.

(4) Providers must document type of isolation used in treatment progress notes.

(5) For members who are under twenty-one (21) years of age and who are receiving a restoration are eligible within three (3) months for consideration of a single crown if endodontically treated.

(b) **Coverage for dental restorations.** Restoration of incipient lesions is not considered medically necessary treatment. Any diagnosis not supported by images requires documentation of the medical need on which the diagnosis was made. Services for dental restorations are covered, for adults and children, as follows:

(1) If the mesial occlusal pit and the distal occlusal pit on an upper molar tooth are restored at the same appointment, this is a one (1) surface restoration.

(2) If any two (2) separate surfaces on a posterior tooth are restored at the same appointment, it is a two (2) surface restoration.

(3) If any three (3) separate surfaces on a posterior tooth are restored at the same appointment, it is a three (3) surface restoration.

(4) If the mesial, distal, facial and/or lingual of an upper anterior tooth is restored at the same appointment, this is a four (4) surface restoration.

(5) If any two (2) separate surfaces on an anterior tooth are restored at the same appointment, it is a two (2) surface restoration.

(6) If any three (3) separate surfaces on an anterior tooth are restored at the same appointment, it is a three (3) surface restoration.

(7) An incisal angle restoration is defined as one (1) of the angles formed by the junction of the incisal and the mesial or distal surface of an anterior tooth. If any of these surfaces are restored at the same appointment, even if separate, it is considered as a single incisal angle restoration.

(8) When four (4) or more separate surfaces on a posterior tooth are restored at the same appointment it is a four (4) surface restoration.

(9) Wide embrasure cavity preparations do not become extra surfaces unless at least one half of cusp or surface is involved in the restoration. An MODFL restoration would have to include the mesial-occlusal-distal surfaces as well as either the buccal groove pit or buccal surface or at least one half the surface of one of the buccal cusps. The same logic applies for the lingual surface.

317:30-5-700. Orthodontic services

(a) Orthodontic services are available for members who are SoonerCare-eligible and under eighteen (18) years of age at the time the request for prior authorization for treatment is received. In order to be eligible for SoonerCare orthodontic services, members must be referred through ~~a~~an OHCA contracted primary care dentist using the DEN-2 form found on the Oklahoma Health Care Authority (OHCA) website; a member can receive a referral from a primary care dentist to the orthodontist only after meeting the following:

(1) The member has had a caries free initial visit; or

(2) Has all decayed areas restored and has remained caries free for twelve 12 months; and

(3) Has demonstrated competency in maintaining an appropriate level of oral hygiene.

(b) Member with cleft palate can be referred directly by their treating physician without a dental referral and are exempt from above requirements.

(c) The SoonerCare Orthodontic Program limits orthodontic services to handicapping malocclusions determined to be severe enough to warrant medically necessary treatment. The orthodontic provider has the ability to determine if members may qualify with a visual screening. Diagnostic record accumulation and/or submission should only occur for members with high potential for acceptance. These orthodontic services include the following:

(1) A handicapping malocclusion, as measured on the Oklahoma Health Care Authority (OHCA) Handicapping Labio-Lingual Deviation Index of Malocclusion (DEN-6) form, with a minimum score of thirty (30);

(2) Any classification secondary to cleft palate or other maxillofacial deformity;

(3) If a single tooth or anterior crossbite is the only medical need finding, service will be limited to interceptive treatment;

(4) Fixed appliances only; and

(5) Permanent dentition with the exception of cleft defects.

(d) Reimbursement for orthodontic services is limited to:

(1) Orthodontists, or

(2) General or Pediatric dental practitioners who have completed at least two-hundred (200) certified hours of continuing education in the field of orthodontics practice and submit for review at least twenty-five successfully completed comprehensive cases. Of these twenty-five comprehensive cases, ten or more must be extraction cases. An applicant for this certification must practice in an OHCA deemed under-served area. The comprehensive cases submitted ~~should~~must be of a complexity consistent with type of handicapping malocclusion likely to be treated in the SoonerCare program.

(A) Cases submitted must include at least one (1) of each of the following types:

(i) Deep overbite where multiple teeth are impinging upon the soft tissue of the palate;

(ii) Impacted canine or molar requiring surgical exposure;

(iii) Bilateral posterior crossbite requiring fixed rapid palatal expansion; and

(iv) Skeletal class II or III requiring orthognathic surgery.

(B) As with all dental or orthodontia treatment performed and reimbursed by SoonerCare, all pre and post orthodontic records must be available for review.

(C) The OHCA requires all general dentists providing comprehensive orthodontic care to submit a copy of the Oklahoma Board of Dentistry continuing education report and verification that at least twenty (20) continuing education hours in the field of orthodontics has been completed per reporting period. All verification reports must be submitted to OHCA Dental Unit every three (3) years, no later than August 30. In addition, verification of adequate progress for all active orthodontic cases will be reviewed by the OHCA Dental Unit upon completion of twenty-four (24) months of therapy.

(e) The following limitations apply to orthodontic services:

(1) Cosmetic orthodontic services are not a covered benefit of the SoonerCare program and no requests should be submitted;

(2) All orthodontic procedures require prior authorization for payment;

(3) Prior authorization for orthodontic treatment is not a notification of the member's eligibility and does not guarantee payment. Payment for authorized services depends on the member's eligibility at the beginning of each treatment year. Treatment year is determined by date of banding; and

(4) The member must be SoonerCare-eligible and under eighteen (18) years of age at the time the request for prior authorization for treatment is received by the OHCA. Services cannot be added or approved after eligibility has expired. It is the orthodontist's responsibility to verify that the member has current SoonerCare eligibility and the date of birth indicates the member is under age eighteen (18).

(f) Orthodontic services are an elective procedure. The orthodontist must interview the prospective member as to his/her understanding of and willingness to cooperate fully in a lengthy treatment program.

(g) The interview information is unavailable to OHCA except through the provider's recommendation of treatment. The interview process for OHCA members is equivalent to that of private pay patients.

(h) Providers are not obligated to accept a member when it appears that the member will not cooperate in the orthodontic hygiene treatment program, does not return to the general dentist for preventive visits or is not willing to keep eligibility for SoonerCare current.

317:30-5-700.1. Orthodontic prior authorization

(a) Orthodontic services are available for members who are SoonerCare-eligible and under eighteen (18) years of age, at the time the request for prior authorization for treatment is received, per Oklahoma Administrative Code 317:30-5-700. The following records and documentation, plainly labeled with the member's full name, recipient identification number (RID), and the orthodontist's name are required for prior authorization of orthodontic services and must be submitted to the Dental Unit of the Oklahoma Health Care Authority (OHCA) Dental Program when the member has a total score of not less than thirty (30) points or meets other eligibility criteria in paragraph (d).

(1) Completed ~~currently approved American Dental Association (ADA) dental claim form~~prior authorization requesting all needed treatments;

(2) Complete and scored Handicapping Labio-Lingual Deviation (HDL) Index with Diagnosis of Angle's classification;

(3) Detailed description of any oral maxillofacial anomaly;

(4) Estimated length of treatment;

(5) Intraoral photographs showing teeth in centric occlusion and/or photographs of trimmed anatomically occluded diagnostic casts. A lingual view of casts may be included to verify impinging overbites;

(6) Cephalometric images with tracing, and panoramic film, with a request for prior authorization of comprehensive orthodontic treatment;

(7) Completed OHCA caries risk assessment form;

(8) If diagnosed as a surgical case, submit an oral surgeon's written opinion that orthognathic surgery is indicated and the surgeon is willing to provide this service; and

(9) Additional pertinent information as determined necessary by the orthodontist or as requested by the OHCA.

(b) All images and required documentation must be submitted in one (1) package. OHCA is not responsible for lost or damaged materials.

(c) All records and documentation submitted in a request for prior authorization for orthodontic treatment are reviewed by the OHCA orthodontic consultant for compensability and length of treatment. Any documentation on which a decision is made will not be returned.

(d) Some children not receiving a minimum score of thirty (30) on the HDL Index may have other conditions to be considered. In the event an orthodontist believes there are other medical, social, or emotional conditions impacting the general health of the child,

he/she refers to the conditions listed on the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) exception section found on the HLD. The following guidelines and restrictions apply to other conditions:

(1) Other medical, social, or emotional conditions are limited to those conditions that affect the medical, social or emotional function of the child;

(2) Other medical, social, or emotional conditions are not scored if the sole condition sought to be improved is the cosmetic appearance of the child;

(3) Such other medical, social, or emotional conditions must be demonstrated by objective evidence such as supported documentation outside the child's immediate family (e.g., a child's teacher, primary care physician, behavioral health provider, school counselor);

(4) Objective evidence must be submitted with the HLD;

(5) When such other medical, social, or emotional conditions are reflected on the HLD, the OHCA orthodontic consultant must review the data and use his or her professional judgment to score the value of the conditions; and

(6) The OHCA orthodontic consultant may consult with and utilize the opinion of the orthodontist who completes the form.

(e) If it is determined that the malocclusion is not severe enough to warrant medically necessary orthodontic services or the member's age precludes approval, a computer generated notice is issued to the provider and member with notice of the denial, the reason for the denial, and appeal rights [see Oklahoma Administrative Code (OAC) 317:2-1 for grievance procedures and processes].

(f) Orthodontic treatment and payment for the services are approved within the scope of the SoonerCare program. If orthodontic treatment is approved, a computer generated notice is issued authorizing the first year of treatment.

(1) Approval of orthodontic treatment is given in accordance with the following:

(A) Authorization for the first year begins on the date of banding and includes the placement of appliances, arch wires, and a minimum of six (6) adjustments. It is expected that orthodontic members be seen every four (4) to eight (8) weeks for the duration of active treatment.

(B) Subsequent adjustments will be authorized in one (1) year intervals and the treating orthodontist must provide a comprehensive progress report at the twenty-four (24) month interval.

(C) All approved treatment is included on the original prior authorization and will include the total payment for that treatment year.

(2) Claim and payment are made as follows:

(A) Payment for comprehensive treatment includes the banding, wires, adjustments as well as all ancillary services, including the removal of appliances, and the construction and placing of retainers.

(B) Payment is not made for comprehensive treatment beyond thirty-six (36) months.

(g) If the member moves from the geographic area or shows a need to change their provider, then the provider who received the yearly payment is financially responsible until completion of that member's orthodontic treatment for the current year.

(h) If the provider who received yearly payment does not agree to be financially responsible, then the OHCA may recoup funds paid for the member's orthodontic treatment.

(i) All orthodontic services are subject to post-utilization review. This review may include a request by the OHCA to submit medical documentation necessary to complete the review. After review is completed, these materials are returned to the orthodontist.

~~(j) Study models or oral/facial images must be diagnostic and meet the following requirements:~~

~~(1) Study models must be properly poured and adequately trimmed without large voids or positive bubbles present.~~

~~(2) Centric occlusion must be clearly indicated by pencil lines on the study models, making it possible to occlude the teeth on the models in centric occlusion.~~

~~(3) 3-D model images are preferred.~~

~~(4) All measurements are made or judged on the basis of greater than or more than the minimal criteria. Measurement, counting, recording, or consideration is performed only on teeth that have erupted and may be seen on the study models.~~

~~(5) For photographic images, the oral/facial portfolio must show a view of the complete lower arch, complete upper arch, and left and right maximum intercuspation of teeth.~~

~~(A) Maximum intercuspation refers to the occlusal position of the mandible in which the cusps of the teeth of both arches fully interpose themselves with the cusps of the teeth of the opposing arch.~~

~~(B) Intercuspation defines both the anterior-posterior and lateral relationships of the mandible and the maxilla, as well as the superior-inferior relationship known as the vertical dimension of occlusion.~~

(j) Electronic images of casts and/or oral/facial images may be requested by OHCA or representatives of OHCA. Providers will be reimbursed for either the study model or images when obtained for orthodontic evaluation and/or therapy.

(1) Documentation of casts and/or photographic images must be kept in the client's medical record and medical necessity identified on the submitted electronic claim.

(2) For photographic images, the oral/facial portfolio must include a view of the complete lower arch, complete upper arch, and left and right maximum intercuspation of teeth.

(A) Maximum intercuspation refers to the occlusal position of the mandible in which the cusps of the teeth of both arches fully interpose themselves with the cusps of the teeth of the opposing arch.

(B) Intercuspation defines both the anterior-posterior and lateral relationships of the mandible and the maxilla, as well as the superior-inferior relationship known as the vertical dimension of occlusion.

(3) 3-D model images or photographic images not in compliance with the diagnostic guidelines will not be compensable. The provider may be allowed to resubmit new images that adhere to the diagnostic guidelines. If the provider does not provide appropriate documentation, the request for treatment will be denied.

317:30-5-705. Billing and reimbursement

~~Billing for dental services may be submitted on the currently approved version of the American Dental Association (ADA) claim form. Diagnosis codes are requested to be listed in box 34 of the current ADA dental claim form. Electronic submission must be made on the HIPPA compliant Form 837D.~~

(a) Dental claims, and any related documents, must be submitted electronically or through the OHCA secure provider portal. Electronic submission must be made on the HIPAA compliant Form 837D.

(b) Billing and reimbursement methodology, including copayments, are outlined in the Oklahoma Medicaid State Plan.

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TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 2. GRIEVANCE PROCEDURES AND PROCESS

SUBCHAPTER ONE. ADMINISTRATIVE APPEALS

317:2-1-2. Appeals

(a) **Request for appeals.**

(1) For the purpose of calculating the timeframe for requesting an administrative appeal of an agency action, the date on the written notice shall not be included. The last day of the timeframe shall be included, unless it is a legal holiday as defined by Title 25 of the Oklahoma Statutes (O.S.) Section (§) 82.1, or any other day the Oklahoma Health Care Authority (OHCA) is closed or closes early, in which case, the timeframe runs until the close of the next full business day.

(2) An appeals request that an aggrieved member or provider sends via mail is deemed filed on the date that the agency receives it.

(b) **Member process overview.**

(1) The appeals process allows a member to appeal a decision relating to program benefits. Examples are decisions involving medical services, prior authorizations for medical services, or discrimination complaints.

(2) In order to initiate an appeal, the member must file a LD-1 (Member Complaint/Grievance Form) within thirty (30) calendar days of the date the OHCA sends written notice of its action, in accordance with Oklahoma Administrative Code (OAC) 317:2-1-2(a), above, or, in matters in which a formal notice is not sent by the agency, within thirty (30) days of the date on which the member knew or should have known the facts or circumstances serving as the basis for appeal.

(3) If the LD-1 form is not received timely, the OHCA administrative law judge (ALJ) will cause to be issued a letter stating the appeal will not be heard. In the case of tax warrant intercept appeals, if the LD-1 form is not received by OHCA within the timeframe pursuant to 68 O.S. § 205.2, OHCA similarly will cause to be issued a letter stating the appeal will not be heard because it is untimely.

(4) If the LD-1 form is not completely filled out or if necessary documentation is not included, then the appeal will not be heard.

(5) OHCA will advise members that if assistance is needed in reading or completing the grievance form, arrangements will be made to provide such assistance.

(6) Upon receipt of the member's appeal, a fair hearing before the OHCA ALJ will be scheduled. The member will be notified in writing of the date and time of the hearing. The member, and/or his/her designated authorized representive, must appear at the hearing, either in person or telephonically. ~~Requests for a telephone hearing must be received in writing on OHCA's LD-4~~

~~(Request for Telephonic Hearing) form no later than ten (10) calendar days prior to the scheduled hearing date.~~ ~~Telephonic hearing requests will only be granted by the OHCA's chief executive officer (CEO) or his/her designee, at his/her sole discretion, for good cause shown, including, for example, the member's physical condition, travel distances, or other limitations that either preclude an in-person appearance or would impose a substantial hardship on the member.~~The preferred method for a hearing is telephonically, requests for an in-person hearing must be received in writing on OHCA's Form LD-4 (Request for In-Person Hearing) no later than ten (10) calendar days prior to the scheduled hearing date.

(7) The hearing shall be conducted according to OAC 317:2-1-5. The OHCA ALJ's decision may in certain instances be appealed to the CEO of the OHCA, or his or her designated independent ALJ, which is a record review at which the parties do not appear (OAC 317:2-1-13).

(8) Member appeals are ordinarily decided within ninety (90) days from the date on which the member's timely request for a fair hearing is received, unless:

(A) The appellant was granted an expedited appeal pursuant to OAC 317:2-1-2.5;

(B) The OHCA cannot reach a decision because the appellant requests a delay or fails to take a required action, as reflected in the record;

(C) There is an administrative or other emergency beyond OHCA's control, as reflected in the record; or

(D) The appellant filed a request for an appeal of a denied step therapy exception request, pursuant to OAC 317:2-1-18.

(9) Tax warrant intercept appeals will be heard directly by the OHCA ALJ. A decision is normally rendered by the OHCA ALJ within twenty (20) days of the hearing~~ before the ALJ~~.

(c) **Provider process overview.**

(1) The proceedings as described in this subsection contain the hearing process for those appeals filed by providers. These appeals encompass all subject matter cases contained in OAC 317:2-1-2(d)(2).

(2) All provider appeals are initially heard by the OHCA ALJ under OAC 317:2-1-2(d)(2).

(A) In order to initiate an appeal, a provider must file the appropriate LD form within thirty (30) calendar days of the date the OHCA sends written notice of its action, in accordance with OAC 317:2-1-2(a), above. LD-2 forms should be used for Program Integrity audit appeals; LD-3 forms are to be used for all other provider appeals.

(B) Except for OHCA Program Integrity audit appeals, if the appropriate LD form is not received timely, the OHCA ALJ will cause a letter to be issued stating that the appeal will not be heard.

(C) A decision ordinarily will be issued by the OHCA ALJ within forty-five (45) days of the close of all evidence in the appeal.

(D) Unless otherwise limited by OAC 317:2-1-7 or 317:2-1-13, the OHCA ALJ's decision is appealable to OHCA's CEO, or his or her designated independent ALJ.

(d) **OHCA ALJ jurisdiction.** The OHCA ALJ has jurisdiction of the following matters:

(1) **Member appeals.**

(A) Discrimination complaints regarding the SoonerCare program;

(B) Appeals which relate to the scope of services, covered services, complaints regarding service or care, enrollment, disenrollment, and reenrollment in the SoonerCare Program;

(C) Fee-for-service appeals regarding the furnishing of services, including prior authorizations;

(D) Appeals which relate to the tax warrant intercept system through the OHCA. Tax warrant intercept appeals will be heard directly by the OHCA ALJ. A decision will be rendered by the OHCA ALJ within twenty (20) days of the hearing;

(E) Proposed administrative sanction appeals pursuant to OAC 317:35-13-7. Proposed administrative sanction appeals will be heard directly by the OHCA ALJ. A decision by the OHCA ALJ will ordinarily be rendered within twenty (20) days of the hearing ~~before the ALJ~~. This is the final and only appeals process for proposed administrative sanctions;

(F) Appeals which relate to eligibility determinations made by OHCA;

(G) Appeals of insureds participating in Insure Oklahoma which are authorized by OAC 317:45-9-8~~; and~~

(H) Appeals which relate to a requested step therapy protocol exception as provided by 63 O.S. § 7310~~.~~; and

(I) Requests for State fair hearing arising from a member's appeal of a managed care adverse benefit determination.

(2) **Provider appeals.**

(A) Whether Pre-admission Screening and Resident Review (PASRR) was completed as required by law;

(B) Denial of request to disenroll member from provider's SoonerCare Choice panel;

(C) Appeals by long-term care facilities for administrative penalty determinations as a result of findings made under OAC 317:30-5-131.2(b)(5)(B) and (d)(8);

(D) Appeals of Professional Service Contract awards and other matters related to the Central Purchasing Act pursuant to Title 74 O.S. § 85.1 et seq.;

(E) Drug rebate appeals;

(F) Provider appeals of OHCA Program Integrity audit findings pursuant to OAC 317:2-1-7. This is the final and only appeals process for appeals of OHCA Program Integrity audit findings;

(G) Oklahoma Electronic Health Records Incentive program appeals related only to incentive payments, incentive payment amounts, provider eligibility determinations, and demonstration of adopting, implementing, upgrading, and meaningful use eligibility for incentives;
(H) Supplemental Hospital Offset Payment Program (SHOPP) annual assessment, supplemental payment, fees or penalties as specifically provided in OAC 317:2-1-15; and
(I) Appeals from any adjustment made to a long-term care facility's cost report pursuant to OAC 317:30-5-132, including any appeal following a request for reconsideration made pursuant to OAC 317:30-5-132.1.
(J) Request for a State fair hearing arising from provider's appeal of managed care audit findings, for-cause or immediate termination of the provider's managed care contract, or managed care claims denial.

