Oklahoma Health Care Authority
MEDICAL ADVISORY COMMITTEE

AGENDA

September 21st, 2017
1:00 PM – 3:30 PM

Charles Ed McFall Board Room

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

II. Action Item: Approval of Minutes of the July 20th, 2017: **Medical Advisory Committee Meeting**

III. Public Comments (2 minute limit)

IV. MAC Member Comments/Discussion

V. Financial Report: **Gloria Hudson, Director of General Accounting**

- **A.** SFY 18 Budget Update- **Carrie Evans, Chief Financial Officer**

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

- **A.** Focus Forward Oklahoma Program Update: **Mary Gowin, LARC Coordinator**
- **B.** Member Audits- **Ginger Clayton, Member Audits Manager**

VII. Legislative Update: **Cate Jefferies, Legislative Liaison**

VIII. Proposed Rule Changes: Presentation, Discussion, and Vote: **Demetria Bennett, Policy Development Coordinator**

- **A.** 17-03 — Indian Health Services, Tribal Program and Urban Indian Clinics (I/T/U) Four Walls
- **B.** 17-07 — School-Based Services Policy Revisions
- **C.** 17-13 — Signature Requirements Revisions
- **D.** 17-14 — Adult Dental Emergency Extractions

IX. Action Item: Vote on Proposed Rule Changes: **Chairman, Steven Crawford, M.D.**

X. Discussion Items Only: **Sherris Harris-Ososanya, Waiver Development Coordinator**

- **A. 1115 Demonstration Renewal & Post Award Forum**

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

XII. Future Meeting:
November 16th, 2017

XIII. Adjourn

Oklahoma Health Care Authority
MEDICAL ADVISORY COMMITTEE
MINUTES of the July 20th, 2017 Meeting
4345 N. Lincoln Blvd., Oklahoma City, OK 73105

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

Co-Chairman Steve Goforth called the meeting to order at 1:00 PM.

***Delegates present were*:** Ms. Renee Banks, Ms. Teresa Bierig, Ms. Debra Billingsley, Dr. Joe Catalano, Ms. Wanda Felty, Dr. Arlen Foulks, Ms. Terri Fritz, Mr. Steve Goforth, Mr. Mark Jones, Dr. Ashley Orynich, Ms. Annette Mays, Mr. Victor Clay, Dr. J. Daniel Post, Ms. Carrie Slatton-Hodges, Mr. Rick Snyder, Mr. Jeff Tallent, and Dr. John Linck.

Alternates present were: Dr. Mike Talley and providing a quorum.

***Delegates absent without an alternate were*:** Ms. Mary Brinkley, Mr. Brett Coble, Dr. Steven Crawford, Mr. James Patterson, Ms. Toni Pratt- Reid, Dr. Jason Rhynes, and Dr. Kanwal Obhrai.

II. Approval of May 18th, 2017 Minutes

Medical Advisory Committee

Co-Chairman Goforth did a call to vote to approve the meeting minutes for May 18th, 2017.
It was motioned by Dr. John Linck and Mr. Jeff Tallent seconded the motion. All members voted to approve the minutes.

III. Public Comments (2 minute limit)

Mr. Richard Desirey commented about serving children in need of treatment. He believes that a community which mobilizes with stakeholders, that are families, persons being served, representatives of varied agencies, state, local, nonprofit and with minority community representative should be able to form a systems of care in a strength base.

Ms. Lola Edwards commented on her concerns for the 49 payments that are planned for the 2018 budget instead of the 52 weeks. They represent the advantage program providers, who have already been cut by DHS to the total of 9.2 million dollars.

Ms. Joy Sloan with CMHC's which serves all 77 counties across the state is asking to reluctantly support the reduction of case management services.

IV. MAC Member Comments

Ms. Anette Mayes asked why the payments are being held three weeks on the advantage program.

Ms. Tasha Black responded to her question. There are two reasons for the delay; Reason one being the loss in F-MAP/ CHIP which acquainted to 50 million dollars in revenue. We were also short 3.4 million dollars in our state appropriation dollars. One cycle is being bumped as a result of the 34

million shortfalls. The other 50 million represents two weeks. If CHIP is reauthorized we are looking at delaying only one payment cycle.

V. Financial Update:

Gloria Hudson, Director of General Accounting

Ms. Gloria Hudson reported on the state's Fiscal Year 2017 financial transactions through the month of April. She reported that the state budget variance is a positive $10.6 million dollars. On the expenditure side, Medicaid Program is under budget by 6 million state dollars and in administration $4 million state dollars. On the revenue side, OHCA is over budget $1.8 million state dollars in Drug Rebates and Collections. Settlements and Overpayments are under budget negative$0.1million state dollars and in Tobacco Tax Collections are negative $1.1 million state dollars.

A. **2018 Budget update:**

MS. Tasha Black reported on the 2018 Budget Work Program. The state officially appropriated $1,025,516,034 for the state fiscal 2018 budget. The appropriation consists of $903 million in general revenue and special cash. $12 million from the tobacco settlement fund, $70 million from the Health Care Enhancement Fund, $32 million in the rainy day funds, a $3 million transfer from the Health Employee and Economy Improvement Act revolving fund and $ 6 million from our Fund 200 revolving fund. In addition to the appropriated dollars we have been authorized to transfer $30 million from the supplemental hospital offset payment fund.

The increases in the appropriations were unable to support the agency's total need. In an effort to balance the current years' budget, we opted to delay that last 3 cycles in June until FY 19. Two of the cycles represent the loss of federal funds associated with the drop in FMAP for Children's Health Insurance Program roughly, $50 million also known as CHIP. The other cycle enables us to continue to maintain the program at the current level. We remain optimistic that CHIP will be reauthorized and will file a revised budget at the time we will reduce the delayed payment cycle to one.

Managed Care's actual projected growth rate is 8.2%. Much of the growth is attributed to the increased enrollment in the Program known as PACE, which is up by 30%. The hospital category increased by 4% as the result of the approval of the new drug Spinraza. We are budgeting an additional $43 million dollars for prescription drugs, which is an increase of 8%. Medicare rates are set by CMS and reassessed yearly in January, which we have no control over the cost. We have seen a 10% increase in rates over the last two years with an impact in FY 18 of 9.3 million. For more detailed information please see item 5A in the full agenda packet.

VI. Legislative Update:

Austin Marshall, Director of Governmental Affairs

Mr. Marshall stated that we now have a budget but unfortunately it is about $34 million short from what we had asked for. We will delay the last week's payment for June 2018; the other two are tied to whether or not CHIP will be reauthorized. $70 million is tied to the cigarette fee, which is currently being ligated in the Oklahoma Supreme Court, which is currently scheduled to be argued in front of the Supreme Court August 8th at 10:00AM. Potentially there could be the $215 million dollars from this cigarette fee plus another $100- 150 million, in law suits that could be taken out of the total state budget for the next year. Mr. Goforth stated that it was time for a long term sustainable budget, as the medical professions here take care of the safety net for very vulnerable people. Mr. Marshall commented that this was the third year in a row with revenue shortage.

VII. SoonerCare Operations Update:

Melinda Thomason, Director of Health Care Systems Innovation

Ms. Thomason presented the SoonerCare Operations Update to the committee. She presented information based on data for May of 2017. Patient Centered Medical Home enrollment is at 70% which is 551,829. Sooner Care Traditional has a current enrollment of 236,214, Insure Oklahoma has a total enrollment of 19,612, SoonerPlan enrollment is at 34,520. In total, SoonerCare enrollment is at 842,175 for May .Total In-State providers are up by 192, giving a total of 34,736. Dual enrollees are up at 14% of membership. Long term care individuals are at 14,904, SoonerCare choice children are 65% of our enrollment at 455,112. Our traditional adults following at 146,998, SoonerCare choice adults are at 96,717 and 89,216 for traditional children who are not enrolled in patient centered medical home.

A. Fast Facts Update:

Andy Garland, Reporting manager

Mr. Garland provided an update for our reports posted on our external website. Data is available for expenditures and members by county, Expenditures and Members by Legislator, Historic category of member services and expenditures, SoonerCare and Insure Oklahoma members by age, and SoonerCare monthly enrollment 2006 to present. Fast facts allow you to view enrollment by the total number, county, children, adults, race, TEFRA, and PACE.

VIII. Proposed Rule Changes:

Demetria Bennett, Policy Development Coordinator

A face to face tribal consultation regarding the following proposed changes was held Tuesday, May 23rd, 2017 and Tuesday, July 11, 2017 in the Board Room of the Oklahoma Health Care Authority (OHCA).

Rule changes within work folders 17-05 A&B and 17-06 were posted on the OHCA public website for a comment period from June 15, 2017 through July 14, 2017. Rule changes within work folder 17-09 will be posted on the OHCA public website for comments through July 28, 2017.

17-05 A&B Medical Identification Card Policy Revisions — the proposed revisions remove references that refer to the issuing/mailing of member medical identification cards. This policy change is the result of the Oklahoma Health Care Authority no longer printing and/or issuing plastic cards. Members now have access to print their medical identification card from their online member account, or non-online enrollment members can visit their local county Oklahoma Department of Human Services (OKDHS) office to obtain a printed card. Providers can verify the member's eligibility online via the Eligibility Verification System. Additionally, revisions update language to reflect how the OKDHS notifies members of eligibility and ineligibility determinations for medical services by mailing out computer-generated notification forms. Finally, the policy revisions update the language for the medical and financial certification processes for the OKDHS ADvantage program.
Budget Impact: Revisions to medical identification cards will result in a total budget savings of $96,000 (CY).
Rule change was motioned to approve by Dr. Joe Catalano and seconded by Mr. Jeff Tallent

17-06 Pharmacy Revisions — the proposed pharmacy revisions remove coverage of optional non-prescription drugs for adults. (Insulin, nicotine replacement products for smoking cessation, and family planning products are not optional.) Additionally, compounded prescriptions for topical use will require a prior authorization for allowable cost exceeding a pre-determined limit. Finally, revisions cleanup language by correcting the number of prescriptions allowed for adults receiving services under the 1915(c) Home and Community-Based Services Waivers from two (2) to three (3), which will align with current practices.
Budget Impact: Revisions that remove coverage of optional non-prescription drugs for adults will result in a total budget savings of $825,000 for SFY 2018; state share $338,992.50; federal share $486,007.50.
Rule change was motioned to approve by Dr. Joe Catalano and seconded by Ms. Carrie Slatton-Hodges.

17-09 Behavioral Health Case Management Limits — the proposed Behavioral Health Targeted Case Management (TCM) revisions establish yearly limits on the amount of basic case management/resource coordination that is reimbursable by SoonerCare on a fee-for-service basis. The current limit of twenty-five (25) units per member per month basic case management/resource coordination will be reduced to sixteen (16) units per member per year. A process for authorizing up to twenty-five (25) units per member per month will be used for individuals who demonstrate the medical need for additional units. These emergency revisions are necessary to reduce the Oklahoma Department of Mental Health Substance Abuse Services'

operations budget for the remainder of SFY 2018 in order to meet the balanced budget requirements as mandated by state law. Without the recommended revisions, the Department is at risk of exhausting its state appropriated dollars required to maintain the State's Medicaid Behavioral Health Program.

Budget Impact: Estimated savings to ODMHSAS for SFY 2018 is $8,447,984 Total; $3,500,000 state share.

Rule change was motioned to approve by Mr. Jeff Tallent and seconded by Dr. Joe Catalano.

Rule change was opposed by Ms. Annette Mays

Ms. Annette Mays asked to hear a little bit of background on how this came out and why this change makes sense as opposed to some others.

Mr. Traylor Rains-Sims responded that was left with a 300 million dollar shortfall, primarily due to the drop of the FMAP. There are two types of case management; this is the basic resource coordination level. There is also an intensive care case management, which is delivered primarily through programs of assertive community treatment, which is a community based team approach of working with adults with serious mental illness. Health homes are available in the state that works with adults with SMI and children SED who uses the systems of care model. On average children are only getting 48 a year even though we authorize up to 25 a month, and adults are getting 26.

IX. Discussion Items Only:

Concern over the concept of a two year budget was brought to discussion. Changes in state level would have to be made; budgeting process is determined by both chambers of legislature, who don't seem interested in changing up the order of business.

A request was made to consider recommending a long term budget to the senate. If this is a route that wants to be taken, it needs to be an agenda item for the next meeting, as guidelines will need to be reviewed.

X. Future Meeting

September 21st, 2017

XI. Adjournment

Mr. Goforth adjourn the meeting

FINANCIAL REPORT

For the State Fiscal Year Ended June 30, 2017
Submitted to the CEO & Board

- Revenues for OHCA through June, accounting for receivables, were **$3,986,402,294** or **1.3% under** budget.
- Expenditures for OHCA, accounting for encumbrances, were **$4,002,172,607 or 1.6% under** budget.
- The state dollar budget variance through June is a **positive $11,953,866.**
- The budget variance is primarily attributable to the following (in millions):

Expenditures:		
Medicaid Program Variance		14.9
Administration		8.4
SFY 2018 Dedicated Carryover		(20.0)
Revenues:		
Drug Rebate		6.3
Taxes and Fees		0.1
Overpayments/Settlements		2.3
Total FY 17 Variance	**$**	**12.0**

ATTACHMENTS

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OKLAHOMA HEALTH CARE AUTHORITY
Summary of Revenues & Expenditures: OHCA
For the Fiscal Year Ended June 30, 2017

REVENUES	FY17 Budget YTD	FY17 Actual YTD	Variance	% Over/ (Under)
State Appropriations	$ 1,007,923,715	$ 1,007,923,715	$ -	0.0%
Federal Funds	2,308,004,911	2,257,395,406	(50,609,506)	(2.2)%
Tobacco Tax Collections	48,824,405	49,541,128	716,723	1.5%
Quality of Care Collections	78,038,320	77,336,221	(702,099)	(0.9)%
Prior Year Carryover	27,584,042	27,584,042	-	0.0%
SFY 2018 Dedicated Carryover	-	(20,000,260)	(20,000,260)	100.0%
Federal Deferral - Interest	168,334	168,334	-	0.0%
Drug Rebates	289,921,061	305,682,952	15,761,891	5.4%
Medical Refunds	40,502,796	42,839,942	2,337,146	5.8%
Supplemental Hospital Offset Payment Program	220,309,661	220,309,661	-	0.0%
Other Revenues	17,531,073	17,621,153	90,080	0.5%
TOTAL REVENUES	**$ 4,038,808,318**	**$ 3,986,402,294**	**$ (52,406,024)**	**(1.3)%**

