Oklahoma Health Care Authority
MEDICAL ADVISORY COMMITTEE
January 5, 2023
1:00 – 3:30 PM
Charles Ed McFall Board Room

AGENDA

Public access via zoom:
https://www.zoomgov.com/j/1606029791
Telephone: 1 669 254 5252 Webinar ID: 160 602 9791

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

II. Action Item: Approval of Minutes of the November 10th, 2022: **Medical Advisory Committee Meeting**

III. Public Comments (2 minute limit)

IV. MAC Member Comments/Discussion

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

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

- **A.** Living Choice Overview and Update: **David Ward, Long Term Services and Supports Director**
- **B.** PERM Update: **Josh Richards, Senior Director of Program Integrity & Account**

VII. New Coverage with Prior Authorization: **Paula Root, Senior Medical Director**

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

- **A. APA WF # 22-11 Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Visit and Sick Visit on the Same Day**
- **B. APA WF # 22-21A&B Increase Income Standard for Pregnant Women and Extend Postpartum Coverage**
- **C. APA WF # 22-22 Ukrainian Humanitarian Parolees**

IX. Election of Chairman and Vice-Chairman: **Chairman, Jason Rhynes, O.D.**

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

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

March 2, 2023
May 4, 2023
July 6, 2023
September 7, 2023
November 2, 2023

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

Oklahoma Health Care Authority
MEDICAL ADVISORY COMMITTEE
MINUTES of the November 10, 2022, Meeting
4345 N. Lincoln Blvd., Oklahoma City, OK 73105

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

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

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

Alternates present were: Ms. Edie Navfa

***Delegates absent without an alternate were*:** Ms. Janet Cizek, Ms. Tina Johnson, and Dr. Raymond Smith.

II. Approval of the September 8th, 2022 Minutes

Medical Advisory Committee

The motion to approve the minutes was by Dr. Daniel Post and seconded by Dr. Whitney Yeates and passed unanimously.

III. Public Comments (2-minute limit):

There were no public comments.

IV. MAC Member Comments/Discussion:

Dr. Switzer read a statement from a Chapter member regarding the 25 Modifier. A 15-month-old patient was brought in for a routine child check in March 2022. The patient had developed cold symptoms 3 days prior to the appointment. The clinician goes overgrowth and development, discusses recommended vaccinations, answers questions during the exam confirming a respiratory infection. The parent is counseled regarding the URI, prescriptions sent to the pharmacy. The visit is billed as a 99213 code with a 25 modifier in addition to a well visit code of 99392. Records are sent to OHCA for review, fast-forward 8 months, none of the codes have been paid. This is conservatory between $140 and $210 that wasn't paid. Imagine every SoonerCare member patient being seen by every clinician in the state was coding appropriately in the scenario and is not getting paid. It's a disincentive to code appropriately and sends a message that they are not valued.

V. Legislative Update:

Katelynn Burns, Legislative Liaison

Ms. Burns stated that session is currently out, but we are starting to prepare for the next session starting February 6, 2023. We have been working with staff, and leadership to requests any bills we

may have. Bill filing begins November 15 ending January 19. Some interim studies were done the last few months, which OHCA was involved with one, making Oklahoma a top 10 state for women for Senator Garvin. Ellen Buettner, our Chief of Staff, spoke to the committee about the services we provide for our members for pregnancies and other preventative services.

VI. Financial Report:

Tasha Black, Senior Director of Financial Services

Ms. Black presented the financial report ending in August 2022. OHCA is 3.3% over budget in revenues and 4.2% over budget in expenditures with the result that our budget variance is a positive $7,118,072. The budget variance is primarily attributed to the following: Medicaid Program Variance is a positive 5.1 million state dollars, and administration is a positive 1.1 million state dollars. For more detailed information, see item 6 in the MAC agenda. For more detailed information, see item 6 in the MAC agenda.

VII. Medicaid Directors Update:

Traylor Rains, State Medicaid Director

Mr. Rains gave an update on a few different things going on with OHCA, starting with us still being in a Public Health Emergency (PHE) with no end in sight. They assured us a 60-day head up when they plan to expire, we could hear something tomorrow. We have about 250,000 individuals who will no longer meet requirements. Our dental RFP closed on Halloween, which have gone through the first level of review. They will be officially evaluated on the 17th and be ready in January. The medical and Children's Specialty plan are expected to post today on the OMES website. Those will be open for 90 days, closing in February.

A. HIE Presentation:

Stephen Miller, State Coordinator for HIE

Mr. Miller gave a presentation on why a Health Information Exchange, Oklahoma history, Legislation, OKSHINE HIE framework, MYHEALTH – the state designated entity for HIE operations, Oklahoma's patient data fragmentation quantified, Care fragmentation, and the current HIE coverage. For more detailed information, see item 7A in the MAC agenda.

VIII. IMD Waiver Post-Award Forum:

Melissa Miller, Senior Director, Behavioral Health Policy and Planning

Ms. Miller gave a presentation regarding Section 1115 Institutions for Mental Disease (IMD) Waiver. She discussed the purpose of the IMD waiver, an overview of Oklahoma's IMD waiver, included populations and services, and updates and achievements for CY 2022. For more detailed information, see item 8 in the MAC agenda.

IX. MAC Meeting Dates for Calendar 2023:

Chairman, Jason Rhynes, O.D.
January 5, 2023
March 2, 2023
May 4, 2023
July 6, 2023
September 7, 2023
November 2, 2023

X. **New Business:**

Chairman, Jason Rhynes, O.D.

No new business was addressed.

XI. Adjourn:

Chairman, Jason Rhynes, O.D.
Chairman Rhynes asked for a motion to adjourn. Motion was provided by Dr. Steven Crawford and seconded by Dr. Daniel Post, there was no dissent and the meeting adjourned at 2:12pm.

OKLAHOMA
Health Care Authority

FINANCIAL REPORT

For the Four Month Period Ending October 31, 2022
Submitted to the CEO & Board

- Revenues for OHCA through October, accounting for receivables, were **$2,653,475,725** or **4.4% over** budget.
- Expenditures for OHCA, accounting for encumbrances, were **$2,483,440,411** or **6.1% over** budget.
- The state dollar budget variance through October is a negative **$31,802,840**
- The budget variance is primarily attributable to the following (in millions):

Expenditures:	
Medicaid Program Variance	(33.1)
Administration	(0.7)
Revenues:	
Drug Rebate	3.0
Medical Refunds	(0.6)
Taxes and Fees	(0.4)
Total FY 23 Variance	**$ (31.8)**

ATTACHMENTS

OKLAHOMA HEALTH CARE AUTHORITY
Summary of Revenues & Expenditures: OHCA
SFY 2023, For the Four Month Period Ending October 31, 2022

REVENUES	FY23 Budget YTD	FY23 Actual YTD	Variance	% Over/ (Under)
State Appropriations	$ 418,882,089	$ 418,882,089	$ -	0.0%
Federal Funds	1,779,655,230	1,879,814,407	100,159,177	5.6%
Tobacco Tax Collections	15,522,510	14,576,275	(946,234)	(6.1)%
Quality of Care Collections	30,094,374	30,648,832	554,458	1.8%
Prior Year Carryover	7,457,921	7,457,921	-	0.0%
Federal Deferral - Interest	299,789	299,789	-	0.0%
Drug Rebates	154,651,609	169,421,841	14,770,233	9.6%
Medical Refunds	11,850,866	9,089,466	(2,761,401)	(23.3)%
Prior Year Carryover Supplemental Hospital Offset Payment Program	-	-	-	0.0%
Supplemental Hospital Offset Payment Program	122,393,669	122,393,669	-	0.0%
Other Revenues	856,214	891,436	35,221	4.1%
TOTAL REVENUES	**$ 2,541,664,272**	**$ 2,653,475,725**	**$ 111,811,453**	**4.4%**

EXPENDITURES	FY23 Budget YTD	FY23 Actual YTD	Variance	% (Over)/ Under
ADMINISTRATION - OPERATING	**$ 22,311,538**	**$ 19,763,677**	**$ 2,547,861**	**11.4%**
ADMINISTRATION - CONTRACTS	**$ 42,276,490**	**$ 44,673,628**	**$ (2,397,138)**	**(5.7)%**
MEDICAID PROGRAMS				
Managed Care:				
SoonerCare Choice	19,140,710	19,328,926	(188,216)	(1.0)%
Acute Fee for Service Payments:				
Hospital Services	556,019,694	550,021,039	5,998,655	1.1%
Behavioral Health	10,356,748	10,022,524	334,224	3.2%
Physicians	194,031,110	195,996,384	(1,965,274)	(1.0)%
Dentists	73,333,402	77,693,305	(4,359,903)	(5.9)%
Other Practitioners	24,334,123	30,239,558	(5,905,436)	(24.3)%
Home Health Care	11,180,786	9,492,124	1,688,662	15.1%
Lab & Radiology	17,133,576	15,327,788	1,805,788	10.5%
Medical Supplies	27,823,232	31,601,103	(3,777,870)	(13.6)%
Ambulatory/Clinics	183,824,929	200,412,352	(16,587,423)	(9.0)%
Prescription Drugs	438,859,062	496,287,798	(57,428,736)	(13.1)%
OHCA Therapeutic Foster Care	186,027	158,247	27,780	14.9%
Other Payments:				
Nursing Facilities	215,540,205	286,384,359	(70,844,154)	(32.9)%
Intermediate Care Facilities for Individuals with Intellectual Disabilities Private	22,715,138	21,874,385	840,753	3.7%
Medicare Buy-In	81,847,437	82,133,690	(286,253)	(0.3)%
Transportation	31,136,911	34,810,757	(3,673,846)	(11.8)%
Money Follows the Person-OHCA	173,227	201,054	(27,827)	(16.1)%
Electronic Health Records-Incentive Payments	(12,630)	(12,630)	-	0.0%
Part D Phase-In Contribution	24,354,716	24,482,083	(127,367)	(0.5)%
Supplemental Hospital Offset Payment Program	338,983,631	329,041,363	9,942,268	2.9%
Telligen	4,186,675	3,506,899	679,776	16.2%
Total OHCA Medical Programs	**2,275,148,707**	**2,419,003,106**	**(143,854,399)**	**(6.3)%**
OHCA Non-Title XIX Medical Payments	89,382	-	89,382	0.0%
TOTAL OHCA	**$ 2,339,826,117**	**$ 2,483,440,411**	**$ (143,614,294)**	**(6.1)%**
REVENUES OVER/(UNDER) EXPENDITURES	**$ 201,838,154**	**$ 170,035,314**	**$ (31,802,840)**	