317:2-1-13. Appeal to the chief executive officer

(a) The Oklahoma Health Care Authority offers approximately forty (40) different types of administrative appeals. Some of the appeals are appealable to the chief executive officer (CEO) and some are not. The following appeals are subject to further review upon timely submission of a request for CEO appeal and may be ~~heard~~reviewed by the CEO, or his or her designated independent administrative law judge (ALJ), following the decision of ~~an administrative law judge~~the OHCA ALJ:

(1) Appeals under Oklahoma Administrative Code (OAC) 317:2-1-2(d)(1)(A) to (d)(1)(H), with the exception of subsection (d)(1)(E); and

(2) Appeals under OAC 317:2-1-2(d)(2)(A) to (d)(2)(I), with the exceptions of subsections (d)(2)(D),(E),(F),(G), and (I).

(b) Appeals to the CEO must be filed with the OHCA within thirty (30) days of the date of the Order, or decision by OHCA.

(c) No new evidence may be presented to the CEO.

(d) Appeals to the CEO under (a) of this Section may be filed by the provider, member, or agency. The CEO will ordinarily render decisions within sixty (60) days of the receipt of the appeal.

(e) The CEO may only designate an independent ALJ at another state agency, as established in the Oklahoma State Medicaid Plan and approved by the Centers for Medicare and Medicaid Services, to review a CEO appeal.

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 27. INDEPENDENT PHYSICAL THERAPISTS AND PHYSICAL THERAPISTS ASSISTANTS

317:30-5-291. Coverage by category

Payment is made to registered physical therapists as set forth in this Section.

(1) **Children.** Initial therapy evaluations do not require prior authorization and must be provided by a fully licensed physical therapist. All therapy services following the initial evaluation must be prior authorized for continuation of service. Prior to the initial evaluation, the therapist must have on file a signed and dated prescription or referral for the therapy services from the member's physician or other licensed practitioner of the healing arts. The prescribing or referring provider must be able to provide, if requested, clinical documentation from the member's medical record that supports the medical necessity for the evaluation and referral.

(2) **Adults.** There is no coverage for adults for services rendered by individually contracted providers. Coverage for adults is permitted in an outpatient hospital setting as described in Oklahoma Administrative Code (OAC) 317:30-5-42.1.

(3) **Individuals eligible for Part B of Medicare.** Services provided to Medicare eligible recipients are filed directly with the fiscal agent.

(4) **Alternative treatments for pain management.** Refer to OAC 317:30-5-725.

PART 81. CHIROPRACTORS

317:30-5-720. Eligible providers

~~In order to be eligible for payment, the provider of chiropractic services must have a current Memorandum of Agreement with the Oklahoma Health Care Authority.~~**Chiropractors.**

(1) Must be appropriately licensed, in good standing in the state in which they practice, and working in accordance with the Oklahoma Chiropractic Practice Act or other applicable statute(s); and

(2) Entered into a provider agreement with the Oklahoma Health Care Authority (OHCA) to provide chiropractic services.

317:30-5-721. Coverage by category

Payment is made to chiropractors as set forth in this Section.

(1) **Children.** There is no coverage for children.

(2) **Adults.** There is no coverage for adults.

(3) **Individuals eligible for Part B of Medicare.** Payment is made utilizing the Medicaid allowable for comparable services.
(4) **Alternative treatments for pain management.** Refer to Oklahoma Administrative Code 317:30-5-724.

PART 82. ALTERNATIVE TREATMENTS FOR PAIN MANAGEMENT

317:30-5-722. General

Alternative treatments for pain management are non-pharmacological treatments recommended by a physician or other licensed practitioner of the healing arts for adults age twenty-one (21) or older with acute, subacute, and chronic spinal/back pain or injury. Treatments are intended to reduce pain, increase mobility, optimize function, and decrease use and misuse of opioid medications and may include the services listed in Part 82, of this Chapter.

317:30-5-723. Eligible providers

(a) **Manual spinal manipulation.** Providers must meet the requirements outlined at Oklahoma Administrative Code (OAC) 317:30-5-720.
(b) **Physical therapy (PT) for treatment of spinal pain.** Providers must meet the requirements outlined at OAC 317:30-5-290.1.

317:30-5-724. Manual spinal manipulation

Manual spinal manipulation includes manipulation of the five (5) regions of the spinal column for the treatment of back pain in a member with a primary diagnosis of acute or chronic pain and is performed by a licensed chiropractor.

(1) **Medical necessity.** All services for alternative treatments for pain management should be determined to be medically necessary for the affected member. Documentation in the member's plan of care should support the medical necessity of the need for alternative treatments for pain management services. The Oklahoma Health Care Authority (OHCA) will 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.

(2) **Documentation/requirements.** All documentation submitted to request services should 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).

(A) **Evaluations.** One initial evaluation and one re-evaluation, for chiropractic manual spinal manipulation, are allowed per calendar year and do not require a PA.

(B) **Prior authorization (PA).** Documentation, for a PA request, will include the following:

(i) The member is over twenty-one (21) years of age;

(ii) Attestation stating that manual spinal manipulation services are being used in place of opioid treatment for pain or used to decrease the use of opioids;

(iii) Primary diagnosis of acute or chronic spinal pain or neuromusculoskeletal disorder related to the spinal column;

(iv) Plan of care that is designed for the treatment of spinal pain;

(v) Signed informed consent for care;

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

(C) **Subsequent PA requests.** Requests for a subsequent PA will include the following:

(i) All documentation found at (2)(B)(i) through (v) of this Section;

(ii) Medical records that document that the treatments meet the functional needs of the member;

(iii) Treatment goals for acute pain/injury, chronic pain management, or chronic back pain;

(iv) Treatment evaluations that should demonstrate improvement, including but not limited to, improved function, decreased use of pain medications, increased activity level;

(v) Records showing persistent or recurrent conditions;

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

(3) **Frequency/coverage.**

(A) SoonerCare covers up to twelve (12) manual spinal manipulation visits per calendar year with an approved PA.

(B) Manual spinal manipulation for the treatment of acute or chronic back pain is the only chiropractic service covered by SoonerCare.

(4) **Reimbursement.** All alternative treatments for pain management services, that are outlined in Part 82 of this Chapter, are reimbursed per the methodology established in the Oklahoma Medicaid State Plan.

(5) **Discontinuation of services.**

(A) If the member's condition is not improving, or the member's condition is regressing, services will not be considered medically necessary.

(B) The OHCA may withdraw authorization of payment at any time if it is determined that the member and/or provider is not in compliance with any of the requirements set forth in this Section.

(6) **Non-covered services.**

(A) Manual spinal manipulation provided solely for maintenance.

(B) Chiropractor services that are not for the alternative treatments of pain management listed in Part 82 of this Chapter.

(C) Manual spinal manipulation services that are provided in a setting other than the chiropractor's office, including but not limited to, inpatient or outpatient hospitals, nursing facilities, rest homes, or the member's home.

317:30-5-725. Physical therapy (PT) for treatment of spinal pain

PT is used to improve a person's ability to move, reduce or manage pain, restore function, and prevent disability. For pain management, PT is provided with the aim of decreasing pain and suffering while improving physical and mental functioning.

(1) **Medical necessity.** All services for alternative treatments for pain management should be determined to be medically necessary for the affected member. Documentation in the member's plan of care should support the medical necessity of the need for alternative treatments for pain management services. The Oklahoma Health Care Authority (OHCA) will 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.

(2) **Documentation/requirements.** All documentation submitted to request services should 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).

(A) **Evaluations.** One (1) initial PT evaluation and one (1) PT re-evaluation, when necessary, will be covered per calendar year at a non-hospital-based setting and do not require a PA, when the service is performed for the evaluation of therapy services related to spinal pain.

(B) **Prior authorization (PA).** Documentation, for a PA request, will include the following:

(i) The member is over twenty-one (21) years of age;

(ii) A prescription or a referral from the member's physician or other licensed practitioner of the healing arts, dated within the previous ninety (90) day requesting the PT services for pain management;

(iii) Attestation stating that PT services are being used in place of opioid treatment for pain or used to decrease the use of opioids;

(iv) Medical records, from the member's physician or other licensed practitioner of the healing arts, documenting the need for the pain management referral;

(v) Documentation from the physical therapist that supports the need for the requested services;

(vi) A detailed report, from the physical therapist, that is gathered from any tool, test, or measure;

(vii) Measurable goals that includes the following:

(I) Timeframe;
(II) Baseline;
(III) Conditions for how goals are expected to be met;
(IV) A statement of rationale; and
(V) Prognosis for achievement.

(viii) A detailed intervention plan that includes:
(I) Frequency and duration of the services and the anticipated length of the intervention;
(II) Location of where the services are provided;
(III) Member and/or family/caregiver involvement in the management and carry-over of the intervention;
(IV) Reasons if the intervention was unsuccessful.

(ix) A completed therapy PA request form;

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

(C) **Subsequent PA requests.** Requests for a subsequent PA will include the following:

(i) All documentation found at (2)(B) (i) through (viii) of this section;

(ii) Detailed listing of previous goals, including instances of which goals were unmet and why they were not achieved;

(iii) Treatment goals for acute pain/injury, chronic pain management, or chronic back pain;

(iv) Records showing persistent or recurrent conditions;

(v) Treatment evaluations that show avoidance/prevention or reduction of opioid use;

(vi) A completed therapy PA request form;

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

(3) **Frequency/coverage.** A PA for PT for adult treatment of spinal pain may be approved for a total of forty-eight (48) units per calendar year. A PT unit for the treatment of spinal pain in adults is 15 minutes. A visit may consist of multiple units of service on the same date, the time for units of service is added together and rounded up only once per visit.

(4) **Reimbursement.** All alternative treatments for pain management services, that are outlined in Part 82 of this Chapter, are reimbursed per the methodology established in the Oklahoma Medicaid State Plan.

(5) **Discontinuation of services.**

(A) If the member's condition is not improving, or the member's condition is regressing, then services will not be considered medically necessary.

(B) The OHCA may withdraw authorization of payment at any time if it is determined that the member and/or provider is not in compliance with any of the requirements set forth in this section.

(6) **Non-covered services.**

(A) PT provided solely for maintenance.
(B) Therapeutic or physical modalities used to augment a PT program.

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

SUBCHAPTER 22. PREGNANCY RELATED BENEFITS COVERED UNDER TITLE XXI

317:35-22-2.1 Non-covered services
~~(a)~~ Services and benefits provided to evaluate and/or treat maternal conditions that are not related to or impact the pregnancy outcome.
~~(b) Dental.~~

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

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

(C) ~~meets~~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. ~~Effective January 1, 2014, children~~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.

"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~~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 ~~OASDI~~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.~~**"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, ~~ICF/IIDs~~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 5. ELIGIBILITY AND COUNTABLE INCOME

PART 3. NON-MEDICAL ELIGIBILITY REQUIREMENTS

317:35-5-25. Citizenship/~~alien~~noncitizen status and identity verification requirements

(a) **Citizenship/~~alien~~noncitizen status and identity verification requirements.** Verification of citizenship/~~alien~~noncitizen status and identity ~~are~~is required for all adults and children approved for SoonerCare. An exception is individuals who are initially eligible for SoonerCare as deemed newborns; according to Section 1903(x) of the Social Security Act, they will not be required to further document citizenship or identity at any subsequent SoonerCare eligibility redetermination. They are considered to have provided satisfactory documentation of citizenship and identity by virtue of being born in the United States.

(1) The types of acceptable evidence that verify identity and citizenship include:

(A) United States (U.S.) ~~Passport~~passport;

(B) Certificate of Naturalization issued by U.S. Citizenship & Immigration Services (USCIS)(Form N-550 or N-570);

(C) Certificate of Citizenship issued by USCIS (Form N-560 or N-561);

(D) Copy of the Medicare card or printout of a ~~BENDEX~~Beneficiary Earnings and Data Exchange (BENDEX) or ~~SDX~~State Data Exchange (SDX) screen showing receipt of Medicare benefits, Supplemental Security Income or disability benefits from the Social Security Administration; or

(E) Tribal membership card or Certificate of Degree of Indian Blood (CDIB) card, with a photograph of the individual.

(2) The types of acceptable evidence that verify citizenship but require additional steps to obtain satisfactory evidence of identity are listed in subparagraphs (A) and (B). Subparagraph (A) lists the most reliable forms of verification and is to be used before using items listed in (B). Subparagraph (B) lists those verifications that are less reliable forms of verification and are used only when the items in (A) are not attainable.

(A) Most reliable forms of citizenship verification are:

(i) A U.S. public Birth Certificate showing birth in one (1) of the ~~50~~fifty (50) states, the District of Columbia, Puerto Rico (on or after 1/13/1941), Guam (on or after 4/10/1899), the U.S. Virgin Islands (on or after 1/17/1917), American Samoa, Swain's Island, or the Northern Mariana Islands after 11/4/1986. For Puerto Ricans whose eligibility is being determined for the first time on or after October 1, 2010 and using a birth certificate to verify citizenship, the birth certificate must be a certified birth certificate issued by Puerto Rico on or after July 1, 2010;

(ii) A Consular Report of Birth Abroad of a U.S. citizen issued by the Department of Homeland Security or a Certification of ~~birth~~Birth issued by the State Department (Form FS-240, FS-545 or DS-1350);

(iii) A U.S. Citizen ~~ID~~Identification Card (Form I-179 or I-197);

(iv) A Northern Mariana Identification Card (Form I-873) (Issued by the former INS to a collectively naturalized citizen of the U.S. who was born in the Northern Mariana Islands before 11/3/1986);

(v) An American Indian Card issued by the Department of Homeland Security with the classification code "KIC" (Form I-872);

(vi) A ~~Final Adoption Decree~~final adoption decree showing the child's name and ~~U. S.~~U.S. place of birth;

(vii) Evidence of U.S. Civil Service employment before 6/1/1976;

(viii) An Official U.S. Military Record of Service showing a U.S. place of birth (for example a DD-214);
(ix) Tribal membership card or Certificate of Degree of Indian Blood (CDIB) card, without a photograph of the individual, for Native Americans;
(x) Oklahoma ~~Voter Registration Card~~voter registration card; ~~or~~
(xi) Other acceptable documentation as approved by OHCA; or
(xii) Other acceptable documentation to the same extent as described and communicated by the United States Citizenship and Immigration Service (USCIS) from time to time.

(B) Other less reliable forms of citizenship verification are:
(i) An extract of a hospital record on hospital letterhead established at the time of the person's birth that was created five (5) years before the initial application date and that indicates a U.S. place of birth. For children under ~~16~~sixteen (16) the evidence must have been created near the time of birth or five (5) years before the date of application;
(ii) Life, health, or other insurance record showing a U.S. place of birth that was created at least five (5) years before the initial application date and that indicates a U.S. place of birth;
(iii) Federal or ~~State~~state census record showing U.S. citizenship or a U.S. place of birth (generally for persons born 1900 through 1950). The census record must also show the applicant's/member's age; or
(iv) One (1) of the following items that show a U.S. place of birth and was created at least five (5) years before the application for SoonerCare. This evidence must be one (1) of the following and show a U.S. place of birth:
(I) Seneca Indian tribal census record;
(II) Bureau of Indian Affairs tribal census records of the Navajo Indians;
(III) U.S. State Vital Statistics official notification of birth registration;
(IV) An amended U.S. public birth record that is amended more than five (5) years after the person's birth; or
(V) Statement signed by the physician or midwife who was in attendance at the time of birth.

(3) Acceptable evidence of identity that must accompany citizenship evidence listed in (A) and (B) of paragraph (2) of this subsection includes:

(A) A driver's license issued by a U.S. state or territory with either a photograph of the individual or other identifying information such as name, age, sex, race, height, weight, or eye color;
(B) A school identification card with a photograph of the individual;
(C) An identification card issued by ~~Federal~~federal, state, or local government with the same information included on driver's licenses;
(D) A U.S. military card or draft record;
(E) A U.S. military dependent's identification card;
(F) A Native American Tribal document including Certificate of Degree of Indian Blood, or other U.S. American Indian/Alaska Native Tribal document with a photograph of the individual or other personal identifying information;
(G) A U.S. Coast Guard Merchant Mariner card;
(H) A state court order placing a child in custody as reported by the OKDHS;
(I) For children under ~~16~~sixteen (16), school records may include nursery or daycare records;
(J) If none of the verification items on the list are available, an affidavit may be used for children under ~~16~~sixteen (16). An affidavit is only acceptable if it is signed under penalty of perjury by a parent or guardian stating the date and place of the birth of the child and cannot be used if an affidavit for citizenship was provided.

(b) **Reasonable opportunity to obtain ~~citizenship~~ verification.**

(1) ~~When the applicant/member is unable to obtain citizenship or alienage verification, a reasonable opportunity is afforded to the applicant/member to obtain the evidence as well as assistance in doing so. A reasonable opportunity is afforded to the applicant/member before taking action affecting the individual's eligibility for SoonerCare. The reasonable opportunity timeframe afforded to SoonerCare members is the same as authorized under Section 1902(cc) of the Social Security act~~Act and is stated on the documentation request the agency ~~sends to the applicant/member.~~The state provides Medicaid to citizens and nationals of the United States and certain noncitizens, including during a reasonable opportunity period pending verification of citizenship, national status, or immigrations status. The reasonable opportunity period begins on the date the notice of reasonable opportunity is received by the individual and extends at minimum ninety (90) days. Receipt by the individual is deemed to occur five (5) days after the date on the notice, unless the individual shows that the notice was not received in the five-day period. The state provides an extension of the reasonable opportunity period if the

individual subject to verification is making a good faith effort to resolve any inconsistencies or obtain any necessary documentation, or the state needs more time to complete the verification process. The state begins to furnish benefits to otherwise eligible individuals on the date of application containing the declaration of citizenship or immigration status and throughout the reasonable opportunity period.

(2) The following methods of verification are the least reliable forms of verification and should only be used as a last resort:

(A) Institutional admission papers from a nursing facility, skilled care facility or other institution. Admission papers generally show biographical information for the person including place of birth; the record can be used to establish U.S. citizenship when it shows a U.S. place of birth;

(B) Medical (clinic, doctor, or hospital) record created at least five (5) years before the initial application date that indicates a U.S. place of birth. For children under the age of sixteen (16), the document must have been created near the time of birth. Medical records generally show biographical information for the person including place of birth; the record can be used to establish U.S. citizenship when it shows a U.S. place of birth. An immunization record is not considered a medical record for purposes of establishing U.S. citizenship;

(C) Written affidavit. Affidavits are only used in rare circumstances. If the verification requirements need to be met through affidavits, the following rules apply:

(i) There must be at least two (2) affidavits by two (2) individuals who have personal knowledge of the event(s) establishing the applicant's/member's claim of citizenship;

(ii) At least one (1) of the individuals making the affidavit cannot be related to the applicant/member;

(iii) In order for the affidavit to be acceptable, the persons making them must be able to provide proof of their own citizenship and identity;

(iv) If the individual(s) making the affidavit has information which explains why evidence establishing the applicant's/member's claim of citizenship does not exist or cannot be readily obtained, the affidavit must contain this information as well;

(v) The State must obtain a separate affidavit from the applicant/member or other knowledgeable individual (guardian or representative) explaining why the evidence does not exist or cannot be obtained; and

(vi) The affidavits must be signed under penalty of perjury.