EXPENDITURES	FY17 Budget YTD	FY17 Actual YTD	Variance	% (Over)/ Under
ADMINISTRATION - OPERATING	**$ 58,013,190**	**$ 51,250,093**	**$ 6,763,097**	**11.7%**
ADMINISTRATION - CONTRACTS	**$ 101,864,429**	**$ 86,330,370**	**$ 15,534,059**	**15.2%**
MEDICAID PROGRAMS				
Managed Care:				
SoonerCare Choice	41,144,343	42,017,858	(873,515)	(2.1)%
Acute Fee for Service Payments:				
Hospital Services	921,501,958	904,976,096	16,525,863	1.8%
Behavioral Health	19,882,016	20,288,086	(406,070)	(2.0)%
Physicians	427,103,707	411,224,989	15,878,718	3.7%
Dentists	128,588,912	126,957,229	1,631,683	1.3%
Other Practitioners	53,735,330	53,428,872	306,458	0.6%
Home Health Care	18,472,976	17,037,908	1,435,068	7.8%
Lab & Radiology	35,866,801	32,221,470	3,645,331	10.2%
Medical Supplies	47,146,589	48,608,724	(1,462,135)	(3.1)%
Ambulatory/Clinics	185,171,261	189,158,982	(3,987,721)	(2.2)%
Prescription Drugs	559,917,410	560,013,240	(95,829)	(0.0)%
OHCA Therapeutic Foster Care	62,636	(81,907)	144,543	0.0%
Other Payments:				
Nursing Facilities	560,565,843	551,179,702	9,386,141	1.7%
Intermediate Care Facilities for Individuals with Intellectual Disabilities Private	62,034,311	61,096,850	937,461	1.5%
Medicare Buy-In	168,686,738	168,452,322	234,416	0.1%
Transportation	65,348,281	66,001,208	(652,926)	(1.0)%
Money Follows the Person-OHCA	353,369	232,376	120,994	0.0%
Electonic Health Records-Incentive Payments	18,554,088	18,554,088	-	0.0%
Part D Phase-In Contribution	99,112,467	99,411,265	(298,798)	(0.3)%
Supplemental Hospital Offset Payment Program	482,985,755	482,985,755	-	0.0%
Telligen	10,277,520	10,773,850	(496,330)	(4.8)%
Total OHCA Medical Programs	**3,906,512,314**	**3,864,538,961**	**41,973,353**	**1.1%**
OHCA Non-Title XIX Medical Payments	89,382	-	89,382	0.0%
TOTAL OHCA	**$ 4,066,479,315**	**$ 4,002,119,424**	**$ 64,359,891**	**1.6%**
REVENUES OVER/(UNDER) EXPENDITURES	**$ (27,670,997)**	**$ (15,717,130)**	**$ 11,953,866**	

OKLAHOMA HEALTH CARE AUTHORITY
Total Medicaid Program Expenditures
by Source of State Funds
For the Fiscal Year Ended June 30, 2017

Category of Service	Total	Health Care Authority	Quality of Care Fund	HEEIA	SHOPP Fund	BCC Revolving Fund	Other State Agencies
SoonerCare Choice	$ 42,140,405	$ 42,006,127	$ -	$ 122,547	$ -	$ 11,731	$ -
Inpatient Acute Care	1,091,431,180	598,052,399	486,687	3,725,858	348,080,392	1,263,170	139,822,674
Outpatient Acute Care	415,158,056	301,220,915	41,604	4,589,989	105,394,228	3,911,320	
Behavioral Health - Inpatient	54,168,518	11,475,706	-	286,076	28,344,970	-	14,061,765
Behavioral Health - Psychiatrist	9,978,544	8,812,379	-	-	1,166,165	-	-
Behavioral Health - Outpatient	16,738,093	-	-	-	-	-	16,738,093
Behaviorial Health-Health Home	39,291,365	-	-	-	-	-	39,291,365
Behavioral Health Facility- Rehab	244,551,429	-	-	-	-	55,524	244,551,429
Behavioral Health - Case Management	18,310,841	-	-	-	-	-	18,310,841
Behavioral Health - PRTF	67,779,270	-	-	-	-	-	67,779,270
Behavioral Health-CCBHC	553,184	-	-	-	-	-	553,184
Residential Behavioral Management	16,645,365	-	-	-	-	-	16,645,365
Targeted Case Management	70,162,638	-	-	-	-	-	70,162,638
Therapeutic Foster Care	(81,907)	(81,907)	-	-	-	-	-
Physicians	473,740,988	406,511,643	58,101	(226,075)	-	4,655,245	62,742,074
Dentists	126,983,370	126,944,872	-	26,141	-	12,357	-
Mid Level Practitioners	2,739,950	2,712,785	-	25,616	-	1,549	-
Other Practitioners	51,141,863	50,173,643	446,364	427,325	-	94,531	-
Home Health Care	17,049,472	17,028,722	-	11,564	-	9,186	-
Lab & Radiology	33,010,159	31,992,017	-	788,689	-	229,453	-
Medical Supplies	48,880,653	45,867,517	2,711,532	271,929	-	29,675	-
Clinic Services	187,946,865	181,725,315	-	1,020,617	-	162,031	5,038,902
Ambulatory Surgery Centers	7,406,661	7,260,236	-	135,025	-	11,399	-
Personal Care Services	11,917,444	-	-	-	-	-	11,917,444
Nursing Facilities	551,179,702	338,041,633	213,138,069	-	-	-	-
Transportation	65,883,772	63,327,098	2,460,093	50,752	-	45,829	-
GME/IME/DME	141,787,176	-	-	-	-	-	141,787,176
ICF/IID Private	61,096,850	49,947,139	11,149,711	-	-	-	-
ICF/IID Public	12,916,226	-	-	-	-	-	12,916,226
CMS Payments	267,863,588	267,070,342	793,246	-	-	-	-
Prescription Drugs	573,266,703	557,657,158	-	13,253,463	-	2,356,082	-
Miscellaneous Medical Payments	168,188	168,188	-	-	-	-	-
Home and Community Based Waiver	201,337,476	-	-	-	-	-	201,337,476
Homeward Bound Waiver	81,553,902	-	-	-	-	-	81,553,902
Money Follows the Person	274,476	232,376	-	-	-	-	42,101
In-Home Support Waiver	25,135,590	-	-	-	-	-	25,135,590
ADvantage Waiver	186,731,259	-	-	-	-	-	186,731,259
Family Planning/Family Planning Waiver	4,800,380	-	-	-	-	-	4,800,380
Premium Assistance*	59,734,547	-	-	59,734,547	-	-	-
Telligen	10,773,850	10,773,850	-	-	-	-	-
Electronic Health Records Incentive Payments	18,554,088	18,554,088	-	-	-	-	-
Total Medicaid Expenditures	**$ 5,310,702,177**	**$ 3,137,474,240**	**$ 231,285,407**	**$ 84,244,064**	**$ 482,985,755**	**$ 12,849,082**	**$ 1,361,919,152**

* Includes $59,308,778.57 paid out of Fund 245

OKLAHOMA HEALTH CARE AUTHORITY
Summary of Revenues & Expenditures:
Other State Agencies
For the Fiscal Year Ended June 30, 2017

		FY17 Actual YTD
REVENUE		
Revenues from Other State Agencies	$	582,766,836
Federal Funds		841,912,859
TOTAL REVENUES	**$**	**1,424,679,695**
EXPENDITURES		**Actual YTD**
Department of Human Services		
Home and Community Based Waiver	$	201,337,476
Money Follows the Person		42,101
Homeward Bound Waiver		81,553,902
In-Home Support Waivers		25,135,590
ADvantage Waiver		186,731,259
Intermediate Care Facilities for Individuals with Intellectual Disabilities Public		12,916,226
Personal Care		11,917,444
Residential Behavioral Management		12,384,160
Targeted Case Management		61,043,571
Total Department of Human Services		**593,061,728**
State Employees Physician Payment		
Physician Payments		62,742,074
Total State Employees Physician Payment		**62,742,074**
Education Payments		
Graduate Medical Education		100,650,804
Graduate Medical Education - Physicians Manpower Training Commission		5,584,986
Indirect Medical Education		33,086,772
Direct Medical Education		2,464,614
Total Education Payments		**141,787,176**
Office of Juvenile Affairs		
Targeted Case Management		2,580,274
Residential Behavioral Management		4,261,204
Total Office of Juvenile Affairs		**6,841,479**
Department of Mental Health		
Case Management		18,310,841
Inpatient Psychiatric Free-standing		14,061,765
Outpatient		16,738,093
Health Homes		39,291,365
Psychiatric Residential Treatment Facility		67,779,270
Certified Community Behavioral Health Clinics		553,184
Rehabilitation Centers		244,551,429
Total Department of Mental Health		**401,285,947**
State Department of Health		
Children's First		1,587,599
Sooner Start		1,298,123
Early Intervention		4,287,590
Early and Periodic Screening, Diagnosis, and Treatment Clinic		857,391
Family Planning		196,961
Family Planning Waiver		4,580,532
Maternity Clinic		7,412
Total Department of Health		**12,815,607**
County Health Departments		
EPSDT Clinic		712,383
Family Planning Waiver		22,887
Total County Health Departments		**735,270**
State Department of Education		**164,229**
Public Schools		**499,376**
Medicare DRG Limit		**130,345,215**
Native American Tribal Agreements		**2,163,592**
Department of Corrections		**1,291,605**
JD McCarty		**8,185,855**
Total OSA Medicaid Programs	**$**	**1,361,919,152**
OSA Non-Medicaid Programs	**$**	**70,496,031**
Accounts Receivable from OSA	**$**	**7,735,488**

OKLAHOMA HEALTH CARE AUTHORITY
SUMMARY OF REVENUES & EXPENDITURES:
Fund 230: Nursing Facility Quality of Care Fund
For the Fiscal Year Ended June 30, 2017

REVENUES	Total Revenue	State Share
Quality of Care Assessment	**$ 77,301,569**	**$ 77,301,569**
Interest Earned	**34,652**	**34,652**
TOTAL REVENUES	**$ 77,336,221**	**$ 77,336,221**

EXPENDITURES	FY 17 Total $ YTD	FY 17 State $ YTD	Total State $ Cost
Program Costs			
Nursing Facility Rate Adjustment	$ 209,503,269	$ 83,382,301	
Eyeglasses and Dentures	272,340	108,391	
Personal Allowance Increase	3,362,460	1,338,259	
Coverage for Durable Medical Equipment and Supplies	2,711,532	1,079,190	
Coverage of Qualified Medicare Beneficiary	1,032,756	411,037	
Part D Phase-In	793,246	315,712	
ICF/IID Rate Adjustment	5,204,890	2,071,546	
Acute Services ICF/IID	5,944,822	2,366,039	
Non-emergency Transportation - Soonerride	2,460,093	979,117	
Total Program Costs	**$ 231,285,407**	**$ 92,051,592**	**$ 92,051,592**
Administration			
OHCA Administration Costs	$ 546,620	$ 273,310	
DHS-Ombudsmen	235,030	235,030	
OSDH-Nursing Facility Inspectors	520,125	520,125	
Mike Fine, CPA	19,200	9,600	
Total Administration Costs	**$ 1,320,975**	**$ 1,038,065**	**$ 1,038,065**
Total Quality of Care Fee Costs	**$ 232,606,382**	**$ 93,089,657**	
TOTAL STATE SHARE OF COSTS			**$ 93,089,657**

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

For the Fiscal Year Ended June 30, 2017

REVENUES	FY 16 Carryover	FY 17 Revenue	Total Revenue
Prior Year Balance	$ 5,199,281	$ -	$ 3,102,480
State Appropriations	(2,000,000)	-	-
Tobacco Tax Collections	-	40,746,938	40,746,938
Interest Income	-	123,437	123,437
Federal Draws	246,145	37,324,712	37,324,712
TOTAL REVENUES	**$ 3,445,426**	**$ 78,195,087**	**$ 81,297,567**

EXPENDITURES		FY 16 Expenditures	FY 17 Expenditures	Total $ YTD
Program Costs:				
	Employer Sponsored Insurance		$ 59,308,779	$ 59,308,779
	College Students/ESI Dental		425,769	169,456
Individual Plan				
	SoonerCare Choice		$ 118,068	$ 46,991
	Inpatient Hospital		3,707,497	1,475,584
	Outpatient Hospital		4,535,130	1,804,982
	BH - Inpatient Services-DRG		274,104	109,093
	BH -Psychiatrist		-	-
	Physicians		(204,757)	(81,493)
	Dentists		25,963	10,333
	Mid Level Practitioner		25,460	10,133
	Other Practitioners		420,612	167,404
	Home Health		9,723	3,870
	Lab and Radiology		771,169	306,925
	Medical Supplies		261,153	103,939
	Clinic Services		998,391	397,359
	Ambulatory Surgery Center		128,938	51,317
	Prescription Drugs		13,066,711	5,200,551
	Transportation		50,075	19,930
	Premiums Collected		-	(573,670)
Total Individual Plan			**$ 24,188,238**	**$ 9,053,249**
	College Students-Service Costs		**$ 321,279**	**$ 127,869**
Total OHCA Program Costs			**$ 84,244,064**	**$ 68,659,353**
Administrative Costs				
	Salaries	$ 32,930	$ 2,095,108	$ 2,128,038
	Operating Costs	15,971	254,814	270,785
	Health Dept-Postponing	-	-	-
	Contract - HP	294,045	1,968,784	2,262,829
Total Administrative Costs		**$ 342,946**	**$ 4,318,706**	**$ 4,661,652**
Total Expenditures				**$ 73,321,005**
NET CASH BALANCE		**$ 3,102,480**		**$ 7,976,563**

OKLAHOMA HEALTH CARE AUTHORITY

SUMMARY OF REVENUES & EXPENDITURES:

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

For the Fiscal Year Ended June 30, 2017

REVENUES	FY 17 Revenue	State Share
Tobacco Tax Collections	$ 813,020	$ 813,020
TOTAL REVENUES	**$ 813,020**	**$ 813,020**

EXPENDITURES	FY 17 Total $ YTD	FY 17 State $ YTD	Total State $ Cost
Program Costs			
SoonerCare Choice	$ 11,731	$ 3,268	
Inpatient Hospital	1,263,170	351,919	
Outpatient Hospital	3,911,320	1,089,694	
Inpatient Services-DRG	-	-	
Psychiatrist	-	-	
TFC-OHCA	-	-	
Nursing Facility	-	-	
Physicians	4,655,245	1,296,951	
Dentists	12,357	3,443	
Mid-level Practitioner	1,549	431	
Other Practitioners	94,531	26,336	
Home Health	9,186	2,559	
Lab & Radiology	229,453	63,926	
Medical Supplies	29,675	8,268	
Clinic Services	162,031	45,142	
Ambulatory Surgery Center	11,399	3,176	
Prescription Drugs	2,356,082	656,404	
Transportation	43,076	12,001	
Miscellaneous Medical	2,753	767	
Total OHCA Program Costs	**$ 12,793,558**	**$ 3,564,285**	
OSA DMHSAS Rehab	$ 55,524	$ 15,469	
Total Medicaid Program Costs	**$ 12,849,082**	**$ 3,579,754**	
TOTAL STATE SHARE OF COSTS			**$ 3,579,754**