OKLAHOMA HEALTH CARE AUTHORITY

Total Medicaid Program Expenditures
by Source of State Funds
SFY 2023, For the Four Month Period Ending October 31, 2022

Category of Service	Total	Health Care Authority	Quality of Care	Insure Oklahoma	SHOPP	BCC	Other State Agencies
SoonerCare Choice	$ 19,328,926	$ 19,326,867	$ -	$ -	$ -	$ 2,059	$ -
Inpatient Acute Care	690,210,124	309,450,201	162,229	(1,753)	253,782,774	198,540	126,618,134
Outpatient Acute Care	300,425,179	239,126,784	13,868	(492)	60,215,602	1,069,417	-
Behavioral Health - Inpatient	41,079,860	6,284,631	-	-	12,331,029	-	22,464,200
Behavioral Health - Psychiatrist	6,449,851	3,732,633	-	-	2,711,958	5,261	-
Behavioral Health - Outpatient	6,545,839	-	-	-	-	-	6,545,839
Behaviorial Health-Health Home	(2,398)	-	-	-	-	-	(2,398)
Behavioral Health Facility- Rehab	79,138,764	-	-	-	-	80,788	79,138,764
Behavioral Health - Case Management	2,102,948	-	-	-	-	-	2,102,948
Behavioral Health - PRTF	4,990,843	-	-	-	-	-	4,990,843
Behavioral Health - CCBHC	110,139,707	-					110,139,707
Residential Behavioral Management	6,430,547	-	-	-	-	-	6,430,547
Targeted Case Management	23,106,375	-	-	-	-	-	23,106,375
Therapeutic Foster Care	158,247	158,247	-	-	-	-	-
Physicians	238,979,080	195,442,914	19,367	2,323	-	534,103	42,980,373
Dentists	77,693,305	77,661,763	-	-	-	31,542	-
Mid Level Practitioners	490,327	489,433	-	-	-	894	-
Other Practitioners	29,749,231	29,575,762	148,788	-	-	24,681	-
Home Health Care	9,492,124	9,491,637	-	-	-	487	-
Lab & Radiology	15,327,788	15,289,642	-	-	-	38,146	-
Medical Supplies	31,601,103	30,684,036	903,844	-	-	13,222	-
Clinic Services	204,260,541	196,658,709	-	398	-	110,101	7,491,332
Ambulatory Surgery Centers	3,643,541	3,639,587	-	-	-	3,954	-
Personal Care Services	2,793,126	-	-	-	-	-	2,793,126
Nursing Facilities	286,384,359	132,548,086	153,836,273	-	-	-	-
Transportation	34,695,966	33,900,890	724,785	1,871	-	68,421	-
IME/DME	46,503,762	-	-	-	-	-	46,503,762
ICF/IID Private	21,874,385	13,653,969	8,220,416	-	-	-	-
ICF/IID Public	7,075,712	-	-	-	-	-	7,075,712
CMS Payments	106,615,772	106,463,021	152,751	-	-	-	-
Prescription Drugs	496,281,136	495,341,377	-	(6,662)	-	946,422	-
Miscellaneous Medical Payments	116,661	114,268	-	-	-	2,393	-
Home and Community Based Waiver	87,892,124	-	-	-	-	-	87,892,124
Homeward Bound Waiver	22,898,129	-	-	-	-	-	22,898,129
Money Follows the Person	894,635	201,054	-	-	-	-	693,581
In-Home Support Waiver	9,611,667	-	-	-	-	-	9,611,667
ADvantage Waiver	65,469,219	-	-	-	-	-	65,469,219
Family Planning/Family Planning Waiver	614,291	-	-	-	-	-	614,291
Premium Assistance*	14,182,804	-	-	14,182,804.47	-	-	-
Telligen	3,506,899	3,506,899	-	-	-	-	-
Electronic Health Records Incentive Payments	(12,630)	(12,630)	-	-	-	-	-
Total Medicaid Expenditures	**$ 3,108,739,870**	**$ 1,922,729,778**	**$ 164,182,322**	**$ 14,178,489**	**$ 329,041,363**	**$ 3,130,431**	**$ 675,558,274**

* Includes $14,038,447.87 paid out of Fund 245

OKLAHOMA HEALTH CARE AUTHORITY
Summary of Revenues & Expenditures:
Other State Agencies
SFY 2023, For the Four Month Period Ending October 31, 2022

REVENUE	FY23 Actual YTD
Revenues from Other State Agencies	135,114,021
Federal Funds	548,735,065
TOTAL REVENUES	**$ 683,849,085**

EXPENDITURES	Actual YTD
Oklahoma Human Services	
Home and Community Based Waiver	87,892,124
Money Follows the Person	693,581
Homeward Bound Waiver	22,898,129
In-Home Support Waivers	9,611,667
Advantage Waiver	65,469,219
Intermediate Care Facilities for Individuals with Intellectual Disabilities Public	7,075,712
Personal Care	2,793,126
Residential Behavioral Management	4,208,490
Targeted Case Management	21,172,500
Total Oklahoma Human Services	**221,814,547**
State Employees Physician Payment	
Physician Payments	42,980,373
Total State Employees Physician Payment	**42,980,373**
Education Payments	
Indirect Medical Education	39,124,998
Direct Medical Education	2,138,541
DSH	5,240,223
Total Education Payments	**46,503,762**
Office of Juvenile Affairs	
Targeted Case Management	666,254
Residential Behavioral Management	2,222,058
Total Office of Juvenile Affairs	**2,888,312**
Department of Mental Health & Substance Abuse Services	
Case Management	2,102,948
Inpatient Psychiatric Free-standing	22,464,200
Outpatient	6,545,839
Health Homes	(2,398)
Psychiatric Residential Treatment Facility	4,990,843
Certified Community Behavioral Health Clinics	110,139,707
Rehabilitation Centers	79,138,764
Total Department of Mental Health & Substance Abuse Services	**225,379,903**
State Department of Health	
Children's First	183,723
Sooner Start	552,139
Early Intervention	701,063
Early and Periodic Screening, Diagnosis, and Treatment Clinic	544,085
Family Planning	274,673
Family Planning Waiver	339,618
Maternity Clinic	5,573
Total Department of Health	**2,600,873**
County Health Departments	
EPSDT Clinic	162,363
Family Planning Waiver	-
Total County Health Departments	**162,363**
State Department of Education	**29,362**
Public Schools	**353,473**
Medicare DRG Limit	**124,010,018**
Native American Tribal Agreements	**6,227,173**
Department of Corrections	**1,321,753**
JD McCarty	**1,286,363**
Total OSA Medicaid Programs	**$ 675,558,274**
OSA Non-Medicaid Programs	**$ 36,424,518**
Accounts Receivable from OSA	**$ 28,133,707**

OKLAHOMA HEALTH CARE AUTHORITY

SUMMARY OF REVENUES & EXPENDITURES:

Fund 205: Supplemental Hospital Offset Payment Program Fund

SFY 2023, For the Four Month Period Ending October 31, 2022

REVENUES		FY 23 Revenue
SHOPP Assessment Fee		**122,355,313**
Federal Draws	**$**	**277,520,575**
Interest		**38,356**
Penalties		**-**
TOTAL REVENUES	**$**	**399,914,244**

EXPENDITURES	Quarter	Quarter	Quarter	Quarter		FY 23 Expenditures
Program Costs:	**7/1/22 - 9/30/22**	**10/1/22 - 12/31/22**	**1/1/23 - 3/31/23**	**4/1/23 - 6/30/23**		
Hospital - Inpatient Care	**62,885,681**	**63,467,990**	**-**	**-**	**$**	**126,353,672**
Hospital -Outpatient Care	**17,328,429**	**16,164,122**	**-**	**-**	**$**	**33,492,551**
Psychiatric Facilities-Inpatient	**3,500,773**	**4,594,904**	**-**	**-**	**$**	**8,095,678**
Rehabilitation Facilities-Inpatient	**749,525**	**1,055,631**	**-**	**-**	**$**	**1,805,157**
Hospital - Inpatient Care - Expansion	**64,714,551**	**62,714,551**	**-**	**-**	**$**	**127,429,103**
Hospital -Outpatient Care - Expansion	**13,361,525**	**13,361,525**	**-**	**-**	**$**	**26,723,051**
Psychiatric Facilities-Inpatient - Expansion	**2,117,676**	**2,117,676**	**-**	**-**	**$**	**4,235,351**
Rehabilitation Facilities-Inpatient - Expansion	**453,400**	**453,400**	**-**	**-**	**$**	**906,801**
Total OHCA Program Costs	**165,111,562**	**163,929,801**	**-**	**-**		**329,041,363**
Total Expenditures					**$**	**329,041,363**

SHOPP Revenue transferred to Fund 340 for Medicaid Program expense	**$**	**70,872,881**

*** Expenditures and Federal Revenue processed through Fund 340

OKLAHOMA HEALTH CARE AUTHORITY
SUMMARY OF REVENUES & EXPENDITURES:
Fund 230: Nursing Facility Quality of Care Fund
SFY 2023, For the Four Month Period Ending October 31, 2022