(c) ~~**Alienage verification requirements**~~**Noncitizen eligibility**. SoonerCare services are provided as ~~listed~~described to the defined groups as indicated in this subsection if they meet all other factors of eligibility, including but not limited to residency requirements, and if the relevant noncitizen status is verifiable by federally approved means. ~~Persons determined as having lawful alien status must have the status verified through Systematic Alien Verification for Entitlement (SAVE).~~

~~(1) **Eligible aliens (qualified aliens).** The groups listed in the following subparagraphs are eligible for the full range of SoonerCare services. A qualified alien is:~~

~~(A) an alien who was admitted to the United States and has resided in the United States for a period greater than five (5) years from the date of entry and who was:~~

~~(i) lawfully admitted for permanent residence under the Immigration and Nationality Act;~~

~~(ii) paroled into the United States under Section 212(d)(5) of such Act for a period of at least one (1) year;~~

~~(iii) granted conditional entry pursuant to Section 203(a)(7) of such Act as in effect prior to April 1, 1980; or~~

~~(iv) a battered spouse, battered child, or parent or child of a battered person with a petition under 204(a)(1)(A) or (B) or 244(a)(3) of the Immigration and Naturalization Act.~~

~~(B) an alien who was admitted to the United States and who was:~~

~~(i) granted asylum under Section 208 of such Act regardless of the date asylum is granted;~~

~~(ii) a refugee admitted to the United States under Section 207 of such Act regardless of the date admitted;~~

~~(iii) an alien with deportation withheld under Section 243(h) of such Act regardless of the date deportation was withheld;~~

~~(iv) a Cuban or Haitian entrant as defined in Section 501(e) of the Refugee Education Assistance Act of 1980, regardless of the date of entry;~~

~~(v) an alien who is a veteran as defined in 38 U.S.C. § 101, with a discharge characterized as an honorable discharge and not on the grounds of alienage;~~

~~(vi) an alien who is on active duty, other than active duty for training, in the Armed Forces of the United States;~~

~~(vii) the spouse or unmarried dependent child of an individual described in (C) of this paragraph;~~

(viii) a victim of a severe form of trafficking pursuant to Section 107(b) of the Trafficking Victims Protection Act of 2000; or

(ix) admitted as an Amerasian immigrant.

(C) permanent residents who first entered the country under (B) of this paragraph and who later converted to lawful permanent residence status.

(2) **Other aliens lawfully admitted for permanent residence (non-qualified aliens).** Non-qualified aliens are those individuals who were admitted to the United States and who do not meet any of the definitions in paragraph (1) of this subsection. Non-qualified aliens are ineligible for SoonerCare for five (5) years from the date of entry except that non-qualified aliens are eligible for emergency services only when the individual has a medical condition (including emergency labor and delivery) with acute symptoms which may result in placing his/her health in serious jeopardy, serious impairment to bodily functions or serious dysfunction of body organ or part without immediate medical attention, in accordance with 317:30-3-32. The only exception is when a pregnant woman qualifies under the pregnancy related benefits covered under the Title XXI program because the newborn child will meet the citizenship requirement at birth.

(3) **Afghan Special Immigrants.** Afghan special immigrants, as defined in Public Law 110-161, who have special immigration status after December 26, 2007, are exempt from the five (5) year period of ineligibility for SoonerCare services. All other eligibility requirements must be met to qualify for SoonerCare services. If these individuals do not meet one of the categorical relationships, they may apply and be determined eligible for Refugee Medical Assistance. Afghan special immigrants are considered lawful permanent residents.

(4) **Iraqi Special Immigrants.** Iraqi special immigrants, as defined in Public Law 110-181, who have special immigration status after January 28, 2008, are exempt from the five (5) year period of ineligibility for SoonerCare services. All other eligibility requirements must be met to qualify for SoonerCare services. If these individuals do not meet one of the categorical relationships, they may apply and be determined eligible for Refugee Medical Assistance. Iraqi special immigrants are considered lawful permanent residents.

(5) **Undocumented aliens.** Undocumented aliens who do not meet any of the definitions in (1)-(2) of this subsection are eligible for emergency services only when the individual has a medical condition (including emergency labor and delivery) with acute symptoms which may result in placing his/her health in serious jeopardy, serious impairment to bodily functions or

~~serious dysfunction of body organ or part without immediate medical attention, in accordance with 30-3-32. The only exception is when a pregnant woman qualifies under the pregnancy related benefits covered under the Title XXI program because the newborn child will meet the citizenship requirement at birth.~~

~~(6)~~ **~~Ineligible aliens.~~**

~~(A) Ineligible aliens who do not fall into the categories in (1) and (2) of this subsection, yet have been lawfully admitted for temporary or specified periods of time include, but are not limited to: foreign students, visitors, foreign government representatives, crewmen, members of foreign media and temporary workers including agricultural contract workers. This group is ineligible for SoonerCare, including emergency services, because of the temporary nature of their admission status. The only exception is when a pregnant woman qualifies under the pregnancy related benefits covered under the Title XXI program because the newborn child will meet the citizenship requirement at birth.~~

~~(B) These individuals are generally issued Form I-94, Arrival Departure Record, on which an expiration date is entered. This form is not the same Form I-94 that is issued to persons who have been paroled into the United States. Parolees carry a Form I-94 that is titled "Arrival-Departure Record B Parole Edition". Two other forms that do not give the individual "Immigrant" status are Form I-186, Nonresident Alien Mexican Border Crossing Card, and Form SW-434, Mexican Border Visitors Permit.~~

~~(d)~~ **~~Alienage.~~** ~~A decision regarding eligibility cannot be made until the eligibility condition of citizenship and alienage is determined.~~

~~(1)~~ **~~Immigrants~~**~~. Aliens lawfully admitted for permanent residence in the United States are classified as immigrants by the USCIS. These are individuals who entered this country with the express intention of residing here permanently.~~

~~(2)~~ **~~Parolees.~~** ~~Under Section 212(d)(5) of the Immigration and Nationality Act, individuals can be paroled into the United States for an indefinite or temporary period at the discretion of the United States Attorney General. Individuals admitted as Parolees are considered to meet the "citizenship and alienage" requirement.~~

~~(3)~~ **~~Refugees and Western Hemisphere aliens~~**~~. Under Section 203(a)(7) of the Immigration and Nationality Act, Refugees and Western Hemisphere aliens may be lawfully admitted to the United States if, because of persecution or fear of prosecution due to race, religion, or political opinion, they have fled from a Communist or Communist-dominated country or from the area of~~

~~the Middle East; or if they are refugees from natural catastrophes. These entries meet the citizenship and alienage requirement. Western Hemisphere aliens will meet the citizenship requirement for SoonerCare if they can provide either of the documents in subparagraphs (A) and (B) of this paragraph as proof of their alien status.~~

~~(A) Form I-94 endorsed "Voluntary Departure Granted-Employment Authorized", or~~

~~(B) The following court-ordered notice sent by USCIS to each of those individuals permitted to remain in the United States: "Due to a Court Order in Silva vs. Levi, 76 C4268 entered by District Judge John F. Grady in the District Court for the Northern District of Illinois, we are taking no action on your case. This means that you are permitted to remain in the United States without threat of deportation or expulsion until further notice. Your employment in the United States is authorized".~~

~~(4)~~ **~~Special provisions relating to Kickapoo Indians~~**~~. Kickapoo Indians migrating between Mexico and the United States carry Form I-94, Arrival-Departure Record (Parole Edition). If Form I-94 carries the statement that the Kickapoo is "paroled pursuant to Section 212(d)(5) of the Immigration and Nationality Act" or that the "Kickapoo status is pending clarification of status by Congress" regardless of whether such statements are preprinted or handwritten and regardless of a specific mention of the "treaty", they meet the "citizenship and alienage" requirement. All Kickapoo Indians paroled in the United States must renew their paroled status each year at any local Immigration Office. There are other Kickapoos who have entered the United States from Mexico who carry Form I-151 or Form I-551, Alien Registration Receipt Cards. These individuals have the same status as other individuals who have been issued Form I-151 or Form I-551 and, therefore, meet the citizenship and alienage requirements. Still other Kickapoos are classified as Mexican Nationals by the USCIS. They carry Form I-94, Arrival-Departure Record, which has been issued as a visiting visa and does not make mention of the treaty. Such form does not meet the "citizenship and alienage" requirements but provides only the ineligible alien status described in (c)(4)(b) of this Section.~~

~~(5)~~ **~~American Indians born in Canada~~**~~. An American Indian born in Canada, who has maintained residence in the United States since entry, is considered to be lawfully admitted for permanent residence if he/she is of at least one-half (1/2) American Indian blood. This does not include the non-citizen whose membership in an Indian tribe or family is created by adoption, unless such person is of at least fifty (50) percent or more~~

~~Indian blood. The methods of documentation are birth or baptismal certificate issued on a reservation, tribal records, letter from the Canadian Department of Indian Affairs, or school records.~~

~~(6) **Permanent non-immigrants.** Marshall Islanders and individuals from the Republic of Palau and the Federated States of Micronesia are classified as permanent non-immigrants by USCIS. They are eligible for emergency services only, in accordance with 30-3-32.~~

(1) **Unauthorized resident noncitizen.** An unauthorized resident noncitizen is a foreign-born individual who is not lawfully present in the United States, regardless of having had authorization during a prior period. Unauthorized resident noncitizens have formerly been known as "illegal" or "undocumented" immigrants or "aliens". Per 8 U.S.C. 1611(a) and (b)(1)(A) an unauthorized resident noncitizen is ineligible for Title XIX Medicaid benefits except for emergency Medicaid as defined at subparagraph (e) below. However, an unauthorized resident noncitizen who is pregnant is eligible for benefits under Title XXI separate Children's Health Insurance Program (CHIP) for services that benefit the unborn child, if the unborn child meets all eligibility requirements.

(2) **Authorized resident noncitizen, not qualified.** An authorized resident noncitizen is a foreign-born individual who is lawfully present in the United States (U.S.) and is lawfully residing in the U.S., but who does not meet the definition of qualified noncitizen, per 8 U.S.C. 1611(a) and (b)(1)(A). The Oklahoma Medicaid program does not exercise the CHIPRA 214 option; therefore, an authorized resident noncitizen is ineligible for Title XIX or Title XXI Medicaid benefits except for emergency Medicaid as defined at subparagraph (e) below. However, an authorized resident noncitizen who is pregnant is eligible for benefits under Title XXI separate CHIP for services that benefit the unborn child, if the unborn child meets all eligibility requirements.

(3) **Qualified noncitizen.** A "qualified noncitizen" is an authorized resident noncitizen who, at the time of applying for Medicaid, has a "qualified noncitizen" immigration status as identified at 8 U.S.C. 1641, as may be amended from time to time. Any qualified noncitizen is eligible for full Title XIX Medicaid benefits after a five-year waiting period beginning on the date of the noncitizen's entry into the U.S. with an immigration status identified as "qualified noncitizen" if the noncitizen meets all other eligibility criteria at the end of the waiting period. During the waiting period, as per 8 U.S.C. 1613(a), any qualified noncitizen is eligible to receive emergency Medicaid as described in subparagraph (e) below if

the noncitizen meets all other eligibility requirements, including but not limited to residency requirements.

(A) **Qualified noncitizen immigration statuses.** Immigration statuses identified by federal law as "qualified noncitizen", as of November 2, 2021, include:

(i) A noncitizen who is lawfully admitted for permanent residence under the Immigration and Nationality Act [INA], per 8 U.S.C. 1101 et seq.;

(ii) A noncitizen who is granted asylum under INA section 208, per 8 U.S.C. 1158;

(iii) A noncitizen who is admitted to the U.S. under INA section 207 refugee, per 8 U.S.C. 1157;

(iv) A noncitizen who is paroled into the U.S. under INA section 212(d)(5), per 8 U.S.C. 1182(d)(5), for a period of at least one (1) year;

(v) A noncitizen whose deportation is being withheld under INA section 243(h), per 8 U.S.C. 1253 (as in effect immediately before the effective date of section 307 of division C of Public Law 104-208) or section 241(b)(3) of such Act, per 8 U.S.C. 1231(b)(3) (as amended by section 305(a) of division C of Public Law 104-208);

(vi) A noncitizen who is granted conditional entry before 1980 pursuant to INA section 203(a)(7), per 8 U.S.C. 1153(a)(7), as in effect prior to April 1, 1980;

(vii) A noncitizen who is a Cuban and Haitian entrant (as defined in section 501(e) of the Refugee Education Assistance Act of 1980);

(viii) A noncitizen who, or whose parent or child, has been battered or subjected to extreme cruelty in the U.S. by a U.S. citizen or lawful permanent resident spouse or parent or by a member of the spouse's or parent's family residing in the same household, except during any period in which the individual responsible for such battery or cruelty resides in the same household or family eligibility unit as the individual subjected to such battery or cruelty and only when the alien meets all of the following requirements:

(I) The noncitizen, if not the individual subjected to battery or extreme cruelty, had no active participation in the battery or cruelty;

(II) The noncitizen is a credible victim; and

(III) The noncitizen is able to show a substantial connection between the need for benefits sought and the batter or extreme cruelty; and

(IV) The noncitizen has been approved or has a petition pending which sets forth a prima facie case for one of the following: status as a spouse or child of a U.S.

citizen under INA 204(a)(1)(A); classification under INA 204(a)(1)(B)(ii) or (iii); suspension of deportation under INA 244(a)(3); status as a spouse or child of a U.S. citizen under INA 204(a)(1)(A); or classification under INA 204(a)(1)(B); or cancellation of removal under INA 240A(b)(2).

(ix) A noncitizen who is or has been a victim of a severe form of trafficking in persons and who has been granted nonimmigrant status under INA 101(a)(15)(T) or who has a pending application that sets forth a prima facie case for eligibility for such immigration status; or

(x) Beginning December 27, 2020, a noncitizen who lawfully resides in the state in accordance with the Compacts of Free Association between the Government of the United States and the Governments of the Federated States of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau.

(B) **Five-year wait exception for refugees and asylees.**

(i) Excepted from the five-year waiting period per 8 U.S.C. 1612(b)(2)(A), the following qualified noncitizens are immediately eligible for a Medicaid determination upon the date:

(I) A noncitizen is admitted to the U.S. as a refugee under INA section 207 [INA 207 Refugee], per 8 U.S.C. 1157;

(II) A noncitizen is granted asylum under INA section 208, per 8 U.S.C. 1158;

(III) A noncitizen's deportation is withheld under INA section 243(h), per 8 U.S.C. 1253 (as in effect immediately before the effective date of section 307 of division C of Public Law 104-208) or section 241(b)(3) of such Act, per 8 U.S.C. 1231(b)(3) (as amended by section 305(a) of division C of Public Law 104-208);

(IV) A noncitizen is granted status as a Cuban and Haitian entrant (as defined in section 501(e) of the Refugee Education Assistance Act of 1980); or

(V) A noncitizen is admitted to the U.S. as an Amerasian immigrant under the Foreign Operations, Export Financing, and Related Programs Appropriations Act, 1988, section 584.

(ii) This exception to the five-year waiting period expires seven (7) years after the date of action indicated in the list at (c)(3)(B)(i) above. Upon expiration of the exception, the five-year waiting period must be calculated.

(C) **Five-year wait exception for certain permanent resident noncitizens.** The five-year waiting period does not apply and the noncitizen is immediately eligible for a Medicaid determination per 8 U.S.C. 1612(b)(2)(B), if:

(i) The noncitizen is lawfully admitted to the U.S. for permanent residence;

(ii) The noncitizen has either:

(I) worked forty (40) qualifying quarters of coverage as defined under the Act; or

(II) can be credited with such qualifying quarters as provided under 8 U.S.C. 1645; and

(iii) In the case of any such qualifying quarters creditable for any period beginning after December 31, 1996, the noncitizen did not receive any federal means-tested public benefit during any such period.

(D) **Five-year wait exception for veteran and active-duty noncitizens.** As per 8 U.S.C. 1612(b)(2)(C) and 1613, the five-year waiting period does not apply, and the noncitizen is immediately eligible for a Medicaid determination if the noncitizen is a qualified noncitizen who is lawfully residing in the state and is:

(i) A veteran (as defined at INA sections 101, 1101, or 1301, or as described at 38 U.S.C. section 107) with a discharge characterized as an honorable discharge and not on account of noncitizenship and who fulfills the minimum active-duty service requirements of 38 U.S.C. section 5303A(d);

(ii) On active duty (other than active duty for training) in the Armed Forces of the United States; or

(iii) The spouse or unmarried dependent child of an individual described herein as a veteran or active-duty noncitizen; or

(iv) The unremarried surviving spouse of an individual described herein as a veteran or active-duty noncitizen who is deceased, if the marriage fulfills the requirements of 38 U.S.C. section 1304.

(E) **Five-year wait exception for COFA migrants.** Per 8 U.S.C. 1613(b)(3) and as of December 27, 2020, any noncitizen who lawfully resides in the state in accordance with the Compacts of Free Association between the Government of the United States and the Governments of the Federated States of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau is, with regard to the Medicaid program, are not subject to the five-year waiting period unless and until the individual's status is adjusted to lawful permanent resident (LPR), at which time the five year waiting

period must be calculated, unless the individual meets a separate exception to the five-year waiting period:

(i) If the individual entered the U.S. before December 27, 2020, and the date of adjustment to LPR status occurred before December 27, 2020, then the waiting period begins on the date of adjustment and ends after five (5) years;

(ii) If the individual entered the U.S. before December 27, 2020, and the date of adjustment to LPR status occurred after December 27, 2020, the waiting period expires on December 27, 2025; and

(iii) If the individual entered the U.S. after December 27, 2020, and the date of adjustment to LPR status occurred after December 27, 2020, the waiting period begins on the date of entry into the U.S. and ends after five (5) years.

(F) **Five-year wait exception for qualified noncitizens receiving SSI.** Per 8 U.S.C. 1612(b)(2)(F), a qualified noncitizen who is receiving benefits under the supplemental security income program (SSI) under Title XVI of the Act shall be eligible for medical assistance under a state plan under Title XIX of the Social Security Act, per 42 U.S.C. 1396 et seq), under the same terms and conditions that apply to other recipients of SSI benefits.

(4) **Special categories of noncitizens and conferred benefits.** For the following noncitizens, federal law has expressly authorized Title XIX Medicaid benefits as described below and at law.

(A) **Certain American Indian / Alaskan Native (AI/AN) noncitizens.** The qualified noncitizen requirement and the five-year waiting period do not apply to any individual who is:

(i) An American Indian born in Canada to whom section 289 of the Immigration and Nationality Act apply, per 8 U.S.C. 1359; or

(ii) A member of a federally recognized Indian tribe as defined at 25 U.S.C. 450b(e).

(B) **Certain Iraqi nationals.**

(i) Public Law 110-181, Section 1244, while in force and as amended from time to time, created a new category of special immigrant for Iraqi nationals, including:

(I) Principal noncitizens who have provided relevant service to the U.S. government, while employed by or on behalf of the U.S. government in Iraq, for not less than 1 year beginning on or after March 20, 2003, and who have experienced or are experiencing an ongoing serious threat as a consequence of that employment;

(II) The spouse or surviving spouse of a principal noncitizen; and

(III) The child of a principal noncitizen.

(ii) Public Law 111-118, Section 8120, while in force and as amended from time to time, extended Iraqi special immigrant eligibility for medical assistance to the same extent as INA 207 Refugees are eligible for medical assistance [see subparagraph (c)(3)(B) above] as of December 19, 2009.

(iii) As of August 3, 2021, pursuant to the Office of Refugee Resettlement Policy Letter 21-07, while in force and as may be amended, Iraqi nationals granted special immigrant parole, noncitizens with applications pending for special immigrant status, are also eligible for medical assistance to the same extent as INA 207 Refugees are eligible for medical assistance [see subparagraph (c)(3)(B) above];

(C) **Certain Afghan nationals.**

(i) Public Law 111-8, Section 602, while in force and as amended from time to time, created a new category of special immigrant for Afghan nationals, including:

(I) Principal noncitizens who have provided relevant service to the U.S. government or the International Security Assistance Force, while employed by or on behalf of the U.S. government in Afghan, for not less than one (1) year beginning on or after October 7, 2001, and who have experienced or are experiencing an ongoing serious threat as a consequence of that employment;

(II) The spouse or surviving spouse of a principal noncitizen; and

(III) The child of a principal noncitizen.

(ii) Public Law 111-118, Section 8120, while in force and as amended from time to time, amended Public Law 111-8, Section 602, to extend Afghan special immigrant eligibility for medical assistance to the same extent as INA 207 Refugees are eligible for medical assistance [see subparagraph (c)(3)(B) above] as of December 19, 2009;

(iii) As of August 3, 2021, pursuant to the Office of Refugee Resettlement Policy Letter 21-07, while in force and as may be amended, Afghan nationals granted special immigrant parole, noncitizens with applications pending for special immigrant status, are also eligible for medical assistance to the same extent as INA 207 Refugees are eligible for medical assistance [see subparagraph (c)(3)(B) above];

(iv) Pursuant to Public Law 117-43, Section 2502, while

in force and as may be amended from time to time, "applicable individuals" have time-limited eligibility for medical assistance to the same extent as INA 207 Refugees are eligible for medical assistance [See subsection (c)(3)(B) above], until March 21, 2023, or the term of parole, whichever is later. In this subparagraph, the term "applicable individual" includes only:

(I) A citizen or national of Afghanistan or a person with no nationality who last habitually resided in Afghanistan, if the individual is paroled into the U.S. between July 31, 2021, and September 30, 2022;

(II) The spouse or child of an individual described at (c)(3)(C)(iv)(I) of this section, if the spouse or child is paroled into the U.S. after September 30, 2022; and

(III) The parent or legal guardian of an individual described at (c)(3)(C)(iv)(I) who is determined to be an unaccompanied child, if the parent or legal guardian is paroled into the U.S. after September 30, 2022.

