OKLAHOMA HEALTH CARE AUTHORITY

MEDICAL ADVISORY COMMITTEE MEETING

AGENDA

July 16, 2015

1:00 p.m. – 3:30pm

Charles Ed McFall Board Room

I. Welcome, Roll Call, and Public Comment Instructions: **Chairman, Steven Crawford, M.D.**

II. Public Comments (2 minute limit)

III. MAC Member Comments/Discussion

IV. **Action Item**: Approval of Minutes of the May 21, 2015 Medical Advisory Committee Meeting

V. Financial Report SFY15 for the 10 months ended April 30, 2015: **Gloria Hudson, Director of General Accounting**

VI. SoonerCare Operations Update: **Marlene Asmussen, Population Care Management Director**

VII. Aged, Blind, and Disabled (ABD) Care Coordination, **Becky Pasternik-Ikard, Deputy State Medicaid Director**

VIII. Department of Strategic Planning and Reforms (DSPAR) report: **Melanie Lawrence, Assistant Director, Strategic Planning & Reform**

A. Central Portfolio Project Management Organization (PMO) developments,

B. Strategic Planning staff survey

IX. Insure Oklahoma Sponsor's Choice Draft Amendment, **Sherris Harris-Ososanya, Waiver Development Coordinator**

X. **Action Item:** Proposed Rule Changes: Presentation, Discussion and Vote: **Demetria Bennett, Policy Development Coordinator and Chairman Crawford**

A. WF #15-01, Adult Dental Coverage for Transplant Clearance

B. WF #15-10, Long Term Care Rules

XI. Informational Items – not actionable: **Demetria Bennett, Policy Development Coordinator**

XII. New Business: **Chairman, Steven Crawford, M.D**.

XIII. Adjourn

Next Meeting
Thursday, September 17, 2015
1:00 p.m. – 3:30pm
Charles Ed McFall Board Room
4345 N Lincoln Blvd
Oklahoma City, OK 73105

MINUTES of the May 21, 2015 Meeting

Welcome and Roll Call

Chairman Crawford called the meeting to order at 1:00PM and asked for a roll call. Delegates present were Ms. Brinkley, Dr. Crawford, Ms. Felty, Ms. Fritz (after roll call), Dr. Gastorf, Mr. Goforth, Dr. Grogg, Ms. Hastings, Mr. Jones, Dr. Kirkpatrick, Ms. Mays, Dr. McNeill, Mr. Patterson (by phone), Dr. Post, Ms. Pratt-Reid, Dr. Rhynes (by phone), Dr. Simon, Mr. Snyder, Mr. Tallent, Dr. Walton, and Dr. Wright (by phone). Alternates present were Ms. Baker, Mr. Clay, Mr. Rains-Sims, and Dr. Talley providing a quorum. Delegates absent without an alternate present were Ms. Booten-Hiser, Dr. Cavallaro, Ms. Galloway, Dr. Cline, and Dr. Woodward.

Public Comments

Barb Landreth (Association of Oklahoma Nurse Practioners, AONP), DeAnne Fortenberry (nurse practioner student), Elizabeth Carlton (Certified Pediatric Nurse Practioner), Damarcus Nelson (APRN-FNRC Family Healthcare), Ann Becker (APRN Rival Health/ER, NW Oklahoma), Benny Vanatta (AONP), Marvin Williams (Perinatologist, Oklahoma University Medical Center), Tim Brittingham (Girling/Gentiva), Cynthia Sanford (Pediatric Nurse Practioner, SE Oklahoma), Vikas Jain MD (Board Certified Sleep Specialist), Hussein Tomati (Nurse Practioner SE Norman), Jeff Frederick (Physician's Assistant - Certified, Oklahoma Otolaryngology Association), Bruce Bartlett (Resmed), Lindsay Flaming (APRN-CNP Affordable Quality Care, Norman), and Don Brown MD (OB-GYN) commented.

Those representing Advanced Nurse Practioners (ANP) and Physician's Assistants-Certified (PAC) spoke to the State Plan and Rate Changes (SPARC) proposal to cut payment to their group of providers by 15%. Most made points about reducing access to services, especially in rural and urban fringe areas due to suggested clinic closures and panel restrictions and pointed to the subsequent increase in emergency room visits. Several expressed concern that the SoonerCare members who have heightened needs may suffer the greatest loss of access. Ms. Sanford suggested that a closer look at Medicaid fraud could supplant this particular provider rate cut.

Dr. Williams suggested that reducing High Risk Obstetric (HROB) services was substandard care according to the American College of Obstetrics and Gynecology. Dr. Brown countered in his remarks that the number of ultrasounds authorized in Proposed Rule Change (PRC) 15-05 was adequate and that the agency now sends many HROB members to Texas.

Mr. Brittingham noted that PRC 15-09, shortening the Timely Filing requirement, did not address recent problems with the currently-mandated, claims-processing vendor that has millions of dollars of claims for home-based services already performed that may not meet the new requirement.

Dr. Jain and Mr. Bartlett addressed PRC 15-04 and 15-06 which eliminates coverage of adult sleep studies and new continuous positive airway pressure (CPAP) devices for adults. Both cited clinical studies that link CPAP therapy to improved health outcomes. Dr. Jain suggested that low compliance rates may be addressed in a different manner.

Member Comments

Ms. Pratt-Reid, AONP representative, remarked that she had fielded a lot of phone calls about the 15% rate cut for mid-level providers. She asked for "the same pay for the same services." She noted that mid-level providers fill a gap for Developmentally Disabled Supports Division (DDSD) members who must sometimes go through "the back door" of clinics to get service. She also noted that the 15% rate cut would be on top of the across-the-board rate cut that was implemented last year.

Dr. McNeill, representing the Oklahoma Academy of Physicians Assistants (PAs) on the committee, noted the contribution of PAs to SoonerCare members, recounting the struggle to get PAs involved in the state's health care and made a personal appeal to Chief Executive Officer, Nico Gomez, to reconsider the 15% cut.

Mr. Goforth, speaking for Home and Community Based Service (HCBS) providers, said that the new Timely Filing requirement would lead to providers never getting paid for services they legitimately provided.

Mr. Clay, a durable medical equipment (DME) provider, questioned the wisdom of cutting out the benefits of adult sleep studies and CPAP noting the regression of health status without this type of treatment. He suggested that more money could be saved by the agency if this breathing treatment was continued.

Approval of Minutes

Mr. Rains-Sims moved that the minutes of the March 12, 2015 meeting be accepted as submitted online. Ms. Fritz seconded the motion. Ms. Mays pointed out that HB 1556 under Legislative Update should be HB1566. With that correction, the vote to accept was unanimous.

Financial Update

Gloria Hudson, Director of General Accounting for the Oklahoma Health Care Authority (OHCA), gave the financial report for the state fiscal year 2015, first nine months, ending March 31, 2015. She added that preliminary data through April 30 indicate that the agency would remain slightly under budget.

SoonerCare Operations Update

Kevin Rupe, Chief Operation Officer for OHCA, gave the SoonerCare Operations report. He said that member enrollment numbers are growing at a very slow steady pace; provider enrollment remains level.

Strategic Planning Conference

Paul Gibson, Planning Coordinator, stepped in for Dana Northrup to ask for the committee's input on the next annual Strategic Planning Conference August 12, 13, and 14. He said that more information about the location would follow.