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 Budget Reductions	SFY 18 Federal Savings - (OHCA)	SFY 18 State Savings - (OHCA)	Effective Date	SPA / Rule Change
Program Changes				
Dental Reductions	**677,191**	**479,017**	**10/1/2017**	**No / Yes**
Rule change from medically necessary extractions to emergency extractions only for adults and elimination on coverage of certain codes to comply with policy changes				
Removing Coverage for Cystic Fibrosis Screening	**315,434**	**255,000**	**11/1/2017**	**No / No**
Change will restrict to allow ONLY for diagnostic purposes				
Delay Capitation Payments Until 1st Primary Care Provider (PCP) Visit	**2,828,192**	**2,000,547**	**1/1/2018**	**No / No**
PRIMARY CARE PROVIDERS - Care Coordination per member per month fee will not be paid until Primary Care Provider office visit				
Member Date Specific End Dates	**761,996**	**539,004**	**1/1/2018**	**No / Yes**
ADULTS and CHILDREN - End date member eligibility based on a 12-day rule instead of the end of the month Excludes Aged, Blind, Disabled; Long Term Care; and Insure Oklahoma members				
Total of Program Changes	**4,582,814**	**3,273,568**		
Proposed Program Changes				
Eliminate Reimbursement for Lactation Consultation Services	**14,598**	**10,326**		**Yes / Yes**
PREGNANT WOMEN ONLY - Member-specific support and education regarding breastfeeding, addressing particular issues, and/or managing lactation crisis				
Eliminate Reimbursement for Nutritional Services	**32,656**	**23,099**		**Yes / Yes**
ADULTS and CHILDREN - Coverage for adults services must be expressly for diagnosing, treating or preventing, or minimizing the effects of illness				
Eliminate Reimbursement for Genetic Counseling Services	**14,180**	**10,030**		**Yes / Yes**
ADULTS and CHILDREN - Analyze and share information with the member to help them understand and adapt to the medical, psychosocial and familial contributions to potential or realized birth defects				
Eliminate Reimbursement for Therapeutic Leave Days in Long Term Care Facilities	**34,693**	**24,541**		**Yes / Yes**
ADULTS and CHILDREN - LTC Nursing Facility (Max 7 days per CY) excludes Intermedicate Care Facilities - Individuals Intellectual Disabilities (ICF-IID)				
DME Rate Reductions	**476,485**	**337,046**		**No / No**
ADULTS and CHILDREN - align rates with Medicare				
Medicare Crossover Coinsurance and Deductible Claims for Dual Eligibles	**10,762,307**	**7,612,811**		**Yes / No**
Hospitals - Change from paying 75% deductible and 25% coinsurance for Part A and Part B to 0% for both	9,386,602	6,639,695		
Nursing Homes - Change from paying 20% Part A and 75% Part B of coinsurance and deductible to 0% for both	1,375,705	973,117		
Total of Proposed Program Changes	**12,012,110**	**8,496,870**		
One-Time Savings Items				
Fiscal Year 2017 Carryover		**12,000,000**		
Other Available Funds (Federal Deferral Fund, Fiscal Year 2018 Potential Savings)		**20,000,000**		
Fiscal Year 2017 General Revenue Return		**4,650,843**		
Administrative Efficiencies Fiscal Year 2018		**1,000,000**		
Total of One-Time Savings Items		**37,650,843**		
Across the Board Rate Reduction				
One Percent (1%)	**3,745,783**	**2,649,612**		**Yes / No**
Two Percent (2%)	**7,491,567**	**5,299,225**		**Yes / No**
Three Percent (3%)	**11,237,350**	**7,948,837**		**Yes / No**

*All optional benefit categories exclude waiver and crossover payments. This estimate DOES NOT account for potential cost shifting to mandatory programs.
Potential "**Shifted Costs**" would be additional spending on OHCA Mandatory Program services such as emergency department, inpatient hospitalization, physician's office, visits, clinics and long term care facility stays. In some cases the shifted costs will far outweigh any reduction in program spending.
EPSDT services may be included in the amounts for these optional groups.
*2018 Federal matching participation 58.57%

OHCA Board Meeting
August, 2017
(June 2017 Data)

SOONERCARE ENROLLMENT/EXPENDITURES

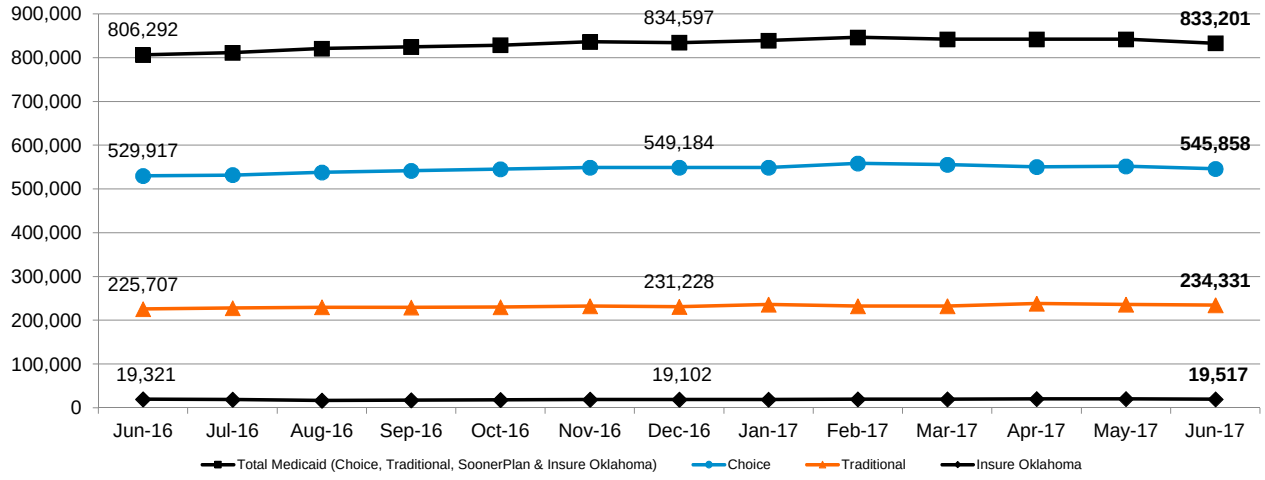
Delivery System			Enrollment June 2017	Children June 2017	Adults June 2017	Enrollment Change	Total Expenditures June 2017	PMPM June 2017	Forecasted June 2017 Trend PMPM
SoonerCare Choice Patient-Centered Medical Home			**545,858**	**450,339**	**95,519**	**-5,971**	**$137,241,339**		
	Lower Cost	*(Children/Parents; Other)*	501,869	436,320	65,549	-5,978	$98,738,181	$197	$208
	Higher Cost	*(Aged, Blind or Disabled; TEFRA; BCC)*	43,989	14,019	29,970	7	$38,503,158	$875	$923
SoonerCare Traditional			**234,331**	**87,765**	**146,566**	**-1,883**	**$174,408,039**		
	Lower Cost	*(Children/Parents; Other)*	120,678	82,861	37,817	-1,897	$37,933,602	$314	$434
	Higher Cost	*(Aged, Blind or Disabled; TEFRA; BCC & HCBS Waiver)*	113,653	4,904	108,749	14	$136,474,437	$1,201	$1,258
SoonerPlan			**33,495**	**2,758**	**30,737**	**-1,025**	**$318,006**	$9	$9
Insure Oklahoma			**19,517**	**505**	**19,012**	**-95**	**$6,755,189**		
	Employer-Sponsored Insurance		14,449	329	14,120	-249	$4,825,065	$334	$326
	Individual Plan		5,068	176	4,892	154	$1,930,124	$381	$421
TOTAL			**833,201**	**541,367**	**291,834**	**-8,974**	**$318,722,573**		

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.

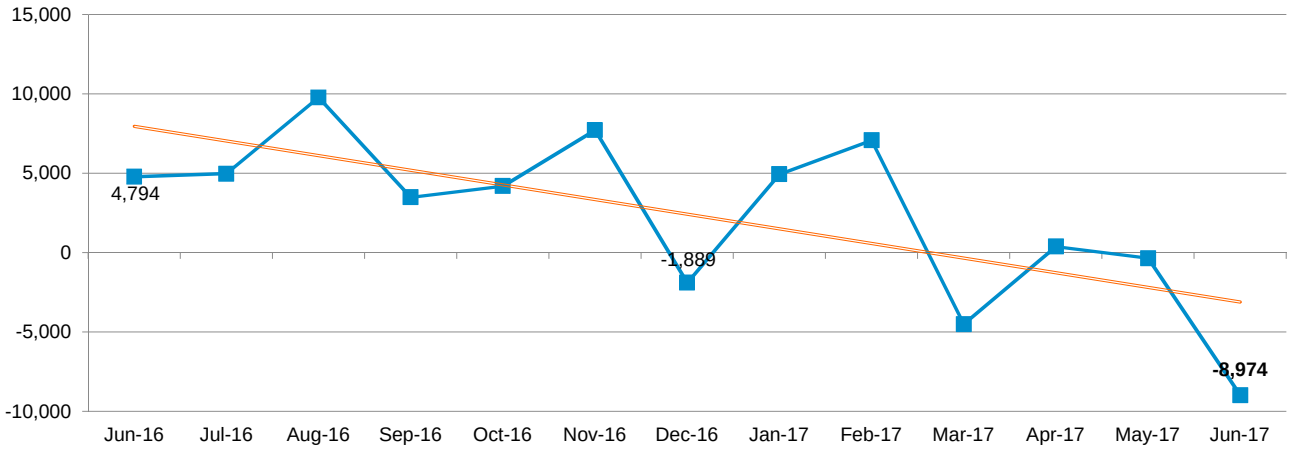
Total In-State Providers: 34,588 (-148) **(In-State Providers counted multiple times due to multiple locations, programs, types, and specialties)**

Physician	Pharmacy	Dentist	Hospital	Mental Health	Optometrist	Extended Care	Total PCPs	PCMH
9,372	973	1,295	188	6,527	561	387	6,703	2,654

ENROLLMENT BY MONTH

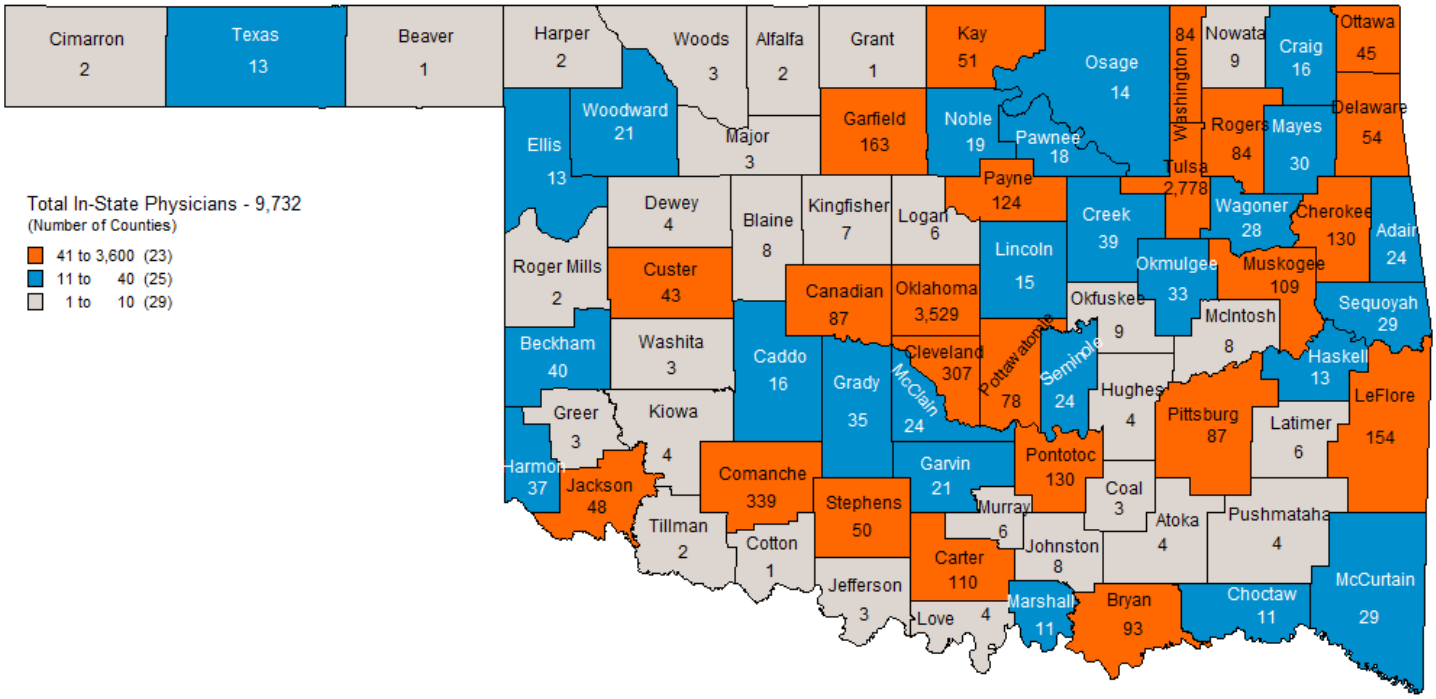


MONTHLY CHANGE IN ENROLLMENT



Includes Insure Oklahoma.

