Oklahoma Health Care Authority
MEDICAL ADVISORY COMMITTEE
September 9th, 2021
1:00 – 3:30 PM

Charles Ed McFall Board Room

AGENDA

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

II. Action Item: Approval of Minutes of the July 8th, 2021: **Medical Advisory Committee Meeting**

III. Public Comments (2 minute limit)

IV. MAC Member Comments/Discussion

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

VI. SoonerCare Operations: **Melinda Thomason, Senior Director for Stakeholder Engagement**

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

- **A. 21-01 Reimbursing Federally Qualified Health Centers (FQHCs) for Long-Acting Reversible Contraceptive (LARCs) Devices Outside of the Encounter Rate**
- **B. 21-10 Transitioning Developmental Disabilities Services Division (DDSD) Members back into the Money Follows (MFP)the Person Demonstration**
- **C. 21-11 Indian Health Service, Tribal and Urban Indian (I/T/U) Shared Savings Program**
- **D. 21-16 Hospital Presumptive Eligibility for Expansion Adults**
- **E. 21-17 Adult Dental Benefit Revisions**
- **F. 21-18 COFA Migrant Medicaid Extension**
- **G. 21-19 Appeals to the Chief Executive Officer (CEO)/Administrative Law Judge (ALJ)**
- **H. 21-20 Alternative Treatments for Pain Management**
- **I. 21-21 Non-hospital based hospice**

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

IX. Future Meeting: **Chairman, Jason Rhynes, O.D.**
November 4, 2021

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

Oklahoma Health Care Authority
MEDICAL ADVISORY COMMITTEE
MINUTES of the July 8, 2021 Meeting
4345 N. Lincoln Blvd., Oklahoma City, OK 73105

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

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

Delegates present were: Ms. Sarah Baker, Ms. Debra Billingsly, Ms. Mary Brinkley, Dr. Erin Balzer, Dr. Joe Catalano, Mr. Victor Clay, Mr. Brett Coble, Ms. Wanda Felty, Dr. Arlen Foulks, Ms. Terrie Fritz, Ms. Allison Garrison, Dr. Craig Kupiec, Ms. Annette Mays, Ms. Melissa Miller, Dr. Daniel Post, Ms. Toni Pratt-Reid, Dr. Jason Rhynes, Dr. Dwight Sublett, Ms. Mitzi McCullock, Mr. Jeff Tallent, and Dr. Whitney Yeates.

Alternates present were: Dr. Chad Douglas, Mr. Terry Bryce and Mr. Tony Fullbright, providing a quorum.

***Delegates absent without an alternate were*:** Mr. Steve Goforth, Mr. Mark Jones, Ms. Jennifer King, Dr. J'Dene Rogers, Mr. James Patterson, and Dr. Raymond Smith.

II. Approval of the June 10, 2021 Minutes

Medical Advisory Committee

The motion to approve the minutes was by Mr. Jeff Tallent and seconded by Mr. Victor Clay and passed unanimously.

III. Public Comments (2 minute limit):

There were no public comments.

IV. MAC Member Comments/Discussion:

Chairman, Jason Rhynes, O.D.

Dr. J. Daniel Post stated that he has been the chiropractic delegate on the committee for many years, and this year in our budget request, we added funds for chiropractic care, which has passed. The total outcome somewhere between $9 - $12 million, which is a great start. He wants to thank the OHCA for all the help to make this happen.

Dr. Whitney Yeates stated that it may be slow going for dental in the beginning with this being so new. Providers did not receive the announcement until July 1st, along with the patients. Providers needed to know that information beforehand, so that way they have prepared beforehand and have the education. They are not getting that education until today at 2:00pm. There is a lot of concern with the benefits, and the offices have already been flooded with phone calls, but have no information about it, so no one wants to schedule just yet.

Mr. Victor Clay stated that in the last board meeting, Mr. Corbett shared some information about the state Supreme Court ruling and what was going on. Mr. Clay asked for a synopsis, or what the next steps are. Ms. Anthony replied discussing what we are doing today. We are currently doing consultation with the Governor office, and we are still waiting on the Governor to give us direction. There has been no change in what Kevin Corbett's update would have been at that time because we are still waiting for directions about what the next steps are.

Mr. Sublett requested that there be a back-and-forth dialog between the MAC and the OHCA Board. It could be done by email on what they are discussing, what the MAC is discussing so that we have an open communication.

Ms. Terrie Fritz discussed the MAC being re-vamped and asked when we would be able to tell our association weather our roles will continue or not. Ms. Anthony responded stating that the bill passed and has an effect date of November 1, 2021. The restructure is outlined in legislation which is public.

V. SoonerCare Operations Update:

Derek Lieser, Senior Director of Eligibility & Coverage Services

Mr. Lieser gave an update on SoonerCare Adult Expansion talking about the foundation of Medicaid Expansion, the funding, population, groups reprocessed & included in expansion, by the numbers, and benefits and coverage. For more detailed information, please see item 5, in the MAC agenda.

VIII. Proposed Rule Changes: Presentation, Discussion, and Vote:

Sandra Puebla, Senior Director of Federal & State Authorities

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

APA WF 21-12 Purchasing Rules Revisions — The proposed revisions will re-establish agency-specific rules for purchasing and procurement. Revisions include provisions related to procurement definitions, procurement ethics and prohibited conduct, conflicts of interest, and procurement of goods and services and professional services.
Budget Impact: Budget neutral
Tribal Consultation: July 6, 2021

Ms. Mitzi McCullock stated that on behalf of OHA and our member hospitals, we don't believe SB 131 authorizes this agency to proceed with promulgating rules for managed care in light of the decision of the Supreme Court on June 1st. For this reason, she will be voting no.