Legislative Update

Carter Kimble, Director of Government Relations for OHCA, identified HJR 1030 as the bill awaiting passage that carries the agency's proposed rule changes. He mentioned that OHCA is scheduling stakeholder meetings to address the requirement s of HB 1566 to request information for care

coordination models for individuals who are dually eligible for Medicaid and Medicare. He commended Representative Derby for his efforts to hold back a potential 5% budget cut.

Budget Report

Nico Gomez, Chief Executive Officer of OHCA, explained that the legislature's promise of $18 million plus and estimated $20 million carry-over of SFY2015 still left $40 million of the $78 million shortfall created by the lowered Federal Medicaid Assistance Percentage in SFY2016. This shortfall translated to the tough choices reflected in the changes before the committee. He then responded to questions from the members.

Dr. Post asked why mid-level providers were targeted. Mr. Gomez responded that he took responsibility for the choice and noted that our neighboring states paid reduced rates to mid-level providers ranging from 92% to 70% of the regular rate.

Dr. McNeill applauded Mr. Gomez for his efforts but reiterated that the 15% cut would be compounded by the rate reduction of last year. Mr. Gomez said that the cut was only on "fee for service" rates. Capitation rates for Patient Centered Medical Homes, Health Access Networks and similar programs were not cut.

Mr. Goforth wondered what the justification was to change timely filing requirements. Mr. Gomez noted that providers get paid within a week of filing a valid claim and said that the change targeted those providers who are not operating in a timely manner.

Dr. Crawford asked what if there were any alternatives to a 15% mid-level rate cut Mr. Gomez had to offer the Board of Directors. Mr. Gomez pointed out that rooting out fraud was a priority and that the agency had one of the lowest payment error rates in the nation. He mentioned that OHCA Board Chair, Ed McFall, was a passionate supporter of mid-level providers and asked the agency to look at an urban rule differential. He said that a 4 to 5% rate cut across the board would be needed to nullify a mid-level rate cut.

Victor Clay asked for the rational for removing adult sleep studies when other checks and balances may be available to monitor improper utilization. Mr. Gomez explained the process of prioritizing cost savings; first eligibility, then optional benefits and some adult services which are considered optional.

Mr. Snyder said that he was not rallying support to reject PRC 15-03 relating to DRG Hospital payments, but asked about the pending Recovery Auditor Contracts' (RAC) impact on OHCA's budget. Mr. Gomez could not forecast any numbers and pointed out that RAC audit monies would be divided between the auditor, the federal government and then the states.

Dr. Gastorf remarked that HROB members from southeast Oklahoma were sent to Texas and asked if the agency pays the same rates to those providers. Mr. Gomez replied that the agency tries to use in-state providers first. Dr. Sylvia Lopez, OHCA's Chief Medical Officer said that most Texas HROB providers accept OHCA in-state rates.

Recess

Dr. Grogg moved that the committee recess for ten minutes. Dr. Talley seconded the motion and it carried without dissent. The meeting recessed from 2:30 to 2:40PM.

Presentation, Discussion, and Action on Proposed Rule Changes

Demetria Bennett, Policy Development Coordinator for OHCA presented the six proposed rules changes (PRC) before the committee.

a) **15-03 DRG Hospital:** There were no questions or discussion. Mr. Rains-Sims moved for acceptance of the change, Dr. Walton seconded the motion and it passed unanimously.

b) **15-04 Revoke payment for removal of benign skin lesions and eliminate coverage for adult sleep studies:** Dr. Crawford asked why the two services where combined and Ms. Bennett explained that they were within the same chapter of the Oklahoma Administrative Rules. Ms. Fritz moved that PRC 15-04 be divided into two parts: 15-04A and 15-04B. Dr. Gastorf seconded the motion.

1. **15-04A Benign Skin Lesions:** Dr. Simon opened the discussion with a question about Neurofibromas that had a strong emotional impact on sufferers. Dr. Lopez responded that the change did not impact services to children and that cosmetic surgery was not a covered benefit. Mr. Tallent moved to accept the PRC, and then amended it to exclude "deforming lesions." Mr. Rains-Sims seconded the motion. Nancy Nantois, Chief of Legal Services interrupted the proceedings to say that the vote could only be up or down. Mr. Tallent rescinded the amendment. A roll call vote to approve the PRC resulted in 19 yes, 4 no and 1 abstention.

2. **15-04B Adult Sleep Studies:** Dr Talley moved to approve the PRC and Ms. Hastings seconded the motion. Mr. requested that the motion be tabled until the long term impact of eliminating sleep studies could be determined. Dr. Crawford denied the motion because the committee would not be able to review the PRC again before it went to the Board. Dr. Walton said that the CPAP was a privilege that should not be denied and Dr. Simon re-joined that a vote for the PRC was a vote for poor medicine. The vote was called and the motion to approve was unanimously voted down.

c) **15-05 High Risk Obstetrical Services:** Mr. Snyder moved for approval, Ms. Fritz seconded and the vote to approve was unanimous.

d) **15-06 Coverage for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS):** Dr. Gastorf moved to approve the PRC, Ms. Hastings seconded and the vote to approve was voted down unanimously.

e) **15-08 Urine Drug Screening and testing:** After the reading of the summary, Mr. Tallent moved for acceptance; Dr. Walton seconded the motion; and it passed unanimously.

f) **15-09 Timely Filing:** Ms. Pratt-Reid asked if the new rule made any provision for the disruption anticipated when the new ICD-10 codes were implemented in October. Ms.

Bennett explained that was not an exception, but there were exceptions built into the policy. Mr. Goforth asked about the third party vendor delay but was told that the agency would take the matter under consideration. Lisa Gifford, Chief of Business Enterprises, reported that the method of determining the cost saving for this PRC hinged partly on the difference between timely filing for SoonerCare and filing for private insurance. The private insurance carriers had a shorter period and the discrepancy often left OHCA with no recourse. Mr. Goforth moved that the PRC be rejected by the committee. Dr. Walton seconded the motion. A roll call vote was 8 in favor of rejecting the PRC and 14 against with 2 abstaining.

Informational Items – State Plan Amendment Rate Changes

Chairman Crawford requested clarification about the agency's restriction on voting the proposed changes up or down. Tywanda Cox, Health Policy Director, explained that the changes did not involve policy changes and had their own process for recommendation, that being the SPARC meeting to be held June 18 with the Board voting June 30, 2015. She said that the agency wanted the MAC to be able to make recommendations and that Mr. Gomez had reiterated that during his Budget Report.

Dr. Rhynes offered a recommendation that the proposal to reduce payment rates for polycarbonate lenses from $30 to $10 be altered to $20.

Dr. McNeill recommended that the 15% rate cut to mid-level providers be removed from consideration.

Mr. Clay cautioned that the proposal to change the DMEPOS to competitive bidding was flawed noting that Medicare added 10% to rural services and only required competitive bids in Metropolitan Statistical Areas such as Tulsa and Oklahoma City.

Dr. Grogg and Ms. Pratt-Reid agreed with Dr. McNeill's recommendation.

New Business

No one introduced new business.

Adjournment

Dr. Grogg moved that the meeting be adjourned and Dr. Talley seconded the motion. There was no dissent and the meeting adjourned at 3:45 PM with a notice that the next meeting will be July 16, 2015.