REVENUES	Total Revenue	State Share
Quality of Care Assessment	**$ 30,639,152**	**$ 30,639,152**
*Quality of Care Penalties (*Non-Spendable Revenue)*	**$ 69,357**	**$ 69,357**
Interest Earned	**9,680**	**$ 9,680**
TOTAL REVENUES	**$ 30,718,189**	**$ 30,718,189**

EXPENDITURES	FY 23 Total $ YTD	FY 23 State $ YTD	Total State $ Cost
Program Costs			
Nursing Facility Rate Adjustment	$ 84,301,634	$ 17,463,118	
Eyeglasses and Dentures	80,377	$ 16,650	
Personal Allowance Increase	1,014,760	$ 210,342	
Coverage for Durable Medical Equipment and Supplies	903,844	$ 187,344	
Coverage of Qualified Medicare Beneficiary	344,252	$ 71,355	
Part D Phase-In	152,751	$ 152,751	
ICF/IID Rate Adjustment	1,684,763	$ 349,015	
Acute Services ICF/IID	2,441,462	$ 505,727	
Non-emergency Transportation - Soonerride	724,785	$ 150,252	
NF Covid-19 Supplemental Payment	68,439,502	$ 14,353,490	
ICF Covid-19 Supplemental Payment	4,094,191	$ 858,524	
Ventilator NF DME Supplemental Payment		$ -	
Total Program Costs	**$ 164,182,322**	**$ 34,318,567**	**$ 34,318,567**
Administration			
OHCA Administration Costs	$ 100,656	$ 50,328	
OHS-Ombudsmen	-	-	
OSDH-Nursing Facility Inspectors	-	-	
Mike Fine, CPA	-	-	
Total Administration Costs	**$ 100,656**	**$ 50,328**	**$ 50,328**
Total Quality of Care Fee Costs	**$ 164,282,978**	**$ 34,368,895**	
TOTAL STATE SHARE OF COSTS			**$ 34,368,895**

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

OKLAHOMA HEALTH CARE AUTHORITY
SUMMARY OF REVENUES & EXPENDITURES:
Insure Oklahoma Program (Fund 245: HEEIA)
SFY 2023, For the Four Month Period Ending October 31, 2022

REVENUES	FY 22 Carryover	FY 23 Revenue	Total Revenue
Prior Year Balance	$ 14,187,453		
State Appropriations	-		
Federal Draws - Prior Year	265,676		
Total Prior Year Revenue			14,453,129
Transfer to 340 for Expansion-current year		-	-
Tobacco Tax Collections	-	11,988,488	11,988,488
Interest Income	-	76,467	76,467
Federal Draws	-	11,452,284	11,452,284
TOTAL REVENUES	**$ 14,453,129**	**$ 23,517,239**	**$ 37,970,368**

EXPENDITURES		FY 22 Expenditures	FY 23 Expenditures	Total State $ YTD
Program Costs:				
	Employer Sponsored Insurance		$ 14,038,448	$ 14,038,448
	College Students/ESI Dental		144,357	29,935
Individual Plan				
	SoonerCare Choice		$ -	$ -
	Inpatient Hospital		(1,753)	(365)
	Outpatient Hospital		(673)	(138)
	BH - Inpatient Services-DRG		-	-
	BH -Psychiatrist		-	-
	Physicians		2,323	468
	Dentists		-	-
	Mid Level Practitioner		-	-
	Other Practitioners		-	-
	Home Health		-	-
	Lab and Radiology		-	-
	Medical Supplies		-	-
	Clinic Services		398	82
	Ambulatory Surgery Center		-	-
	Skilled Nursing		-	-
	Prescription Drugs		(6,662)	(1,387)
	Transportation		1,871	383
	Premiums Collected			-
Total Individual Plan			**$ (4,496)**	**$ (957)**
	College Students-Service Costs		**$ 181**	**$ 39**
Total OHCA Program Costs			**$ 14,178,489**	**$ 14,067,465**
Administrative Costs				
	Salaries	$ -	$ 483,806	$ 483,806
	Operating Costs	323	429	751
	E&E Development Gainwell	-	-	-
	Contract - Gainwell	375,519	273,667	649,186
Total Administrative Costs		**$ 375,842**	**$ 757,902**	**$ 1,133,744**
Total Expenditures				**$ 15,201,209**
Transfer to Fund 340 for Expansion Costs				**$ 5,889,367**
NET CASH BALANCE		**$ 14,077,287**	**$ 2,802,505**	**$ 16,879,791**

OKLAHOMA HEALTH CARE AUTHORITY

Combining Statement of Revenues, Expenditures and Changes in Fund Balance

SFY 2023, For the Four Month Period Ending October 31, 2022

	Administration Fund 200	Supplemental Hospital Offset Payment Program Fund 205	Quality of Care Fund 230	Rate Preservation Fund 236	Federal Deferral Fund 240	Health Employee and Economy Act Fund 245	Belle Maxine Hilliard Breast & Cervical Cancer Treatment (Tobacco) Fund 250	Medicaid Program (Tobacco) Fund 255	Medicaid Program Fund 340	Clearing Account 1807B	Total Cash Balance
October Beginning Fund Balance:											
Prior year	30,064,198	954,274	158,274	173,190,614	66,105,110	14,077,287	-	-	879,558,637	122,008,556	1,286,116,950
Current year	9,522,719	12,862,035	(130,497)	35,246,622	217,017	6,133,429	-	-	(12,233,125)	2,604,149	54,222,349
Total	39,586,917	13,816,309	27,777	208,437,236	66,322,127	20,210,716	-	-	867,325,512	124,612,705	1,340,339,299
October Revenues:											
Prior year	2,275,037	-	-	-	-	-	-	-	5,397,754	-	7,672,791
Current year	3,311,428	47,678,073	7,829,066	-	82,772	6,107,578	65,426	3,920,543	791,584,973	17,549,506	878,129,366
Total	5,586,466	47,678,073	7,829,066	-	82,772	6,107,578	65,426	3,920,543	796,982,727	17,549,506	885,802,157
October Expenditures:											
Prior year	997,764	-	-	-	-	-	-	-	-	-	997,764
Current year	19,055,092	-	-	-	-	3,633,043	-	-	832,334,017	-	855,022,153
Total	20,052,857	-	-	-	-	3,633,043	-	-	832,334,017		856,019,917
Operating Transfers In											
Prior year											
Current year	5,815,823	-	-	13,678,171	-	-	-	-	157,993,897	-	177,487,891
Total	5,815,823	-	-	13,678,171	-	-	-	-	157,993,897	-	177,487,891
Operating Transfers Out											
Prior year	1,147,870	-	-	-	-	-	-	-	-		1,147,870
Current year	-	60,767,416	7,711,014	-	-	5,889,367	65,426	3,920,543	-	122,008,556	200,362,323
Total	1,147,870	60,767,416	7,711,014	-	-	5,889,367	65,426	3,920,543	-	122,008,556	201,510,193
Change in CY Fund Balance	***(405,122)***	***(227,309)***	***(12,445)***	***48,924,793***	***299,789***	***2,718,597***	***-***	***-***	***105,011,728***	***(101,854,901)***	***54,455,130***
Ending Fund Balance	**29,788,479**	**726,965**	**145,829**	**222,115,407**	**66,404,899**	**16,795,884**	**-**	**-**	**989,968,119**	**20,153,655**	**1,346,099,237**

OKLAHOMA HEALTH CARE AUTHORITY
HEALTHY ADULT PROGRAM EXPENDITURES - OHCA
SFY 2023, For the Four Month Period Ending October 31, 2022

PROGRAM / ACTIVITY	FY23 BUDGETED EXPENDITURES Full Year	FY23 BUDGETED EXPENDITURES Year to Date	FY23 ACTUAL EXPENDITURES YTD through October	BUDGET VARIANCE (Over)/ Under
OHCA MEDICAID PROGRAMS				
Managed Care				
SoonerCare Choice	3,765,223	1,255,074	1,348,958	(93,883)
Total Managed Care	**3,765,223**	**1,255,074**	**1,348,958**	**(93,883)**
Fee for Service				
Hospital Services:				
Inpatient Acute Care	273,604,093	90,565,569	82,410,287	8,155,282
SHOPP	265,696,456	130,067,538	159,294,306	(29,226,768)
Outpatient Acute Care	261,235,739	86,397,838	91,799,193	(5,401,355)
Total Hospitals	**800,536,288**	**307,030,945**	**333,503,785**	**(26,472,841)**
Behavioral Mental Health:				
Inpatient Services - DRG	9,301,433	3,040,853	7,594,261	(4,553,408)
Outpatient	-	-	-	-
Total Behavioral Mental Health	**9,301,433**	**3,040,853**	**7,594,261**	**(4,553,408)**
Physicians & Other Providers:				
Physicians	165,125,830	54,915,175	59,541,018	(4,625,843)
Dentists	41,644,615	13,614,586	19,056,402	(5,441,817)
Mid-Level Practitioner	470,555	153,835	144,783	9,052
Other Practitioners	17,826,615	5,827,932	7,475,070	(1,647,138)
Home Health Care	1,057,567	345,743	389,602	(43,859)
Lab & Radiology	18,732,473	6,124,078	6,673,536	(549,459)
Medical Supplies	12,693,042	4,149,648	5,299,734	(1,150,086)
Clinic Services	143,276,094	47,771,992	54,253,368	(6,481,376)
Ambulatory Clinics	3,935,341	1,286,554	1,439,371	(152,817)
Total Physicians & Other Providers	**404,762,132**	**134,189,543**	**154,272,885**	**(20,083,342)**
Misc Medical & Health Access Network	**81,869**	**26,765**	**43,724**	(16,959)
Transportation	**22,433,552**	**7,334,046**	**9,742,222**	(2,408,176)
Health Access Network	**-**	**-**	**13,145**	(13,145)
Prescription Drugs	**538,724,708**	**178,357,693**	**217,858,523**	(39,500,829)
Total OHCA Medicaid Programs	**1,779,605,206**	**631,234,919**	**724,377,502**	**(93,142,583)**