The rule change motion to approve was by Dr. J. Daniel Post and seconded by Mr. Jeff Tallent and passed with 12 yes, and 11 no.

APA WF 21-13 Grievance Procedures and Process Rules 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

Ms. Mitzi McCullock stated that on behalf of OHA and our member hospitals, we don't believe SB 131 authorizes this agency to proceed with promulgating rules for managed care in light of the decision of the Supreme Court on June 1st. For this reason, she will be voting no.

The rule change motion to approve was by Dr. Arlen Foulks and seconded by Mr. Jeff Tallent with 1 yes, and 22 no.

APA WF 21-14 Expansion Adults into SoonerCare Choice — The proposed revisions will add expansion adults, as per 42 C.F.R. 435.119, as a group eligible to receive services through the patient centered medical home (PCMH) service delivery model.
Budget Impact: Agency staff has determined that the proposed changes would potentially result in a combined federal and state spending of $8,829,743 total, with $882,974 in state share for State Fiscal Year (SFY) 2022.
Tribal Consultation: July 6, 2021
The rule change motion to approve was by Mr. Victor Clay and seconded by Mr. Jeff Tallent and passed unanimously, with 1 abstention.

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

Ms. Mitzi McCullock stated that on behalf of OHA and our member hospitals, we don't believe SB 131 authorizes this agency to proceed with promulgating rules for managed care in light of the decision of the Supreme Court on June 1st. For this reason, she will be voting no.

Ms. Terrie Fritz wants it to be known that its really critical with this population, that we mandate and utilize those community-based network providers that are there, who do a comprehensive service system with the population, being brought in.

The rule change motion to approve was by Mr. Jeff Tallent, and seconded by Dr. Arlen Foulks with 1 yes, and 22 no.

IX. MAC Meeting Dates for Calendar 2021:
Chairman, Jason Rhynes, O.D.

September 9, 2021
November 4, 2021

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

XI. Adjourn:
Chairman, Jason Rhynes, O.D.
Chairman Rhynes asked for a motion to adjourn. Motion was provided by Dr. Arlen Foulks and seconded by Ms. Terrie Fritz, there was no dissent and the meeting adjourned at 2:53pm.

OKLAHOMA
Health Care Authority

FINANCIAL REPORT

For the Fiscal Year Ended June 30, 2021
Submitted to the CEO & Board

- Revenues for OHCA through June, accounting for receivables, were **$4,814,111,370** or **2.3% under** budget.
- Expenditures for OHCA, accounting for encumbrances, were **$4,618,145,721** or **3.7% under** budget.
- The state dollar budget variance through June is a positive **$62,706,272.**
- The budget variance is primarily attributable to the following (in millions):

Expenditures:		
Medicaid Program Variance		52.7
Administration		10.8
Revenues:		
Drug Rebate		2.1
Medical Refunds		1.8
Taxes and Fees		(4.7)
Total FY 21 Variance	**$**	**62.7**

ATTACHMENTS

OKLAHOMA HEALTH CARE AUTHORITY
Summary of Revenues & Expenditures: OHCA
SFY 2021, For the Fiscal Year Ended June 30, 2021

REVENUES	FY21 Budget YTD	FY21 Actual YTD	Variance	% Over/ (Under)
State Appropriations	$ 975,239,368	$ 975,239,368	$ -	0.0%
Federal Funds	3,186,381,824	3,063,442,350	(122,939,474)	(3.9)%
Tobacco Tax Collections	45,988,251	48,189,548	2,201,296	4.8%
Quality of Care Collections	85,403,334	77,451,428	(7,951,906)	(9.3)%
Prior Year Carryover	23,420,980	23,420,980	-	0.0%
Federal Deferral - Interest	228,087	228,087	-	0.0%
Rate Preservation Fund	4,092,470	4,092,470	-	0.0%
Drug Rebates	398,067,708	406,159,359	8,091,651	2.0%
Medical Refunds	35,416,190	42,345,801	6,929,611	19.6%
Supplemental Hospital Offset Payment Program	161,783,459	161,783,459	-	0.0%
GME Federal Disallowance Repayment - OU/OSU	-	-	-	0.0%
Other Revenues	10,770,644	11,758,520	987,876	9.2%
TOTAL REVENUES	**$ 4,926,792,315**	**$ 4,814,111,370**	**$ (112,680,945)**	**(2.3)%**