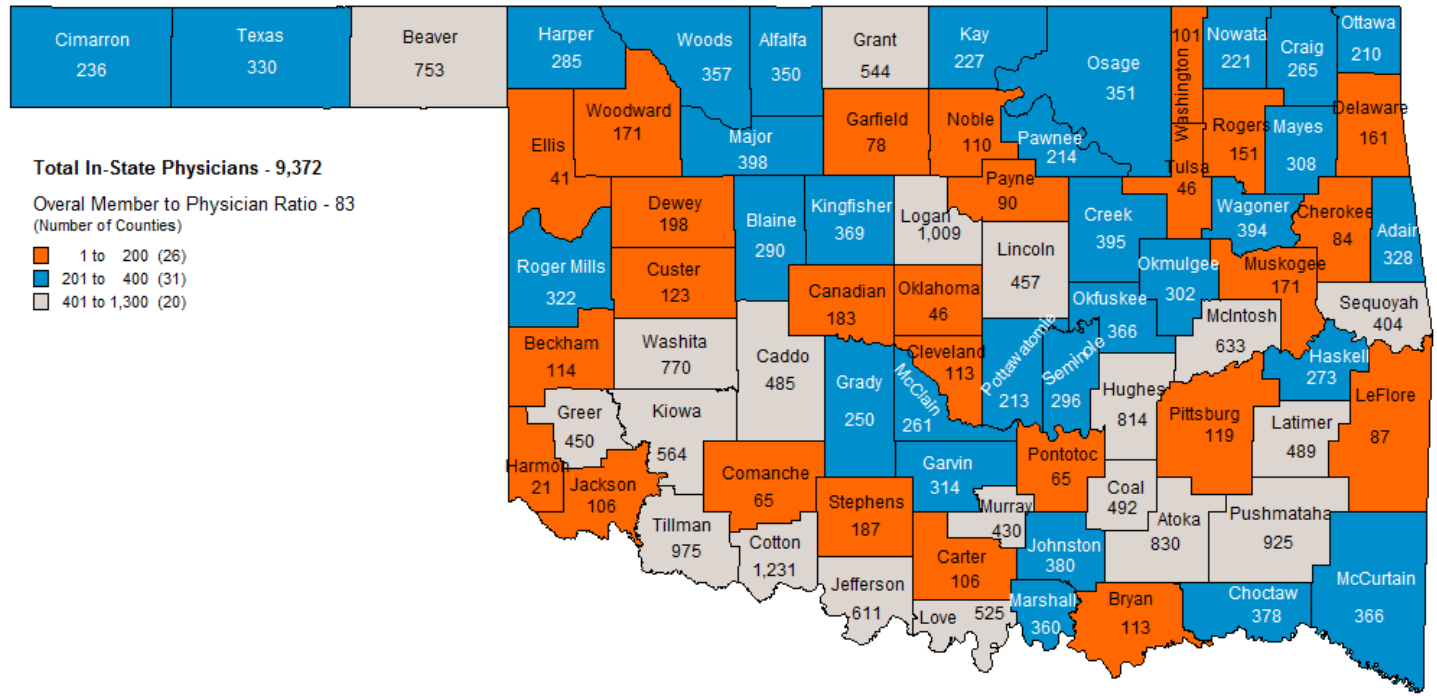
Physician by County - June 2017



Total In-State Physicians - 9,732
(Number of Counties)

- 41 to 3,600 (23)
- 11 to 40 (25)
- 1 to 10 (29)

Member to Physician Ratio - June 2017



Total In-State Physicians - 9,372

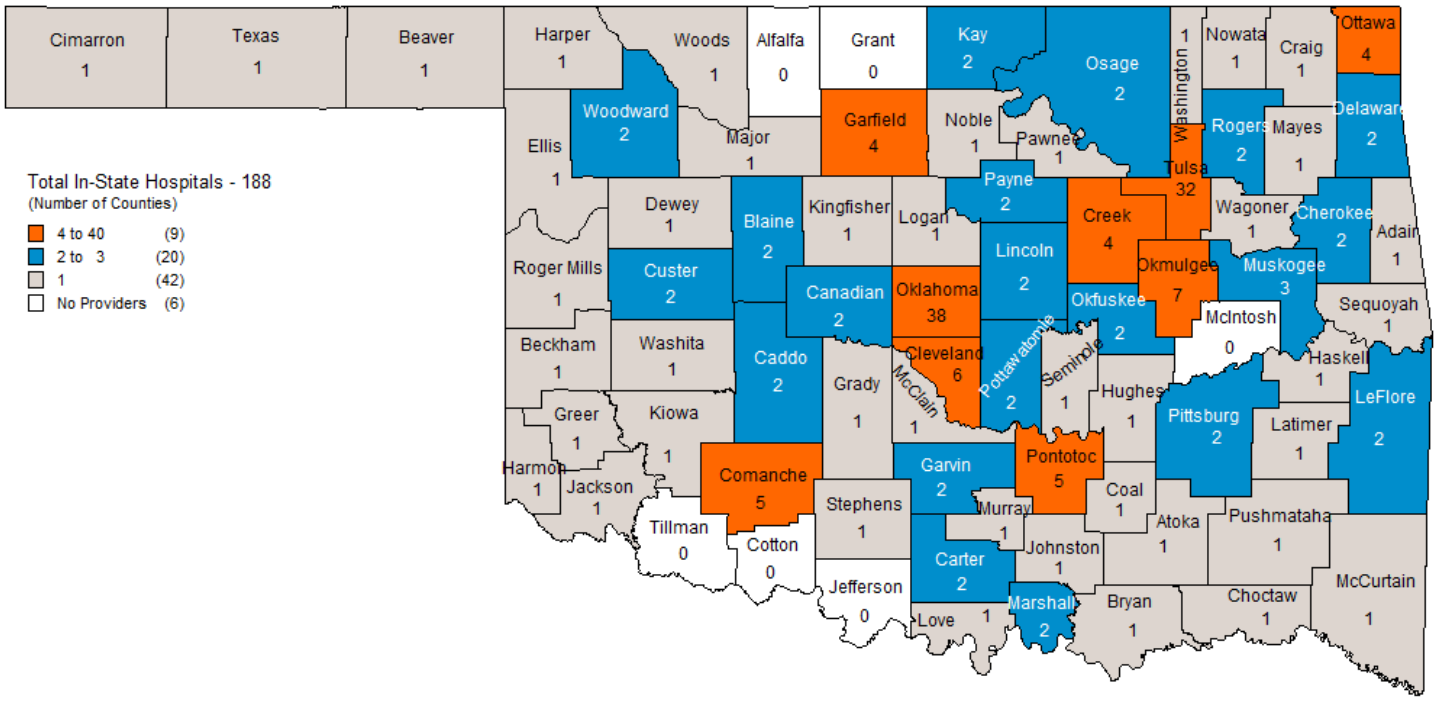
Overal Member to Physician Ratio - 83
(Number of Counties)

- 1 to 200 (26)
- 201 to 400 (31)
- 401 to 1,300 (20)

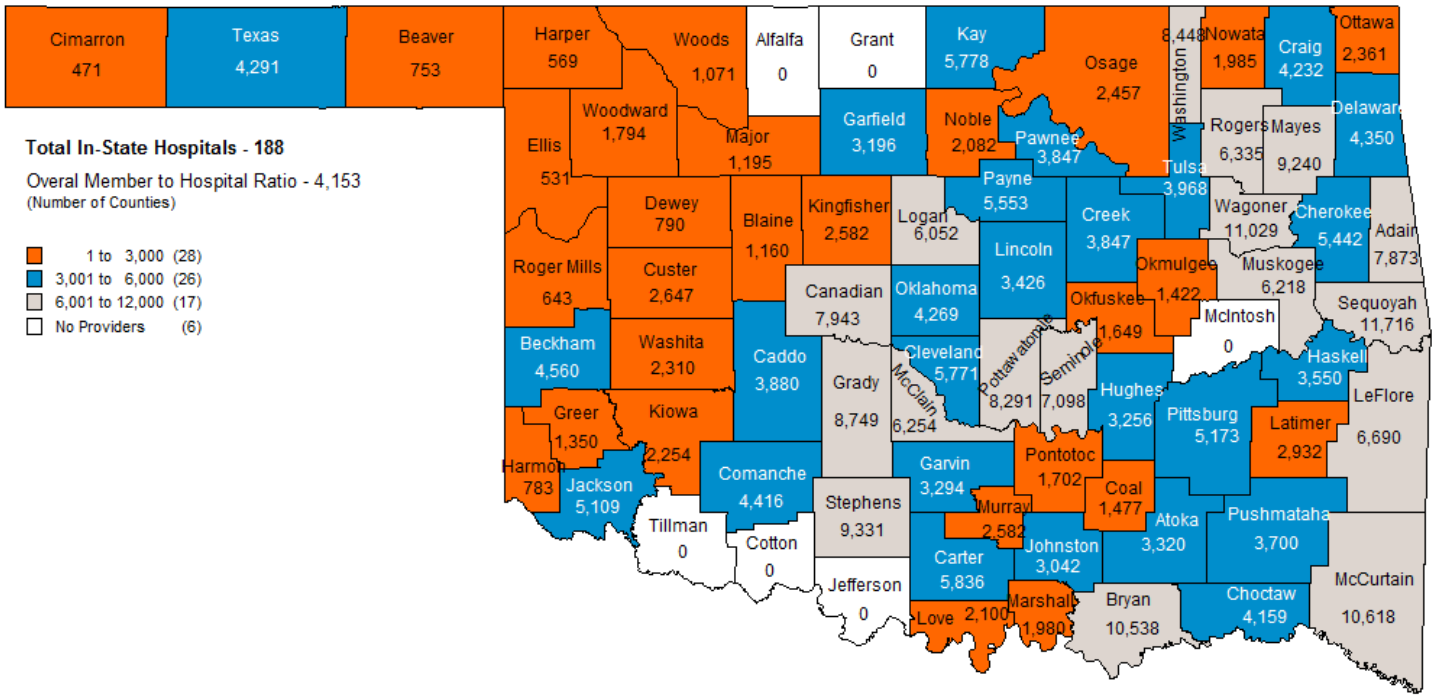
Includes in-state providers only. Excludes 6,984 out-of-state physicians. Excludes Insure Oklahoma and Family Planning members.
Physician counts based on Physician provider type.

7/31/2017

Hospitals by County - June 2017



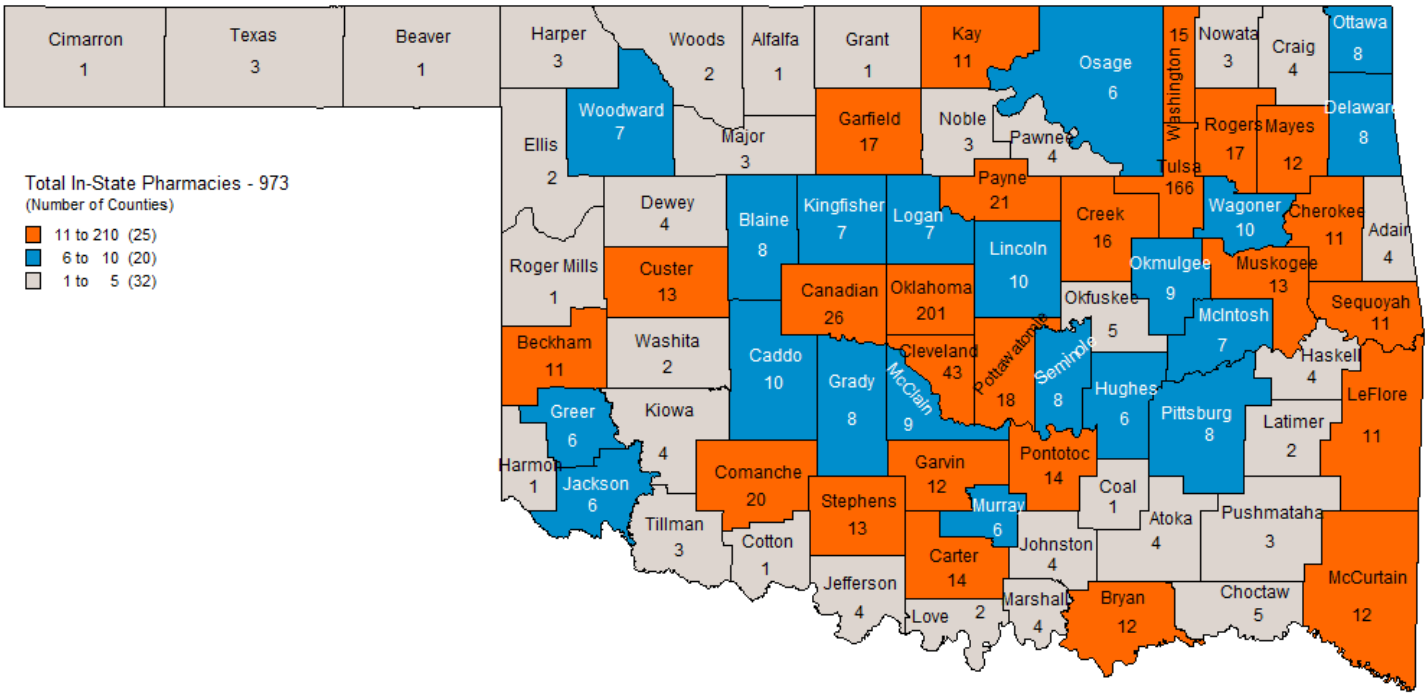
Member to Hospital Ratio - June 2017



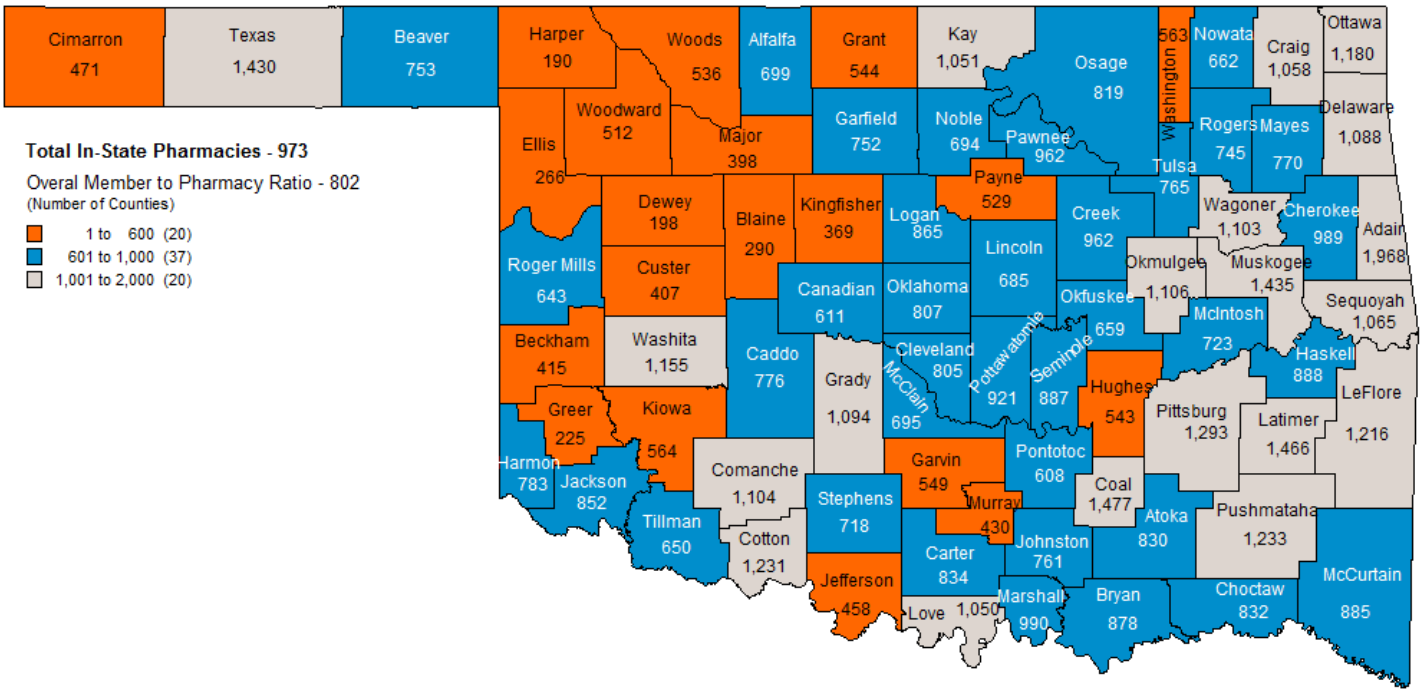
Includes in-state providers only. Excludes 458 out-of-state hospitals. Excludes Insure Oklahoma and Family Planning members.
Hospital counts based on Hospital provider type.