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Oklahoma Health Care Authority **MEDICAL ADVISORY COMMITTEE MEETING**

FINANCIAL REPORT

For the Ten Months Ended April 30, 2015
Submitted to the CEO & Board

- Revenues for OHCA through April, accounting for receivables, were **$3,381,611,546** or **.8% under** budget.
- Expenditures for OHCA, accounting for encumbrances, were **$3,366,734,316 or 1.4% under** budget.
- The state dollar budget variance through April is a **positive $20,125,538.**
- The budget variance is primarily attributable to the following (in millions):

Expenditures:		
Medicaid Program Variance		18.8
Administration		3.4
Revenues:		
Drug Rebate		.4
Taxes and Fees		3.1
Overpayments/Settlements		8.4
FY15 Carryover Committed to FY16		(14.0)
Total FY 15 Variance	**$**	**20.1**

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Summary of Revenues & Expenditures: OHCA
Fiscal Year 2015, For the Ten Months Ended April 30, 2015

REVENUES	FY15 Budget YTD	FY15 Actual YTD	Variance	% Over/ (Under)
State Appropriations	$ 813,346,029	$ 813,346,029	$ -	0.0%
Federal Funds	1,986,626,916	1,957,258,473	(29,368,442)	(1.5)%
Tobacco Tax Collections	37,409,682	40,442,800	3,033,118	8.1%
Quality of Care Collections	64,020,318	63,466,681	(553,637)	(0.9)%
SFY 15 Carryover Committed to SFY16	14,000,000	-	(14,000,000)	100.0%
Prior Year Carryover	61,029,661	61,029,661	-	0.0%
Federal Deferral - Interest	218,233	218,233	-	0.0%
Drug Rebates	185,828,146	187,014,631	1,186,485	0.6%
Medical Refunds	37,688,414	48,463,956	10,775,542	28.6%
Supplemental Hospital Offset Payment Program	197,421,201	197,421,201	-	0.0%
Other Revenues	12,825,175	12,949,880	124,705	1.0%
TOTAL REVENUES	**$ 3,410,413,775**	**$ 3,381,611,546**	**$ (28,802,229)**	**(0.8)%**

EXPENDITURES	FY15 Budget YTD	FY15 Actual YTD	Variance	% (Over)/ Under
ADMINISTRATION - OPERATING	**$ 48,116,815**	**$ 42,504,496**	**$ 5,612,319**	**11.7%**
ADMINISTRATION - CONTRACTS	**$ 103,707,264**	**$ 101,207,787**	**$ 2,499,477**	**2.4%**
MEDICAID PROGRAMS				
Managed Care:				
SoonerCare Choice	33,757,527	30,147,655	3,609,872	10.7%
Acute Fee for Service Payments:				
Hospital Services	764,729,527	766,492,636	(1,763,109)	(0.2)%
Behavioral Health	16,859,489	16,446,341	413,148	2.5%
Physicians	416,519,412	409,383,689	7,135,723	1.7%
Dentists	115,349,697	108,201,429	7,148,268	6.2%
Other Practitioners	35,077,606	31,476,650	3,600,957	10.3%
Home Health Care	17,699,799	16,824,422	875,377	4.9%
Lab & Radiology	64,207,499	63,497,042	710,458	1.1%
Medical Supplies	33,557,233	33,665,649	(108,416)	(0.3)%
Ambulatory/Clinics	105,718,048	104,118,100	1,599,947	1.5%
Prescription Drugs	402,878,932	404,907,431	(2,028,499)	(0.5)%
OHCA Therapeutic Foster Care	1,701,405	1,413,070	288,336	16.9%
Other Payments:				
Nursing Facilities	488,413,542	475,252,389	13,161,153	2.7%
Intermediate Care Facilities for Individuals with Intellectual Disabilities Private	51,260,416	49,726,688	1,533,728	3.0%
Medicare Buy-In	113,832,198	111,545,372	2,286,826	2.0%
Transportation	59,156,977	57,827,264	1,329,713	2.2%
Money Follows the Person-OHCA	865,357	542,328	323,030	0.0%
Electonic Health Records-Incentive Payments	27,615,297	27,615,297	-	0.0%
Part D Phase-In Contribution	64,693,785	64,083,708	610,078	0.9%
Supplemental Hospital Offset Payment Program	449,854,873	449,854,873	-	0.0%
Total OHCA Medical Programs	**3,263,748,621**	**3,223,022,033**	**40,726,588**	**1.2%**
OHCA Non-Title XIX Medical Payments	89,382	-	89,382	0.0%
TOTAL OHCA	**$ 3,415,662,082**	**$ 3,366,734,316**	**$ 48,927,767**	**1.4%**
REVENUES OVER/(UNDER) EXPENDITURES	**$ (5,248,308)**	**$ 14,877,230**	**$ 20,125,538**	

Total Medicaid Program Expenditures
by Source of State Funds
Fiscal Year 2015, For the Ten Months Ended April 30, 2015

Category of Service	Total	Health Care Authority	Quality of Care Fund	HEEIA	SHOPP Fund	BCC Revolving Fund	Other State Agencies
SoonerCare Choice	$ 30,270,340	$ 30,135,162	$ -	$ 122,685	$ -	$ 12,493	$ -
Inpatient Acute Care	962,930,884	526,021,680	405,572	2,957,682	347,449,538	1,193,804	84,902,608
Outpatient Acute Care	316,824,070	235,265,616	34,670	3,286,503	74,665,987	3,571,294	
Behavioral Health - Inpatient	47,339,514	9,956,334	-	225,272	26,415,674	-	10,742,234
Behavioral Health - Psychiatrist	7,813,681	6,490,007	-	-	1,323,674	-	-
Behavioral Health - Outpatient	23,611,187	-	-	-	-	-	23,611,187
Behaviorial Health-Health Home	1,442,219	-	-	-	-	-	1,442,219
Behavioral Health Facility- Rehab	212,997,313	-	-	-	-	76,019	212,997,313
Behavioral Health - Case Management	17,538,051	-	-	-	-	-	17,538,051
Behavioral Health - PRTF	76,386,542	-	-	-	-	-	76,386,542
Residential Behavioral Management	19,528,861	-	-	-	-	-	19,528,861
Targeted Case Management	56,068,464	-	-	-	-	-	56,068,464
Therapeutic Foster Care	1,413,070	1,413,070	-	-	-	-	-
Physicians	461,400,271	404,349,249	48,417	4,634,514	-	4,986,023	47,382,067
Dentists	108,217,025	108,190,337	-	15,596	-	11,093	-
Mid Level Practitioners	2,528,421	2,511,793	-	14,977	-	1,651	-
Other Practitioners	29,037,491	28,584,582	371,970	74,285	-	6,654	-
Home Health Care	16,829,524	16,806,432	-	5,103	-	17,990	-
Lab & Radiology	64,878,923	63,067,308	-	1,381,881	-	429,734	-
Medical Supplies	33,897,466	31,335,362	2,259,613	231,817	-	70,675	-
Clinic Services	103,990,178	97,097,296	-	580,254	-	173,375	6,139,253
Ambulatory Surgery Centers	7,017,890	6,825,811	-	170,461	-	21,619	-
Personal Care Services	10,928,982	-	-	-	-	-	10,928,982
Nursing Facilities	475,252,389	299,391,089	175,859,318	-	-	1,982	-
Transportation	57,542,256	55,295,589	2,178,930	-	-	67,736	-
GME/IME/DME	112,531,140	-	-	-	-	-	112,531,140
ICF/IID Private	49,726,688	40,752,515	8,974,173	-	-	-	-
ICF/IID Public	35,480,065	-	-	-	-	-	35,480,065
CMS Payments	175,629,080	175,027,196	601,884	-	-	-	
Prescription Drugs	412,930,668	403,292,931	-	8,023,237	-	1,614,500	-
Miscellaneous Medical Payments	285,008	269,684	-	-	-	15,324	-
Home and Community Based Waiver	156,331,836	-	-	-	-	-	156,331,836
Homeward Bound Waiver	74,825,193	-	-	-	-	-	74,825,193
Money Follows the Person	10,832,625	542,328	-	-	-	-	10,290,297
In-Home Support Waiver	21,105,940	-	-	-	-	-	21,105,940
ADvantage Waiver	143,909,403	-	-	-	-	-	143,909,403
Family Planning/Family Planning Waiver	6,590,469	-	-	-	-	-	6,590,469
Premium Assistance*	35,088,297	-	-	35,088,297	-	-	-
Electronic Health Records Incentive Payments	27,615,297	27,615,297	-	-	-	-	-
Total Medicaid Expenditures	**$ 4,408,566,722**	**$ 2,570,236,668**	**$ 190,734,547**	**$ 56,812,564**	**$ 449,854,873**	**$ 12,271,964**	**$1,128,732,125**