EXPENDITURES	FY21 Budget YTD	FY21 Actual YTD	Variance	% (Over)/ Under
ADMINISTRATION - OPERATING	**$ 62,315,411**	**$ 52,811,936**	**$ 9,503,475**	**15.3%**
ADMINISTRATION - CONTRACTS	**$ 148,517,318**	**$ 133,986,008**	**$ 14,531,310**	**9.8%**
MEDICAID PROGRAMS				
Managed Care:				
SoonerCare Choice	49,418,554	49,356,375	62,179	0.1%
Acute Fee for Service Payments:				
Hospital Services	1,094,354,553	1,055,172,969	39,181,584	3.6%
Behavioral Health	20,457,311	18,354,027	2,103,284	10.3%
Physicians	409,280,214	378,416,149	30,864,064	7.5%
Dentists	140,403,889	139,582,281	821,609	0.6%
Other Practitioners	57,056,492	49,153,313	7,903,179	13.9%
Home Health Care	33,665,121	31,865,515	1,799,607	5.3%
Lab & Radiology	34,031,090	32,806,219	1,224,871	3.6%
Medical Supplies	63,196,246	64,580,475	(1,384,228)	(2.2)%
Ambulatory/Clinics	309,817,807	296,179,028	13,638,779	4.4%
Prescription Drugs	724,625,893	719,430,089	5,195,804	0.7%
OHCA Therapeutic Foster Care	421,629	467,813	(46,185)	(11.0)%
Other Payments:				
Nursing Facilities	717,905,115	676,343,664	41,561,451	5.8%
Intermediate Care Facilities for Individuals with Intellectual Disabilities Private	68,502,309	68,198,425	303,884	0.4%
Medicare Buy-In	200,621,486	201,216,141	(594,655)	(0.3)%
Transportation	83,537,638	81,994,125	1,543,513	1.8%
Money Follows the Person-OHCA	211,367	215,210	(3,843)	(1.8)%
Electronic Health Records-Incentive Payments	388,104	388,104	-	0.0%
Part D Phase-In Contribution	81,580,408	74,453,855	7,126,553	8.7%
Supplemental Hospital Offset Payment Program	481,658,672	481,658,672	-	0.0%
Telligen	11,476,928	11,515,328	(38,400)	(0.3)%
Total OHCA Medical Programs	**4,582,610,827**	**4,431,347,777**	**151,263,050**	**3.3%**
OHCA Non-Title XIX Medical Payments	89,382	-	89,382	0.0%
TOTAL OHCA	**$ 4,793,532,939**	**$ 4,618,145,721**	**$ 175,387,218**	**3.7%**
REVENUES OVER/(UNDER) EXPENDITURES	**$ 133,259,377**	**$ 195,965,649**	**$ 62,706,272**	

OKLAHOMA HEALTH CARE AUTHORITY

Total Medicaid Program Expenditures
by Source of State Funds
SFY 2021, For the Fiscal Year Ended June 30, 2021

Category of Service	Total	Health Care Authority	Quality of Care Fund	HEEIA	SHOPP Fund	BCC Revolving Fund	Other State Agencies
SoonerCare Choice	$ 49,563,306	$ 49,346,967	$ -	$ 206,931	$ -	$ 9,408	$ -
Inpatient Acute Care	1,218,086,055	658,717,011	486,687	8,395,020	368,993,018	1,224,811	180,269,508
Outpatient Acute Care	501,644,524	387,851,411	41,604	12,774,130	94,125,934	6,851,445	-
Behavioral Health - Inpatient	69,729,061	9,113,024	-	1,520,645	16,167,599	-	42,927,792
Behavioral Health - Psychiatrist	11,613,123	9,233,141	-	-	2,372,121	7,862	-
Behavioral Health - Outpatient	18,465,826	-	-	-	-	-	18,465,826
Behavioral Health-Health Home	15,161,083	-	-	-	-	-	15,161,083
Behavioral Health Facility- Rehab	213,069,768	-	-	-	-	144,074	213,069,768
Behavioral Health - Case Management	5,396,646	-	-	-	-	-	5,396,646
Behavioral Health - PRTF	14,043,917	-	-	-	-	-	14,043,917
Behavioral Health - CCBHC	122,904,504	-					122,904,504
Residential Behavioral Management	19,794,845	-	-	-	-	-	19,794,845
Targeted Case Management	62,000,591	-	-	-	-	-	62,000,591
Therapeutic Foster Care	467,813	467,813	-	-	-	-	-
Physicians	482,405,942	374,750,589	58,101	9,946,328	-	3,607,460	94,043,464
Dentists	139,778,498	139,572,384	-	196,217	-	9,896	-
Mid Level Practitioners	1,178,412	1,135,811	-	42,075	-	526	-
Other Practitioners	49,091,915	47,449,970	446,364	1,074,939	-	120,641	-
Home Health Care	31,885,226	31,851,616	-	19,712	-	13,899	-
Lab & Radiology	34,442,163	32,616,099	-	1,635,944	-	190,120	-
Medical Supplies	65,205,127	60,436,938	4,086,164	624,652	-	57,373	-
Clinic Services	310,725,458	289,001,017	-	6,150,026	-	285,355	15,289,061
Ambulatory Surgery Centers	7,248,692	6,884,070	-	356,035	-	8,587	-
Personal Care Services	9,913,497	-	-	-	-	-	9,913,497
Nursing Facilities	676,343,664	401,093,767	275,224,293	-	-	25,604	-
Transportation	81,934,073	78,526,246	2,690,719	502,163	-	214,944	-
IME/DME/GME	61,797,963	-	-	-	-	-	61,797,963
ICF/IID Private	68,198,425	52,571,835	15,626,591	-	-	-	-
ICF/IID Public	21,800,127	-	-	-	-	-	21,800,127
CMS Payments	275,669,996	275,263,417	406,579	-	-	-	-
Prescription Drugs	747,849,538	716,400,214	-	28,419,450	-	3,029,875	-
Miscellaneous Medical Payments	562,216	556,809	-	-	-	5,407	-
Home and Community Based Waiver	248,470,669	-	-	-	-	-	248,470,669
Homeward Bound Waiver	76,328,000	-	-	-	-	-	76,328,000
Money Follows the Person	215,210	215,210	-	-	-	-	-
In-Home Support Waiver	25,182,022	-	-	-	-	-	25,182,022
ADvantage Waiver	188,869,302	-	-	-	-	-	188,869,302
Family Planning/Family Planning Waiver	3,686,831	-	-	-	-	-	3,686,831
Premium Assistance*	61,432,224	-	-	61,432,224.37	-	-	-
Telligen	11,515,328	11,515,328	-	-	-	-	-
Electronic Health Records Incentive Payments	388,104	388,104	-	-	-	-	-
Total Medicaid Expenditures	**$ 6,004,059,684**	**$ 3,634,958,790**	**$ 299,067,101**	**$ 133,296,490**	**$ 481,658,672**	**$ 15,807,287**	**$ 1,439,415,417**