7/31/2017

Pharmacy by County - June 2017



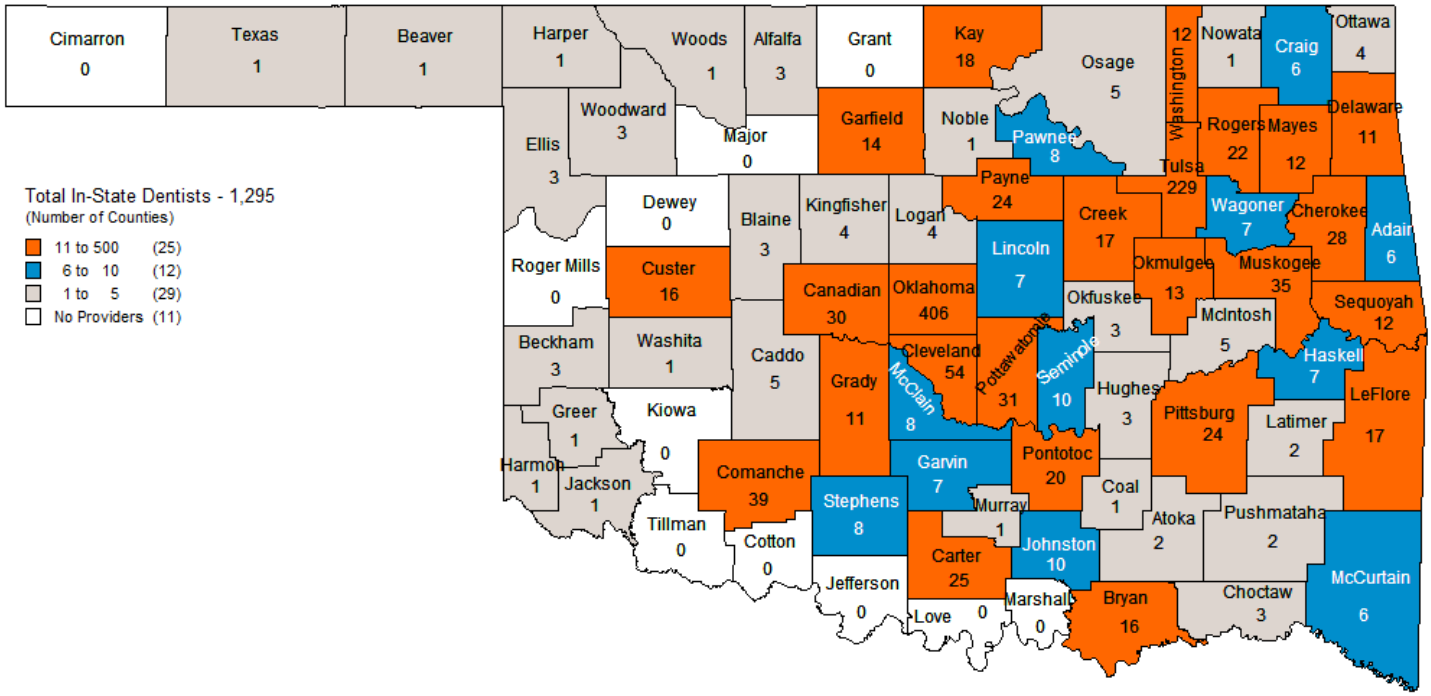
Member to Pharmacy Ratio - June 2017



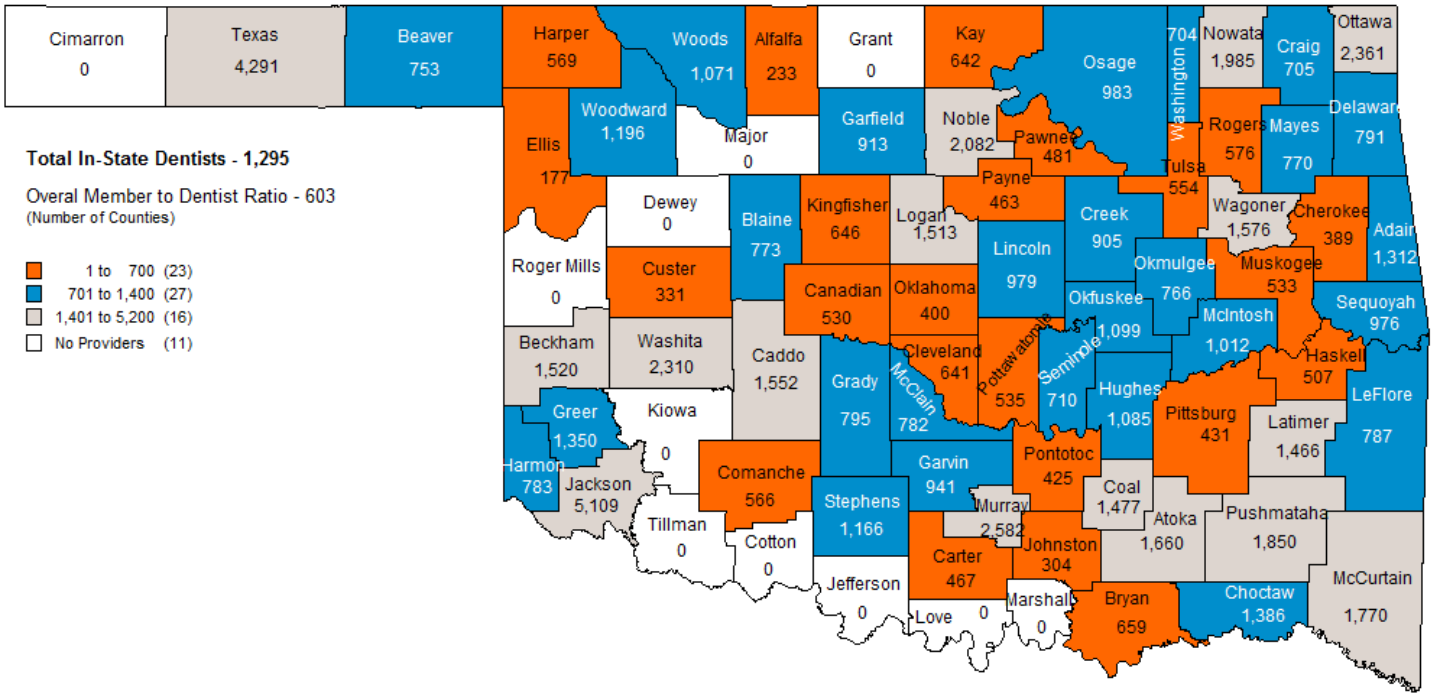
Includes in-state providers only. Excludes 368 out-of-state pharmacies. Excludes Insure Oklahoma and Family Planning members.
Pharmacy counts based on Pharmacy provider type.

7/31/2017

Dentists by County - June 2017



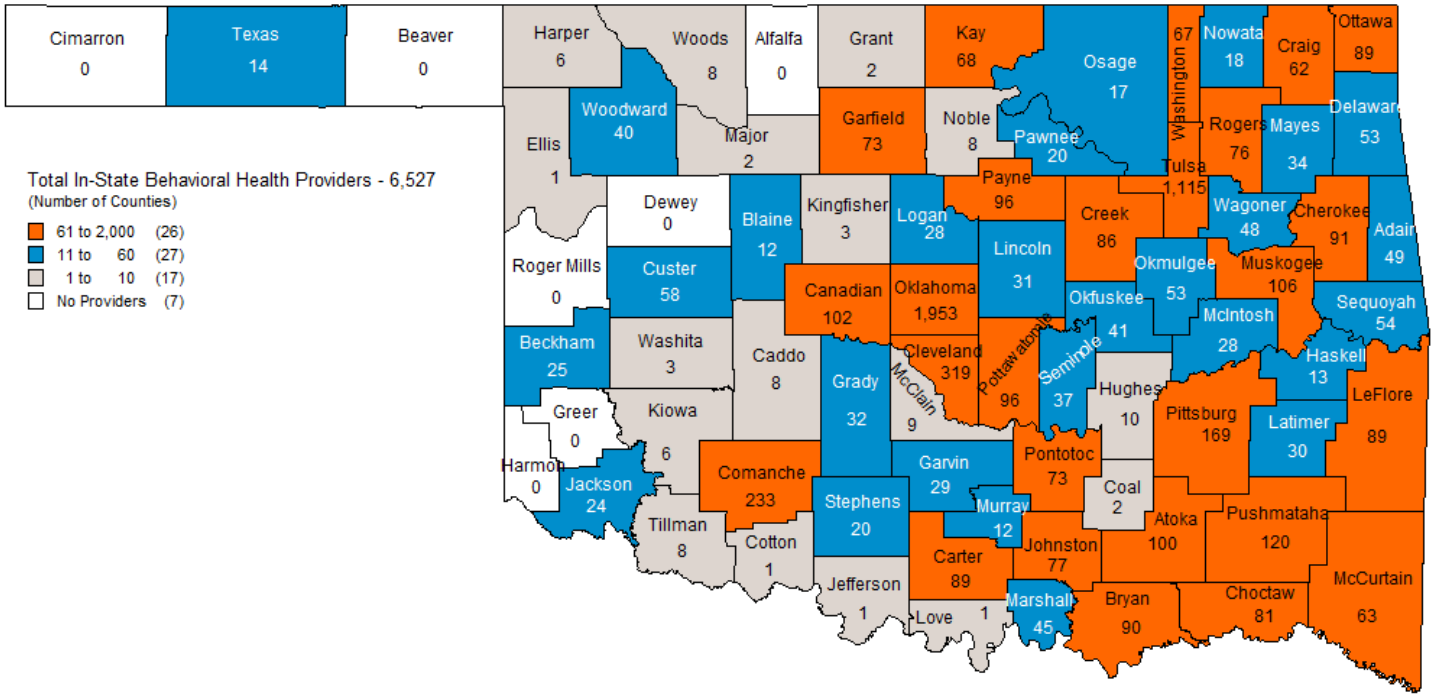
Member to Dentist Ratio - June 2017



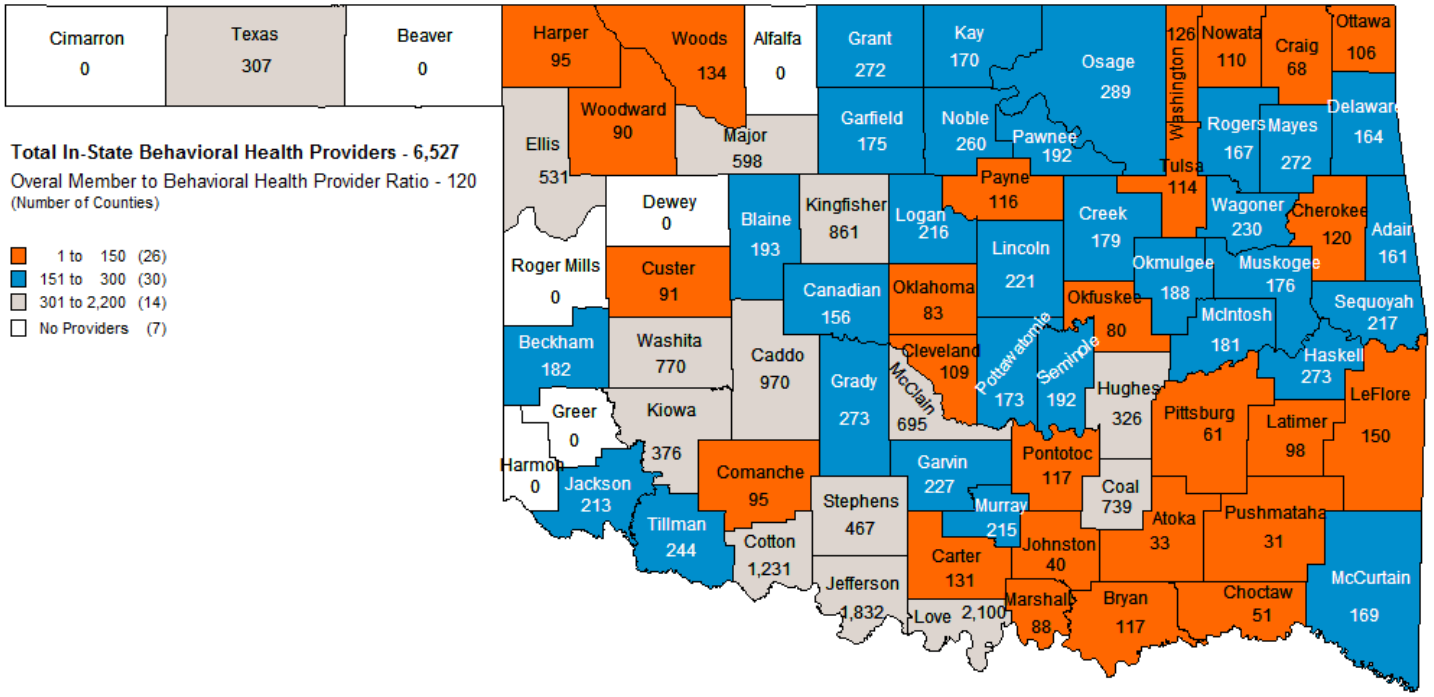
Includes in-state providers only. Excludes 258 out-of-state dentists. Excludes Insure Oklahoma and Family Planning members.
Dentist counts based on Dentist provider type.