* Includes $34,832,340.23 paid out of Fund 245

Summary of Revenues & Expenditures:
Other State Agencies
Fiscal Year 2015, For the Ten Months Ended April 30, 2015

	FY15
REVENUE	**Actual YTD**
Revenues from Other State Agencies	$ 468,773,622
Federal Funds	712,150,327
TOTAL REVENUES	**$ 1,180,923,949**
EXPENDITURES	**Actual YTD**
Department of Human Services	
Home and Community Based Waiver	$ 156,331,836
Money Follows the Person	10,290,297
Homeward Bound Waiver	74,825,193
In-Home Support Waivers	21,105,940
ADvantage Waiver	143,909,403
Intermediate Care Facilities for Individuals with Intellectual Disabilities Public	35,480,065
Personal Care	10,928,982
Residential Behavioral Management	14,800,949
Targeted Case Management	43,923,568
Total Department of Human Services	**511,596,233**
State Employees Physician Payment	
Physician Payments	47,382,067
Total State Employees Physician Payment	**47,382,067**
Education Payments	
Graduate Medical Education	70,019,832
Graduate Medical Education - Physicians Manpower Training Commission	4,529,375
Indirect Medical Education	31,865,924
Direct Medical Education	6,116,009
Total Education Payments	**112,531,140**
Office of Juvenile Affairs	
Targeted Case Management	2,707,504
Residential Behavioral Management	4,717,166
Total Office of Juvenile Affairs	**7,424,669**
Department of Mental Health	
Case Management	17,538,051
Inpatient Psychiatric Free-standing	10,742,234
Outpatient	23,611,187
Health Homes	1,442,219
Psychiatric Residential Treatment Facility	76,386,542
Rehabilitation Centers	212,997,313
Total Department of Mental Health	**342,717,546**
State Department of Health	
Children's First	1,178,505
Sooner Start	2,269,253
Early Intervention	3,531,297
Early and Periodic Screening, Diagnosis, and Treatment Clinic	1,735,819
Family Planning	(47,871)
Family Planning Waiver	6,617,939
Maternity Clinic	26,550
Total Department of Health	**15,311,491**
County Health Departments	
EPSDT Clinic	643,806
Family Planning Waiver	20,402
Total County Health Departments	**664,208**
State Department of Education	**107,217**
Public Schools	**4,631,120**
Medicare DRG Limit	**77,041,622**
Native American Tribal Agreements	**1,463,825**
Department of Corrections	**1,451,481**
JD McCarty	**6,409,505**
Total OSA Medicaid Programs	**$ 1,128,732,125**
OSA Non-Medicaid Programs	**$ 62,839,588**
Accounts Receivable from OSA	**$ 10,647,763**

SUMMARY OF REVENUES & EXPENDITURES:
Fund 205: Supplemental Hospital Offset Payment Program Fund
Fiscal Year 2015, For the Ten Months Ended April 30, 2015

REVENUES	FY 15 Revenue
SHOPP Assessment Fee	$ 197,156,731
Federal Draws	282,239,613
Interest	133,816
Penalties	130,354
State Appropriations	(30,200,000)
TOTAL REVENUES	$ 449,460,514

EXPENDITURES	Quarter	Quarter	Quarter	Quarter	FY 15 Expenditures
Program Costs:	7/1/14 - 9/30/14	10/1/14 - 12/31/14	1/1/15 - 3/31/15	4/1/15 - 6/30/15	
Hospital - Inpatient Care	92,872,986	92,764,153	78,587,045	83,225,354	$ 347,449,538
Hospital -Outpatient Care	15,052,817	15,729,600	21,418,128	22,465,442	$ 74,665,987
Psychiatric Facilities-Inpatient	6,919,304	7,316,146	5,914,677	6,265,547	$ 26,415,674
Rehabilitation Facilities-Inpatient	272,784	288,429	370,249	392,213	$ 1,323,674
Total OHCA Program Costs	115,117,891	116,098,329	106,290,098	112,348,555	$ 449,854,873
Total Expenditures					$ 449,854,873
CASH BALANCE					$ (394,358)

*** Expenditures and Federal Revenue processed through Fund 340

SUMMARY OF REVENUES & EXPENDITURES:
Fund 230: Nursing Facility Quality of Care Fund
Fiscal Year 2015, For the Ten Months Ended April 30, 2015

REVENUES	Total Revenue	State Share
Quality of Care Assessment	**$ 63,432,810**	**$ 63,432,810**
Interest Earned	**33,871**	**33,871**
TOTAL REVENUES	**$ 63,466,681**	**$ 63,466,681**

EXPENDITURES	FY 15 Total $ YTD	FY 15 State $ YTD	Total State $ Cost
Program Costs			
Nursing Facility Rate Adjustment	$ 172,832,785	$ 65,157,960	
Eyeglasses and Dentures	228,132	86,006	
Personal Allowance Increase	2,798,400	1,054,997	
Coverage for Durable Medical Equipment and Supplies	2,259,613	851,874	
Coverage of Qualified Medicare Beneficiary	860,630	324,457	
Part D Phase-In	601,884	601,884	
ICF/IID Rate Adjustment	4,325,754	1,630,809	
Acute Services ICF/IID	4,648,419	1,752,454	
Non-emergency Transportation - Soonerride	2,178,930	821,457	
Total Program Costs	**$ 190,734,547**	**$ 72,281,898**	**$ 72,281,898**
Administration			
OHCA Administration Costs	$ 416,688	$ 208,344	
DHS-Ombudsmen	177,158	177,158	
OSDH-Nursing Facility Inspectors	400,000	400,000	
Mike Fine, CPA	6,000	3,000	
Total Administration Costs	**$ 999,846**	**$ 788,502**	**$ 788,502**
Total Quality of Care Fee Costs	**$ 191,734,393**	**$ 73,070,399**	
TOTAL STATE SHARE OF COSTS			**$ 73,070,399**

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.