* Includes $60,796,857.84 paid out of Fund 245

OKLAHOMA HEALTH CARE AUTHORITY
Summary of Revenues & Expenditures:
Other State Agencies
SFY 2021, For the Fiscal Year Ended June 30, 2021

REVENUE	FY21 Actual YTD
Revenues from Other State Agencies	$ 459,567,673
Federal Funds	1,068,616,829
TOTAL REVENUES	**$ 1,528,184,502**

EXPENDITURES	Actual YTD
Department of Human Services	
Home and Community Based Waiver	248,470,669
Money Follows the Person	-
Homeward Bound Waiver	76,328,000
In-Home Support Waivers	25,182,022
ADvantage Waiver	188,869,302
Intermediate Care Facilities for Individuals with Intellectual Disabilities Public	21,800,127
Personal Care	9,913,497
Residential Behavioral Management	12,792,516
Targeted Case Management	55,195,086
Total Department of Human Services	**638,551,218**
State Employees Physician Payment	
Physician Payments	94,043,464
Total State Employees Physician Payment	**94,043,464**
Education Payments	
Graduate Medical Education	-
Indirect Medical Education	36,950,916
Direct Medical Education	7,077,682
DSH	17,769,365
Total Education Payments	**61,797,963**
Office of Juvenile Affairs	
Targeted Case Management	2,236,817
Residential Behavioral Management	7,002,330
Total Office of Juvenile Affairs	**9,239,147**
Department of Mental Health	
Case Management	5,396,646
Inpatient Psychiatric Free-standing	42,927,792
Outpatient	18,465,826
Health Homes	15,161,083
Psychiatric Residential Treatment Facility	14,043,917
Certified Community Behavioral Health Clinics	122,904,504
Rehabilitation Centers	213,069,768
Total Department of Mental Health	**431,969,536**
State Department of Health	
Children's First	-
Sooner Start	1,043,830
Early Intervention	2,740,093
Early and Periodic Screening, Diagnosis, and Treatment Clinic	661,232
Family Planning	238,017
Family Planning Waiver	3,448,814
Maternity Clinic	-
Total Department of Health	**8,131,986**
County Health Departments	
EPSDT Clinic	300,828
Family Planning Waiver	-
Total County Health Departments	**300,828**
State Department of Education	**165,650**
Public Schools	**1,662,946**
Medicare DRG Limit	**165,198,423**
Native American Tribal Agreements	**13,283,171**
Department of Corrections	**4,647,184**
JD McCarty	**10,423,902**
Total OSA Medicaid Programs	**$ 1,439,415,417**
OSA Non-Medicaid Programs	**$ 115,130,284**
Total Other State Agencies	**$ 1,554,545,701**

Accounts Receivable from OSA	**$ 26,361,199**

OKLAHOMA HEALTH CARE AUTHORITY

SUMMARY OF REVENUES & EXPENDITURES:

Fund 205: Supplemental Hospital Offset Payment Program Fund

SFY 2021, For the Fiscal Year Ended June 30, 2021

REVENUES		FY 21 Revenue
SHOPP Assessment Fee		158,214,825
SHOPP Assessment Fee - Expansion		3,415,272
Federal Draws	$	355,147,671
Interest		153,362
Penalties		-
State Appropriations		(30,200,000)
TOTAL REVENUES	$	486,731,130

EXPENDITURES	Quarter	Quarter	Quarter	Quarter		FY 21 Expenditures
Program Costs:	7/1/20 - 9/30/20	10/1/20 - 12/31/20	1/1/21 - 3/31/21	4/1/21 - 6/30/21		
Hospital - Inpatient Care	87,121,848	97,820,590	92,361,119	91,689,461	$	368,993,018
Hospital -Outpatient Care	20,307,378	22,294,727	22,315,951	29,207,878		94,125,934
Psychiatric Facilities-Inpatient	3,554,176	3,995,809	4,342,763	4,274,852		16,167,599
Rehabilitation Facilities-Inpatient	432,709	486,476	732,193	720,743		2,372,121
Total OHCA Program Costs	111,416,110	124,597,602	119,752,025	125,892,934	$	481,658,672
Total Expenditures					$	481,658,672

CASH BALANCE		
	$	5,072,458

*** Expenditures and Federal Revenue processed through Fund 340

OKLAHOMA HEALTH CARE AUTHORITY
SUMMARY OF REVENUES & EXPENDITURES:
Fund 230: Nursing Facility Quality of Care Fund
SFY 2021, For the Fiscal Year Ended June 30, 2021

REVENUES	Total Revenue	State Share
Quality of Care Assessment	**77,418,030**	**$ 77,418,030**
*Quality of Care Penalties (*Non-Spendable Revenue)*	**215,240**	**$ 215,240**
Interest Earned	**33,399**	**33,399**
TOTAL REVENUES	**$ 77,666,668**	**$ 77,666,668**