(d) **Continuing conformance with federal law.** Notwithstanding any other provision of this section, any noncitizen population that federal law or authority, as amended from time to time, identifies as eligible for medical assistance under Title XIX is eligible for such benefits to the same extent, under the same conditions, and for the same period of time as indicated in the relevant federal law or official federal guidance documents, including any amendments to the law or guidance.

(e) **Emergency Medicaid.** Emergency Medicaid in this section means medical assistance provided to a noncitizen under Title XIX for care and services that are necessary for the treatment of an emergency medical condition, as defined by section 1903(v)(3) of the Act and including labor and delivery but not related to organ transplant procedure, of the noncitizen involved if the noncitizen otherwise meets eligibility requirements for medical assistance under the state plan, including but not limited to residency requirements.

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OHCA BOARD MEETING DATES

2022

January 19, 2022 · 2:00 p.m.
Oklahoma Health Care Authority

March 16, 2022 · 2:00 p.m.
Oklahoma Health Care Authority

May 18, 2022 · 2:00 p.m.
Oklahoma Health Care Authority

June 29, 2022 · 2:00 p.m.
Oklahoma Health Care Authority

September 14, 2022 · 2:00 p.m.
Oklahoma Health Care Authority

November 16, 2022 · 2:00 p.m.
Oklahoma Health Care Authority

January

Su	Mo	Tu	We	Th	Fr	Sa
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	**19**	20	21	22
23	24	25	26	27	28	29
30	31					

March

Su	Mo	Tu	We	Th	Fr	Sa
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6	7	8	9	10	11	12
13	14	15	**16**	17	18	19
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27	28	29	30	31		

May

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15	16	17	**18**	19	20	21
22	23	24	25	26	27	28
29	30	31				

June

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5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	**29**	30		

September

Su	Mo	Tu	We	Th	Fr	Sa
				1	2	3
4	5	6	7	8	9	10
11	12	13	**14**	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	

November

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27	28	29	30			

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OPERATIONAL METRICS

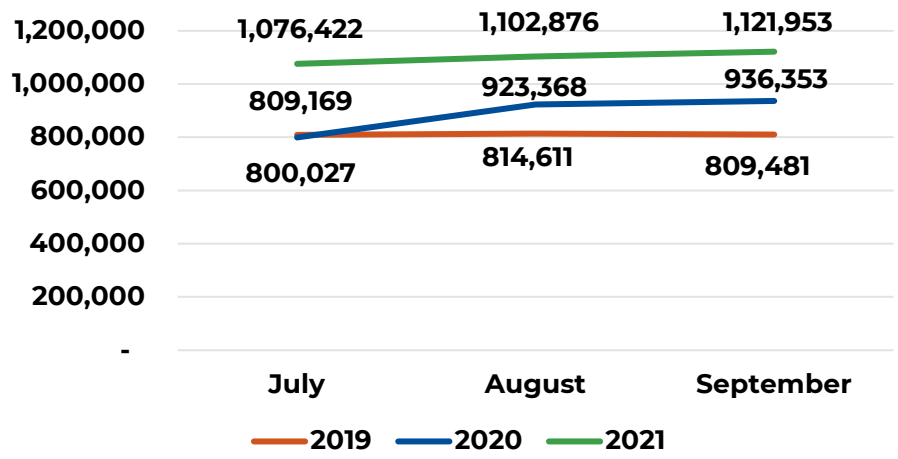
November 2021 Board Meeting

OKLAHOMA HEALTH CARE AUTHORITY

4345 N. LINCOLN BLVD. | OKHCA.ORG |

Enrollment & Utilization

Total Enrolled Members

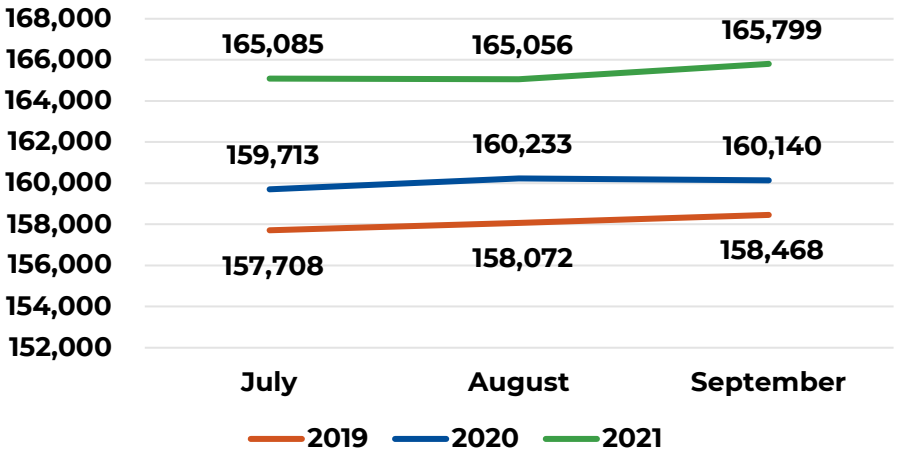


Month	2019	2020	2021
July	809,169	800,027	1,076,422
August	814,611	923,368	1,102,876
September	809,481	936,353	1,121,953

2020 vs 2021	Count Change	Percent Change
July	276,395	35%
August	179,508	19%
September	185,600	20%

2020 vs 2021 Quarterly Percent Change	20%

Aged/Blind/Disabled Enrolled



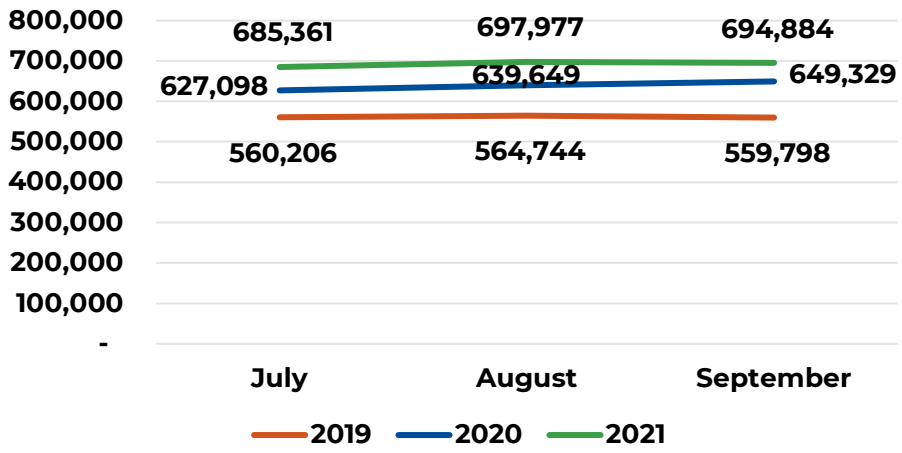
Month	2019	2020	2021
July	157,708	159,713	165,085
August	158,072	160,233	165,056
September	158,468	160,140	165,799

2020 vs 2021	Count Change	Percent Change
July	5,372	3%
August	4,823	3%
September	5,659	4%

2020 vs 2021 Quarterly Percent Change	3%

Enrollment & Utilization (Cont.)

Children & Parent/Caretaker Enrolled

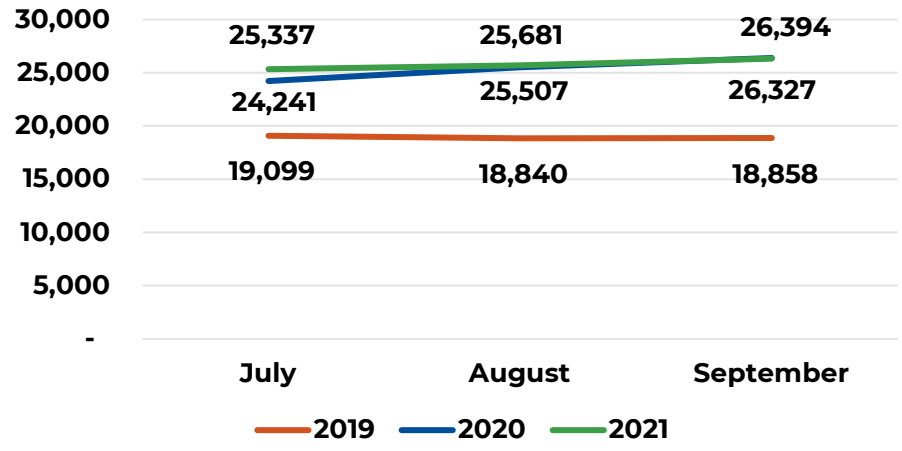


Month	2019	2020	2021
July	560,206	627,098	685,361
August	564,744	639,649	697,977
September	559,798	649,329	694,884

2020 vs 2021	Count Change	Percent Change
July	58,263	9%
August	58,328	9%
September	45,555	7%

2020 vs 2021 Quarterly Percent Change	9%

Pregnant (Full Scope) Enrolled



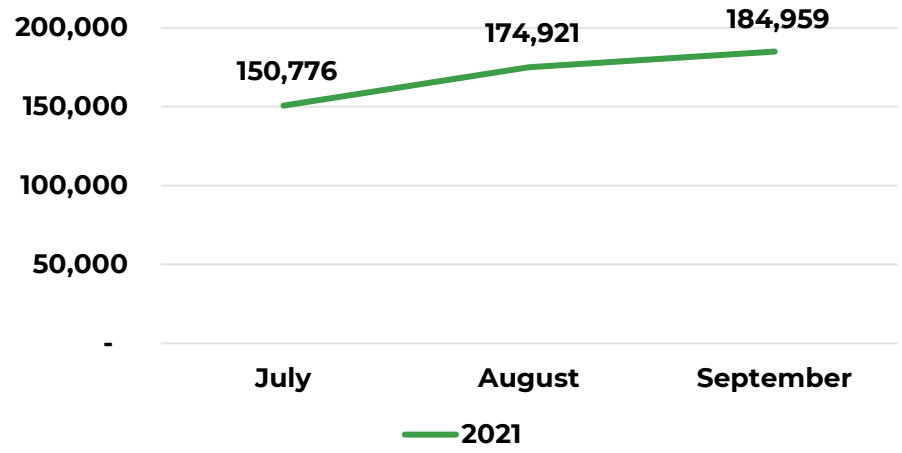
Month	2019	2020	2021
July	19,099	24,241	25,337
August	18,840	25,507	25,681
September	18,858	26,394	26,327

2020 vs 2021	Count Change	Percent Change
July	1,096	5%
August	174	1%
September	(67)	0%

2020 vs 2021 Quarterly Percent Change	2%

Enrollment & Utilization (Cont.)

Expansion Enrolled (Effective July 2021)

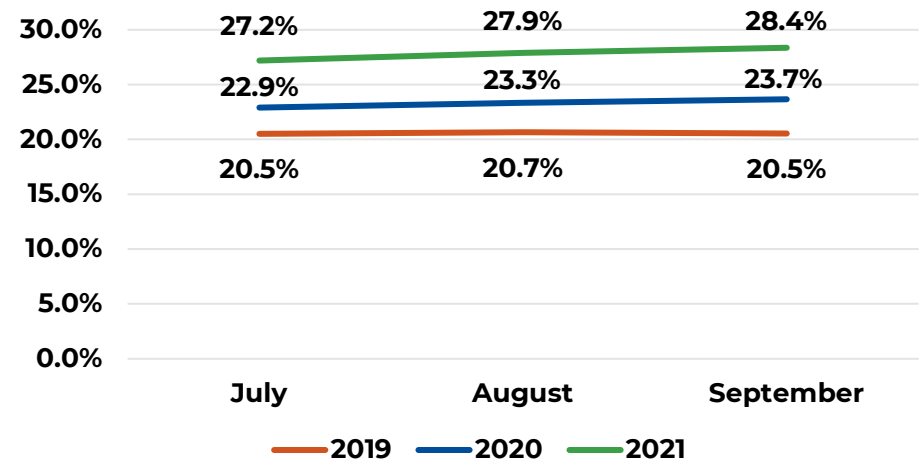


Month	2019	2020	2021
July	-	-	150,776
August	-	-	174,921
September	-	-	184,959

2020 vs 2021	Count Change	Percent Change
July	150,776	#DIV/0!
August	174,921	#DIV/0!
September	184,959	#DIV/0!

2020 vs 2021 Quarterly Percent Change	100%

Percent of OK Population Enrolled



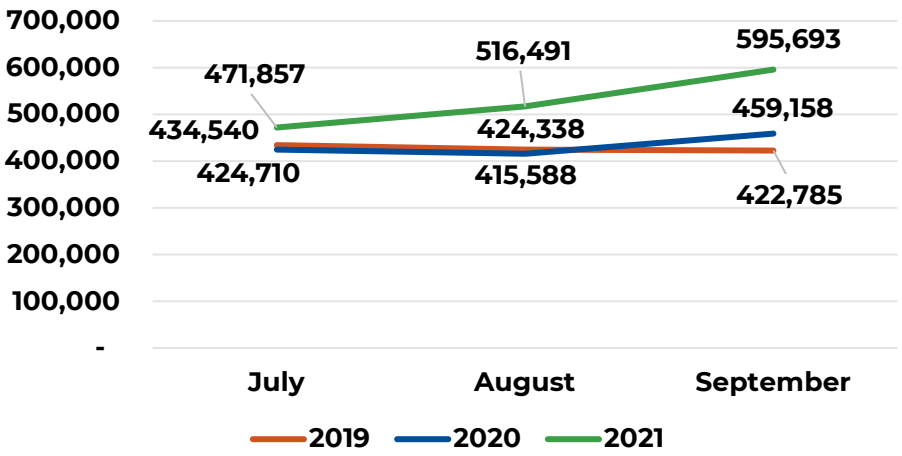
Month	2019	2020	2021
July	20.5%	22.9%	27.2%
August	20.7%	23.3%	27.9%
September	20.5%	23.7%	28.4%

2020 vs 2021	Count Change	Percent Change
July	4.3%	19%
August	4.5%	19%
September	4.7%	20%

2020 vs 2021 Quarterly Percent Change	19%

Enrollment & Utilization (Cont.)

Total Members Utilization

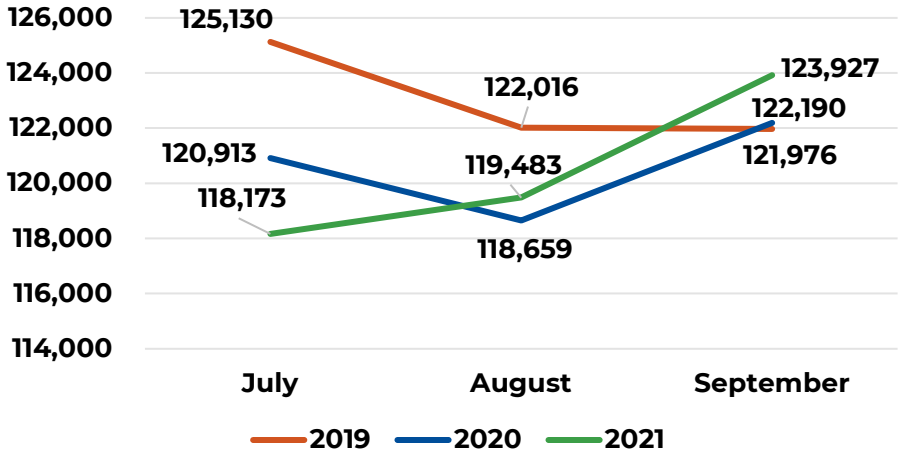


Month	2019	2020	2021
July	434,540	424,710	471,857
August	424,338	415,588	516,491
September	422,785	459,158	595,693

2020 vs 2021	Count Change	Percent Change
July	47,147	11%
August	100,903	24%
September	136,535	30%

2020 vs 2021 Quarterly Percent Change	23%

Aged/Blind/Disabled Utilization



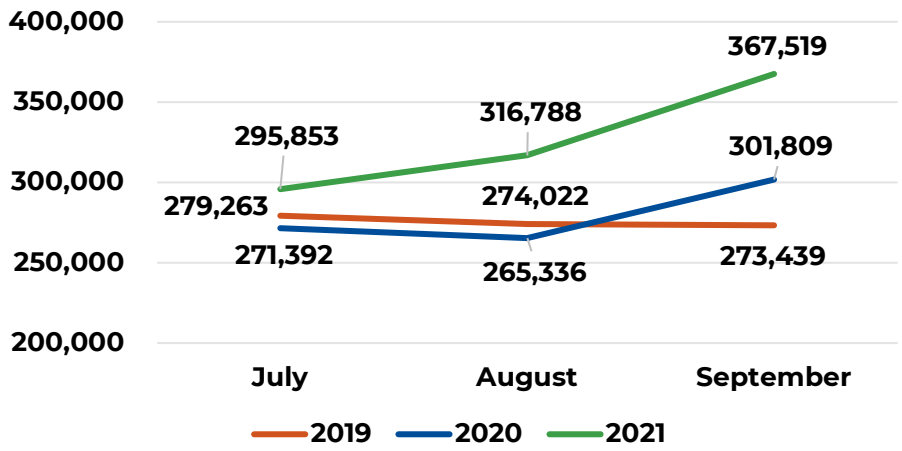
Month	2019	2020	2021
July	125,130	120,913	118,173
August	122,016	118,659	119,483
September	121,976	122,190	123,927

2020 vs 2021	Count Change	Percent Change
July	(2,740)	-2%
August	824	1%
September	1,737	1.4%

2020 vs 2021 Quarterly Percent Change	1%

Enrollment & Utilization (Cont.)

Children & Parent/Caretaker Utilization

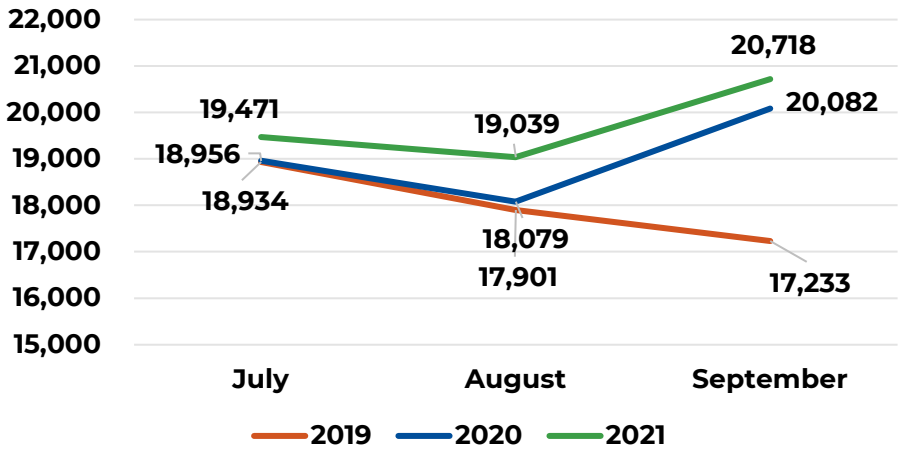


Month	2019	2020	2021
July	279,263	271,392	295,853
August	274,022	265,336	316,788
September	273,439	301,809	367,519

2020 vs 2021	Count Change	Percent Change
July	24,461	9%
August	51,452	19%
September	65,710	22%

2020 vs 2021 Quarterly Percent Change	16%

Pregnant (Full Scope) Utilization



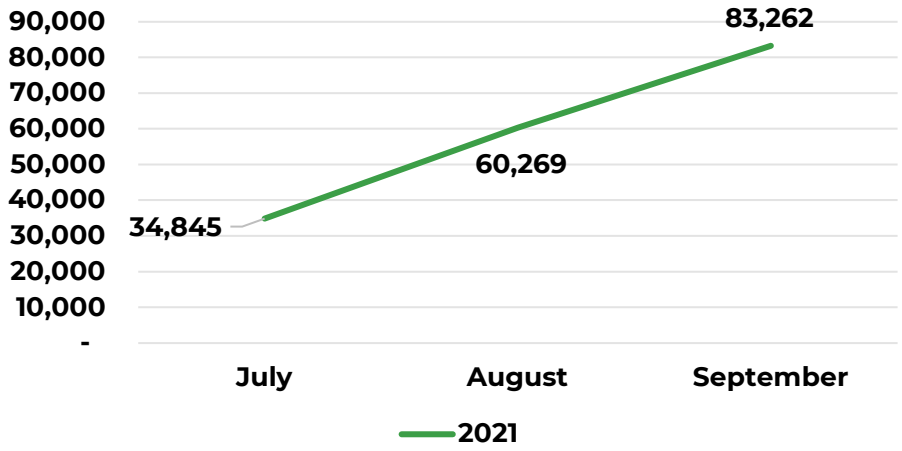
Month	2019	2020	2021
July	18,934	18,956	19,471
August	17,901	18,079	19,039
September	17,233	20,082	20,718

2020 vs 2021	Count Change	Percent Change
July	515	3%
August	960	5%
September	636	3%

2020 vs 2021 Quarterly Percent Change	7%

Enrollment & Utilization (Cont.)