SUMMARY OF REVENUES & EXPENDITURES:

Fund 245: Health Employee and Economy Improvement Act Revolving Fund

Fiscal Year 2015, For the Ten Months Ended April 30, 2015

REVENUES		FY 14 Carryover	FY 15 Revenue	Total Revenue
Prior Year Balance		$ 13,950,701	$ -	$ 7,221,671
State Appropriations		-	-	-
Tobacco Tax Collections		-	33,263,990	33,263,990
Interest Income		-	288,089	288,089
Federal Draws		160,262	23,093,755	23,093,755
All Kids Act		(6,636,667)	108,344	108,344
TOTAL REVENUES		$ 7,474,296	$ 56,754,178	$ 63,867,504
EXPENDITURES		**FY 14 Expenditures**	**FY 15 Expenditures**	**Total $ YTD**
Program Costs:				
	Employer Sponsored Insurance		$ 34,531,411	$ 34,531,411
	College Students		255,957	92,093
	All Kids Act		300,929	300,929
Individual Plan				
	SoonerCare Choice		$ 118,053	$ 42,475
	Inpatient Hospital		2,932,612	1,055,154
	Outpatient Hospital		3,235,649	1,164,187
	BH - Inpatient Services-DRG		222,368	80,008
	BH -Psychiatrist		-	-
	Physicians		4,620,173	1,662,338
	Dentists		14,876	5,352
	Mid Level Practitioner		14,240	5,124
	Other Practitioners		73,005	26,267
	Home Health		5,103	1,836
	Lab and Radiology		1,366,853	491,794
	Medical Supplies		220,168	79,217
	Clinic Services		573,252	206,256
	Ambulatory Surgery Center		163,427	58,801
	Prescription Drugs		7,905,193	2,844,288
	Miscellaneous Medical		-	-
	Premiums Collected		-	(456,609)
Total Individual Plan			$ 21,464,972	$ 7,266,488
	College Students-Service Costs		$ 259,100	$ 93,224
	All Kids Act- Service Costs		$ 195	$ 70
Total OHCA Program Costs			$ 56,812,563	$ 42,284,215
Administrative Costs				
	Salaries	$ 30,565	$ 1,123,928	$ 1,154,493
	Operating Costs	125,839	488,926	614,765
	Health Dept-Postponing	-	-	-
	Contract - HP	96,221	758,464	854,685
Total Administrative Costs		$ 252,625	$ 2,371,318	$ 2,623,943
Total Expenditures				$ 44,908,159
NET CASH BALANCE		$ 7,221,671		$ 18,959,346

SUMMARY OF REVENUES & EXPENDITURES:
Fund 250: Belle Maxine Hilliard Breast and Cervical Cancer Treatment Revolving Fund
Fiscal Year 2015, For the Ten Months Ended April 30, 2015

REVENUES	FY 15 Revenue	State Share
Tobacco Tax Collections	$ 663,658	$ 663,658
TOTAL REVENUES	**$ 663,658**	**$ 663,658**

EXPENDITURES	FY 15 Total $ YTD	FY 15 State $ YTD	Total State $ Cost
Program Costs			
SoonerCare Choice	$ 12,493	$ 3,297	
Inpatient Hospital	1,193,804	315,045	
Outpatient Hospital	3,571,294	942,465	
Inpatient Services-DRG	-	-	
Psychiatrist	-	-	
TFC-OHCA	-	-	
Nursing Facility	1,982	523	
Physicians	4,986,023	1,315,811	
Dentists	11,093	2,927	
Mid-level Practitioner	1,651	436	
Other Practitioners	6,654	1,756	
Home Health	17,990	4,748	
Lab & Radiology	429,734	113,407	
Medical Supplies	70,675	18,651	
Clinic Services	173,375	45,754	
Ambulatory Surgery Center	21,619	5,705	
Prescription Drugs	1,614,500	426,067	
Transportation	67,736	17,876	
Miscellaneous Medical	15,324	4,044	
Total OHCA Program Costs	$ 12,195,945	$ 3,218,510	
OSA DMHSAS Rehab	$ 76,019	$ 20,061	
Total Medicaid Program Costs	$ 12,271,964	$ 3,238,571	
TOTAL STATE SHARE OF COSTS			**$ 3,238,571**

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.

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SoonerCare Operations Report

April 2015 Data for June 2015 Board Meeting

SOONERCARE ENROLLMENT/EXPENDITURES

Delivery System		Monthly Enrollment Average SFY2014	Enrollment April 2015	Total Expenditures April 2015	Average Dollars Per Member Per Month April 2015
SoonerCare Choice Patient-Centered Medical Home		559,363	544,782	$182,246,829	
Lower Cost	*(Children/Parents; Other)*		498,758	$133,184,060	$267
Higher Cost	*(Aged, Blind or Disabled; TEFRA; BCC)*		46,024	$49,062,769	$1,066
SoonerCare Traditional		196,936	235,746	$257,267,458	
Lower Cost	*(Children/Parents; Other)*		125,154	$96,126,154	$768
Higher Cost	*(Aged, Blind or Disabled; TEFRA; BCC & HCBS Waiver)*		110,592	$161,141,305	$1,457
SoonerPlan*		48,266	41,330	$492,643	$12
Insure Oklahoma		23,567	17,941	$6,541,587	
Employer-Sponsored Insurance		14,795	13,532	$4,098,538	$303
*Individual Plan**		8,772	4,409	$2,443,048	$554
TOTAL		828,131	839,799	$446,548,517	

The enrollment totals above include all members enrolled during the report month; therefore, some members may not have expenditure data.
Custody expenditures are excluded. Non-member specific expenditures of $146,943,287 are excluded.

Effective July 2014, members with other forms of credible health insurance coverage were no longer eligible for Choice PCMH.

*In January 2014, SoonerPlan's qualifying income guidelines decreased from 185% to 133% of FPL and Insure Oklahoma IP's qualifying income guidelines decreased from 200% to 100% of FPL.

Net Enrollee Count Change from Previous Month Total	(866)

New Enrollees	17,822

Members that have not been enrolled in the past 6 months.

Dual Enrollees & Long-Term Care Members (subset of data above)

Medicare and SoonerCare	Monthly Average SFY2014	Enrolled April 2015
Dual Enrollees	109,653	110,697
Child	192	170
Adult	109,461	110,527

	Monthly Average SFY2014	Enrolled April 2015	FACILITY PER MEMBER PER MONTH
Long-Term Care Members	15,358	14,876	$4,046
Child	63	59	
Adult	15,295	14,817	

Child is defined as an individual under the age of 21.

SOONERCARE CONTRACTED PROVIDER INFORMATION

Provider Counts	Monthly Average SFY2014	Enrolled April 2015
Total Providers	38,330	42,070
In-State	29,277	31,768
Out-of-State	9,053	10,302

Provider Network includes providers who are contracted to provide health care services by locations, programs, types, and specialties. Providers are being counted multiple times if they have multiple locations, programs, types, and specialties.

Program	% of Capacity Used
SoonerCare Choice	44%
SoonerCare Choice I/T/U	19%
Insure Oklahoma IP	1%

Select Provider Type Counts	*In-State*		*Totals*	
	Monthly Average SFY2014	*Enrolled April 2015**	Monthly Average SFY2014	Enrolled April 2015
Physician	*8,452*	*9,225*	*13,597*	15,907
Pharmacy	*936*	*924*	*1,266*	1,226
Mental Health Provider	*4,864*	*4,857*	*4,902*	4,915
Dentist	*1,069*	*1,125*	*1,206*	1,306
Hospital	*183*	*192*	*685*	965
Optometrist	*565*	*608*	*594*	644
Extended Care Facility	*356*	*345*	356	345

Above counts are for specific provider types and are not all-inclusive.

Total Primary Care Providers**	*5,410*	*6,198*	7,011	8,348
Patient-Centered Medical Home	*2,099*	*2,376*	2,188	2,465

**Including Physicians, Physician Assistants and Advance Nurse Practitioners.

*Items shaded above represent a 10% or more increase (green) or decrease (red) from the previous fiscal year's average.