EXPENDITURES	FY 21 Total $ YTD	FY 21 State $ YTD	Total State $ Cost
Program Costs			
Nursing Facility Rate Adjustment	$ 212,057,395	$ 55,876,917	
Eyeglasses and Dentures	238,896	$ 62,995	
Personal Allowance Increase	3,037,560	$ 800,171	
Coverage for Durable Medical Equipment and Supplies	2,711,532	$ 713,201	
Coverage of Qualified Medicare Beneficiary	1,032,756	$ 271,641	
Part D Phase-In	406,579	$ 406,579	
ICF/IID Rate Adjustment	5,197,670	$ 1,369,455	
Acute Services ICF/IID	6,592,388	$ 1,735,180	
Non-emergency Transportation - Soonerride	2,690,719	$ 708,514	
NF Covid-19 Supplemental Payment	59,890,442	$ 15,457,723	
ICF Covid-19 Supplemental Payment	3,836,533	$ 990,209	
Ventilator NF DME Supplemental Payment	1,374,632	$ 354,793	
Total Program Costs	**$ 299,067,101**	**$ 78,747,377**	**$ 78,747,377**
Administration			
OHCA Administration Costs	$ 608,557	$ 304,278	
DHS-Ombudsmen	397,319	397,319	
OSDH-Nursing Facility Inspectors	-	-	
Mike Fine, CPA	18,000	9,000	
Total Administration Costs	**$ 1,023,876**	**$ 710,597**	**$ 710,597**
Total Quality of Care Fee Costs	**$ 300,090,977**	**$ 79,457,974**	
TOTAL STATE SHARE OF COSTS			**$ 79,457,974**

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

OKLAHOMA HEALTH CARE AUTHORITY
SUMMARY OF REVENUES & EXPENDITURES:
Fund 245: Health Employee and Economy Improvement Act Revolving Fund
SFY 2021, For the Fiscal Year Ended June 30, 2021

REVENUES	FY 20 Carryover	FY 21 Revenue	Total Revenue
Prior Year Balance	$ 16,831,479		
State Appropriations	(8,000,000)		
Federal Draws - Prior Year	254,424		
Total Prior Year Revenue			9,085,903
Tobacco Tax Collections	-	39,634,434	39,634,434
Interest Income	-	314,602	314,602
Federal Draws	-	45,548,765	45,548,765
TOTAL REVENUES	**$ 9,085,903**	**$ 85,497,801**	**$ 94,583,704**

EXPENDITURES		FY 20 Expenditures	FY 21 Expenditures	Total State $ YTD
Program Costs:				
	Employer Sponsored Insurance		$ 60,796,858	$ 60,796,858
	College Students/ESI Dental		635,367	167,148
Individual Plan				
	SoonerCare Choice		$ 201,447	$ 52,785
	Inpatient Hospital		8,193,034	2,149,708
	Outpatient Hospital		12,583,042	3,296,745
	BH - Inpatient Services-DRG		1,477,349	386,621
	BH -Psychiatrist		-	-
	Physicians		9,766,032	2,560,530
	Dentists		192,942	50,476
	Mid Level Practitioner		41,523	10,892
	Other Practitioners		1,057,347	277,215
	Home Health		19,712	5,148
	Lab and Radiology		1,597,703	418,828
	Medical Supplies		611,388	160,254
	Clinic Services		5,972,638	1,561,597
	Ambulatory Surgery Center		354,109	93,311
	Skilled Nursing		-	-
	Prescription Drugs		27,931,832	7,317,977
	Transportation		496,792	129,764
	Premiums Collected			(52,936)
Total Individual Plan			**$ 70,496,890**	**$ 18,418,915**
	College Students-Service Costs		**$ 1,367,376**	**$ 358,047**
Total OHCA Program Costs			**$ 133,296,490**	**$ 79,740,969**
Administrative Costs				
	Salaries	$ -	$ 2,108,635	$ 2,108,635
	Operating Costs	3,088	12,030	15,118
	E&E Development DXC	-	-	-
	Contract - DXC	273,666	1,055,815	1,329,481
Total Administrative Costs		**$ 276,754**	**$ 3,176,479**	**$ 3,453,233**
Total Expenditures				**$ 83,194,202**
NET CASH BALANCE		**$ 8,809,149**	**$ 2,580,353.23**	**$ 11,389,502**

OKLAHOMA HEALTH CARE AUTHORITY

SUMMARY OF REVENUES & EXPENDITURES:

Fund 250: Belle Maxine Hilliard Breast and Cervical Cancer Treatment Revolving Fund

SFY 2021, For the Fiscal Year Ended June 30, 2021

REVENUES	FY 21 Revenue	State Share
Tobacco Tax Collections	$ 790,974	$ 790,974
TOTAL REVENUES	**$ 790,974**	**$ 790,974**

EXPENDITURES	FY 21 Total $ YTD	FY 21 State $ YTD	Total State $ Cost
Program Costs			
SoonerCare Choice	$ 9,408	$ 2,039	
Inpatient Hospital	1,224,811	$ 266,515	
Outpatient Hospital	6,851,445	$ 1,474,523	
Inpatient Services-DRG	-	$ -	
Psychiatrist	7,862	$ 1,762	
TFC-OHCA	-	$ -	
Nursing Facility	25,604	$ 5,738	
Physicians	3,607,460	$ 783,781	
Dentists	9,896	$ 2,153	
Mid-level Practitioner	526	$ 118	
Other Practitioners	120,641	$ 26,058	
Home Health	13,899	$ 2,990	
Lab & Radiology	190,120	$ 41,299	
Medical Supplies	57,373	$ 12,556	
Clinic Services	285,355	$ 61,989	
Ambulatory Surgery Center	8,587	$ 1,821	
Prescription Drugs	3,029,875	$ 658,266	
Transportation	214,944	$ 46,813.72	
Miscellaneous Medical	5,407	$ 1,158.57	
Total OHCA Program Costs	**$ 15,663,213**	**$ 3,389,579**	
OSA DMHSAS Rehab	144,074	31,279	
Total Medicaid Program Costs	**$ 15,807,287**	**$ 3,420,858**	
TOTAL STATE SHARE OF COSTS			**$ 3,420,858**

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

OHCA Monthly Metrics
August 2021
(June 2021 Data)