7/24/2017

Behavioral Health Providers by County - June 2017



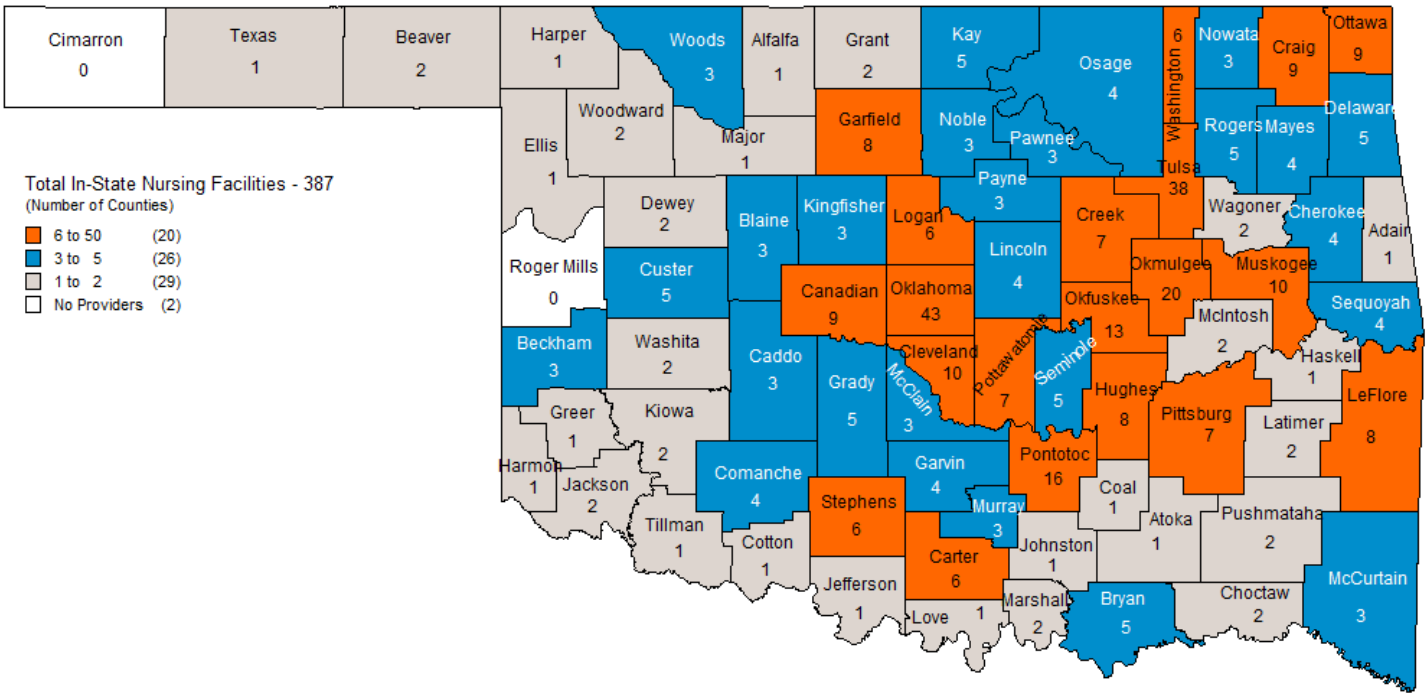
Member to Behavioral Health Provider Ratio - June 2017



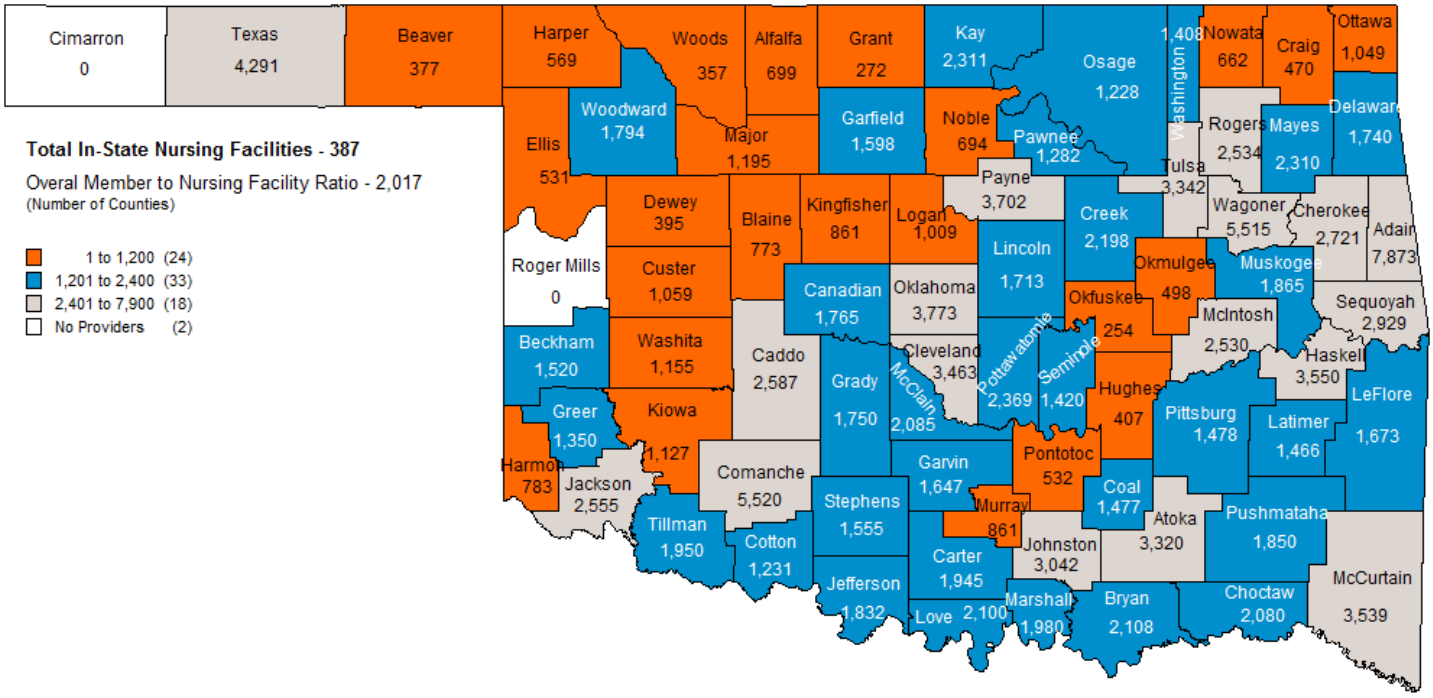
Includes in-state providers only. Excludes 77 out-of-state behavioral health providers. Excludes Insure Oklahoma and Family Planning members.
Behavioral Health Provider counts based on Behavioral Health Provider provider type.

7/31/2017

Nursing Facility by County - June 2017



Member to Nursing Facility Ratio - June 2017



Includes in-state providers only. Excludes 1 out-of-state nursing facility. Excludes Insure Oklahoma and Family Planning members.
Nursing Facility counts based on Extended Care Facility provider type.

7/31/2017

focus forward

oklahoma

Focus Forward Oklahoma Mission

to decrease unintended pregnancies in Oklahoma by increasing access to and utilization of long-acting reversible contraception (LARC)

Program Funding

- State Funds
  - George Kaiser Family Foundation
  - David and Jean McLaughlin
  - Anonymous Donor
- Federal Funds
  - Children's Health Insurance Program (CHIP)

Program Overview

- Three Primary Strategies
  - Policy Change
  - Communication
  - Education

Program Overview

- Policy Change
  - Policy review
  - Recommendations
  - Policy change

Program Overview

- Communication
  - Logo/Branding
  - Website
  - Outreach

focus forward
oklahoma

Program Overview

- Education
  - Provider Education
  - Member Education

Program Evaluation

- **Long-Term (Outcome) Objectives**
  - Unintended Pregnancies
  - Teen Pregnancies
- **Short-Term (Impact) Objectives**
  - SoonerCare LARC Utilization
  - SoonerCare LARC Providers

focus forward

oklahoma

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Phone: (405) 522-7391

Oklahoma HealthCare Authority

Member Audit Unit

September 21, 2017

Ginger Clayton

Primary Investigative Functions

- Investigate Information Referrals
- Research Cases and Complete Interviews
- Determine Ineligibility or Misuse
- Discuss Findings with Member
- Recommend Case Action or Penalties
- Report Findings

Primary Audit Functions

- Review Federal Audit cases and Initiate Corrective Action or Dispute
- Review Eligibility and Data Match Information
- System Audits
- Random Case Audits on Specific Criteria
- Audit Eligibility Determinations Made by Outside Entities
- Determine the Nature and Validity of Information Referrals
- Report Error Trends or Training Needs

Information Referrals

- Information Related to SoonerCare Member Case Information
- Received From a Variety of Sources
  - Partnering Agencies
  - Public
  - OHCA Divisions
  - Healthcare Providers
  - Law Enforcement

Common Types of Referrals

- Household Composition
- Income
- Financial Resources
- Benefit Card Issues
- Residency
- Duplication of Benefits
- Third Party Liability
- Prescription Issues

Screening and Assignment

- Screening Process
- Assignment of Referrals
- Determine Potential Impact
- Determine Appropriate Action
- Refer Findings to Appropriate Department for Action
  - Member Services
  - Insure Oklahoma
  - Pharmacy Unit
  - Third Party Liability

Moving Forward

- Case Tracker Implementation
  - Case Documentation
  - Case Level Findings
  - Reporting Capabilities
  - Overpayment Calculation
- Future Development
  - iCE Data
  - Data Collection Related to Findings
  - Member Specific Findings
  - Audit Generation

September MAC
Proposed Rule Amendment Summaries

Face to face tribal consultations regarding the following proposed changes were held Tuesday, July 11, 2017 and Tuesday, September 5, 2017 in the Board Room of the Oklahoma Health Care Authority (OHCA).

APA work folders 17-03 and 17-07 were posted on the OHCA public website for a comment period from August 14, 2017 through September 13, 2017. APA work folder 17-13 was posted on the OHCA public website for a comment period from August 30, 2017 through September 21, 2017. APA work folder 17-14 was posted on the OHCA public website for a comment period from September 6, 2017 through September 21, 2017.

17-03 Indian Health Services, Tribal Program and Urban Indian Clinics (I/T/Us) Reimbursement Outside of Four Walls — The proposed revisions will allow I/T/Us, who are designated as Federally Qualified Health Centers, to be reimbursed at the Office of Management and Budget rate for services provided outside of the four walls of their facilities. These changes are necessary to comply with federal regulations.
Budget Impact: Budget neutral

17-07 School-Based Services Revisions — The proposed revisions will remove unintended barriers for medical services rendered in a school setting pursuant to an Individual Education Plan (IEP). Revisions will align with Oklahoma statute that recognizes certain providers who provide services pursuant to the Individual with Disabilities Education Act as practitioners of the healing arts. The proposed revisions will eliminate the need for prior authorization for certain services in a school setting if the therapies are documented in the child's IEP and have been prescribed or referred by a physician or other licensed practitioner of the healing arts. The Oklahoma State Department of Education will be required to be the referring entity for IEP services. Additionally, revisions remove specific references to policy sections that are no longer applicable.
Budget Impact: Revisions will result in a positive impact to the Oklahoma school districts of about $6.5 million. The Oklahoma school districts have been providing school-based services using state only dollars and Individuals with Disability Education Act funding and will now be able to draw down federal matching funds. Schools will pay the state share for these services, so there is no impact to the OHCA budget.

17-13 Signature Requirements Revisions — The proposed revisions will clarify the authentication of electronic medical records. Current policy that became effective September 1, 2017 requires that the record be authenticated within three (3) days of the provision of the underlying service. New revisions will revert the three (3) day signature language to the policy that was in place on June 25, 2011. The proposed revisions will clarify that the authentication of medical records is expected on the day the record is completed. Additionally, revisions will describe that the signature of the rendering provider and date entry is expected within three (3) business days from the day the record is completed if the record is being transcribed.
Budget Impact: Budget neutral

17-14 Adult Dental Emergency Extractions — The proposed revisions will clarify dental coverage for adults by amending the rule that limits dental services for adults to "emergency" extractions. The policy was initially intended for emergency extractions and was later revised to medically necessary extractions. The intent of the change was to ensure the emergency extractions were medically necessary; therefore, the policy will revert back to the original language to include the term emergency along with reference to where emergency dental care is defined in policy. Additionally, the proposed revisions will add new language on the medically necessary images and oral examination that can accompany an emergency extraction.
Budget Impact: Revisions for clarifying dental coverage for adults will result in approximately $479,017 of state share savings for eight months of SFY 2018. Additionally, the proposed revision is an effort to not exhaust additional dollars to services that were not intended to be covered.

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)

317:30-5-1096. ~~I/T/U off-site services~~Off-site services

~~I/T/U covered services provided off-site or outside of the I/T/U setting, including mobile clinics or places of residence, are compensable when billed by the I/T/U.~~ I/T/U covered services provided off-site or outside of the I/T/U setting, including mobile clinics or places of residence, are compensable at the OMB rate when billed by an I/T/U that has been designated as a Federally Qualified Health Center. The I/T/U must meet provider participation requirements listed in 317:30-5-1088. I/T/U off-site services may be covered if the services rendered were within the provider's scope of practice and are of the same integrity of services rendered at the I/T/U facility.

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 103. QUALIFIED SCHOOLS AS PROVIDERS OF HEALTH RELATED SERVICES

317:30-5-1020. General provisions

(a) Payment is made to eligible qualified school providers for delivery of Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services to eligible individuals under the age of 21. School-based services must be medically necessary and have supporting documentation to be considered for reimbursement. ~~In addition, services provided in the school setting are only compensable when provided to eligible SoonerCare members pursuant to an Individual Education Plan (IEP).~~

(b) EPSDT services are comprehensive child-health services, designed to ensure the availability of, and access to, required health care resources and to help parents and guardians of SoonerCare eligible children use these resources. Effective EPSDT services assure that health problems are diagnosed and treated early before they become more complex and their treatment more costly. The Schools play a significant role in educating parents and guardians about all services available through the EPSDT program.