Expansion Utilization (Effective July 2021)

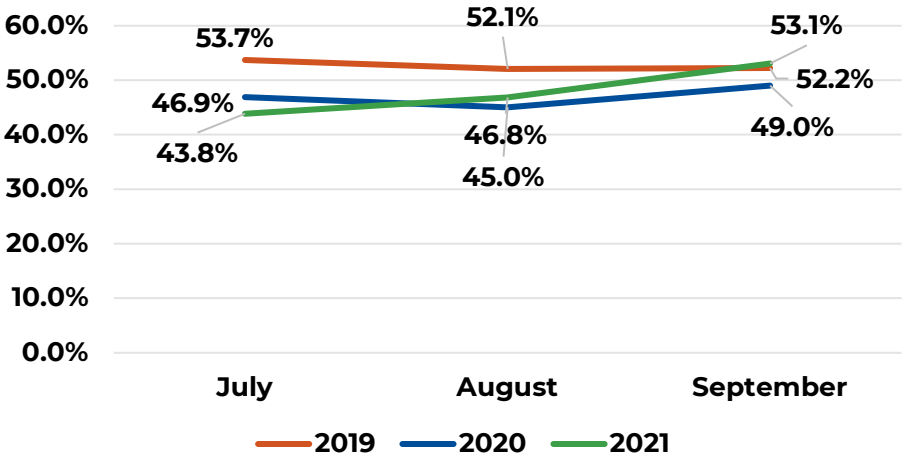


Month	2019	2020	2021
July	-	-	34,845
August	-	-	60,269
September	-	-	83,262

2020 vs 2021	Count Change	Percent Change
July	34,845	#DIV/0!
August	60,269	#DIV/0!
September	83,262	#DIV/0!

2020 vs 2021 Quarterly Percent Change	100%

Percent of Total Enrolled Members Utilization



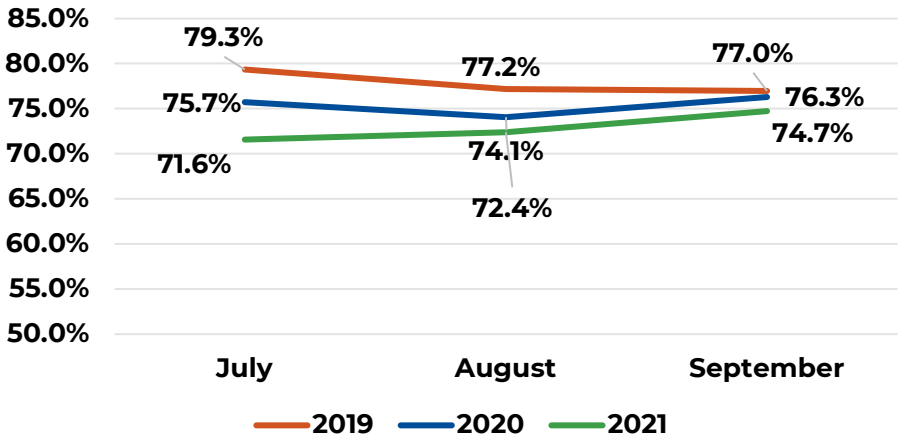
Month	2019	2020	2021
July	53.7%	46.9%	43.8%
August	52.1%	45.0%	46.8%
September	52.2%	49.0%	53.1%

2020 vs 2021	Count Change	Percent Change
July	-3.0%	-6%
August	1.8%	4%
September	4.1%	8%

2020 vs 2021 Quarterly Percent Change	2%

Enrollment & Utilization (Cont.)

Percent of Aged/Blind/Disabled Enrolled Members Utilization

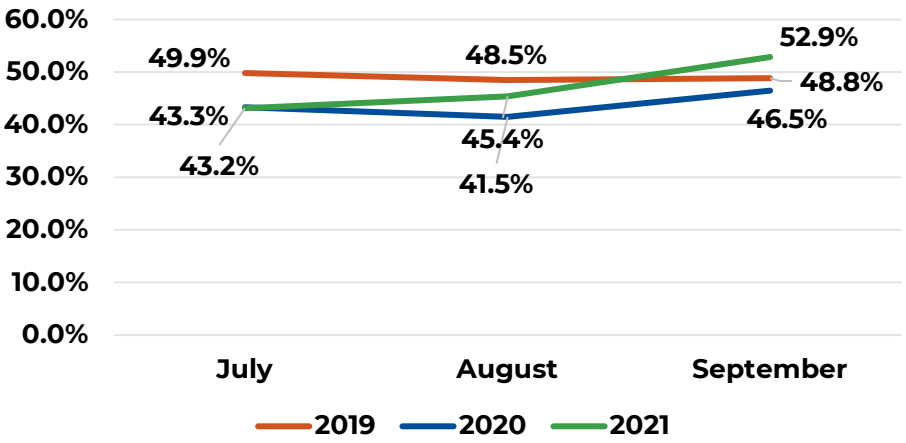


Month	2019	2020	2021
July	79.3%	75.7%	71.6%
August	77.2%	74.1%	72.4%
September	77.0%	76.3%	74.7%

2020 vs 2021	Count Change	Percent Change
July	-4.1%	-5%
August	-1.7%	-2%
September	-1.6%	-2%

2020 vs 2021 Quarterly Percent Change	-1%

Percent of Children & Parent/Caretaker Enrolled Members Utilization



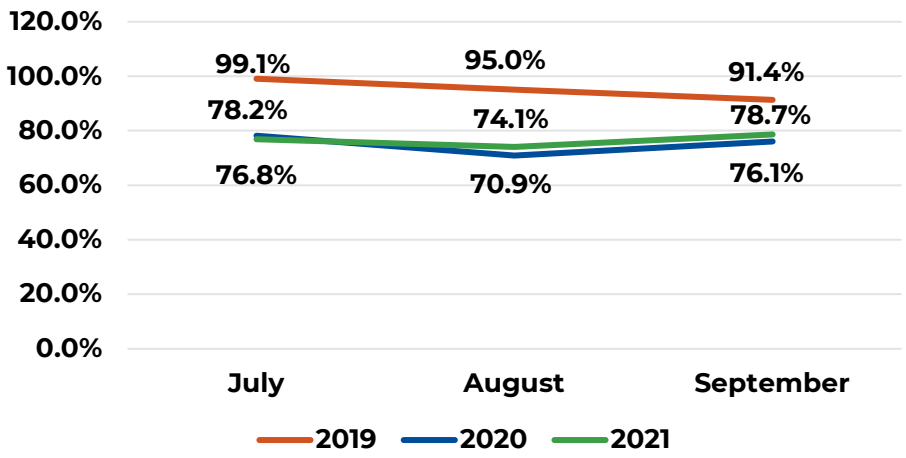
Month	2019	2020	2021
July	49.9%	43.3%	43.2%
August	48.5%	41.5%	45.4%
September	48.8%	46.5%	52.9%

2020 vs 2021	Count Change	Percent Change
July	-0.1%	0%
August	3.9%	9%
September	6.4%	14%

2020 vs 2021 Quarterly Percent Change	7%

Enrollment & Utilization (Cont.)

Percent of Pregnant (Full Scope) Enrolled Members Utilization

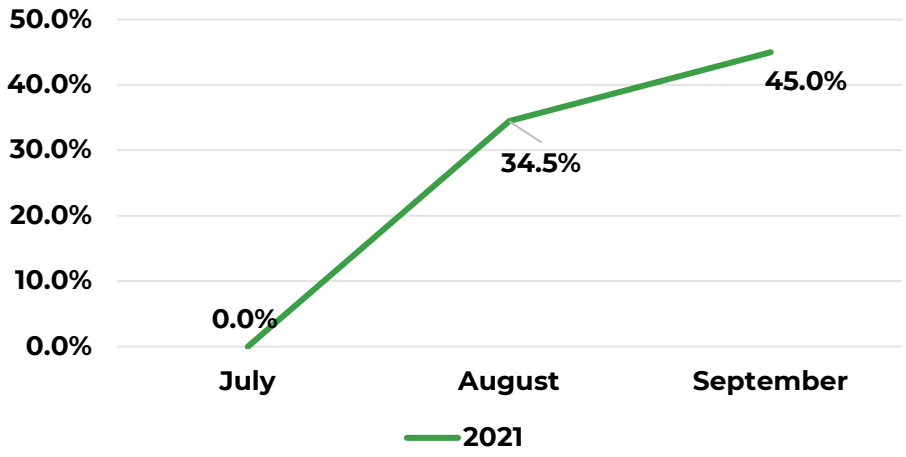


Month	2019	2020	2021
July	99.1%	78.2%	76.8%
August	95.0%	70.9%	74.1%
September	91.4%	76.1%	78.7%

2020 vs 2021	Count Change	Percent Change
July	-1.4%	-2%
August	3.3%	5%
September	2.6%	3%

2020 vs 2021 Quarterly Percent Change	4%

Percent of Expansion Enrolled Members Utilization (Effective July 2021)



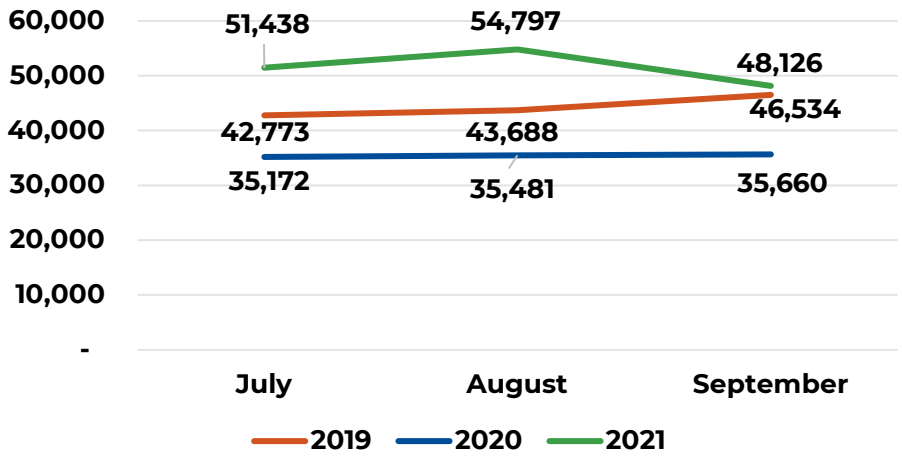
Month	2019	2020	2021
July	0.0%	0.0%	0.0%
August	0.0%	0.0%	34.5%
September	0.0%	0.0%	45.0%

2020 vs 2021	Count Change	Percent Change
July	0.0%	#DIV/0!
August	34.5%	#DIV/0!
September	45.0%	#DIV/0!

2020 vs 2021 Quarterly Percent Change	100%

Utilization

Emergency Department Visits (Claims)

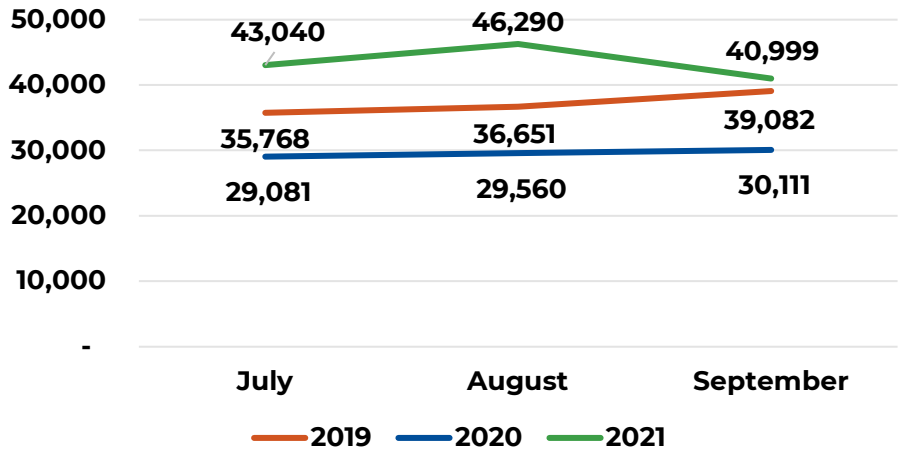


Month	2019	2020	2021
July	42,773	35,172	51,438
August	43,688	35,481	54,797
September	46,534	35,660	48,126

2020 vs 2021	Count Change	Percent Change
July	16,266	46%
August	19,316	54%
September	12,466	35%

2020 vs 2021 Quarterly Percent Change	45%

Members Utilizing Emergency Department



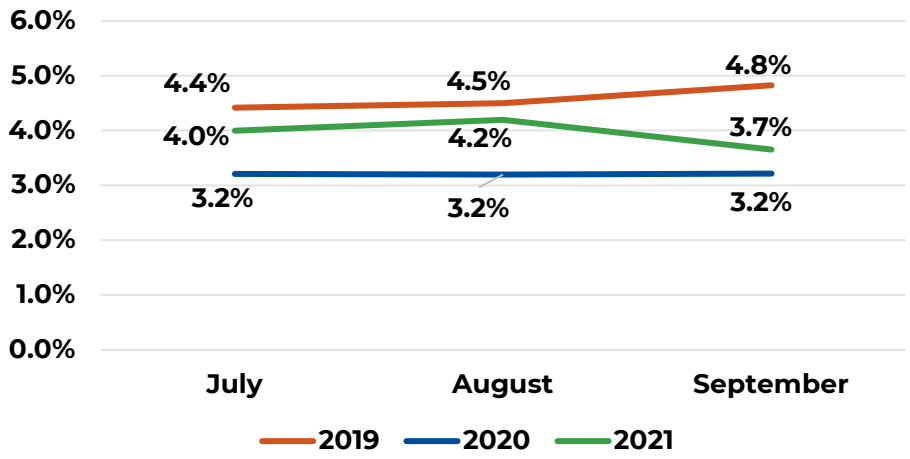
Month	2019	2020	2021
July	35,768	29,081	43,040
August	36,651	29,560	46,290
September	39,082	30,111	40,999

2020 vs 2021	Count Change	Percent Change
July	13,959	48%
August	16,730	57%
September	10,888	36%

2020 vs 2021 Quarterly Percent Change	47%

Utilization (Cont.)

Percent Total Enrolled Using ED

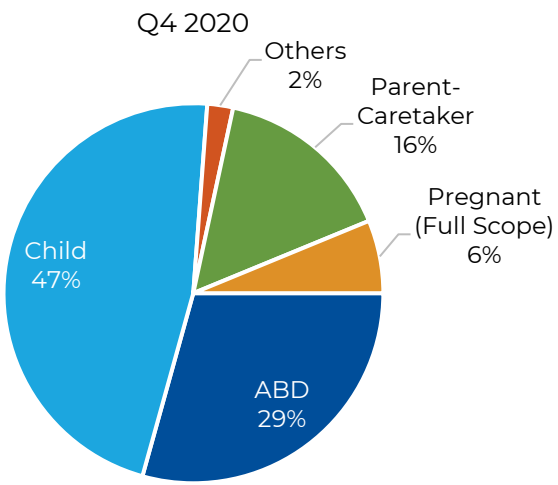


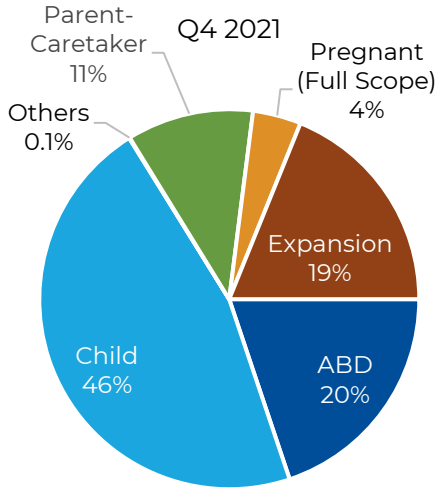
Month	2019	2020	2021
July	4.4%	3.2%	4.0%
August	4.5%	3.2%	4.2%
September	4.8%	3.2%	3.7%

2020 vs 2021	Count Change	Percent Change
July	0.8%	25%
August	1.0%	31%
September	0.4%	14%

2020 vs 2021 Quarterly Percent Change	22%

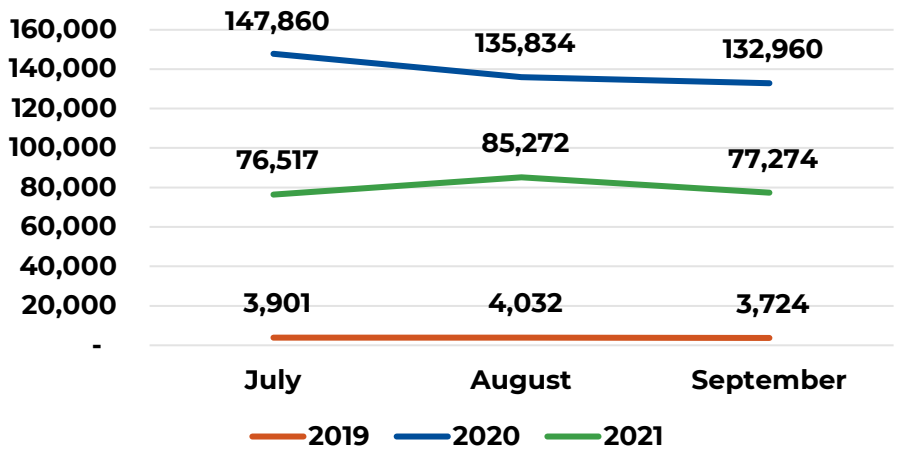
Members Utilizing Emergency Department By Qualifying Group





Utilization (Cont.)