SOONERCARE ENROLLMENT/EXPENDITURES

Delivery System			Enrollment June 2021	Children June 2021	Adults June 2021	Enrollment Change	Total Expenditures June 2021	PMPM June 2021
SoonerCare Choice Patient-Centered Medical Home			**644,160**	**520,944**	**123,216**	**6,892**	**$186,170,570**	
	Lower Cost	*(Children/Parents; Other)*	600,891	507,311	93,580	7,068	$129,223,846	$215
	Higher Cost	*(Aged, Blind or Disabled; TEFRA; BCC)*	43,269	13,633	29,636	-176	$56,946,724	$1,316
SoonerCare Traditional			**284,051**	**111,492**	**172,559**	**1,129**	**$248,324,097**	
	Lower Cost	*(Children/Parents; Other; Q1; SLMB)*	162,329	106,559	55,770	1,026	$53,491,950	$330
	Higher Cost	*(Aged, Blind or Disabled; LTC; TEFRA; BCC & HCBS Waiver)*	121,722	4,933	116,789	103	$194,832,147	$1,601
Insure Oklahoma			**40,867**	**1,111**	**39,756**	**511**	**$14,656,838**	
	Employer-Sponsored Insurance		15,580	501	15,079	-185	$5,599,161	$359
	Individual Plan		25,287	610	24,677	696	$9,057,677	$358
SoonerPlan			**55,517**	**1,610**	**53,907**	**5,133**	**$331,605**	$6
TOTAL (UNDUPLICATED)			**1,024,574**	**635,157**	**389,438**	**13,665**	**$449,483,110**	

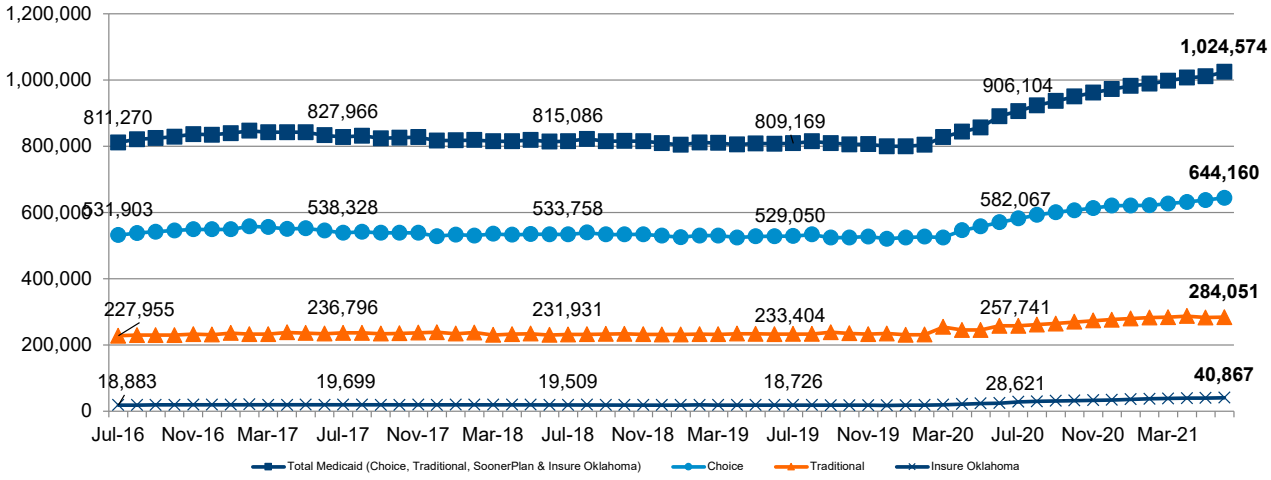
Enrollment totals include all members enrolled during the report month. Members may not have expenditure data. Children are members aged 0 - 20 or for Insure Oklahoma enrolled as Students or Dependents.
Dual Eligibles (Medicare & Medicaid) are in the Traditional delivery system in both the Low Cost (Q1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

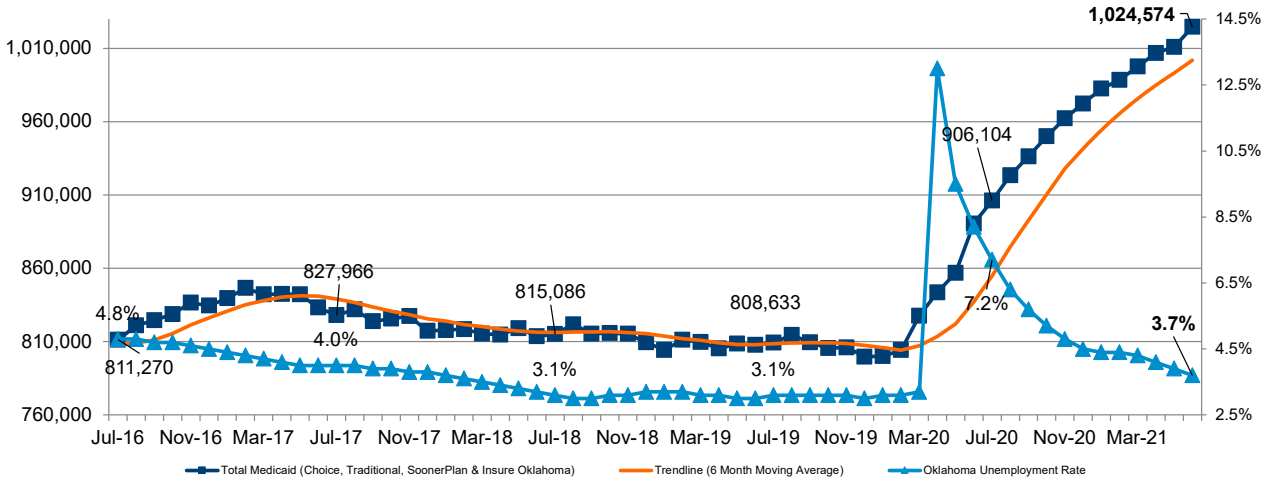
Total In-State Providers: 48,053 (+198) **(In-State Providers counted multiple times due to multiple locations, programs, types, and specialties)**

Physician	Pharmacy	Dentist	Hospital	MH/BH	Optometrist	Extended Care	Total PCPs*	PCMH
9,314	922	1,291	148	12,140	585	434	7,709	2,691

*PCPs consist of all providers contracted as a Certified Registered Nurse Practitioner, Family Practitioner, General Pediatrician, General Practitioner, Internist, General Internist, and Physician Assistant.