Living Choice Project

Money Follows the Person

Money Follows the Person Living Choice Demonstration

Created from the 2005 Deficit Reduction Act

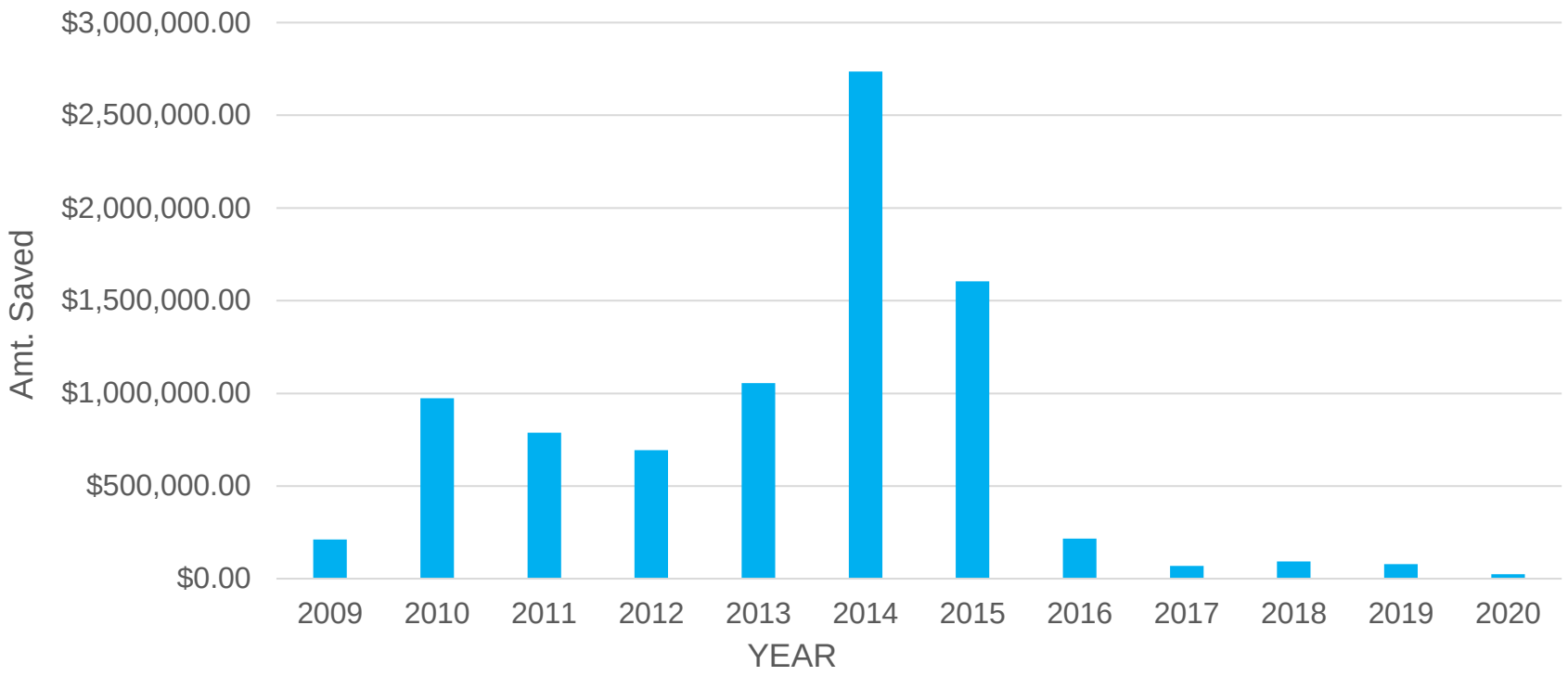
- Rebalance and restructure state's long-term care systems.
- Transition qualified members from the institution back into the community.
- Centers for Medicare and Medicaid Services award the grant.

President George W. Bush Signing the Deficit Reduction Act

Why We Serve: Oklahoma's Living Choice Demonstration

- First Transition occurred in 2009
- Rebalance and restructure state's long-term care systems
- To date, Living Choice has transitioned more than 800 members

Rebalancing Funds
Over $8.5 million saved



The report indicates average monthly expenditures per beneficiary declined by approximately $1,840 (23%), equating to a mean cost-savings of $22,080 following the first transition year.

Source - ***The 2017 MFP Rebalancing Demonstration Report to Congress***

Who We Serve

Older Adults

- ages 65 and older

Physically Disabled

- ages 19 and older

Intellectually Disabled

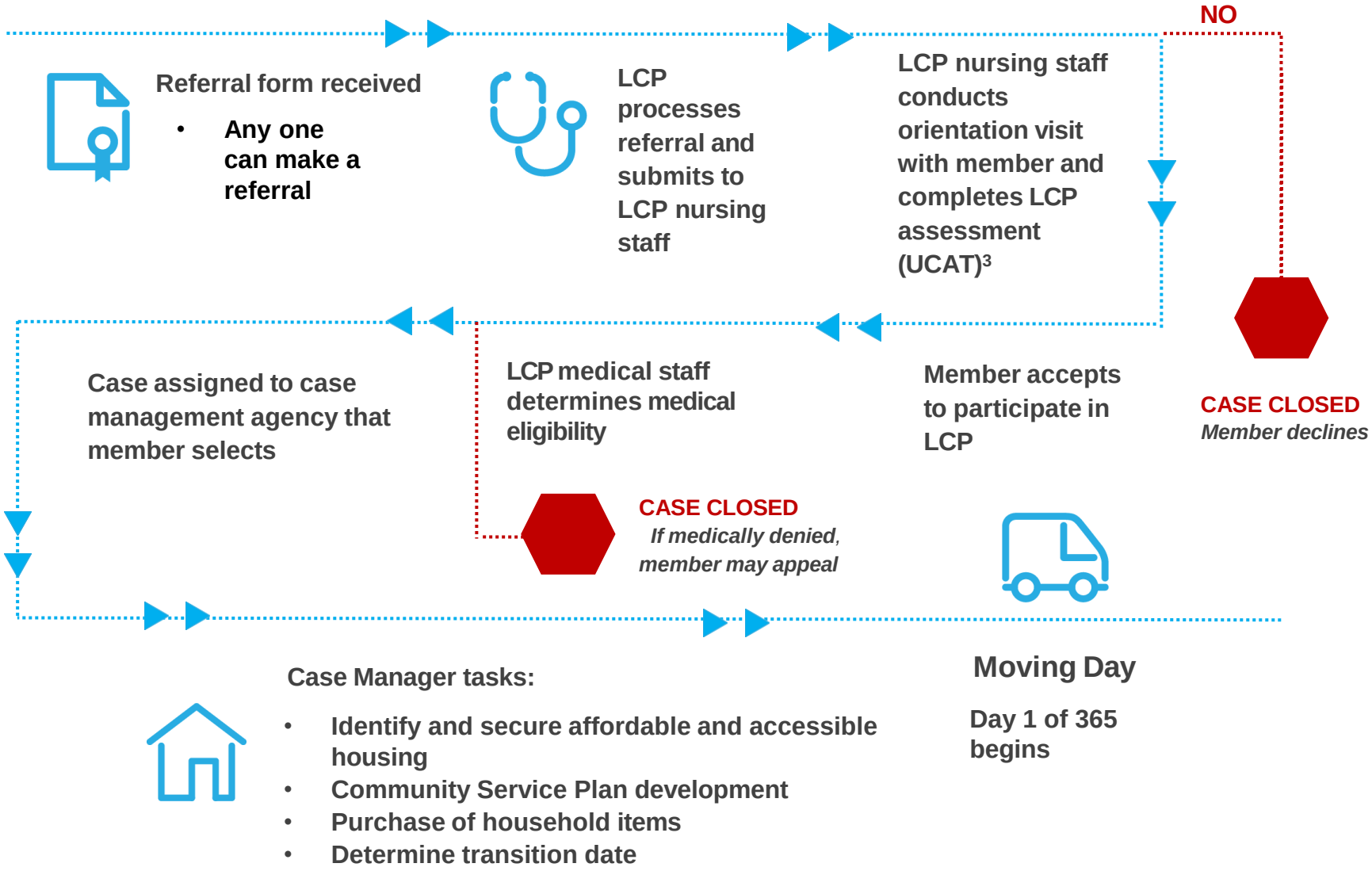
- Population is served under Living Choice and administered by Developmental Disability Services [DDS]

Goal: Transition qualified members from the facility back into the community

When We Serve:
Living Choice Eligibility Requirements

- Medicaid eligible
- Reside in a facility for 60 consecutive days
- One day of stay paid by Medicaid
- Must be willing to actively participate in transition

HOW WE SERVE:
Living Choice Transition Process



WHAT WE SERVE: SERVICES

- Assisted Living
- Case management
- Home-Delivered Meals
- Personal care
- Self-Direction
- Skilled nursing
- Therapy Services
- $2,400 in transitional funds are available in a one-time allotment