Telemedicine - Total Visits

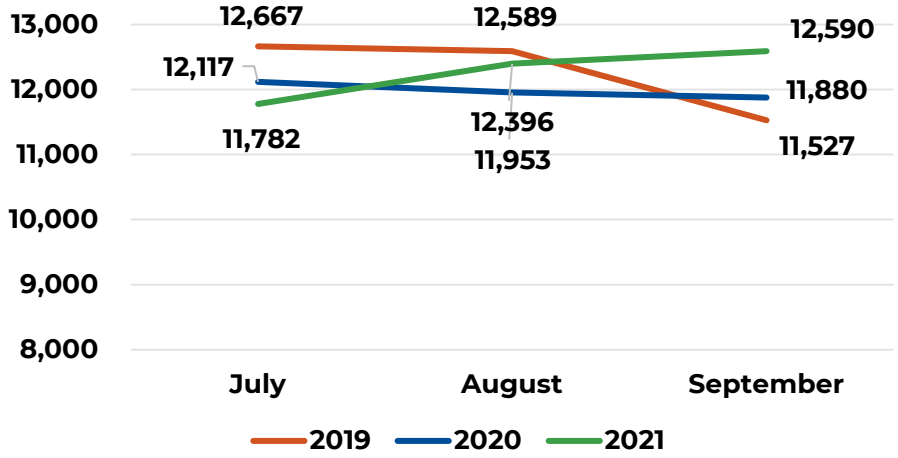


Month	2019	2020	2021
July	3,901	147,860	76,517
August	4,032	135,834	85,272
September	3,724	132,960	77,274

2020 vs 2021	Count Change	Percent Change
July	(71,343)	-48%
August	(50,562)	-37%
September	(55,686)	-42%

2020 vs 2021 Quarterly Percent Change	-43%

Members With Opioid Claims



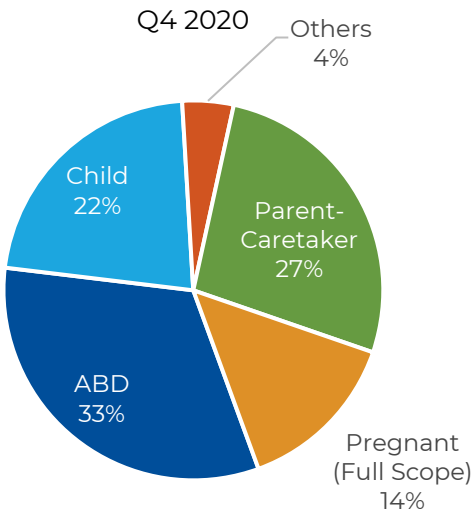
Month	2019	2020	2021
July	12,667	12,117	11,782
August	12,589	11,953	12,396
September	11,527	11,880	12,590

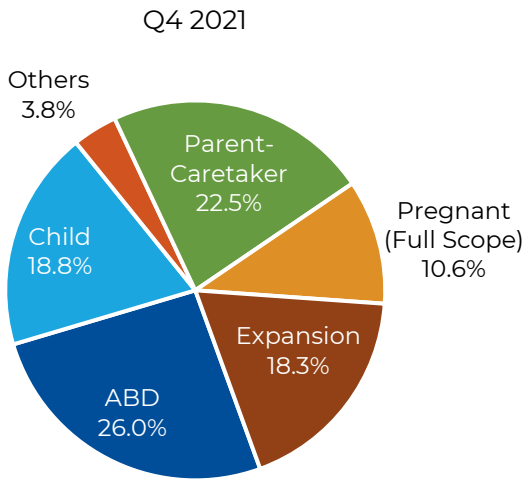
2020 vs 2021	Count Change	Percent Change
July	(335)	-3%
August	443	4%
September	710	6%

2020 vs 2021 Quarterly Percent Change	7%

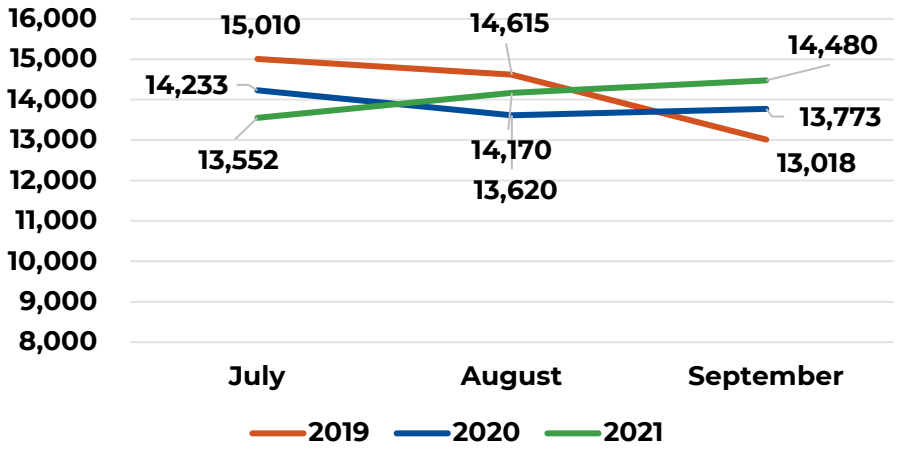
Utilization (Cont.)

Members With Opioid Claims By Qualifying Group





Total Opioid Claims



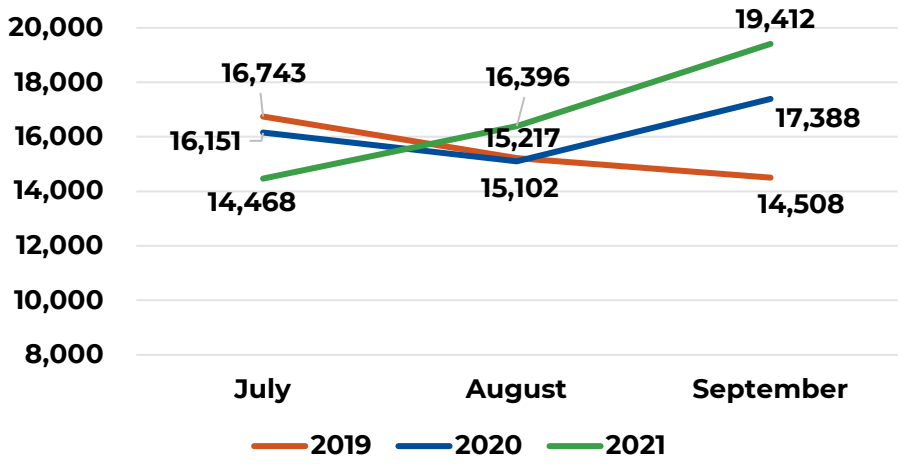
Month	2019	2020	2021
July	15,010	14,233	13,552
August	14,615	13,620	14,170
September	13,018	13,773	14,480

2020 vs 2021	Count Change	Percent Change
July	(681)	-5%
August	550	4%
September	707	5%

2020 vs 2021 Quarterly Percent Change	1%

Utilization (Cont.)

Out of State Services - Total Members Utilization



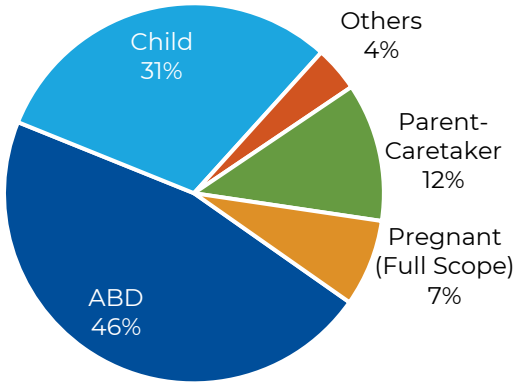
Month	2019	2020	2021
July	16,743	16,151	14,468
August	15,217	15,102	16,396
September	14,508	17,388	19,412

2020 vs 2021	Count Change	Percent Change
July	(1,683)	-10%
August	1,294	9%
September	2,024	12%

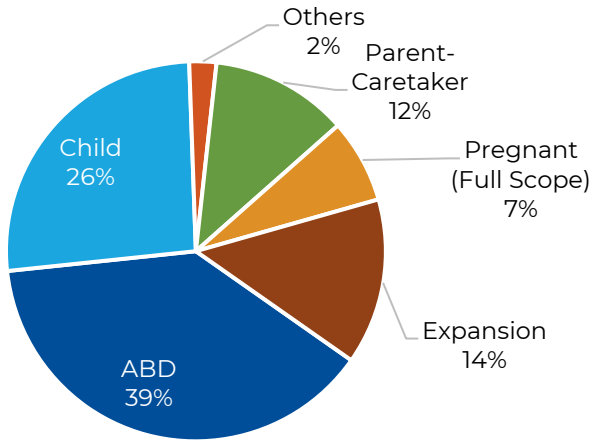
2020 vs 2021 Quarterly Percent Change	9%

Out of State Services - Total Members Utilization By Qualifying Group

Q4 2020

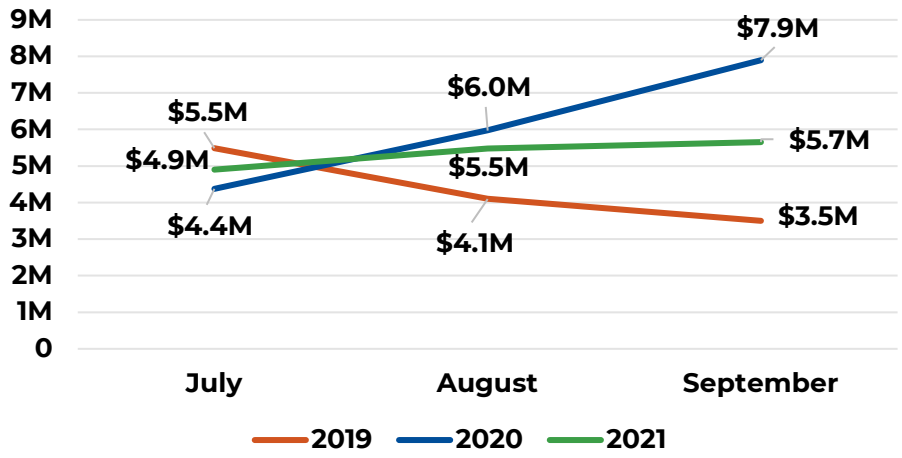


Q4 2021



Utilization (Cont.)

Out of State Services - Total Reimbursements

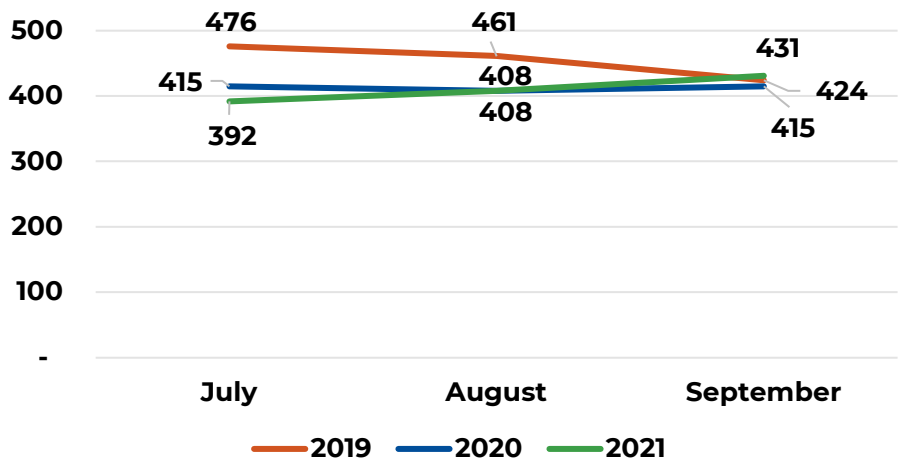


Month	2019	2020	2021
July	$ 5,489,271	$ 4,382,797	$ 4,903,995
August	$ 4,100,530	$ 5,975,597	$ 5,479,145
September	$ 3,507,469	$ 7,894,659	$ 5,655,083

2020 vs 2021	Count Change	Percent Change
July	521,198	12%
August	(496,452)	-8%
September	(2,239,576)	-28%

2020 vs 2021 Quarterly Percent Change	-12%

Out of State Services - Total Active Billing Providers



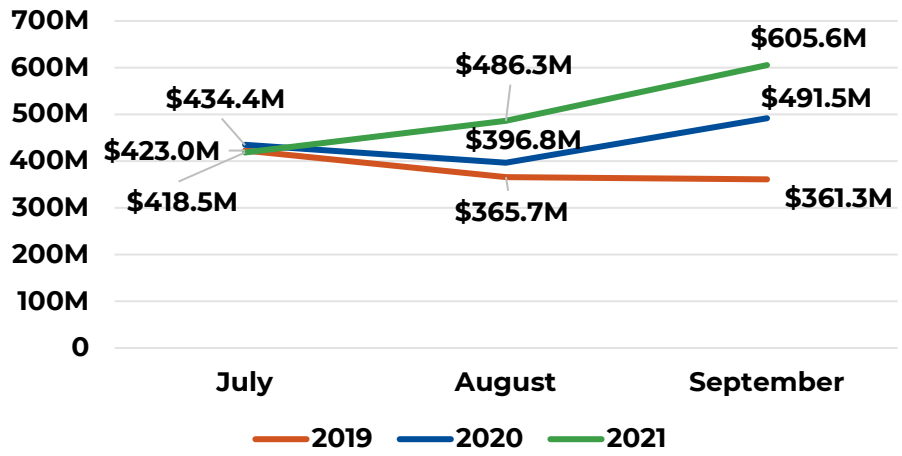
Month	2019	2020	2021
July	476	415	392
August	461	408	408
September	424	415	431

2020 vs 2021	Count Change	Percent Change
July	(23)	-6%
August	-	0%
September	16	4%

2020 vs 2021 Quarterly Percent Change	1%

Financials

Total Agency Expenditures

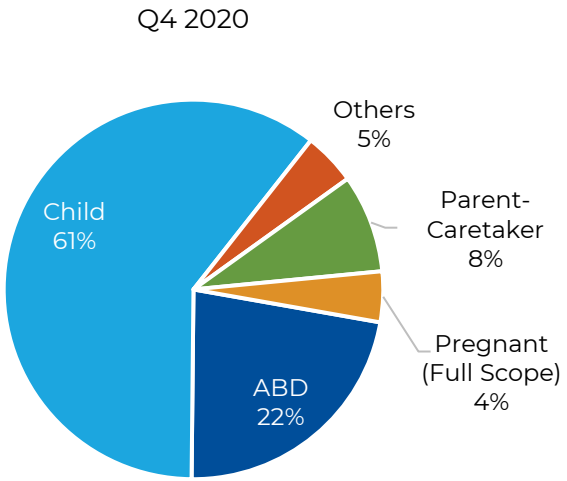


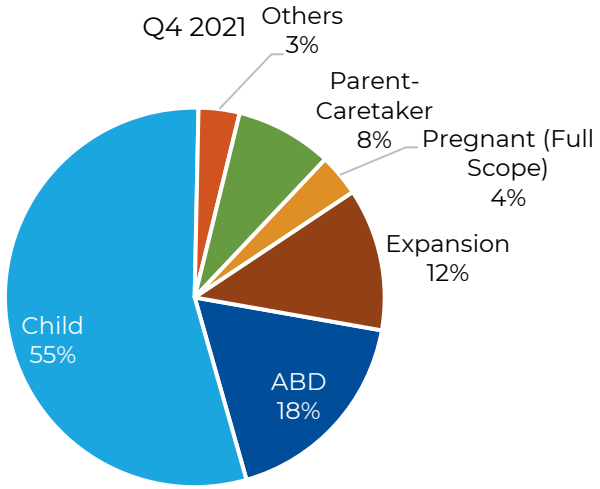
Month	2019	2020	2021
July	$ 422,982,605	$ 434,362,730	$ 418,456,636
August	$ 365,653,473	$ 396,750,031	$ 486,331,080
September	$ 361,251,537	$ 491,541,256	$ 605,613,043

2020 vs 2021	Count Change	Percent Change
July	$ (15,906,094)	-4%
August	$ 89,581,049	23%
September	$ 114,071,787	23%

2020 vs 2021 Quarterly Percent Change	14%

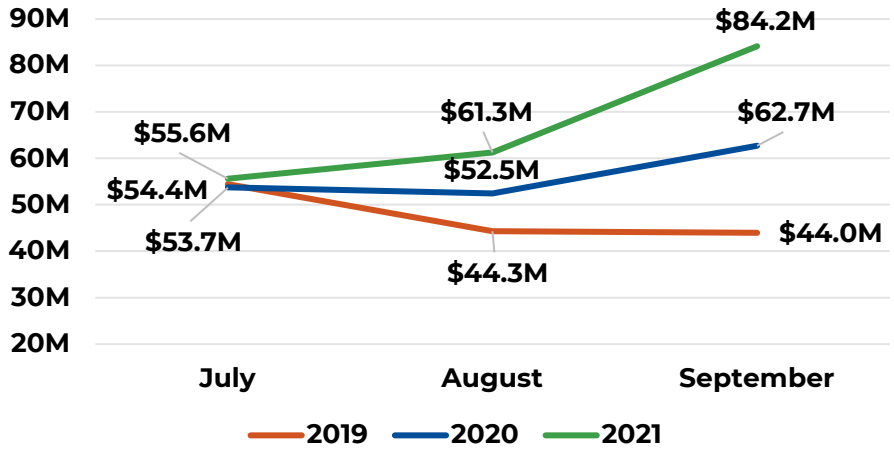
Total Agency Members Utilization by Qualifying Group





Financials (Cont.)

Inpatient Services Expenditures

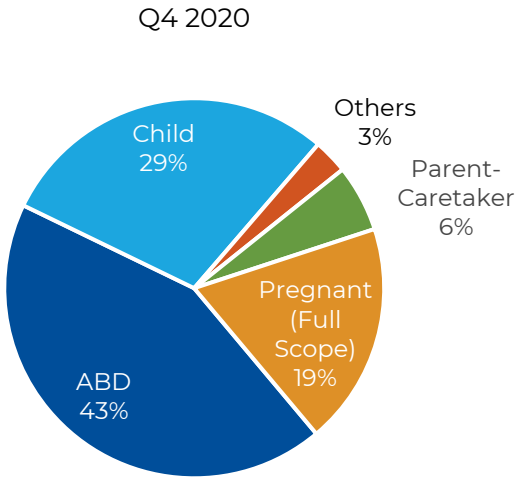


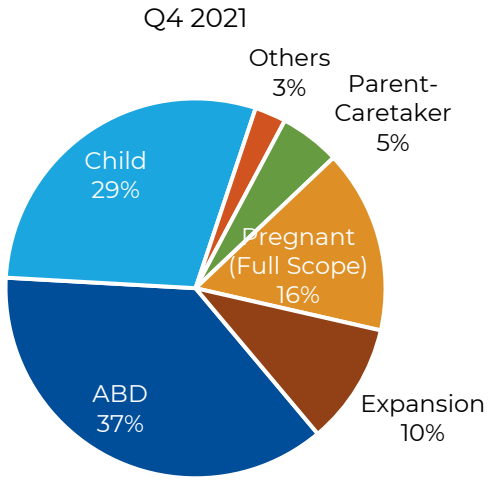
Month	2019	2020	2021
July	$ 54,427,549	$ 53,716,873	$ 55,633,553
August	$ 44,329,238	$ 52,496,446	$ 61,276,848
September	$ 43,958,412	$ 62,746,638	$ 84,154,404

2020 vs 2021	Count Change	Percent Change
July	$ 1,916,680	4%
August	$ 8,780,401	17%
September	$ 21,407,767	34%

2020 vs 2021 Quarterly Percent Change	19%

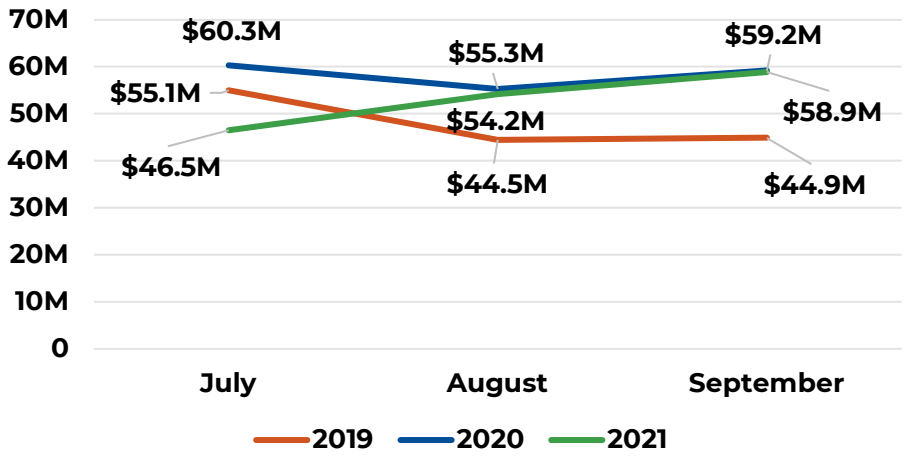
Inpatient Services Members Utilization by Qualifying Group





Financials (Cont.)