(c) The receipt of an identified EPSDT screening makes the SoonerCare child eligible for all necessary follow-up care that is within the scope of the SoonerCare Program. An Individualized Education Program (IEP) or Individual Family Services Plan (IFSP) entitles the SoonerCare eligible child to medically necessary and appropriate health related EPSDT treatment services. ~~For reimbursement purposes, ~~In addition to any other notification and/or consent requirements related to IEP/IFSP evaluation and/or treatments, schools must provide sufficient notification to a child's parents and obtain adequate consent from them prior ~~to rendering a medically related evaluation and/or service pursuant to an eligible SoonerCare child's IEP or IFSP, either through an IEP/IFSP addendum or a new IEP/IFSP, parental consent must be obtained ~~to accessing a child's or parent's public benefits or insurance for the first time, and annually thereafter, in accordance with 34 CFR 300.154. An IEP or IFSP serves as the plan of care for consideration of reimbursement for health related EPSDT treatment services. ~~The IEP or IFSP may not serve as an evaluation. Services that require prior authorization will need~~

~~to be authorized prior to the development of the IEP or IFSP.~~ The IEP/IFSP must be completed and signed during the meeting by all required providers and individuals and must include the type, frequency, and duration of the service(s) provided, the signatures, including credentials, of the provider(s) and the direct care staff delivering services under the supervision of the professional, and the specific place of services if other than the school (e.g., field trip, home). The IEP/IFSP must also contain measurable goals for each of the identified needs. Goals must be updated to reflect the current therapy, evaluation, or service that is being provided and billed to SoonerCare. ~~In order to bill SoonerCare for services rendered in the school, including evaluations, these services must result in or be identified in the IEP.~~In order to bill SoonerCare for school-based services, these services must result from or be identified on the IEP. Federal regulations require that diagnosis and treatment be provided for conditions identified during a screening whether or not they are covered under the Authority's current program. Such services must be allowable under federal Medicaid regulations and must be necessary to ameliorate or correct defects of physical or mental illnesses/conditions.

(d) Federal regulations require that the State set standards and protocols for each component of EPSDT services. The standards must provide for services at intervals which meet reasonable standards of medical and dental practice. The standards must also provide for EPSDT services at other intervals as medically necessary to determine the existence of certain physical and mental illnesses or conditions. SoonerCare providers who offer EPSDT screenings must assure that the screenings they provide meet the minimum standards for those services in order to be reimbursed at the level established for EPSDT services.

(e) To assure full payment for the EPSDT screening, providers must perform and document all necessary components of the screening examination. Documentation of screening services performed must be retained for future review.

(f) Evaluations must~~ be prior authorized when medically necessary and/or required and prescribed or referred by a treating physician or other practitioner of the healing arts with supporting medical documentation~~, as required, be prescribed or referred by a physician or other licensed practitioner of the healing arts. Such documentation shall include, but not be limited to, prescriptions for physical or occupational therapy, or referrals for services for individuals with speech, hearing, and language disorders, as required by 42 CFR 440.110 and in conformance with state law; provided, however, that any prescription or referral ordered by a physician or other licensed practitioner of the healing arts who

has, or whose immediate family member has, a financial interest in the delivery of the underlying service shall not be valid, and services provided thereto shall not be eligible for reimbursement by OHCA. Initial evaluations (e.g. initial physical therapy evaluation) ~~that do not require a prior authorization and~~ that are performed as part of the IEP development process are compensable when the appropriate documented referral and supporting ~~medical~~ documentation are in place. Evaluations completed for educational purposes only are not compensable. All evaluations must be medically necessary and support the services billed to SoonerCare. The evaluations must be included in the IEP for reimbursement consideration. ~~A diagnosis alone is not sufficient documentation to support the medical necessity of services.~~ The child's diagnosis must clearly establish and support that the prescribed therapy is medically necessary. Evaluations must be completed annually and updated to accurately reflect the participant's current status. Evaluations include but are not limited to hearing and speech services, physical therapy, occupational therapy, and psychological evaluations and must include the following information:

(1) ~~Medical documentation~~Documentation that supports why the member was referred for evaluation;

(2) Diagnosis;

(3) Member's strengths, needs, and interests;

(4) Recommended interventions for identified needs, including outcomes and goals;

(5) Recommended units and frequency of services; and

(6) Dated signature and credentials of professional completing the evaluation.

(g) Annual evaluations/re-evaluations are required prior to each annual IEP.

(h) No more than five SoonerCare members can be present during a group therapy session. A daily log/list must be maintained and must identify the participants for each group session.

317:30-5-1021. Eligible providers

(a) Eligible providers are local, regional, and state educational services agencies as defined by State law and the Individuals with Disabilities Education Act (IDEA), as amended in 1997. A completed contract to provide EPSDT services through the schools must be submitted to the Oklahoma Health Care Authority (OHCA). The OHCA must approve the contract in order for eligible school providers to receive reimbursement.

(b) Qualified Schools must notify OHCA of all subcontractors performing IEP related evaluations and services in the school

setting prior to services being rendered. The notification must include a copy of the agreement between the school and subcontractor and must reflect the start and ending dates of the agreement for services. ~~OHCA may request that schools enroll with SoonerCare all entities and individuals that provide SoonerCare services in the school setting and may require that the rendering provider be included on any claim for payment by the school.~~All subcontractors must be enrolled with SoonerCare and if rendering services must be identified on any claim for payment as the rendering provider.

317:30-5-1023. Coverage by category

[Revised 09-12-14]

(a) **Adults.** There is no coverage for services rendered to adults.

(b) **Children.** Payment is made for compensable services rendered by local, regional, and state educational services agencies as defined by IDEA:

(1) **Child health screening.** An initial screening may be requested by an eligible individual at any time and must be provided without regard to whether the individual's age coincides with the established periodicity schedule. Coordination referral is made to the SoonerCare provider to assure at a minimum, that periodic screens are scheduled and provided in accordance with the periodicity schedule following the initial screening. Child Health screening must adhere to the following requirements:

(A) Children enrolled in SoonerCare must be referred to their SoonerCare provider for child health screenings. In cases where the SoonerCare provider authorizes the school to perform this screen or fails to schedule an appointment within three weeks and a request has been made and documented by the school, the school may then furnish the EPSDT child health screening. Written notification must be mailed to the Soonercare member's PCP prior to the school's intent to furnish and bill for the screen. Results of this screening must be forwarded to the child's SoonerCare provider.

(B) Child health screenings must be provided by a state licensed physician (M.D. or D.O.), state licensed nurse practitioner with prescriptive authority, or state licensed physician assistant. Screening services must include the following:

(i) Comprehensive health and developmental history, including assessment of both physical and mental health development;

(ii) Comprehensive unclothed physical exam;

(iii) Appropriate immunizations according to the age and health history;

(iv) Laboratory test, including blood level assessment; and

(v) Health education, including anticipatory guidance.

(C) Mass screenings for any school-based service are not billable to SoonerCare, nor are screenings that are performed as a child find activity pursuant to an IDEA requirement. There must be a documented referral in place that indicates the child has an individualized need that warrants a screening to be performed.

(2) **Child health encounter.** The child health encounter may include a diagnosis and treatment encounter, a follow-up health encounter, or a home visit. A Child Health Encounter may include any of the following:

(A) vision
(B) hearing
(C) dental
(D) a child health history
(E) physical examination
(F) developmental assessment
(G) nutrition assessment and counseling
(H) social assessment and counseling
(I) genetic evaluation and counseling
(J) indicated laboratory and screening tests
(K) screening for appropriate immunizations
(L) health counseling and treatment of childhood illness and conditions

(3) **Diagnostic encounters.** Diagnostic encounters are defined as those services necessary to fully evaluate defects, physical or behavioral health illnesses or conditions discovered by the screening. Approved diagnostic encounters may include the following:

(A) **Hearing and Hearing Aid evaluation.** Hearing evaluation includes pure tone air, bone and speech audiometry. Hearing evaluations ~~must adhere to guidelines found at OAC 317:30-5-676 and~~ must be provided by a state licensed audiologist who:

(i) holds a certificate of clinical competence from the American Speech and Hearing Association; or

(ii) has completed the equivalent educational requirements and work experience necessary for the certificate; or

(iii) has completed the academic program and is acquiring supervised work experience to qualify for the certificate.

(B) **Audiometry test.** Audiometric test (Immittance

[Impedance] audiometry or tympanometry) includes bilateral assessment of middle ear status and reflex studies (when appropriate) provided by a state licensed audiologist who:

(i) holds a certificate of clinical competence from the American Speech and Hearing Association; or

(ii) has completed the equivalent educational requirements and work experience necessary for the certificate; or

(iii) has completed the academic program and is acquiring supervised work experience to qualify for the certificate.

(C) **Ear impression (for earmold).** Ear impression (for earmold) includes taking impression of a member's ear and providing a finished earmold which is used with the member's hearing aid provided by a state licensed audiologist who:

(i) holds a certificate of clinical competence from the American Speech and Hearing Association; or

(ii) has completed the equivalent educational requirements and work experience necessary for the certificate; or

(iii) has completed the academic program and is acquiring supervised work experience to qualify for the certificate.

(D) **Vision Screening.** Vision screening in schools includes application of tests and examinations to identify visual defects or vision disorders. The vision screening may be performed by a Registered Nurse (RN) or Licensed Practical Nurse (LPN) under the supervision of an RN, or State Certified Vision Impairment Teacher. The service can be billed when a SoonerCare member has an individualized documented concern that warrants a screening. A vision examination must be provided by a state licensed Doctor of Optometry (O.D.) or licensed physician specializing in ophthalmology (M.D. or D.O.). This vision examination, at a minimum, includes diagnosis and treatment for defects in vision.

(E) **Speech Language evaluation.** Speech Language evaluation is for the purpose of identification of children with speech or language disorders and the diagnosis and appraisal of specific speech and language services. Speech Language evaluations ~~must adhere to guidelines found at OAC 317:30-5-676 and~~ must be provided by state licensed speech language pathologist who:

(i) holds a certificate of clinical competence from the American Speech and Hearing Association; or

(ii) has completed the equivalent educational requirements and work experience necessary for the certificate; or

(iii) has completed the academic program and is acquiring supervised work experience to qualify for the certificate.

(F) **Physical Therapy evaluation.** Physical Therapy evaluation includes evaluating the student's ability to move throughout the school and to participate in classroom activities and the identification of movement dysfunction and related functional problems and must be provided by a state licensed physical therapist. Physical Therapy evaluations must adhere to guidelines found at OAC 317:30-5-291.

(G) **Occupational Therapy evaluation.** Occupational Therapy evaluation services include determining what therapeutic services, assistive technology, and environmental modifications a student requires for participation in the special education program and must be provided by a state licensed occupational therapist. ~~Occupational Therapy evaluations must adhere to guidelines found at OAC 317:30-5-296.~~

(H) **Psychological Evaluation and Testing.** Psychological Evaluation and Testing are for the purpose of diagnosing and determining if emotional, behavioral, neurological, or developmental issues are affecting academic performance and for determining recommended treatment protocol. Evaluation/testing for the sole purpose of academic placement (e.g. diagnosis of learning disorders) is not a compensable service. Psychological Evaluation and Testing must be provided by state licensed, Board Certified, Psychologist or School Psychologist certified by State Department of Education (SDE). Psychological evaluations and testing services must adhere to guidelines found at OAC 317:30-5-241.1 and 317:30-5-241.2.

(4) **Child guidance treatment encounter.** A child guidance treatment encounter may occur through the provision of individual, family, or group treatment services to children who are identified as having specific disorders or delays in development, emotional, or behavioral problems, or disorders of speech, language or hearing. These types of encounters are initiated following the completion of a diagnostic encounter and subsequent development of a treatment plan, or as a result of an IEP or IFSP and may include the following:

(A) **Hearing and Vision Services.** Hearing and vision services ~~must adhere to guidelines found at OAC 317:30-5-676 and~~ may include provision of habilitation activities,

such as auditory training, aural and visual habilitation training, including Braille, and communication management, orientation and mobility, counseling for vision and hearing losses and disorders. Services must be provided by or under the direct guidance of one of the following individuals practicing within the scope of his or her practice under State law:

(i) state licensed, Master's Degree Audiologist who:

(I) holds a certificate of clinical competence from the American Speech and Hearing Association; or

(II) has completed the equivalent educational requirements and work experience necessary for the certificate; or

(III) has completed the academic program and is acquiring supervised work experience to qualify for the certificate;

(ii) state licensed, Master's Degree Speech Language Pathologist who:

(I) holds a certificate of clinical competence from the American Speech and Hearing Association; or

(II) has completed the equivalent educational requirements and work experience necessary for the certificate; or

(III) has completed the academic program and is acquiring supervised work experience to qualify for the certificate;

(iii) state certified deaf education teacher;

(iv) certified orientation and mobility specialists; and

(v) state certified vision impairment teachers.

(B) **Speech Language Therapy Services.** Speech Language Therapy Services include provisions of speech and language services for the habilitation or prevention of communicative disorders. Speech Language Therapy services ~~must adhere to guidelines found at OAC 317:30-5-676 and~~ must be provided by or under the direct guidance and supervision of a state licensed Speech Language Pathologist within the scope of his or her practice under State law who:

(i) holds a certificate of clinical competence from the American Speech and Hearing Association; or

(ii) has completed the equivalent educational requirements and work experience necessary for the certificate; or

(iii) has completed the academic program and is acquiring supervised work experience to qualify for the certificate; or

(C) **Physical Therapy Services.** Physical Therapy Services are provided for the purpose of preventing or alleviating movement dysfunction and related functional problems that adversely affects the child's education. Physical Therapy services must adhere to guidelines found at OAC 317:30-5-291 and must be provided by or under the direct guidance and supervision of a state licensed physical therapist; services may also be provided by a Physical Therapy Assistant who has been authorized by the Board of Examiners working under the supervision of a licensed Physical Therapist. The licensed Physical Therapist may not supervise more than three Physical Therapy Assistants.

(D) **Occupational Therapy Services.** Occupational therapy may include provision of services to improve, develop or restore impaired ability to function independently. Occupational Therapy services ~~must adhere to guidelines found at OAC 317:30-5-296 and~~ must be provided by or under the direct guidance and supervision of a state licensed Occupational Therapist; services may also be provided by an Occupational Therapy Assistant who has been authorized by the Board of Examiners, working under the supervision of a licensed Occupational Therapist.

(E) **Nursing Services.** Nursing Services may include provision of services to protect the health status of children, correct health problems and assist in removing or modifying health related barriers and must be provided by a registered nurse or licensed practical nurse under supervision of a registered nurse. Services include medically necessary procedures rendered at the school site, such as catheterization, suctioning, tube feeding, and administration and monitoring of medication.