Where We Serve: Community Transition Options

Your home, your community, and your choice

Member will spend 365 days with Living Choice

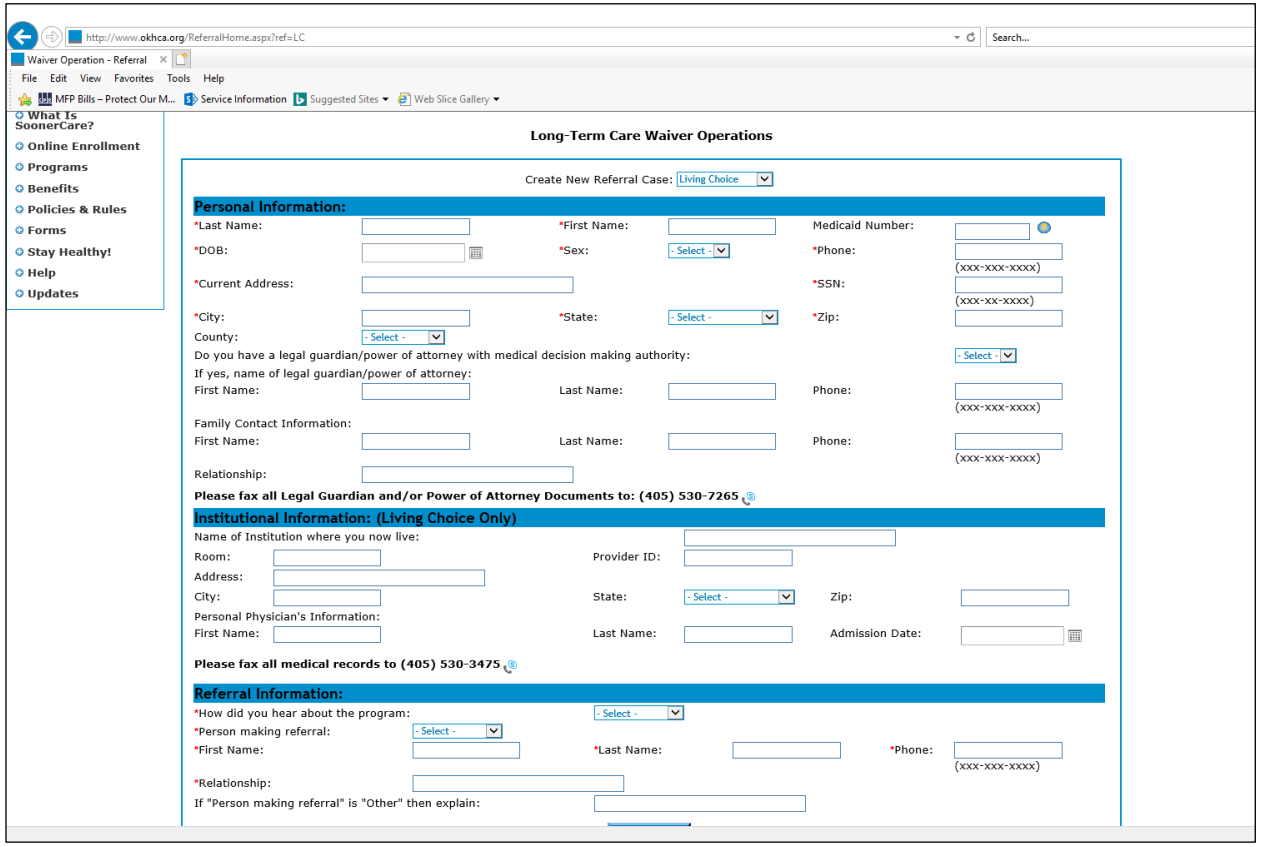
Transition on day 366 to ADvantage Waiver upon approval

Member Success Story

Ms. Melissa Conner

https://youtu.be/AbKUqmcsweY

It All Begins With A Referral



http://www.okhca.org/LTSSreferral

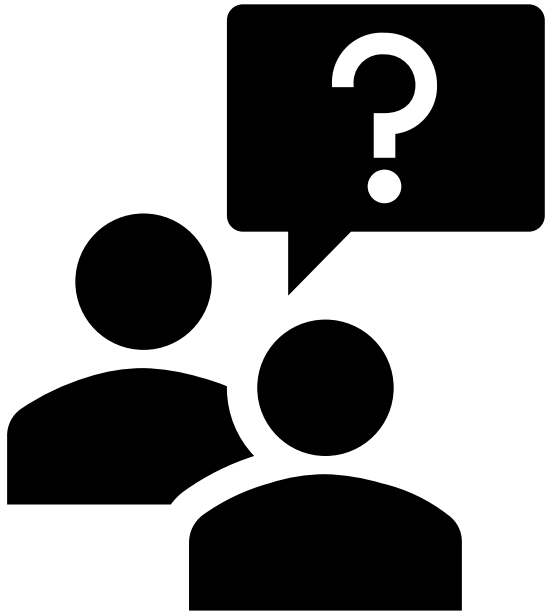
PROGRAM CONTACTS

Living Choice Phone Number: (888) 287-2443

Living Choice Fax Number: (405) 530-7265

https://oklahoma.gov/ohca/individuals/programs/living-choice-contacts.html

Questions



PATHWAYS
to Community Living

(Money follows the person – tribal initiative)

Johnney Johnson, MFP-TI Director

December 26, 2022

ABOUT THE GRANT

- The grant was approved by CMS in 2014 as means of bringing elders out of nursing homes and long-term care facilities and transitioning them back into tribal communities.

- The Oklahoma Health Care Authority and CMS recognized that tribal nations already do an excellent job of assisting elders to continue to live in their homes and out of long-term care facilities.

- In 2020, the Money Follows the Person – Tribal Initiative was modified to work independently with tribes to provide funding to match the specific needs of each tribal program.

Program Goal

Establish sustainable and culturally appropriate long-term services and supports in tribal communities.

The state's overarching goal will be to further establish a meaningful and effective partnership with participating tribal partners in order to:

- Expand the leadership role of tribes in the creation, implementation and operation of Medicaid-funded programs tailored for the needs of tribal members.

- Transition eligible and interested tribal members out of in-patient institutional settings back to their homes and communities.

How this benefits tribes

- Continue to build on government-to-government relationships.
- Enhance tribal infrastructure through capacity building.
- Increase access to needed long-term health services in their community.
- Improve health disparities and rural areas
- Design, implement and support effective tribal health care programs.
- Maximize fiscal resources and support self-determination.

OHCA Partnership

Consistent Support

- Application support
- Aid with outreach and awareness
  - MFP-TI
  - SoonerCare program education

Community Outreach Coordinators available for:

- Outreach events, health fairs, etc.
- SoonerCare training opportunities

MFP-TI Tribal Partners

2 full grantees
3 in application/MOA phase
3 in discovery phase

Partners in 4 other states:

- Minnesota
- North Dakota
- Washington
- Wisconsin

What has been accomplished

In 2022, CMS awarded the Muscogee Nation one of the largest grant awards in the history of MFP-TI.

In December of 2022, the Cheyenne & Arapaho Tribes became the third grant partner with OHCA.

OKLAHOMA
Health Care Authority

GET IN TOUCH

Johnney Johnson, Director for Pathways to Community Living
Carley Fryrear, Community Outreach Coordinator

Johnney.Johnson@okhca.org
Carley.Fryrear@okhca.org

4345 N. Lincoln Blvd.
Oklahoma City, OK 73105

oklahoma.gov/ohca
mysoonercare.org

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

QUESTIONS

MAC PRESENTATION

Dr. Paula Root

OPTUNE THERAPY

OPTUNE THERAPY

What is Optune Therapy?

- Optune is a wearable, portable device to treat a type of brain cancer called glioblastoma multiforme (GBM) in adult patients.
- GBM can be hard to reach, and surgery may not be able to remove the entire tumor.
- GBM also grows fast and can spread quickly.
- Optune works by creating Tumor Treatment Fields (TTFields), which are electric fields that disrupt cancer cell division.
- Using 4 adhesive patches called transducer arrays which are placed on the head, TTField therapy is delivered right into the area of the body where the cancer is located.

OPTUNE THERAPY APPROVAL CRITERIA

INDICATIONS

Tumor treatment field therapy is considered medically necessary for the following:

- Newly diagnosed or recurrent GBM by biopsy or imaging.
- Surgery completed or surgery not feasible.
- Radiation therapy with chemotherapy completed.
- Performance scale assessment completed and within range.
- No disease progression at time of device initiation.
- Tumor treatment field therapy planned for an average of 18 hours per day.
- Age 22 years and older.

NONE of the following:

- Implanted medical devices that are electrically activated (such as a pacemaker).
- Skull defect.
- Evidence of increased intracranial pressure.
- Severe sensitivity to conductive hydrogels.

ELASTOGRAPHY ULTRASOUND OF ORGAN TISSUE

ELASTOGRAPHY ULTRASOUND

What is Elastography Ultrasound of Organ Tissue?

- Elastography uses low frequency vibrations during an ultrasound to measure the stiffness (or elasticity) of organs inside the body.
- Elastography is particularly useful for detecting the presence and severity of liver disease.
- This is a noninvasive way to assess hepatic fibrosis.
- More invasive methods to determine liver fibrosis, such as liver biopsy, come with a high risk of undesirable complications.

ELASTOGRAPHY ULTRASOUND APPROVAL CRITERIA

INDICATIONS

Elastography ultrasound is considered medically necessary when requested for liver fibrosis staging for 1 or more of the risk factors listed below:

A. In patients 18 years and older, risk factors for liver disease must include 1 or more of the following:

- Alcoholic hepatitis
- Autoimmune hepatitis
- Hepatitis B
- Hepatitis C
- Non-alcoholic fatty liver disease

B. In patients who are less than 18 years and younger, additional risk factors include:

- Biliary atresia
- Wilson disease
- Primary sclerosing cholangitis

THORACOSCOPY FOR LUNG VOLUME REDUCTION SURGERY (LVRS)

THORACOSCOPY FOR LUNG VOLUME REDUCTION SURGERY (LVRS)

What is Thoracoscopy for Lung Volume Reduction Surgery?

LVRS is partial removal of the lung to reduce lung volume using an endoscope.