ENROLLMENT BY MONTH





*In June 2017 there were changes to the passive renewal system criteria that reduced the number of passively renewed members by 2/3rds. Increase beginning in March 2020 due to COVID relief measures.

September MAC
Proposed Rules Amendment Summaries

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

APA WF # 21-01 Reimbursing Federally Qualified Health Centers (FQHCs) for Long-Acting Reversible Contraceptive (LARCs) Devices Outside of the Encounter Rate - The proposed rules 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

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 revision will be removing 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

APA WF # 21-11 Indian Health Service, Tribal and Urban Indian (I/T/U) Shared Savings Program – The proposed new rules comply with Senate Bill 434 (SB 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: Pending

Tribal Consultation: July 6, 2021

APA WF # 21-16 Hospital Presumptive Eligibility 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

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 current established reimbursement methodology within the Oklahoma State Plan. Finally, revisions will involve minor cleanup to fix grammatical and formatting errors.

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

APA WF # 21-18 COFA Migrant Medicaid Extension - The proposed policy will update the alien status policy so that effective December 27, 2020, Compact of Free Association (COFA) migrants from the Republic of the Marshall Islands, the Republic of Palau, and Federated States of Micronesia are eligible for SoonerCare without the five-year waiting period requirement, provided all other eligibility factors are met and provided they maintain the status of qualified non-citizens, per Section 208 of the Consolidated Appropriations Act of 2020. Previously COFA migrants were eligible for emergency services only.

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

Tribal Consultation: September 7, 2021

APA WF # 21-19 Appeals to the Chief Executive Officer (CEO)/Administrative Law Judge (ALJ) — The proposed rule changes will comply with Senate Bill 207 by revising policies regarding appeals to the Agency's chief executive officer (CEO) pursuant to 63 O.S. §5052(C). The changes 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 in-person hearing requests will need to be submitted on the updated LD-4 form.

Budget Impact: Budget neutral

Tribal Consultation: July 6, 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. Additionally, 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, revisions will involve minor cleanup to fix formatting errors and add references to the new sections.

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

APA WF # 21-21 Non-hospital based hospice — The proposed rule will add hospice services as a covered benefit for the adult expansion population as described per the Code of Federal Regulations (CFR) Title 42 Section 435.119. The proposed rule changes will outline hospice coverage, eligibility criteria, reimbursement, provider qualifications/requirements, and prior authorization requirements.

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

Tribal Consultation: May 4, 2021

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.

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.

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.

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 should 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 once every six (6) months. An examination should 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, the six-point periodontal charting, and both dental and general health needs of the member. Images must be properly labeled with date and member name, and must be of diagnostic quality. 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. 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 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 should 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 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.~~ Images must be properly labeled with date and member name, and must be of diagnostic quality. 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. 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) **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 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) **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) **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) **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) **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~~Electronic images of diagnostic casts and/or oral/facial images.** ~~Diagnostic~~Electronic images of 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 casts and/or 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)~~(ii) ~~Study models~~3-D model images 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.

(R) **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 for the intellectually disabled.** 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. 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, and a completed current ADA form requesting all treatments requiring prior authorization. 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) **Removable prosthetics.**

(A) This includes full dentures, cast frame partial dentures, and acrylic partial dentures.

(i) One (1) per every five (5) years is available for adults up to 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 one (1) or more of the six-point measurements (probing pocket depths) equivalent to five (5) millimeters or greater, and image supported alveolar bone loss. Subgingival calculus and inflammation must be demonstrated 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 are not allowed with 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 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.

~~(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. ~~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.

(2) **Crowns for permanent teeth.** Crowns are compensable for restoration of natural teeth for members who are sixteen (16) years of age or older 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 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. 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.

(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 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~~years of age and older. 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.

(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) **Occlusal guard.** Narrative of medical necessity must be sent with prior authorization. Model should not be made or sent unless requested.

(6) **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) **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 one (1) or more of the six-point measurements (probing pocket depths) equivalent to five (5) millimeters or greater, and image supported alveolar bone loss. Subgingival calculus and inflammation must be demonstrated 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 are not allowed with oral prophylaxis.

(8) **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 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;

(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~~3-D model images 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)~~(1) 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)~~(2) 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.

317:30-5-705. Billing and reimbursement

(a) 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.
(b) Billing and reimbursement methodology, including copayments, are outlined in the Oklahoma Medicaid State Plan.

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

SUBCHAPTER 5. ELIGIBILITY AND COUNTABLE INCOME

PART 3. NON-MEDICAL ELIGIBILITY REQUIREMENTS

317:35-5-25. Citizenship/alien status and identity verification requirements

(a) **Citizenship/alien status and identity verification requirements.** Verification of citizenship/alien status and identity are 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.

(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(ee) of the Social Security ~~act~~Act and is stated on the documentation request the agency sends to the applicant/member.