Nursing Facility Expenditures

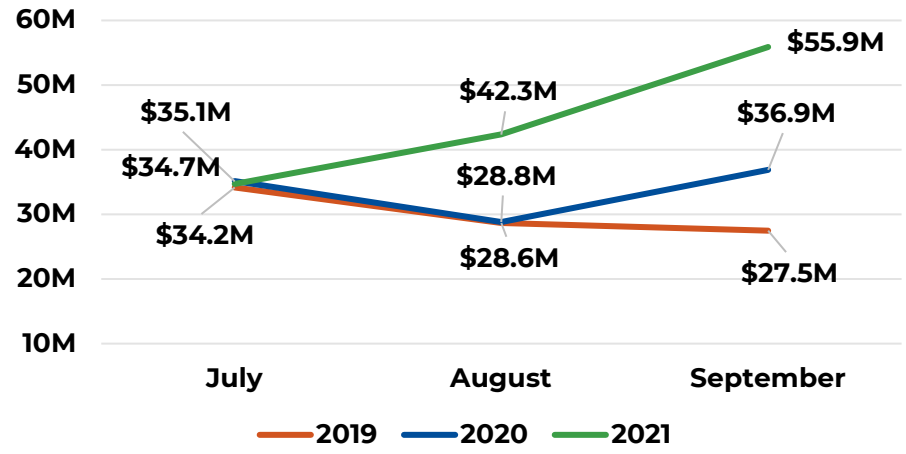


Month	2019	2020	2021
July	$ 55,053,075	$ 60,319,959	$ 46,523,174
August	$ 44,466,509	$ 55,285,577	$ 54,150,765
September	$ 44,897,072	$ 59,201,527	$ 58,889,322

2020 vs 2021	Count Change	Percent Change
July	$ (13,796,785)	-23%
August	$ (1,134,812)	-2%
September	$ (312,205)	-1%

2020 vs 2021 Quarterly Percent Change	-9%

Outpatient Hospital Expenditures



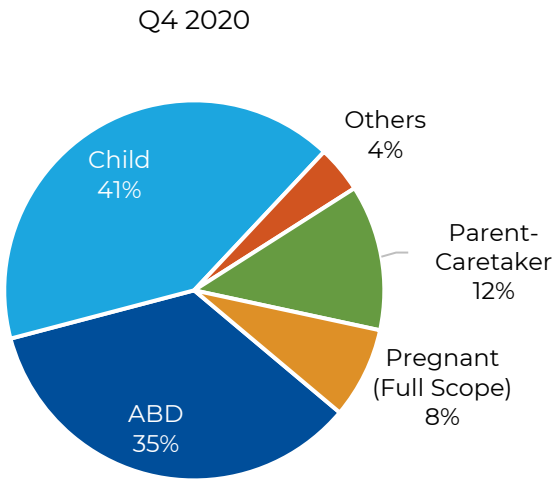
Month	2019	2020	2021
July	$ 34,158,628	$ 35,111,863	$ 34,697,304
August	$ 28,649,593	$ 28,822,256	$ 42,342,760
September	$ 27,476,262	$ 36,891,916	$ 55,891,402

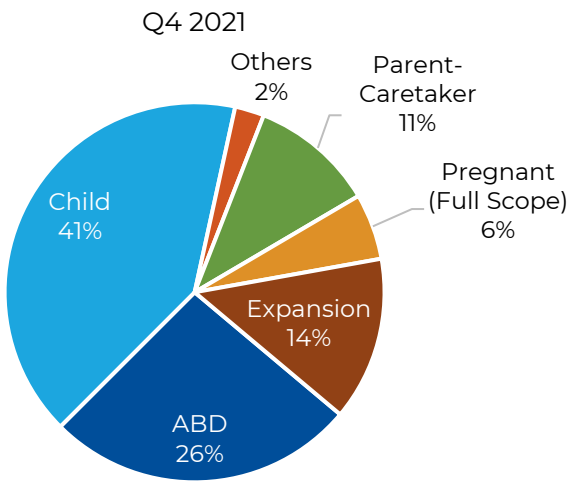
2020 vs 2021	Count Change	Percent Change
July	$ (414,559)	-1%
August	$ 13,520,504	47%
September	$ 18,999,486	52%

2020 vs 2021 Quarterly Percent Change	32%

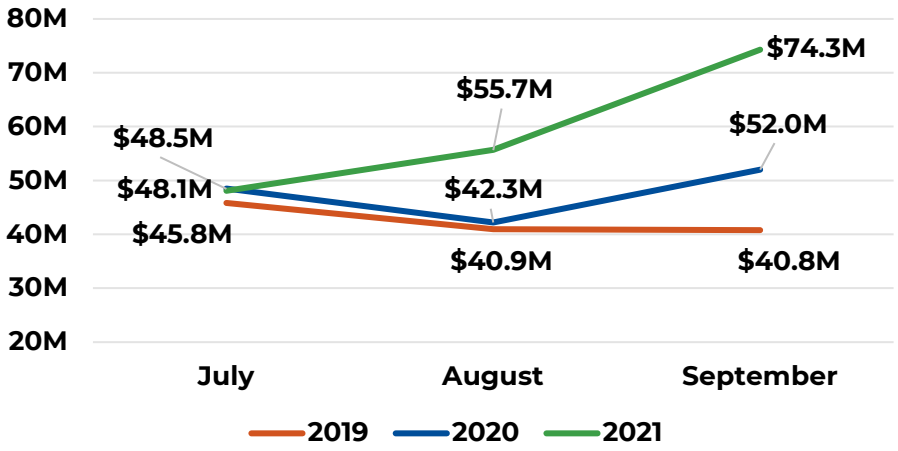
Financials (Cont.)

Outpatient Hospital Members Utilization by Qualifying Group





Physician Expenditures



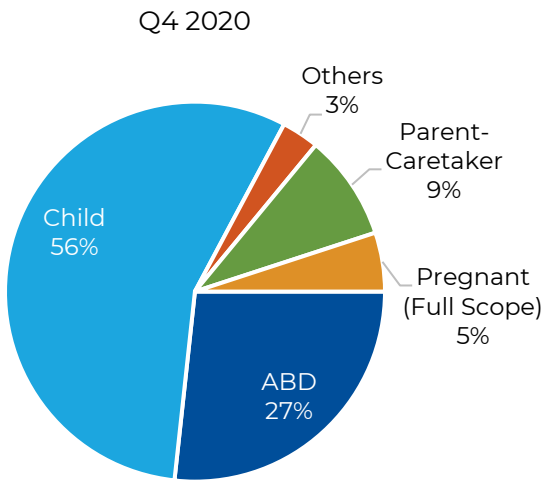
Month	2019	2020	2021
July	$ 45,844,681	$ 48,471,965	$ 48,134,117
August	$ 40,942,215	$ 42,258,941	$ 55,674,733
September	$ 40,833,786	$ 52,027,903	$ 74,307,066

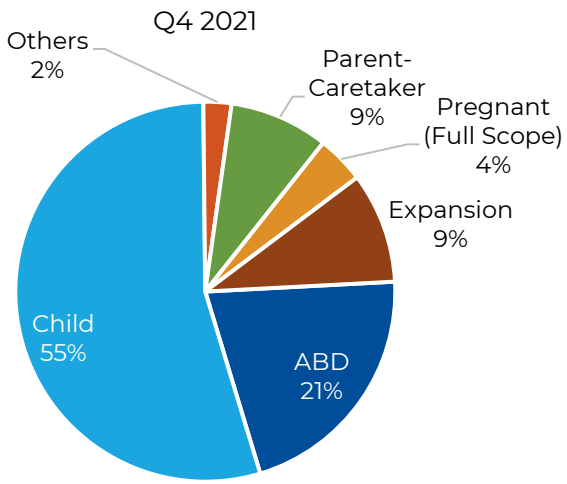
2020 vs 2021	Count Change	Percent Change
July	$ (337,848)	-1%
August	$ 13,415,792	32%
September	$ 22,279,163	43%

2020 vs 2021 Quarterly Percent Change	25%

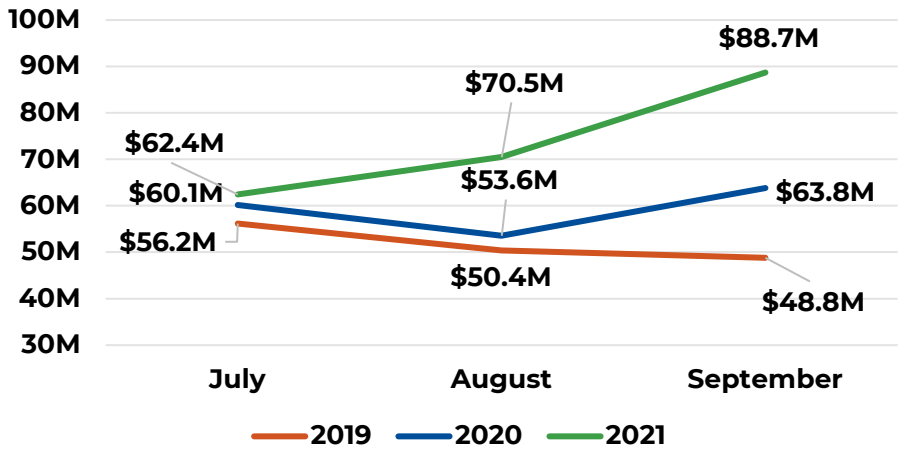
Financials (Cont.)

Physician Members Utilization By Qualifying Group





Prescribed Drugs Expenditures



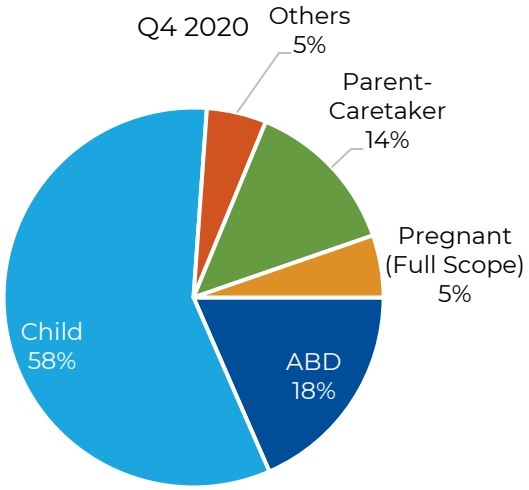
Month	2019	2020	2021
July	$ 56,163,149	$ 60,128,090	$ 62,446,364
August	$ 50,406,732	$ 53,571,215	$ 70,461,256
September	$ 48,848,432	$ 63,820,983	$ 88,704,910

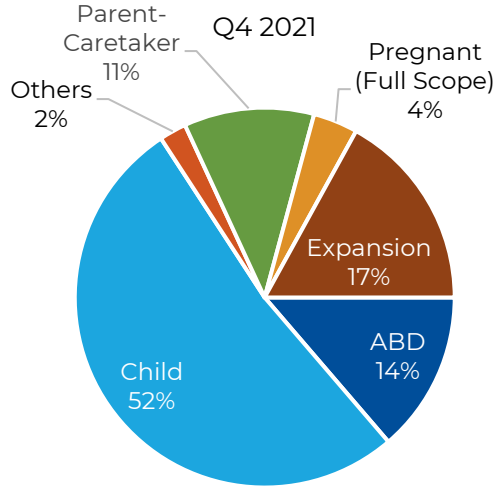
2020 vs 2021	Count Change	Percent Change
July	$ 2,318,275	4%
August	$ 16,890,041	32%
September	$ 24,883,928	39%

2020 vs 2021 Quarterly Percent Change	25%

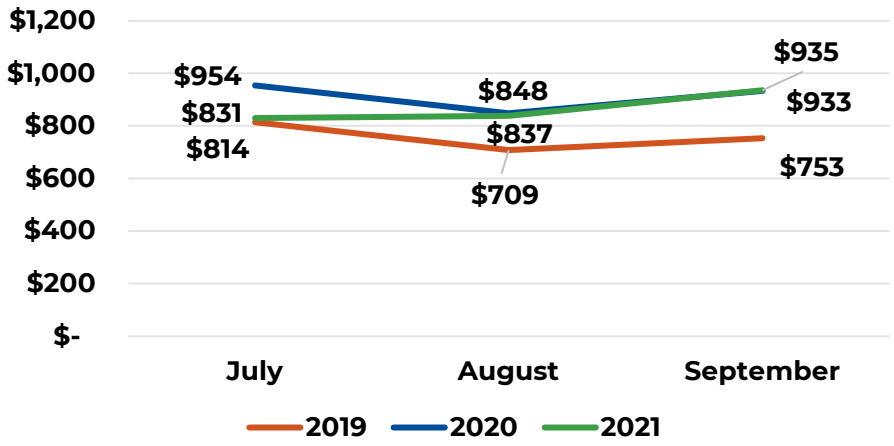
Financials (Cont.)

Prescribed Drugs Members Utilization By Qualifying Group





Average Per Total Member Served



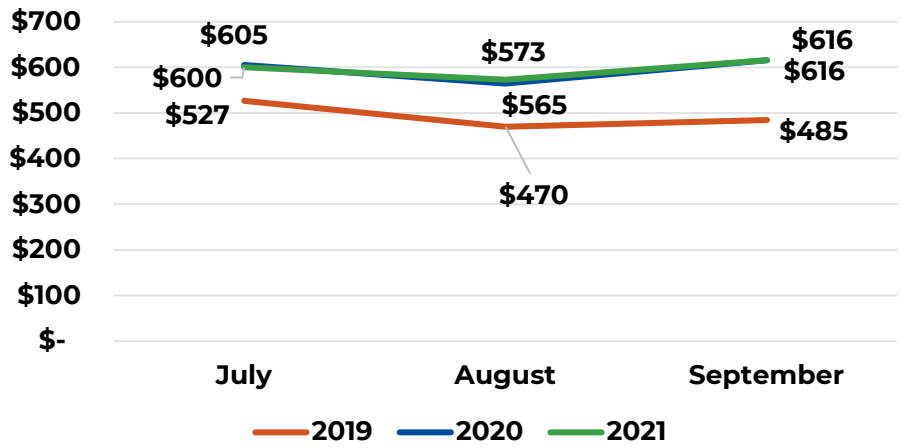
Month	2019	2020	2021
July	$ 814	$ 954	$ 831
August	$ 709	$ 848	$ 837
September	$ 753	$ 933	$ 935

2020 vs 2021	Count Change	Percent Change
July	$ (123)	-13%
August	$ (11)	-1%
September	$ 2	0%

2020 vs 2021 Quarterly Percent Change	-5%

Financials (Cont.)

Average Per Child (Under 21) Member Served

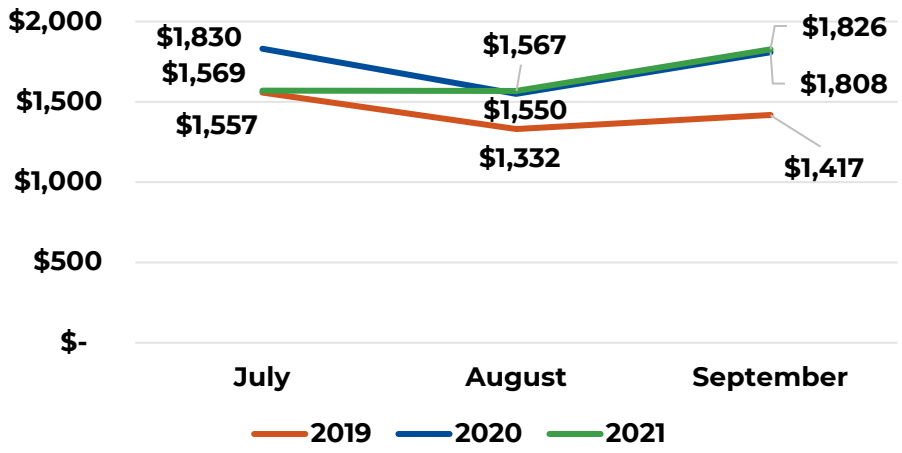


Month	2019	2020	2021
July	$ 527	$ 605	$ 600
August	$ 470	$ 565	$ 573
September	$ 485	$ 616	$ 616

2020 vs 2021	Count Change	Percent Change
July	$ (5)	-1%
August	$ 8	1%
September	$ 0	0%

2020 vs 2021 Quarterly Percent Change	2%

Average Per Aged/Blind/Disabled Member Served



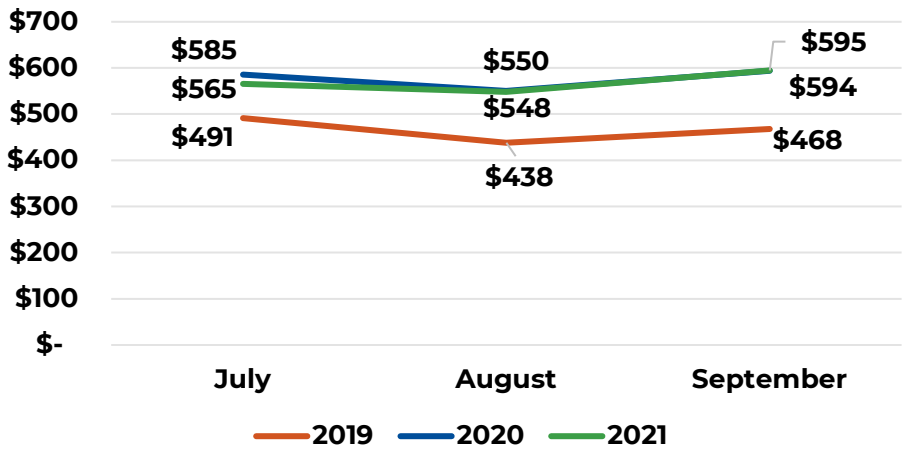
Month	2019	2020	2021
July	$ 1,557	$ 1,830	$ 1,569
August	$ 1,332	$ 1,550	$ 1,567
September	$ 1,417	$ 1,808	$ 1,826

2020 vs 2021	Count Change	Percent Change
July	$ (262)	-14%
August	$ 17	1%
September	$ 17	1%

2020 vs 2021 Quarterly Percent Change	-5%

Financials (Cont.)

Average Per Children & Parent/Caretaker Member Served

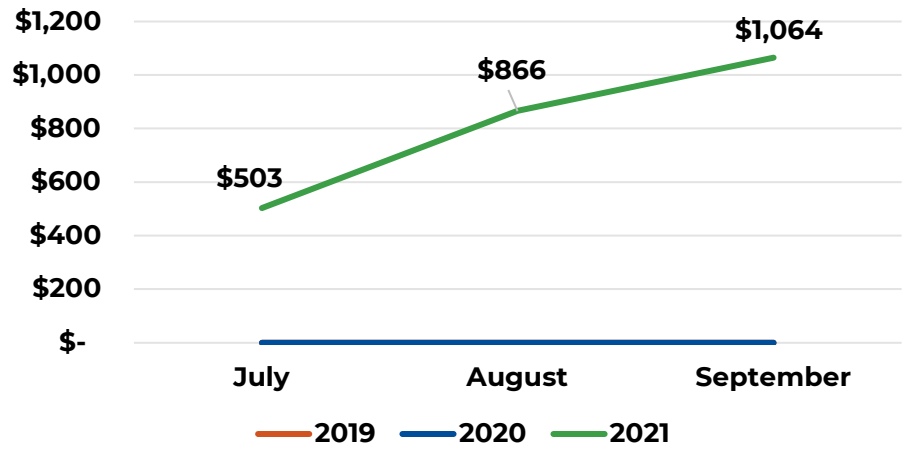


Month	2019	2020	2021
July	$ 491	$ 585	$ 565
August	$ 438	$ 550	$ 548
September	$ 468	$ 594	$ 595

2020 vs 2021	Count Change	Percent Change
July	$ (20)	-3%
August	$ (2)	0%
September	$ 1	0%

2020 vs 2021 Quarterly Percent Change	0%

Average Per Expansion Member Served (Effective July 2021)



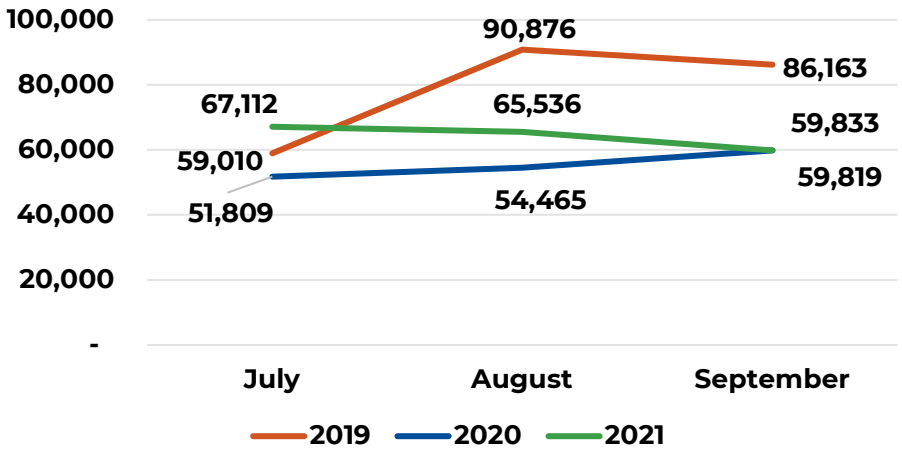
Month	2019	2020	2021
July	$ -	$ -	$ 503
August	$ -	$ -	$ 866
September	$ -	$ -	$ 1,064

2020 vs 2021	Count Change	Percent Change
July	$ 503	#DIV/0!
August	$ 866	#DIV/0!
September	$ 1,064	#DIV/0!