THORACOSCOPY FOR LUNG VOLUME REDUCTION SURGERY (LVRS)

What is the goal with LVRS?

To remove up to 30 percent of each lung, making the lungs smaller and allowing them to function better.

THORACOSCOPY FOR LUNG VOLUME REDUCTION SURGERY (LVRS)

LVRS is currently covered by OHCA.

OHCA seeks to create a Prior Authorization for this procedure.

LVRS APPROVAL CRITERIA

INDICATIONS

LVRS is considered medically necessary when the following criteria are met:

- Age greater than or equal to 18 years old.
- Nonsmoker or no smoking for at least 6 months.
- Bilateral emphysema diagnosed on CT.
- Difficulty breathing at rest or with minimal exertion.
- Body Mass Index (BMI) no more than 31 for males and 32 for females.
- Abnormal arterial blood gas values.
- Abnormal pulmonary function test results.
- Ability to meet exercise tolerance requirements after at least 6 weeks of supervised pulmonary rehabilitation:
    - Able to ambulate 140 meters or more in 6 minutes, AND
    - Able to complete 3-minute bicycle ergometry test.
- No other pulmonary or cardiac issues OR cleared by cardiologist for procedure.

Patients with mostly upper lobe emphysema and low exercise capacity may receive the most benefit from LVRS.

INHERITED BONE MARROW FAILURE SYNDROMES (IBMFS)

INHERITED BONE MARROW FAILURE SYNDROMES (IBMFS)

What are Inherited Bone Marrow Failure Syndromes (IBMFS)?

- IBMFS are a group of rare genetic blood disorders causing failure of the bone marrow to produce enough blood cells.
- IBMFS are associated with a family history of the same disorder.
- Several different types of IBMFS exist.
- IBMFS disorders are characterized by:
  - Varying degrees of bone marrow failure
  - Predisposition to developing blood cancers and solid tumors
  - Congenital abnormalities
  - Other non-cancer conditions

What about Treatment?

- Hematopoietic stem cell transplantation (HCT) is the preferred therapy.

INHERITED BONE MARROW FAILURE SYNDROMES (IBMFS)

How is IBMFS diagnosed?

- Diagnosis is suspected based upon:
  - Hematopoietic test results
  - Physical features
  - Family history
- Timely genetic testing is **essential** to establish a diagnosis and to guide appropriate management, treatment, and cancer surveillance.

INHERITED BONE MARROW FAILURE SYNDROMES (IBMFS)

- OHCA Medical Guideline for IBMFS:
  - *Target panel testing may be considered medically necessary for confirmatory diagnostic testing in members with clinical features suggestive of inherited bone marrow failure syndrome(s).*

COCHLEAR STIMULATING SYSTEMS: NEW CODES

COCHLEAR STIMULATING SYSTEMS: NEW CODES

Three new codes in 2023 for cochlear stimulating systems:

- **69728** – removal of an osseointegrated skull implant
- **69729** – implantation of an osseointegrated skull implant
- **69730** – replacement of an osseointegrated skull implant

Why is there a need for these new codes?

- **69728-69730** further define location of placement (outside of the mastoid bone) and amount of bone removed (greater than or equal to 100 sq mm).

COCHLEAR STIMULATING SYSTEMS: NEW CODES

- OHCA currently covers the three existing codes **69727, 69716, 69719** for location within the mastoid bone and amount of bone removal equal to or less than 100 sq cm.
- The three new codes will be set up to "mirror" their established counterparts, with the location and amount of bone removal being the differences between the established and new codes.

OKLAHOMA
Health Care Authority

GET IN TOUCH

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Helpline: 800-987-7767

January MAC
Proposed Rules Amendment Summaries

APA WF # 22-11 Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Visit and Sick Visit on the Same Day – Policy will be revised to allow reimbursement for an EPSDT visit and a sick visit that occur on the same date of service, when it is deemed medically appropriate. The revisions will outline the requirements that must be met including, but not limited to, separate documentation/note to justify additional condition(s), information on the appropriate use of Modifier 25, a provider's ability to only claim the additional time required above and beyond the completion of the EPSDT screening, and clarification that any health problem that is encountered in the EPSDT screening and does not require significant additional work will be included in the EPSDT visit and should not be billed separately.

Budget Impact: The estimated budget impact, for SFY2023, will be an increase in the total amount of $418,468; with $115,665 in state share. The estimated budget impact, for SFY2024 will be an increase in the total amount of $1,255,404; with $409,513 in state share.

Proposed Emergency Rule Timeline:
Tribal Consultation: Nov. 1, 2022
15-Day Public Comment Period: Nov. 1 – Nov. 16, 2022
OHCA Board Meeting: Jan. 18, 2023
Emergency Rule Requested Effective Date: Contingent upon Governor's approval or the 45th day post submission of the rules to the Governor (Mar. 6, 2023)

APA WF # 22-21A&B Increase Income Standard for Pregnant Women and Extend Postpartum Coverage – The proposed policy revisions will expand Medicaid eligibility for pregnant women by increasing the federal poverty level (FPL) percentage income standard from 133% to 185%, or 210% FPL once converted to MAGI and applying the applicable MAGI disregards. Additionally, the proposed revisions will extend Medicaid postpartum coverage from sixty (60) days to twelve (12) months. This new coverage option afforded through the American Rescue Plan Act was made permanent with the passing of the 2023 Consolidated Appropriations Act.

Budget Impact: The estimated budget impact, for SFY 2023, will be an increase in the total amount of $6,150,000; with $1,509,210 in state share. The estimated budget impact, for SFY 2024, will be an increase in the total amount of $12,300,000; with $4,054,326 in state share.

Proposed Emergency Rule Timeline:
Tribal Consultation: Nov. 1, 2022
15-Day Public Comment Period: Nov. 1 – Nov. 16, 2022
OHCA Board Meeting: Jan. 18, 2023
Emergency Rule Requested Effective Date: Contingent upon Governor's approval or the 45th day post submission of the rules to the Governor (Mar. 6, 2023)

APA WF # 22-22 Ukrainian Humanitarian Parolees – Policy will be updated to comply with Public Law 117-128, which entitles certain Ukrainian nationals who enter the United States, during a designated period of time, to receive SoonerCare services provided all other eligibility factors are met. Ukrainian humanitarian parolees are eligible for the same benefits available to refugees admitted under Section 207 of the Immigration and Nationality Act, except for the program of initial resettlement.

Budget Impact: The estimated budget impact, for SFY 2023, will be an increase in the total amount of $323,915; with $62,517 in state share. The estimated budget impact, for SFY 2024, will be an increase in the total amount of $680,220, with $211,419 in state share.

Proposed Emergency Rule Timeline:

Tribal Consultation: Nov. 1, 2022

15-Day Public Comment Period: Nov. 1 – Nov. 16, 2022

OHCA Board Meeting: Jan. 18, 2023

Emergency Rule Requested Effective Date: Contingent upon Governor's approval or the 45th day post submission of the rules to the Governor (Mar. 6, 2023)

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

SUBCHAPTER 3. GENERAL PROVIDER POLICIES

PART 4. EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT (EPSDT) PROGRAM/CHILD-HEALTH SERVICES

317:30-3-65. Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Program/Child-health Services

Payment is made to eligible providers for Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services on behalf of eligible individuals under the age of twenty-one (21).

(1) The EPSDT program is a comprehensive child-health program, designed to ensure the availability of, and access to, required health care resources and help parents and guardians of Medicaid-eligible children and adolescents use these resources. An effective EPSDT program assures that health problems are diagnosed and treated early before they become more complex and their treatment more costly. The physician plays a significant role in educating parents and guardians about all services available through the EPSDT program. The receipt of an identified EPSDT screening makes the member eligible for all necessary follow-up care that is within the scope of the SoonerCare program. Early and Periodic Screening, Diagnostic and Treatment (EPSDT) covers services, supplies, or equipment that are determined to be medically necessary for a child or adolescent, and which are included within the categories of mandatory and optional services in Section 1905(a) of Title XIX, regardless of whether such services, supplies, or equipment are listed as covered in Oklahoma's Medicaid State Plan.

(2) Federal regulations also 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 or behavioral health illnesses or conditions.

(3) SoonerCare providers who perform EPSDT screenings must assure that the screenings they provide meet the minimum standards established by the Oklahoma Health Care Authority in order to be reimbursed at the level established for EPSDT services.

(4) An EPSDT screening is considered a comprehensive examination. ~~A provider billing SoonerCare for an EPSDT screen may not bill any other Evaluation and Management Current Procedure Terminology (CPT) code for that patient on that same day. It is expected that the screening provider will perform necessary treatment as part of the screening charge. However, there may be other additional diagnostic procedures or treatments not normally considered part of a comprehensive examination, including diagnostic tests and administration of immunizations, required at the time of screening. Additional diagnostic procedures or treatments may be billed independently from the screening. Some services as set out in this section may require prior authorization.~~

(A) If a member is receiving an EPSDT screening and an additional focused complaint arises that requires evaluation and management to address the complaint, the provider may deliver all medically necessary care and submit a claim for both the EPSDT screening and the appropriate level of focused service if the following requirements are met:

(i) The medical issue is significant enough to require additional work to address the issue;

(ii) The visit is documented on a separate note;
(iii) Appropriate documentation that clearly lists the condition being managed at the time of the encounter and supports the billing of both services; and
(iii) Modifier 25 is added to the appropriate code that indicates that a separate evaluation and management service was provided by the same physician on the same day as the EPSDT screening. All claims submitted with Modifier 25 will be reviewed prior to payment, per Oklahoma Administrative Code (OAC) 317:30-3-33. The following items will be reviewed prior to any payment:

(I) Medical necessity;
(II) Appropriate utilization of Modifier 25; and
(III) All documentation to support both the EPSDT screening and the additional evaluation and management for a focused complaint must be submitted for review.