(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.** SoonerCare services are provided as listed to the defined groups as indicated in this subsection if they meet all other factors of eligibility. 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~~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~~Lawfully admitted for permanent residence under the Immigration and Nationality Act;

(ii) ~~paroled~~Paroled into the United States under Section 212(d)(5) of such Act for a period of at least one (1) year;

(iii) ~~granted~~Granted conditional entry pursuant to Section 203(a)(7) of such Act as in effect prior to April 1, 1980; or

(iv) ~~a~~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~~An alien who was admitted to the United States and who was:

(i) ~~granted~~Granted asylum under Section 208 of such Act regardless of the date asylum is granted;

(ii) ~~a~~A refugee admitted to the United States under Section 207 of such Act regardless of the date admitted;

(iii) ~~an~~An alien with deportation withheld under Section 243(h) of such Act regardless of the date deportation was withheld;

(iv) ~~a~~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~~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~~An alien who is on active duty, other than active duty for training, in the Armed Forces of the United States;

(vii) ~~the~~The spouse or unmarried dependent child of an individual described in (C) of this paragraph;

(viii) ~~a~~A victim of a severe form of trafficking pursuant to Section 107(b) of the Trafficking Victims Protection Act of 2000; or

(ix) ~~admitted~~Admitted as an Amerasian immigrant.

(C) ~~permanent~~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 Oklahoma Administrative Code (OAC) 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 (1) 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 (1) of the categorical relationships, they may apply and be determined eligible for Refugee Medical Assistance. Iraqi special immigrants are considered lawful permanent residents.

(5) **Qualified non-citizens.** Effective December 27, 2020, per Section 208 of the Consolidated Appropriations Act of 2020, Compact of Free Association (COFA) migrants from the Republic of the Marshall Islands, the Republic of Palau, and Federated States of Micronesia, are classified as qualified non-citizens. COFA migrants are not classified as permanent immigrants; therefore, they are not subject to the five (5) year waiting period. As long as all other eligibility requirements are met and COFA migrants maintain the status of qualified non-citizens, they are eligible for SoonerCare services without a five (5) year waiting period. As indicated in paragraph (c), the immigrant status of COFA applicants must be verified through the Department of Homeland Security Systematic Alien Verification for Entitlement (DHS SAVE) program.

~~(5)~~(6) **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~~OAC 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.

~~(6)~~(7) **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 (2) 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.~~

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~~an in-person hearing must be received in writing on OHCA's Form LD-4 (Request for ~~Telephonic~~In-Person 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.~~

(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.

(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.

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 treatment 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 treatment 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 limited to the services based on the diagnoses listed in Part 82, of this Chapter, and are aimed at reducing the number of pain medications prescribed to adult SoonerCare members. It is recommended that clinicians and patients initially select nonpharmacological treatment including spinal manipulation for acute, subacute, or chronic back pain.

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 these alternative treatment for pain management services for the affected member. 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.** Initial evaluations and re-evaluations are allowed once 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.

(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 described in the Oklahoma Medicaid State Plan.

(5) **Discontinuation of services.**

(A) If the member's condition is not improving or 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 treatment 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 these alternative treatment for pain management services for the affected member. 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 evaluation and one (1) 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 a contracted qualified health professional dated within the previous ninety (90) day;

(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 referring contracted qualified health professional, documenting the need for services;

(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 the goal is 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 described in the Oklahoma Medicaid State Plan.

(5) **Discontinuation of services.**
(A) If the member's condition is not improving or 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 30. MEDICAL PROVIDERS-FEE FOR SERVICE

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 58. NON-HOSPITAL BASED HOSPICE

317:30-5-530. Eligible providers

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

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

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

317:30-5-531. Coverage for adults

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

Coverage for hospice services is provided to Medicaid eligible expansion adults only. For medical review purposes, all hospice services will be authenticated in accordance with OAC 317:30-3-30. For information regarding hospice provision provided through waivers, refer to Oklahoma Administrative Code (OAC) 317:30-5-763, 317:30-5-1200, and 317:30-5-1202.

(1) **Definition.** Hospice is palliative and/or comfort care provided to the member and his/her family when a physician certifies that the member has a terminal illness and has a life expectancy of six (6) months or less. A hospice program offers palliative and supportive care to meet the special needs resulting from 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.

(2) **Eligibility.**

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

(B) Hospice care eligibility requires physician certification

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

(3) **Levels of care.** There are four (4) levels of care for hospice:

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

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

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

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

(5) **Approval criteria.** All services must be prior authorized, and a written plan of care must be established before services are rendered.

(A) **General.** Hospice care services:

(i) Are provided in lieu of curative care for the terminal illness. The member or authorized representative must sign an election statement, and by doing so waives his or her right to other Medicaid benefits, except for care not related to the terminal illness and care provided by the attending physician.

(I) The member signs a statement choosing hospice care instead of routine medical care with the objective to treat and cure the member's terminal illness.

(II) Once the member has elected hospice care, the hospice medical team assumes responsibility for the member's medical care for the terminal illness.

(ii) Include nursing care; physician services; medical equipment and supplies; drugs for symptom control and pain relief; home health aide services; personal care services, physical, occupational and/or speech therapy; medical social services; dietary counseling; and grief and bereavement counseling to the member and/or family.

(iii) May be revoked by the member or representative at any time. Upon revoking the election of Medicaid coverage of hospice care for a particular election period, the

member resumes Medicaid coverage of the benefits waived when hospice care was elected. The member may at any time elect to receive hospice coverage for any other hospice election periods for which he or she is eligible.

(B) **Frequency.** Hospice care services:

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

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

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

(6) **Reimbursement.** All hospice care related services are reimbursed at a predetermined rate for each day in which a member receives the respective type and intensity of service. A description of the payment for each level of care is described in the Oklahoma Medicaid State Plan.