DSPAR Report

Department of Strategic Planning and Reform Update

Melanie Lawrence, Asst. Director

Strategic Planning Conference Information

The 2015 OHCA Strategic Planning Conference will be August 12 – 14, 2015. The location will be in Oklahoma City. The agenda and registration will be available very soon on the banner at the top of our home page, www.okhca.org.

Central Portfolio and Project Management Office (PMO) Update

In July 2015, the Division of Strategic Planning and Reform is implementing new processes and procedures to begin operating as the agency's Central Portfolio and Project Management Office. This means that we are overseeing projects throughout the agency and managing and reporting on them in a consistent, meaningful way. Currently our agency has approximately 75 active projects. Our objectives are to provide increased visibility and communication and current, accurate information on the mix and health of these projects to agency leadership.

Strategic Planning Staff Survey

We have completed this year's annual staff survey. We were very pleased with the response rate: 72% of employees responded to the survey this year, compared to 51% last year. We received over 1079 suggestions, compared to 550 last year.

OHCA employees' recommendations covered a wide range of topics. The five top categories receiving comments focused on member education, benefits and responsibilities and OHCA employees and processes. Common themes include decreasing the unnecessary usage of the Emergency Room and increasing member responsibility through copays and incentives. OHCA employees offered several ideas to save money by changing policy or benefits or ways to recoup more money through Program Integrity efforts.

Throughout the responses, the undertone of serving Oklahoma in the very best way possible is apparent.

New Categories brought up by Responses to This Year's Survey

Behavioral Health: Suggestions focus on improvements or changes to behavioral health services, policies, or benefits.

Defining Medical Necessity of Services: Ideas for ensuring members only receive medically necessary benefits through prior authorizations or other processes.

Eligibility and Online Enrollment: Suggestions to increase or decrease eligibility, or improve existing eligibility and Online Enrollment Processes.

Federal, State Agency, and Contracting Partners: Strengthen and improve collaboration with federal agencies, other state agencies, and contractors to improve the health of Oklahomans.

Information Technology: Ideas to improve existing OHCA Information Technology or to expand the use of Electronic Health Records in order to improve services to members.

Member Responsibility and Incentives for Healthy Behaviors: Ideas to encourage healthy behaviors and improve health outcomes by incentivizing member behavior and encouraging members to take more responsibility for their healthcare use, payment, and decisions.

OHCA Processes and Administration: Suggestions to improve OHCA internal administrative functions that will result in more efficient and effective operations for OHCA.

Pregnancy: Responses focus on pregnancy related benefits, services, and issues.

Provider Services, Communication, and Feedback: Responses focus on improvements that could be made to the way OHCA does business with, communicates, and obtains feedback from our contracted providers.

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1115 Waiver

Link to the Insure Oklahoma 1115 Waiver information on the OHCA website

Proposed Rule Changes

July MAC
Proposed Rule Amendment Summaries

Face to face tribal consultations regarding the following proposed changes were held Tuesday, January 6, 2015 and Tuesday May 5, 2015 in the Board Room of the OHCA.

The following rules are posted for comment from June 16, 2015 through July 16, 2015.

15-01 Adult dental coverage for organ transplant clearance — The proposed policy revisions add coverage for medically necessary dental services for adult SoonerCare members needing dental clearance for organ transplant approval.
Budget Impact: The proposed rule change has a projected cost to the agency of $60,000 state only dollars. This is a limited set of covered dental services specific to SoonerCare adults needing organ transplant clearance. Federal regulation prohibits Oklahoma from limiting services to a subgroup of SoonerCare members; therefore, the agency has elected to use state only dollars to reimburse dental providers for services rendered. Due to State budgetary constraints, all other SoonerCare adults will still be limited to emergency extractions as set forth in state statute. There are approximately 60 SoonerCare adults pending approval for organ transplant clearance and the agency has estimated dental services at a cost of $1,000 per member.

15-10 Long-Term Care Rule Changes — Long-term care eligibility rules are clarified to be consistent with 42 U.S. Code § 1396p. Changes include increasing home equity maximum amount to $500,000 plus the increase by the annual percentage increase in the urban component of the consumer price index, and allowing the individual to decrease this equity interest through the use of a reverse mortgage or home equity loan. The term "relative" is removed from the home exemption rules for members who fail to return back home from a long-term care institution. The term "assets" is changed to also include annuities purchased by, or on behalf of, an annuitant seeking long-term care services.
Budget Impact: Budget neutral

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TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 79. DENTIST

317:30-5-696. Coverage by category

Payment is made for dental services as set forth in this Section.

(1) **Adults.**

(A) Dental coverage for adults is limited to:

(i) medically necessary extractions and approved boney adjustments. Tooth extraction must have medical need documented;

(ii) Smoking and Tobacco Use Cessation Counseling; and

(iii) 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 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 have prior authorization for all services before delivery of dental service, with the exception of evaluation and extractions. All requests must be filed on the currently approved ADA form and must include diagnostic X-rays, six-point periodontal charting, narratives and comprehensive treatment plans. The 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 radiographic bitewings,

(iii)prophylaxis,

(iv)fluoride application,

(v)limited restorative procedures, and

(vi)periodontal scaling/root planing.

(2) **Home and community based waiver services (HCBWS) for the intellectually disabled.** All providers participating in the HCBWS must have a separate contract with the OHCA to provide services under the HCBWS. Dental services are defined in each waiver and must be prior authorized.

(3) **Children.** The OHCA Dental Program provides the basic medically necessary treatment. The services listed below are

compensable for members under 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. 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 may be performed for any member every 36 months. An examination should precede any radiographs, and chart documentation must include radiographic interpretations, caries risk assessment and both medical and dental health history of member. The comprehensive treatment plan should be the final results of this procedure.

(B) **Periodic oral evaluation.** This procedure may be provided for a member of record if not seen by a dentist for more than six months. An examination should precede any radiographs, and chart documentation must include radiographic interpretations, caries risk assessment and both medical and dental health history of member. The comprehensive treatment plan should be the final results of this procedure.

(C) **Emergency examination/limited oral evaluation.** This procedure is not compensable within two months of a periodic oral examination or if the member is involved in active treatment unless trauma or acute infection is the presenting complaint. This procedure is only compensable to the same dentist or practice for two visits prior to an examination being completed.

(D) **Radiographs (x-rays).** To be SoonerCare compensable, x-rays must be of diagnostic quality and medically necessary. A clinical examination must precede any radiographs, and chart documentation must include member history, prior radiographs, caries risk assessment and both dental and general health needs of the member. The referring dentist is responsible for providing properly identified x-rays of acceptable quality with a referral, if that provider chooses to expose and submit for reimbursement prior to referral. Periapical radiograph must include at least 3 millimeters beyond the apex of the tooth being x-rayed. Panoramic films and full mouth radiographs (minimum of 12 periapical films and two posterior bitewings) are allowable once in a three year period and must be of diagnostic quality. Individually listed intraoral radiographs by the same dentist/dental office are considered a complete series if the fee for individual radiographs equals or exceeds the fee 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 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 18 years of age and is compensable once every 36 months if medical necessity is documented.

(F) **Dental prophylaxis.** This procedure is provided once every 184 days including topical application of fluoride.

(G) **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 years of age or under;

(II) 70 percent or more of the root structure remains; or

(III) the procedure is provided more than 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 surfaces of extensive decay exist; or

(III) primary teeth where cuspal occlusion is lost due to decay or accident.

(iii) Preoperative periapical x-rays 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 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.