(iv) All claims are subject to a post payment review by the OHCA's Program Integrity Unit.

(B) When providing evaluation and management of a focused complaint, during an EPSDT screening, the provider may claim only the additional time that is required above and beyond the completion of the EPSDT screening.
(C) An insignificant or trivial problem that is encountered in the process of performing the preventive evaluation and management service and does not require additional work is included in the EPSDT visit and should not be billed/reported.

(5) There may be other additional diagnostic procedures or treatments not normally considered part of a comprehensive examination, including diagnostic tests and administration of immunizations, required at the time of screening. Additional diagnostic procedures or treatments may be billed independently from the screening. Some services as set out in this section may require prior authorization.
~~(5)~~(6) For an EPSDT screening to be considered a completed reimbursable service, providers must perform, and document, all required components of the screening examination. Documentation of screening services performed must be retained for future review.
~~(6)~~(7) All comprehensive screenings provided to individuals under age twenty-one (21) must be filed on HCFA-1500 using the appropriate preventive medicine procedure code or an appropriate Evaluation and Management code from the Current Procedural Terminology Manual (CPT) accompanied by the appropriate ~~"V"~~well-child exam diagnosis code.
~~(7)~~(8) For EPSDT services in a school-based setting that are provided pursuant to an IEP, please refer to Part 103, Qualified Schools As Providers Of Health-Related Services, in ~~Oklahoma Administrative Code~~OAC 317:30-5-1020 through 317:30-5-1028.

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

SUBCHAPTER 3. GENERAL PROVIDER POLICIES

PART 3. GENERAL MEDICAL PROGRAM INFORMATION

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

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

(1) Inpatient hospital services.

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

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

(2) Emergency department services.

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

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

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

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

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

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

(9) Maternity clinic services.

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

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

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

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

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

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

(C) Immunizations.

(D) Outpatient care.
(E) Dental services as outlined in OAC 317:30-3-65.8.
(F) Optometrists' services. The EPSDT periodicity schedule provides for at least one (1) visual screening and glasses each twelve (12) months. In addition, payment is made for glasses for children with congenital aphakia or following cataract removal. Interperiodic screenings and glasses at intervals outside the periodicity schedule for optometrists are allowed when a visual condition is suspected. Payment is limited to two (2) glasses per year. Any glasses beyond this limit must be prior authorized and determined to be medically necessary.
(G) Hearing services as outlined in OAC 317:30-3-65.9.
(H) Prescribed drugs.
(I) Outpatient psychological services as outlined in OAC 317:30-5-275 through 317:30-5-278.
(J) Inpatient psychiatric services as outlined in OAC 317:30-5-94 through 317:30-5-97.
(K) Transportation. Provided when necessary in connection with examination or treatment when not otherwise available.
(L) Inpatient hospital services.
(M) Medical supplies, equipment, appliances, orthotics and prosthetics.
(N) EPSDT services furnished in a qualified child health center.

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

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

(16) Medical care and any other type of remedial care recognized under state law, furnished by licensed practitioners within the scope of their practice as defined by state law. See applicable provider section for limitations to covered services for:
(A) Podiatrists' services;
(B) Optometrists' services;
(C) Psychologists' services;
(D) Certified registered nurse anesthetists;
(E) Certified nurse midwives;
(F) Advanced practice registered nurses; and
(G) Anesthesiologist assistants.

(17) Freestanding ambulatory surgery centers.

(18) Prescribed drugs not to exceed a total of six (6) prescriptions with a limit of two (2) brand name prescriptions per month. Exceptions to the six (6) prescription limit are:
(A) Unlimited medically necessary monthly prescriptions for:
(i) Members under the age of twenty-one (21) years; and
(ii) Residents of long-term care facilities or ICF/IID.
(B) Seven (7) medically necessary generic prescriptions per month in addition to the six

(6) covered under the State Plan (including three (3) brand name prescriptions) are allowed for adults receiving services under the 1915(c) home and community-based services (HCBS) waivers. These additional medically necessary prescriptions beyond the three (3) brand name or thirteen (13) total prescriptions are covered with prior authorization.

(19) Rental and/or purchase of medical supplies, equipment, and appliances.

(20) Adaptive equipment, when prior authorized, for members residing in private ICF/IID's.

(21) Dental services for members residing in private ICF/IID's in accordance with the scope of dental services for members under age twenty-one (21).

(22) For non-expansion adults, prosthetic devices are limited to catheters and catheter accessories, colostomy and urostomy bags and accessories, tracheostomy accessories, nerve stimulators, hyperalimentation and accessories, home dialysis equipment and supplies, external breast prostheses and support accessories, oxygen/oxygen concentrator equipment and supplies, respirator or ventilator equipment and supplies, and those devices inserted during the course of a surgical procedure. There is no coverage for orthotic devices for adults.

(23) Orthotics and prosthetics are covered for expansion adult members, above the limitations within (22) of this Section, when prescribed by the treating provider (physician, physician assistant, or an advanced practice registered nurse) and medical necessity is documented in accordance with OAC 317:30-5-211.13.

(24) Standard medical supplies.

(25) Eyeglasses under EPSDT for members under age twenty-one (21). Payment is also made for glasses for children with congenital aphakia or following cataract removal. Payment is limited to two (2) glasses per year. Any glasses beyond this limit must be prior authorized and determined to be medically necessary.

(26) Blood and blood fractions for members when administered on an outpatient basis.

(27) Inpatient services for members age sixty-five (65) or older in institutions for mental diseases, limited to those members whose Medicare, Part A benefits are exhausted for this particular service and/or those members who are not eligible for Medicare services.

(28) Long-term care facility services, limited to members preauthorized and approved by OHCA for such care.

(29) Inpatient psychiatric facility admissions for members are limited to an approved length of stay with provision for requests for extensions.

(30) Transportation and subsistence (room and board) to and from providers of medical services to meet member's needs (ambulance or bus, etc.), to obtain medical treatment.

(31) Extended services for pregnant women including all pregnancy-related and postpartum services to continue to be provided, as though the women were pregnant, for ~~sixty (60) days~~twelve (12) months after the pregnancy ends regardless of the reason, beginning on the last date of pregnancy.

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

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

(34) Medicare Part A, Part B, and Part C deductibles, coinsurance, and copays.

(35) HCBS for the intellectually disabled.

(36) Home health services can be provided without a PA for the first thirty-six (36) visits. A PA will be required beyond the 36th visit. The visits are limited to any combination of RN and nurse aide visits.

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

paragraph:

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

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

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

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

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

(38) HCBS for intellectually disabled members who were determined to be inappropriately placed in a long-term care facility (Alternative Disposition Plan - ADP).

(39) Case management services for the chronically and/or seriously mentally ill.

(40) Emergency medical services, including emergency labor and delivery for undocumented or ineligible aliens.

(41) Services delivered in Federally Qualified Health Centers (FQHCs). Payment is made on an encounter basis.

(42) Early intervention services for children ages zero (0) to three (3).

(43) Residential behavior management in therapeutic foster care setting.

(44) Case management services through the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS).

(45) HCBS for aged or physically disabled members.

(46) Outpatient ambulatory services for members infected with tuberculosis.

(47) Smoking and tobacco use cessation counseling for children and adults.

(48) Services delivered to American Indians/Alaskan Natives (AI/AN) in Indian Health Services, Tribal Programs, and Urban Indian Clinics (I/T/Us). Payment is made on an encounter basis.

(49) OHCA contracts with designated agents to provide disease state management for individuals diagnosed with certain chronic conditions. Disease state management treatments are based on protocols developed using evidence-based guidelines.

(50) Residential substance use disorder (SUD) services.

(51) Medication-assisted treatment (MAT) services.

(52) Diabetes self-management education and support (DSMES).

PART 16. MATERNAL AND INFANT HEALTH LICENSED CLINICAL SOCIAL WORKERS

317:30-5-208. Reimbursement

(a) Maternal and infant health social work services must be billed using appropriate CPT codes and guidelines.

(b) SoonerCare does not allow more than ~~32~~thirty-two (32) units ~~(15 minutes = 1 unit)~~[fifteen (15) minutes = one (1) unit] during the pregnancy which includes ~~60 days~~twelve (12) months postpartum.

(c) LCSWs that are employed by or remunerated by another provider may not bill the SoonerCare program directly for services if that billing would result in duplicate payment for the same service.

(d) Only the LCSW directly performing the care or a county health department may bill the SoonerCare Program.

(e) The time indicated on the claim form must be the time actually spent with the member.

PART 18. GENETIC COUNSELORS

317:30-5-221. Coverage

(a) Genetic counseling services are covered for SoonerCare members who meet the criteria for receiving medically necessary genetic testing as set forth in 317:30-5-2 (a)(1)(FF) and for pregnant/postpartum SoonerCare members as set forth in this section. Services for pregnant/postpartum SoonerCare members must be referred by a provider involved in the provision of obstetric or pediatric care. Members are eligible for genetic counseling during pregnancy which includes ~~sixty (60) days~~twelve (12) months postpartum. Reasons for genetic counseling include but are not limited to the following:

(1) Advanced maternal age;
(2) Abnormal maternal serum first or second screening;
(3) Previous child or current fetus/infant with an abnormality;
(4) Consanguinity/incest;
(5) Parent is a known carrier or has a family history of a genetic condition;
(6) Parent was exposed to a known or suspected reproductive hazard;
(7) Previous fetal demise, stillbirth, or neonatal death involving known/suspected abnormalities;
(8) History of recurrent pregnancy loss; or
(9) Parent(s) are in an ethnic or racial group associated with an increased risk for specific genetic conditions.

(b) These services may be provided in an office or outpatient setting.