2020 vs 2021 Quarterly Percent Change	100%

Call Center

Call Center - Member Calls Answered

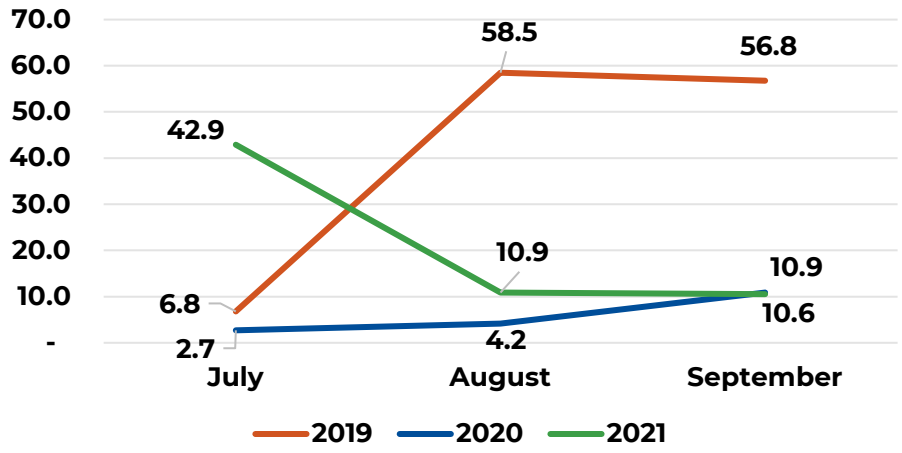


Month	2019	2020	2021
July	59,010	51,809	67,112
August	90,876	54,465	65,536
September	86,163	59,833	59,819

2020 vs 2021	Count Change	Percent Change
July	15,303	30%
August	11,071	20%
September	(14)	0%

2020 vs 2021 Quarterly Percent Change	16%

Call Center - Average Wait Time (In Seconds)



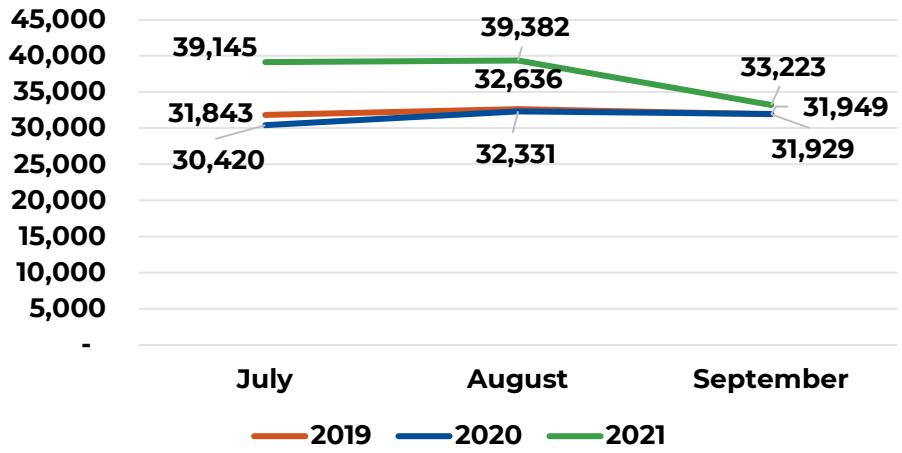
Month	2019	2020	2021
July	6.8	2.7	42.9
August	58.5	4.2	10.9
September	56.8	10.9	10.6

2020 vs 2021	Count Change	Percent Change
July	40	1488%
August	7	162%
September	(0)	-3%

2020 vs 2021 Quarterly Percent Change	N/A

Prior Authorization

Prior Authorization - Total Combined - Total Completed PA Volume

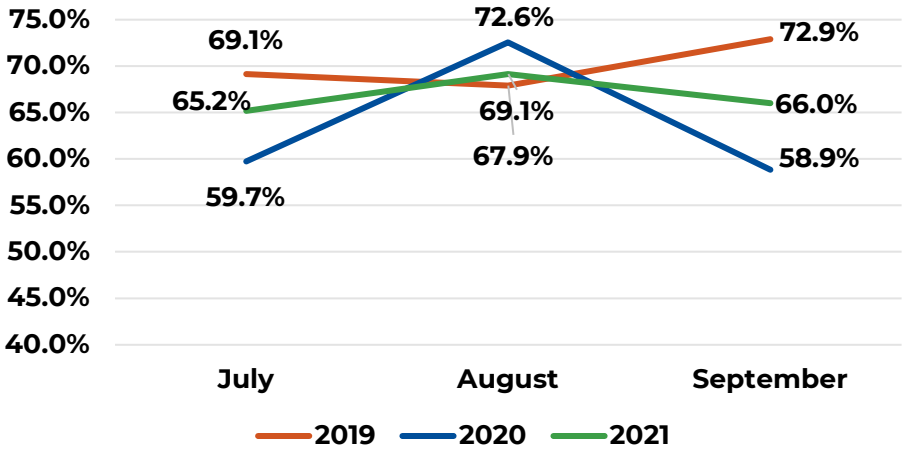


Month	2019	2020	2021
July	31,843	30,420	39,145
August	32,636	32,331	39,382
September	31,929	31,949	33,223

2020 vs 2021	Count Change	Percent Change
July	8,725	29%
August	7,051	22%
September	1,274	4%

2020 vs 2021 Quarterly Percent Change	18%

Prior Authorization - Total Combined - Total Percent Completed 0-6 Days



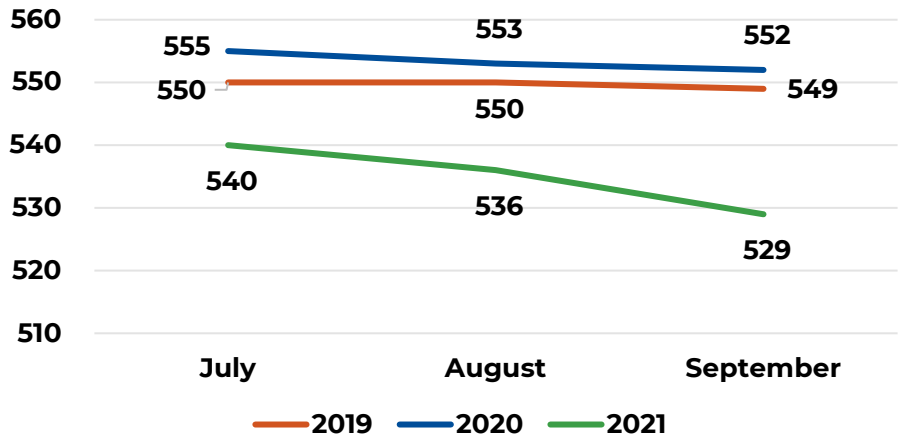
Month	2019	2020	2021
July	69.1%	59.7%	65.2%
August	67.9%	72.6%	69.1%
September	72.9%	58.9%	66.0%

2020 vs 2021	Count Change	Percent Change
July	5.5%	9%
August	-3.4%	-5%
September	7.1%	12%

2020 vs 2021 Quarterly Percent Change	5%

Agency Stats & Provider Network

OHCA Admin - Number of FTEs

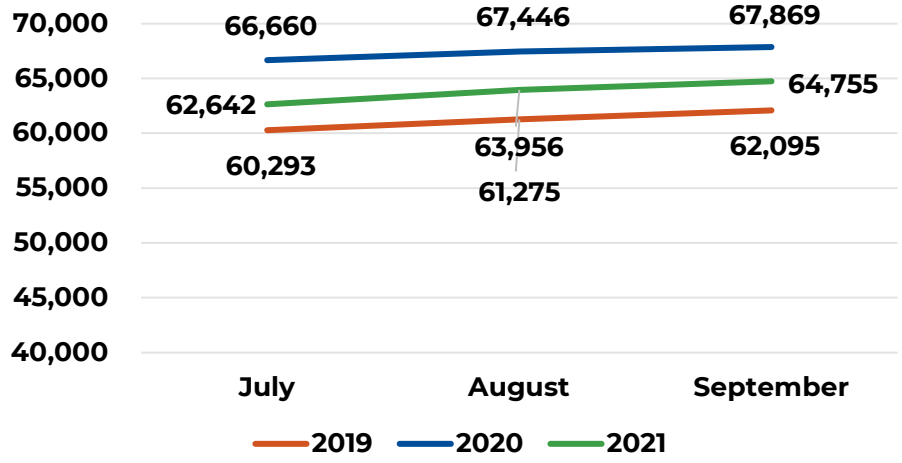


Month	2019	2020	2021
July	550	555	540
August	550	553	536
September	549	552	529

2020 vs 2021	Count Change	Percent Change
July	(15)	-3%
August	(17)	-3%
September	(23)	-4.2%

2020 vs 2021 Quarterly Percent Change	N/A

Total Providers



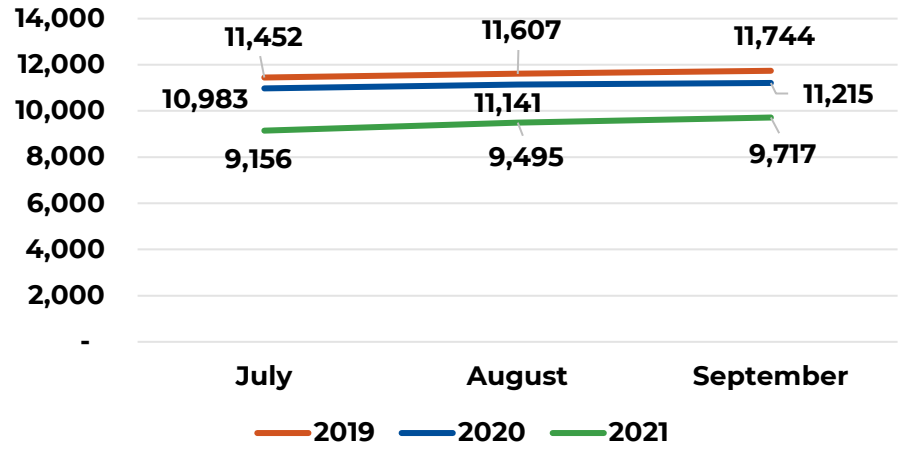
Month	2019	2020	2021
July	60,293	66,660	62,642
August	61,275	67,446	63,956
September	62,095	67,869	64,755

2020 vs 2021	Count Change	Percent Change
July	(4,018)	-6%
August	(3,490)	-5%
September	(3,114)	-5%

2020 vs 2021 Quarterly Percent Change	-4%

Agency Stats & Provider Network (Cont.)

Mental Health Providers (In-State Only)

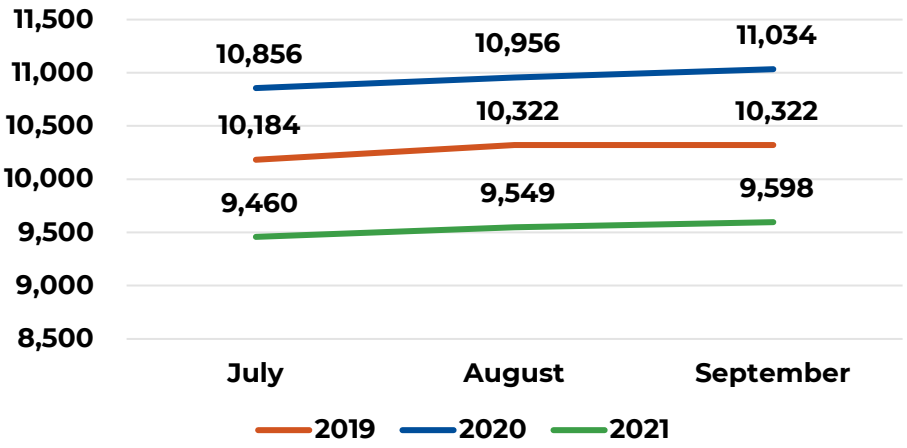


Month	2019	2020	2021
July	11,452	10,983	9,156
August	11,607	11,141	9,495
September	11,744	11,215	9,717

2020 vs 2021	Count Change	Percent Change
July	(1,827)	-17%
August	(1,646)	-15%
September	(1,498)	-13%

2020 vs 2021 Quarterly Percent Change	-11%

Physicians (In-State Only)



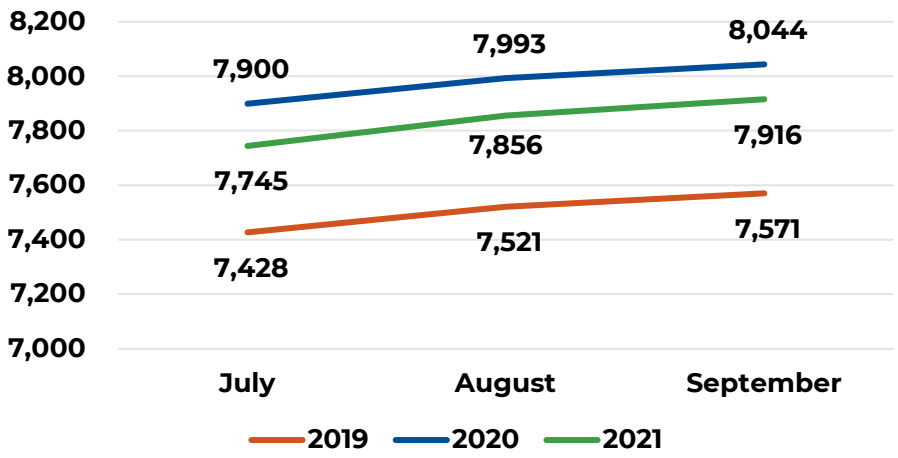
Month	2019	2020	2021
July	10,184	10,856	9,460
August	10,322	10,956	9,549
September	10,322	11,034	9,598

2020 vs 2021	Count Change	Percent Change
July	(1,396)	-13%
August	(1,407)	-13%
September	(1,436)	-13%

2020 vs 2021 Quarterly Percent Change	-12%

Agency Stats & Provider Network (Cont.)

Primary Care Providers (In-State Only)

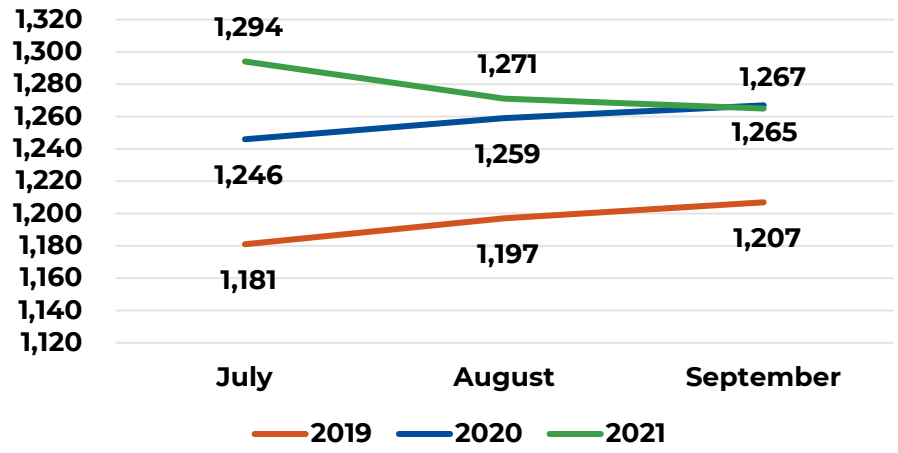


Month	2019	2020	2021
July	7,428	7,900	7,745
August	7,521	7,993	7,856
September	7,571	8,044	7,916

2020 vs 2021	Count Change	Percent Change
July	(155)	-2%
August	(137)	-2%
September	(128)	-2%

2020 vs 2021 Quarterly Percent Change	-1%

Dentists (In-State Only)



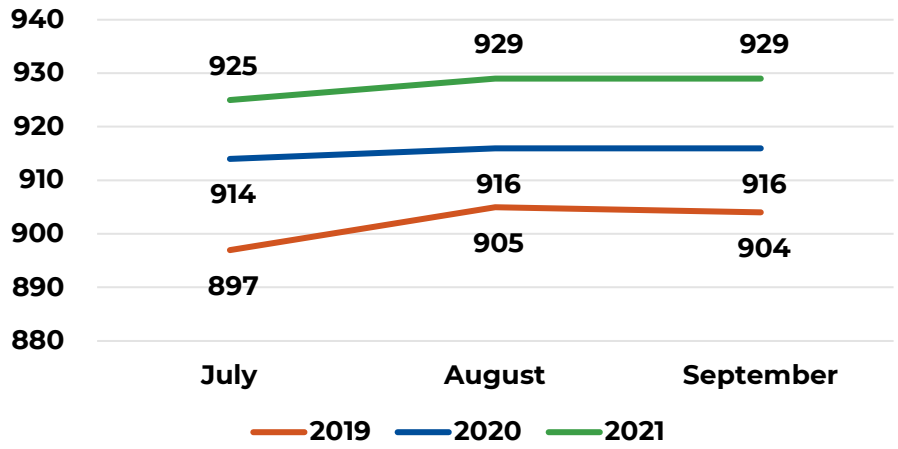
Month	2019	2020	2021
July	1,181	1,246	1,294
August	1,197	1,259	1,271
September	1,207	1,267	1,265

2020 vs 2021	Count Change	Percent Change
July	48	4%
August	12	1%
September	(2)	0%

2020 vs 2021 Quarterly Percent Change	3%

Agency Stats & Provider Network (Cont.)

Pharmacy (In-State Only)

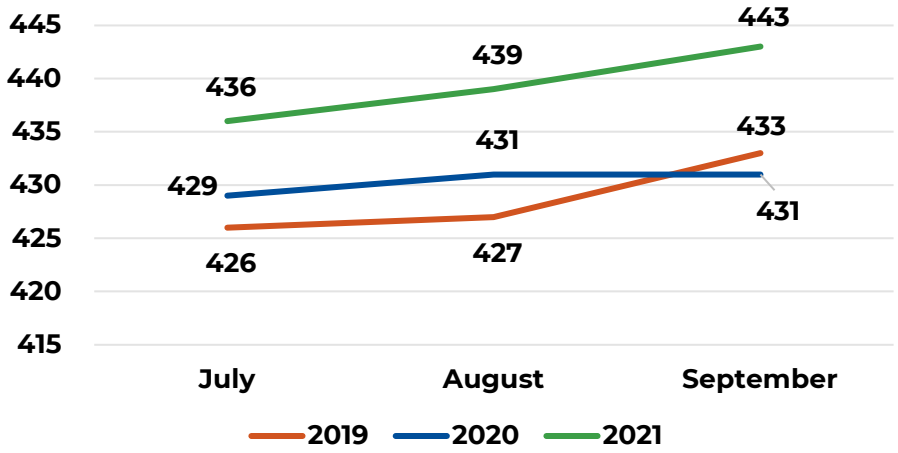


Month	2019	2020	2021
July	897	914	925
August	905	916	929
September	904	916	929

2020 vs 2021	Count Change	Percent Change
July	11	1%
August	13	1%
September	13	1%

2020 vs 2021 Quarterly Percent Change	4%

Extended Care Facilities (In-State Only)



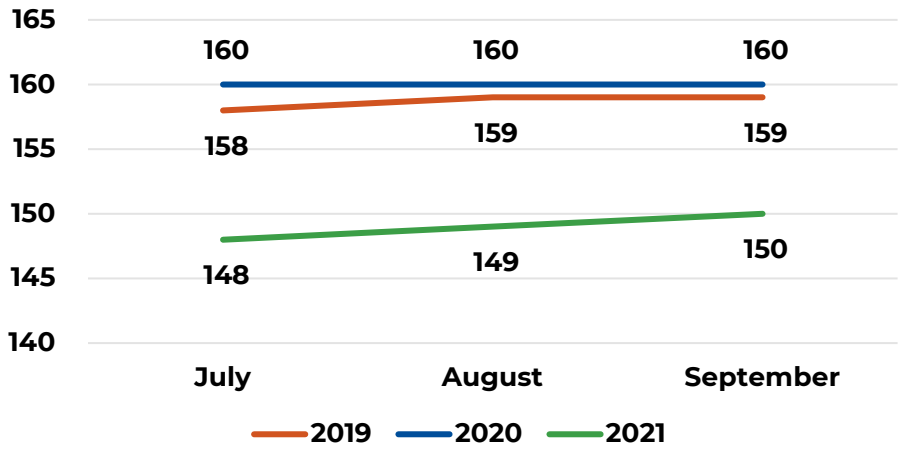
Month	2019	2020	2021
July	426	429	436
August	427	431	439
September	433	431	443

2020 vs 2021	Count Change	Percent Change
July	7	2%
August	8	2%
September	12	3%

2020 vs 2021 Quarterly Percent Change	2%

Agency Stats & Provider Network (Cont.)

Hospitals (In-State Only)



Month	2019	2020	2021
July	158	160	148
August	159	160	149
September	159	160	150

2020 vs 2021	Count Change	Percent Change
July	(12)	-8%
August	(11)	-7%
September	(10)	-6%

2020 vs 2021 Quarterly Percent Change	-6%