(H) **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 or more surfaces of tooth is destroyed;

(II) posterior permanent teeth that have three or more surfaces of extensive decay; or

(III) where cuspal occlusion is lost due to decay prior to age 16 years.

(ii) Preoperative periapical x-rays 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 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) **Pulpotomies and pulpectomies.**

(i) Therapeutic pulpotomies and pulpal debridement are allowable once per lifetime. Pre-and post-operative periapical x-rays must be available for review, if requested. Therapeutic pulpotomies and pulpal debridement is available for the following:

(I) Primary molars having at least 70 percent or more of their root structure remaining or more than 12 months prior to normal exfoliation;

(II) Tooth numbers O and P before age 5 years;

(III) Tooth numbers E and F before 6 years;

(IV) Tooth numbers N and Q before 5 years;

(V) Tooth numbers D and G before 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 year or if 70 percent or more of root structure is remaining.

(J) **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 anterior and/or two posterior root canals.

(iv) Pre and post-operative periapical x-rays 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 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.

(K) **Space maintainers.** Certain limitations apply with regard to this procedure. Providers are responsible for recementation of any maintainer placed by them for six 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 5mm 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 x-rays must be available for review.

(VI) Bilateral band and loop space maintainer is allowed if member does not have eruption of the four 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 x-rays must be available.

(L) **Analgesia.** Analgesia services are reimbursable in accordance with the following:

(i) **Inhalation of nitrous oxide.** Use of nitrous oxide is compensable for four occurrences per year and is not separately reimbursable, if provided on the same date by the same provider 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.

(M) **Pulp caps.** Indirect and direct pulp cap must be ADA accepted calcium hydroxide or Mineral Trioxide Aggregate

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.

(N) **Protective restorations.** This restoration includes removal of decay, if present, and is reimbursable for the same tooth on the same date of service with a direct or indirect pulp cap, if needed. Permanent restoration of the tooth is allowed after 60 days unless the tooth becomes symptomatic and requires pain relieving treatment.

(O) **Smoking and Tobacco Use Cessation Counseling.** Smoking and Tobacco Use Cessation Counseling is covered when performed utilizing the five 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 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, nurse midwives, Oklahoma State Health Department and FQHC nursing, and Maternal/Child Health Licensed Clinical Social Workers with a certification as a Tobacco Treatment Specialist Certification (CTTS) staff in addition to other appropriate services rendered. Chart documentation must include a separate note, separate signature, and the member specific information addressed in the five steps and the time spent by the practitioner performing the counseling. Anything under three minutes is considered part of a routine visit.

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15-10 – Long Term Care Rules

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 35. MEDICAL ASSISTANCE FOR ADULTS AND CHILDREN-ELIGIBILITY
SUBCHAPTER 5. ELIGIBILITY AND COUNTABLE INCOME
PART 5. COUNTABLE INCOME AND RESOURCES

317:35-5-41.8. Eligibility regarding long-term care services

(a) **Home Property.** In determining eligibility for long-term care services for applications filed on or after January 1, 2006, home property is excluded from resources unless the individual's equity interest in his or her home exceeds $500,000 (increased by the annual percentage increase in the urban component of the consumer price index beginning in 2011, rounded to the nearest $1,000).

(1) Long-term care services include nursing facility services and other long-term care services. For purposes of this Section, other long-term care services include ~~services detailed in (A) through (B) of this paragraph.~~:

(A) A level of care in any institution equivalent to nursing facility services; and

(B) Home and community-based services furnished under a waiver.

(2) An individual whose equity interest exceeds $500,000 (increased by the annual percentage increase in the urban component of the consumer price index beginning in 2011, rounded to the nearest $1,000) is not eligible for long-term care services unless one of the following circumstances applies:

(A) The individual has a spouse who is lawfully residing in the individual's home;

(B) The individual has a child under the age of twenty-one who is lawfully residing in the individual's home;

(C) The individual has a child of any age who is blind or permanently and totally disabled who is lawfully residing in the individual's home; or

(D) The denial would result in undue hardship. Undue hardship exists when denial of SoonerCare long-term care services based on an individual's home equity exceeding $500,000 would deprive the individual of medical care such that the individual's health or life would be endangered; or of food, clothing, shelter, or other necessities of life.

(E) An individual may reduce their total equity interest in the home through the use of a reverse mortgage or home equity loan.

(3) Absence from home due to nursing facility care does not affect the home exclusion as long as the individual intends to return home within 12 months from the time he/she entered the facility. The OKDHS Form 08MA010E, Acknowledgment of Temporary Absence/Home Property Policy, is completed at the time of

application for nursing facility care when the applicant has home property. After an explanation of temporary absence, the member, guardian, or responsible person indicates whether there is or is not intent to return to the home and signs the form.

(A) If at the time of application the applicant states he/she does not have plans to return to the home, the home property is considered a countable resource. For members in nursing facilities, a lien may be filed in accordance with OAC 317:35-9-15 and OAC 317:35-19-4 on any real property owned by the member when it has been determined, after notice and opportunity for a hearing, that the member cannot reasonably be expected to be discharged and return home. However, a lien is not filed on the home property of the member while any of the persons described in OAC 317:35-9-15(b)(1) and OAC 317:35-19-4(b)(1) are lawfully residing in the home:

(B) If the individual intends to return home, he/she is advised that:

(i) the 12 months of home exemption begins effective with the date of entry into the nursing home regardless of when application is made for SoonerCare benefits, and

(ii) after 12 months of nursing care, it is assumed there is no reasonable expectation the member will be discharged from the facility and return home and a lien may be filed against real property owned by the member for the cost of medical services received.

(C) "Intent" in regard to absence from the home is defined as a clear statement of plans in addition to other evidence and/or corroborative statements of others.

(D) At the end of the 12-month period the home property becomes a countable resource unless medical evidence is provided to support the feasibility of the member to return to the home within a reasonable period of time (90 days). This 90-day period is allowed only if sufficient medical evidence is presented with an actual date for return to the home.

(E) A member who leaves the nursing facility must remain in the home at least three months for the home exemption to apply if he/she has to re-enter the facility.

(F) However, if the spouse, ~~minor child(ren) under 18, or relative who is aged, blind or disabled or a recipient of TANF~~minor child under 21, or child who is blind or permanently disabled resides in the home during the individual's absence, the home continues to be exempt as a resource so long as the spouse~~ or relative~~, minor child, or child who is blind or permanently disabled lives there (regardless of whether the absence is temporary).

~~(G) For purpose of this reference a relative is defined as: son, daughter, grandson, granddaughter, stepson, stepdaughter, in-laws, mother, father, stepmother, stepfather, half-sister, half-brother, niece, nephew,~~

~~grandmother, grandfather, aunt, uncle, sister, brother, stepbrother, or stepsister.~~

~~(H)~~<u>(G)</u> Once a lien has been filed against the property of an NF resident, the property is no longer considered as a countable resource.

(b) **Promissory notes, loans, or mortgages.** The rules regarding the treatment of funds used to purchase a promissory note, loan, or mortgage on or after February 8, 2006, are found in (1) through (2) of this subsection.

(1) Funds used to purchase a promissory note, loan, or mortgage on or after February 8, 2006, are treated as assets transferred ~~for less than fair market value in~~<u>, and the value of such note, loan, or mortgage shall be</u> the amount of the outstanding balance due on the note, loan, or mortgage as of the date of the individual's application for medical assistance unless the note, loan, or mortgage meets all of the conditions in paragraphs (A) through (C) of this paragraph.