(F) **Psychotherapy Services.** Psychotherapy services are the provision of counseling for children and parents. All services must be for the direct benefit of the child. Psychotherapy services must be provided by a state licensed Social Worker, a state Licensed Professional Counselor, a State licensed Psychologist or School Psychologist certified by the SDE, a State licensed Marriage and Family Therapist or a State licensed Behavioral Practitioner, or under Board supervision to be licensed in one of the above stated areas. Psychotherapy services must adhere to guidelines found at OAC 317:30-5-241.1 and 317:30-5-241.2.

(G) **Assistive Technology.** Assistive technology are the provision of services that help to select a device and assist a student with disability(ies) to use an Assistive technology device including coordination with other

therapies and training of child and caregiver. Services must be provided by a:

(i) state licensed, Speech Language Pathologist who:

(I) holds a certificate of clinical competence from the American Speech and Hearing Association; or

(II) has completed the equivalent educational requirements and work experience necessary for the certificate; or

(III) has completed the academic program and is acquiring supervised work experience to qualify for the certificate;

(ii) state licensed Physical Therapist; or

(iii) state licensed Occupational Therapist.

(H) **Personal Care.** Provision of personal care services allow students with disabilities to safely attend school; includes, but is not limited to assistance with toileting, oral feeding, positioning, hygiene, and riding school bus to handle medical or physical emergencies. Services must be provided by registered paraprofessionals/assistants that have completed training approved or provided by SDE, or Personal Care Assistants, including Licensed Practical Nurses, who have completed on-the-job training specific to their duties. Personal Care services do not include behavioral monitoring. Paraprofessionals are not allowed to administer medication, nor are they allowed to assist with or provide therapy services to SoonerCare members. Tube feeding of any type may only be reimbursed if provided by a registered nurse or licensed practical nurse. Catheter insertion and Catheter/Ostomy care may only be reimbursed when done by a registered nurse or licensed practical nurse.

(I) **Therapeutic Behavioral Services.** Therapeutic behavioral services are interventions to modify the non-adaptive behavior necessary to improve the student's ability to function in the community as identified on the plan of care. Medical necessity must be identified and documented through assessment and annual evaluations/re-evaluations. Services encompass behavioral management, redirection, and assistance in acquiring, retaining, improving, and generalizing socialization, communication and adaptive skills. This service must be provided by a Behavioral Health School Aide (BHSA) who has a high school diploma or equivalent and has successfully completed the paraprofessional training approved by the State Department of Education and a training curriculum in behavioral interventions for Pervasive Developmental Disorders as recognized by OHCA. BHSA must be supervised by a bachelors

level individual with a special education certification. BHSA must have CPR and First Aid certification. Six additional hours of related continuing education are required per year.

(J) **Immunization.** Immunizations must be coordinated with the Primary Care Physician for children enrolled in SoonerCare. An administration fee, only, can be paid for immunizations provided by the schools.

(c) **Individuals eligible for Part B of Medicare.** EPSDT school health related services provided to Medicare eligible members are billed directly to the fiscal agent.

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

SUBCHAPTER 3. GENERAL PROVIDER POLICIES

PART 1. GENERAL SCOPE AND ADMINISTRATION

317:30-3-4.1. Uniform Electronic Transaction Act

These rules regulate the format, use, and retention of electronic records and signatures generated, sent, communicated, received, or stored by the Oklahoma Health Care Authority (OHCA), in conformity with the Uniform Electronic Transaction Act, found at Section 15-101 et seq. of Title 12A of the Oklahoma Statutes.

(1) **Use of electronic records and electronic signatures.** The rules regarding electronic records and electronic signatures apply when both parties agree to conduct business electronically. Nothing in these regulations requires parties to conduct business electronically. However, should a party have the capability and desire to conduct business electronically with the OHCA, then the following guidelines must be adhered to:

(A) Only employees designated by the provider's agency may make entries in the member's medical record. All entries in the member's medical record must be dated and authenticated with a method established to identify the author. The identification method may include computer keys, Private/Public Key Infrastructure (PKIs), voice authentication systems that utilize a personal identification number (PIN) and voice authentication, or other codes. Providers must have a process in place to deactivate an employee's access to records upon termination of employment of the designated employee.

(B) When PKIs, computer key/code(s), voice authentication systems or other codes are used, a signed statement must be completed by the agency's employee documenting that the chosen method is under the sole control of the person using it and further demonstrate that:

(i) A list of PKIs, computer key/code(s), voice authentication systems or other codes can be verified;

(ii) All adequate safeguards are maintained to protect against improper or unauthorized use of PKIs, computer keys, or other codes for electronic signatures; and

(iii) Sanctions are in place for improper or unauthorized use of computer key/code(s), PKIs, voice authentication systems or other code types of electronic signatures.

(C) There must be a specific action by the author to

indicate that the entry is verified and accurate. Systems requiring an authentication process include, but are not limited to:

(i) Computerized systems that require the provider's employee to review the document on-line and indicate that it has been approved by entering a unique computer key/code capable of verification;

(ii) A system in which the provider's employee signs off against a list of entries that must be verified in the member's records;

(iii) A mail system that sends transcripts to the provider's employee for review;

(iv) A postcard identifying and verifying the accuracy of the record(s) signed and returned by the provider's employee; or

(v) A voice authentication system that clearly identifies the author by a designated personal identification number or security code.

(D) Auto-authentication systems that authenticate a report prior to the transcription process do not meet the stated requirements and will not be an acceptable method for the authentication process.

(E) The authentication of an electronic medical record (signature and date entry) ~~must occur within three (3) days of the provision of the underlying service, including those instances in which~~ is expected on the day the record is completed. If the electronic medical record is transcribed by someone other than the provider, the signature of the rendering provider and date entry is expected within three (3) business days from the day the record is completed. Before any claim is submitted to OHCA for payment of a provided service, the provider must authenticate the electronic medical records relating to that service.

(F) Records may be edited by designated administrators within the provider's facility. Edits must be in the form of a correcting entry which preserves entries from the original record. Edits must be completed prior to claims submission or no later than forty-five (45) days after the date of service, whichever occurs first.

(G) Use of the electronic signature, for clinical documentation, shall be deemed to constitute a signature and will have the same effect as a written signature on the clinical documentation. The section of the electronic record documenting the service provided must be authenticated by the employee or individual who provided the described service.

(H) Any authentication method for electronic signatures

must:

(i) be unique to the person using it;

(ii) identify the individual signing the document by name and title;

(iii) be capable of verification, assuring that the documentation cannot be altered after the signature has been affixed;

(iv) be under the sole control of the person using it;

(v) be linked to the data in such a manner that if the data is changed, the signature is invalidated; and

(vi) provide strong and substantial evidence that will make it difficult for the signer to claim that the electronic representation is not valid.

(I) Failure to properly maintain or authenticate medical records (i.e., signature and date entry) may result in the denial or recoupment of SoonerCare payments.

(2) **Record retention for provider medical records.** Providers must retain electronic medical records and have access to the records in accordance with guidelines found at OAC 317:30-3-15.

(3) **Record retention for documents submitted to OHCA electronically.**

(A) The OHCA's system provides that receivers of electronic information may both print and store the electronic information they receive. The OHCA is the custodian of the original electronic record and will retain that record in accordance with a disposition schedule as referenced by the Records Destruction Act. The OHCA will retain an authoritative copy of the transferable record as described in the Electronic Transaction Act that is unique, identifiable and unalterable.

(i) **Manner and format of electronic signature.** The manner and format required by the OHCA will vary dependent upon whether the sender of the document is a member or a provider. In the limited case where a provider is a client, the manner and format is dependent upon the function served by the receipt of the record. In the case the function served is a request for services, then the format required is that required by a recipient. In the case the function served is related to payment for services, then the format required is that required by a provider.

(ii) **Member format requirements.** The OHCA will allow members to request SoonerCare services electronically. An electronic signature will be authenticated after a validation of the data on the form by another database or databases.

(iii) **Provider format requirements.** The OHCA will

permit providers to contract with the OHCA, check and amend claims filed with the OHCA, and file prior authorization requests with the OHCA. Providers with a social security number or federal employer's identification number will be given a personal identification number (PIN). After using the PIN to access the database, a PIN will be required to transact business electronically.

(B) Providers with the assistance of the OHCA will be required to produce and enforce a security policy that outlines who has access to their data and what transaction employees are permitted to complete as outlined in the policy rules for electronic records and electronic signatures contained in paragraph two (2) of this section.

(C) Third Party billers for providers will be permitted to perform electronic transaction as stated in paragraph two (2) only after the provider authorizes access to the provider's PIN and a power of attorney by the provider is executed.

(4) **Time and place of sending and receipt.** The provisions of the Electronic Transaction Act apply to the time and place of sending and receipt. Should a power failure, Internet interruption or Internet virus occur, confirmation by the receiving party will be required to establish receipt.

(5) **Illegal representations of electronic transaction.** Any person who fraudulently represents facts in an electronic transaction, acts without authority, or exceeds his or her authority to perform an electronic transaction may be prosecuted under all applicable criminal and civil laws.

317:30-3-30. Signature requirements

(a) For medical review purposes, the Oklahoma Health Care Authority (OHCA) requires that all services provided and/or ordered be authenticated by the author. The method used shall be a handwritten signature, electronic signature, or signature attestation statement. Stamped signatures are not acceptable. Pursuant to Federal and/or State law, there are some circumstances for which an order does not need to be signed.

(1) Facsimile of original written or electronic signatures are acceptable for the certifications of terminal illness for hospice.

(2) Orders for clinical diagnostic tests are not required to be signed. If the order for the clinical diagnostic test is unsigned, there must be medical documentation by the treating physician that he/she intended the clinical diagnostic test be performed. This documentation showing the intent that the test be performed must be authenticated by the author via a handwritten or electronic signature.

(3) Orders for outpatient prescription drugs are not required to be signed. If the order for a prescription drug is unsigned, there must be medical documentation by the treating physician that he/she intended that the prescription drug be ordered. This documentation showing the intent that the prescription drug be ordered must be authenticated by the author via a handwritten or electronic signature.

(b) A handwritten signature is a mark or sign by an individual on a document to signify knowledge, approval, acceptance, or obligation. The authentication of a medical record (signature and date entry) ~~must occur within three (3) days of provision of the underlying service, including those instances in which the electronic medical record is transcribed by someone other than the provider. Before any claim is submitted to the OHCA for payment of a provided service, the provider must authenticate the electronic medical records relating to that service.~~ is expected on the day the record is completed. If the medical record is transcribed by someone other than the provider, the signature of the rendering provider and date entry is expected within three (3) business days from the day the record is completed. Before any claim is submitted to OHCA for payment of a provided service, the provider must authenticate the medical records relating to that service.

(1) If a signature is illegible, the OHCA will consider evidence in a signature log or attestation statement to determine the identity of the author of a medical record entry.

(2) If the signature is missing from an order, the OHCA will disregard the order during the review of the claim.

(3) If the signature is missing from any other medical documentation, the OHCA will accept a signature attestation from the author of the medical record entry.

(c) Providers may include in the documentation they submit a signature log that lists the typed or printed name of the author associated with initials or an illegible signature.

(1) The signature log may be included on the actual page where the initials or illegible signature are used or may be a separate document.

(2) The OHCA will not deny a claim for a signature log that is missing credentials.

(3) The OHCA will consider all submitted signature logs regardless of the date they were created.

(d) Providers may include in the documentation they submit a signature attestation statement. In order to be considered valid for medical review purposes, an attestation statement must be signed and dated by the author of the medical record entry and must contain sufficient information to identify the member.

(1) The OHCA will not consider signature attestation

statements where there is no associated medical record entry.

(2) The OHCA will not consider signature attestation statements from someone other than the author of the medical record entry in question.

(3) The OHCA will consider all signature attestation statements that meet the above requirements regardless of the date the attestation was created, except in those cases where the regulations or rules indicate that a signature must be in place prior to a given event or a given date.

(e) Providers may use electronic signatures as an alternate signature method.

(1) Providers must use a system and software products which are protected against modification and must apply administrative procedures which are adequate and correspond to recognized standards and laws.

(2) Providers utilizing electronic signatures bear the responsibility for the authenticity of the information being attested to.

(3) Providers utilizing electronic signatures must comply with OAC 317:30-3-4.1.

(f) Nothing in this section is intended to absolve the provider of their obligations in accordance with the conditions set forth in their SoonerCare contract and the rules delineated in OAC 317:30.

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.**

(A) Dental coverage for adults is limited to:

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

(ii) limited oral examinations and medically necessary radiographs associated with the emergency extraction or with a clinical presentation with reasonable expectation that an emergency extraction will be needed;

~~(ii)~~(iii) Smoking and Tobacco Use Cessation Counseling; and

~~(iii)~~(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 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 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 image 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 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 results of this procedure.

(B) **Periodic oral evaluation.** This procedure may be provided for a member of record if not seen by any dentist for more than six months. An examination should precede any images, and chart documentation must include images 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) **Limited oral evaluation.** This procedure is only compensable to the same dentist or practice for two 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 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. Periapical images must include at least three millimeters beyond the apex of the tooth being imaged. Panoramic films and two bitewings are considered full mouth images. Full

mouth images as noted above or traditional (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 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 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 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 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 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 24 months. No other restoration on that tooth is compensable during that period of time.

(I) **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 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 five years;

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

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

(V) Tooth numbers D and G before five 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 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 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 images 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 images 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, certified 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 that addresses the 5A's, 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.

(P) **Diagnostic casts and oral/facial images**. Diagnostic casts or oral/facial images may be requested by OHCA or representatives of OHCA. If cast or images are received they will be considered supporting documentation and may be used to make a determination for authorization of services. Submitted documentation used to base a decision will not be returned. Providers will be reimbursed for either the study model or images.

(i) Documentation of photographic images must be kept in the client's medical record and medical necessity identified on the submitted electronic or paper claim.

(ii) Oral/facial photographic images are allowed under the following conditions:

(I) When radiographic images do not adequately support the necessity for requested treatment.

(II) When photo images better support medical necessity for the requested treatment rather than diagnostic models.

(III) If a comprehensive orthodontic workup has not been performed.

(iii) For photographic images, the oral/facial portfolio must include a view of the complete lower arch, complete upper arch, and left and right maximum intercuspation of teeth.

(I) Maximum intercuspation refers to the occlusal position of the mandible in which the cusps of the teeth of both arches fully interpose themselves with the cusps of the teeth of the opposing arch.

(II) Intercuspation defines both the anterior-posterior and lateral relationships of the mandible and the maxilla, as well as the superior-inferior relationship known as the vertical dimension of occlusion.

(iv) Study models or photographic images not in compliance with the above described diagnostic guidelines will not be compensable. The provider may be allowed to resubmit new images that adhere to the

diagnostic guidelines. If the provider does not provide appropriate documentation, the request for treatment will be denied.