(A) The note, loan, or mortgage has a repayment term that is actuarially sound (as determined in accordance with actuarial publications of the Office of the Chief Actuary of the United States Social Security Administration).

(B) The note, loan, or mortgage provides for payments to be made in equal amounts during the term of the loan, with no deferral and no balloon payments made.

(C) The note, loan, or mortgage prohibits the cancellation of the balance upon the death of the lender.

(2) Funds used to purchase a promissory note, loan, or mortgage for less than its fair market value are treated as assets transferred for less than fair market value regardless of whether:

(A) The note, loan, or mortgage was purchased before February 8, 2006; or

(B) The note, loan, or mortgage was purchased on or after February 8, 2006, and the conditions described in paragraph (1) of this subsection were met.

(c) **Annuities.** Treatment of annuities purchased on or after February 8, 2006.

~~(1) The entire amount used to purchase an annuity on or after February 8, 2006, is treated as assets transferred for less than fair market value unless the annuity meets one of the conditions described in (A) through (C) of this paragraph.~~

~~(A) The annuity is an annuity described in subsection (b) or (q) of Section 408 of the United States Internal Revenue Code of 1986.~~

~~(B) The annuity is purchased with proceeds from:~~

~~(i) An account or trust described in subsection (a), (c), or (p) of Section 408 of the United States Internal Revenue Code of 1986;~~

~~(ii) A simplified employee pension as defined in Section 408(k) of the United States Internal Revenue Code of 1986;~~

~~(iii) A Roth IRA described in Section 408A of the United States Internal Revenue Code of 1986.; or~~

~~(C) The annuity:~~

~~(i) is irrevocable and nonassignable;~~

~~(ii) is actuarially sound as determined in accordance with actuarial publications of the Office of the Chief Actuary of the United States Social Security Administration; and~~

~~(iii) provides for payments in equal amounts during the term of the annuity, with no deferral and no balloon payments made.~~

~~(2) In addition, the entire amount used to purchase an annuity on or after February 8, 2006, is treated as a transfer of assets unless the Oklahoma Health Care Authority is named as the remainder beneficiary either:~~

~~(A) in the first position for at least the total amount of medical assistance paid on behalf of the institutionalized individual; or~~

~~(B) in the second position after the community spouse, child under 21 years of age, or disabled child and in the first position if the spouse or a representative of the child disposes of any of the remainder for less than fair market value.~~

(1) The purchase of an annuity shall be treated as the disposal of an asset for less than fair market value unless the Oklahoma Health Care Authority is named as the remainder beneficiary –

(A) in the first position for at least the total amount of medical assistance paid on behalf of the institutionalized individual; or

(B) in the second position after the community spouse, child under 21 years of age, or disabled child and is named in the first position if the spouse or a representative of the child disposes of any such remainder for less than fair market value.

(2) For purposes of determining financial eligibility for long-term care services under this chapter, the term “assets” shall include an annuity purchased by or on behalf of an annuitant who has applied for SoonerCare nursing facility services or other long-term care services unless the annuity meets one of the following conditions.

(A) The annuity is an annuity described in subsection (b) or (q) of Section 408 of the United States Internal Revenue Code of 1986; or

(B) The annuity is purchased with proceeds from:

(i) An account or trust described in subsection (a), (c), or (p) of Section 408 of the United States Internal Revenue Code of 1986;

(ii) A simplified employee pension as defined in Section 408(k) of the United States Internal Revenue Service Code of 1986;

(iii) A Roth IRA described in Section 408A of the United States Internal Revenue Service Code of 1986; or

(C) The annuity:

(i) is irrevocable and nonassignable;

(ii) is actuarially sound as determined in accordance with actuarial publications of the Office of the Chief Actuary of the United States Social Security Administration; and

(iii) provides for payments in equal amounts during the term of the annuity, with no deferral and no balloon payments made.

(d) **Life Estates.** This subsection pertains to the purchase of a life estate in another individual's home.

(1) The entire amount used to purchase a life estate in another individual's home on or after February 8, 2006, is treated as assets transferred for less than fair market value, unless the purchaser resides in the home for at least one year after the date of the purchase.

(2) Funds used to purchase a life estate in another individual's home for less than its fair market value are treated as assets transferred for less than fair market value regardless of whether:

(A) The life estate was purchased before February 8, 2006; or

(B) The life estate was purchased on or after February, 8, 2006, and the purchaser resided in the home for one year after the date of purchase.

(e) **Oklahoma Long-Term Care Partnership (LTCP) Program.** This subsection pertains to individuals with Oklahoma Long-Term Care Partnership policies. The Oklahoma Insurance Department approves long-term care insurance policies as Long-term Care Partnership Program policies. The face page of the policy document will indicate if the insurance qualifies as a ~~Long Term~~Long-Term Care Partnership Program policy.

(1) Benefits from the LTCP policy must be exhausted before the individual can be eligible for ~~long term~~long-term care under the SoonerCare program.

(2) Assets in an amount equal to the amount paid out under the LTCP policy can be protected for the insured individual once the LTCP policy benefits are exhausted. Protected assets are disregarded when determining eligibility for the SoonerCare program per 317:35-5-41.9(26). A record of the amount paid on behalf of the policy holder is available through the OHCA or insurance company holding the LTCP policy.

(A) At the time of application for SoonerCare the individual must determine the asset(s) to be protected. The protected asset(s) cannot be changed. If the value of the protected asset(s) decreases, the individual does not have the option to select additional assets to bring the total up to the protected amount.

(B) If the protected asset(s) are income-producing, the income earned while on SoonerCare is counted in accordance with 317:35-5-42.

(C) The individual can choose to transfer the protected asset without incurring a transfer of assets penalty.

(D) When determining resource eligibility for a couple when one of them enters the nursing home or applies for a HCBS waiver, the LTCP protected asset(s) are disregarded in determining the total amount of the couple's resources.

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Informational Items

July 2015 MAC

Proposed State Plan Amendment and/or Rate Change Summaries

Information Only

OHCA has prepared this document to give members of the MAC a preview of proposed rate and state plan revisions, as applicable. This document is for informational purposes only.

DHS Rates — The Department of Human Services (DHS) is proposing to reduce the ADvantage/State Plan Personal Care and DDS provider rates by 3.5%.

Mental Health Substance Use Screenings — The State Plan will be amended to add coverage for mental health/substance use disorder screening for SoonerCare members within an outpatient behavioral health agency setting.

Distinction Between LBHP & Licensure Candidate — Outpatient behavioral health coverage in the State Plan will be revised to create distinction between licensed behavioral health professionals and licensure candidates.

Rate for SCID Newborn Screen — The Oklahoma State Department of Health (OSDH) proposes to set the rate for Severe Combined Immunodeficiency Disorder (SCID) newborn screening, CPT code 81479, at $6.00 to offset the cost of adding SCID testing to the Oklahoma newborn screening panel. Early identification of the asymptomatic SCID infant during the first few weeks of life is essential for successful treatment. SCID infants who are treated early have almost 10-fold lower total clinical care costs compared with those treated later. If undiagnosed, SCID infants usually die from severe infections with the first year of life.

Exome Sequence Analysis Rate — OHCA proposes to set the rate for exome sequence analysis (81415) at the sum of the rates for the codes that were billed for the service prior to 2015.

Independent Licensed Behavioral Health Practitioners Rate Equalization — The Department of Mental Health and Substance Abuse Services proposes to reimburse independent Licensed Behavioral Health Practitioners at the same rate as those in outpatient behavioral health agency settings.

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