317:30-5-222. Reimbursement

(a) Counseling services must be billed using appropriate CPT codes and guidelines and must be medically necessary. SoonerCare does not allow more than six units ~~(30 minutes = 1 unit)~~[thirty (30) minutes = one (1) unit] per pregnancy including ~~60 days~~twelve (12) months postpartum care.

(b) Genetic Counselors who are employed by or remunerated by another provider may not bill the SoonerCare program directly for services if that billing would result in duplicate payment for the same service.

PART 20. LACTATION CONSULTANTS

317:30-5-232. Coverage

Lactation Consultant services are covered for pregnant women and women up to ~~60 days~~twelve (12) months postpartum. SoonerCare members may self-refer or be referred by any provider. Reasons for lactation services include but are not limited to the following:

(1) ~~prenatal~~Prenatal education/training for ~~first time~~first-time mothers;
(2) ~~women~~Women who have not previously breastfed, have a history of breastfeeding difficulty, have identified risk factors for breastfeeding difficulty or lactation insufficiency (e.g., history of breast surgery, infertility, hormonal imbalance, diabetes, obesity);
(3) ~~women~~Women expecting an infant with risk factors for ineffective breastfeeding (e.g., preterm, multiples, congenital birth defects);
(4) ~~latch-on~~Latch-on difficulties;
(5) ~~low~~Low milk supply;
(6) ~~breastfeeding~~Breastfeeding a premature baby (~~36~~thirty-six (36) weeks or less gestation);

(7) ~~breastfeeding~~Breastfeeding multiples; and
(8) ~~a~~A baby with special needs (e.g., Down Syndrome, cleft lip/or palate).

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

SUBCHAPTER 5. ELIGIBILITY AND COUNTABLE INCOME

PART 1. DETERMINATION OF QUALIFYING CATEGORICAL RELATIONSHIP

317:35-5-6. Determining categorical relationship to pregnancy-related services

(a) For applications made prior to January 1, 2014, categorical relationship to pregnancy-related services can be established by determining through medical evidence that the individual is currently or has been pregnant. Pregnancy must be verified by providing medical proof of pregnancy within ~~30~~thirty (30) days of application submission. OKDHS form 08MA005E, Notification of Needed Medical Services, is not required but will be accepted as medical verification. If proof of pregnancy is not provided within ~~30~~thirty (30) days of application submission, SoonerCare benefits will be closed for the pregnant woman at the end of the thirty (30) day period. The expected date of delivery must be established either by information from the applicant's physician or certified nurse midwife or the member's statement.

(b) Effective January 1, 2014, women who are pregnant, including ~~60 days~~twelve (12) months postpartum, are related to the pregnant women group. Pregnancy does not have to be verified unless the declaration that an applicant or member is pregnant is not reasonably compatible with other information available to the agency. The individual must also provide the expected date of delivery.

SUBCHAPTER 6. SOONERCARE FOR PREGNANT WOMEN AND FAMILIES WITH CHILDREN

PART 7. CERTIFICATION, REDETERMINATION, AND NOTIFICATION

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

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

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

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

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

(b) **Certification as a TANF (cash assistance) recipient.** A categorically needy individual who is determined eligible for TANF is certified effective the first day of the month of TANF eligibility.

(c) **Certification of non-cash assistance individuals related to the children and parent and**

caretaker relative groups. The certification period for the individual related to the children or parent and caretaker relative groups is twelve (12) months. The certification period can be less than twelve (12) months if the individual:

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

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

(3) Becomes ineligible for SoonerCare after the initial month; or

(4) Becomes financially ineligible.

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

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

(d) **Certification of individuals related to pregnancy-related services.** The certification period for the individual related to pregnancy-related services will cover the prenatal, delivery and postpartum periods. The postpartum period is defined as the ~~two (2)~~twelve (12) months following the month the pregnancy ends. Financial eligibility is based on the income received in the first month of the certification period. No consideration is given to changes in income after certification.

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

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

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

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

(A) ~~loses~~Loses Oklahoma residence; or

(B) ~~expires~~Expires.

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

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

SUBCHAPTER 5. ELIGIBILITY AND COUNTABLE INCOME

PART 3. NON-MEDICAL ELIGIBILITY REQUIREMENTS

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

(a) **Citizenship/noncitizen status and identity verification requirements.** Verification of citizenship/noncitizen status and identity is required for all adults and children approved for SoonerCare. An exception is individuals who are initially eligible for SoonerCare as deemed newborns; according to Section 1903(x) of the Social Security Act, they will not be required to further document citizenship or identity at any subsequent SoonerCare eligibility redetermination. They are considered to have provided satisfactory documentation of citizenship and identity by virtue of being born in the United States.

(1) The types of acceptable evidence that verify identity and citizenship include:

(A) United States (U.S.) passport;

(B) Certificate of Naturalization issued by U.S. Citizenship & Immigration Services (USCIS)(Form N-550 or N-570);

(C) Certificate of Citizenship issued by USCIS (Form N-560 or N-561);

(D) Copy of the Medicare card or printout of a Beneficiary Earnings and Data Exchange (BENDEX) or State Data Exchange (SDX) screen showing receipt of Medicare benefits, Supplemental Security Income or disability benefits from the Social Security Administration; or

(E) Tribal membership card or Certificate of Degree of Indian Blood (CDIB) card, with a photograph of the individual.

(2) The types of acceptable evidence that verify citizenship but require additional steps to obtain satisfactory evidence of identity are listed in subparagraphs (A) and (B). Subparagraph (A) lists the most reliable forms of verification and is to be used before using items listed in (B). Subparagraph (B) lists those verifications that are less reliable forms of verification and are used only when the items in (A) are not attainable.

(A) Most reliable forms of citizenship verification are:

(i) A U.S. public Birth Certificate showing birth in one (1) of the fifty (50) states, the District of Columbia, Puerto Rico (on or after 1/13/1941), Guam (on or after 4/10/1899), the U.S. Virgin Islands (on or after 1/17/1917), American Samoa, Swain's Island, or the Northern Mariana Islands after 11/4/1986. For Puerto Ricans whose eligibility is being determined for the first time on or after October 1, 2010 and using a birth certificate to verify citizenship, the birth certificate must be a certified birth certificate issued by Puerto Rico on or after July 1, 2010;

(ii) A Consular Report of Birth Abroad of a U.S. citizen issued by the Department of Homeland Security or a Certification of Birth issued by the State Department (Form FS-240, FS-545 or DS-1350);

(iii) A U.S. Citizen Identification Card (Form I-179 or I-197);

(iv) A Northern Mariana Identification Card (Form I-873) (Issued by the former INS to a collectively naturalized citizen of the U.S. who was born in the Northern Mariana Islands before 11/3/1986);

(v) An American Indian Card issued by the Department of Homeland Security with the classification code "KIC" (Form I-872);
(vi) A final adoption decree showing the child's name and U.S. place of birth;
(vii) Evidence of U.S. Civil Service employment before 6/1/1976;
(viii) An Official U.S. Military Record of Service showing a U.S. place of birth (for example a DD-214);
(ix) Tribal membership card or Certificate of Degree of Indian Blood (CDIB) card, without a photograph of the individual, for Native Americans;
(x) Oklahoma voter registration card;
(xi) Other acceptable documentation as approved by OHCA; or
(xii) Other acceptable documentation to the same extent as described and communicated by the United States Citizenship and Immigration Service (USCIS) from time to time.

(B) Other less reliable forms of citizenship verification are:

(i) An extract of a hospital record on hospital letterhead established at the time of the person's birth that was created five (5) years before the initial application date and that indicates a U.S. place of birth. For children under sixteen (16) the evidence must have been created near the time of birth or five (5) years before the date of application;
(ii) Life, health, or other insurance record showing a U.S. place of birth that was created at least five (5) years before the initial application date and that indicates a U.S. place of birth;
(iii) Federal or state census record showing U.S. citizenship or a U.S. place of birth (generally for persons born 1900 through 1950). The census record must also show the applicant's/member's age; or
(iv) One (1) of the following items that show a U.S. place of birth and was created at least five (5) years before the application for SoonerCare. This evidence must be one (1) of the following and show a U.S. place of birth:

(I) Seneca Indian tribal census record;
(II) Bureau of Indian Affairs tribal census records of the Navajo Indians;
(III) U.S. State Vital Statistics official notification of birth registration;
(IV) An amended U.S. public birth record that is amended more than five (5) years after the person's birth; or
(V) Statement signed by the physician or midwife who was in attendance at the time of birth.

(3) Acceptable evidence of identity that must accompany citizenship evidence listed in (A) and (B) of paragraph (2) of this subsection includes:

(A) A driver's license issued by a U.S. state or territory with either a photograph of the individual or other identifying information such as name, age, sex, race, height, weight, or eye color;
(B) A school identification card with a photograph of the individual;
(C) An identification card issued by federal, state, or local government with the same information included on driver's licenses;
(D) A U.S. military card or draft record;
(E) A U.S. military dependent's identification card;
(F) A Native American Tribal document including Certificate of Degree of Indian Blood, or other U.S. American Indian/Alaska Native Tribal document with a photograph of the individual or other personal identifying information;

(G) A U.S. Coast Guard Merchant Mariner card;
(H) A state court order placing a child in custody as reported by the OKDHS;
(I) For children under sixteen (16), school records may include nursery or daycare records;
(J) If none of the verification items on the list are available, an affidavit may be used for children under sixteen (16). An affidavit is only acceptable if it is signed under penalty of perjury by a parent or guardian stating the date and place of the birth of the child and cannot be used if an affidavit for citizenship was provided.

(b) **Reasonable opportunity to obtain verification.**

(1) The state provides Medicaid to citizens and nationals of the United States and certain noncitizens, including during a reasonable opportunity period pending verification of citizenship, national status, or immigrations status. The reasonable opportunity period begins on the date the notice of reasonable opportunity is received by the individual and extends at minimum ninety (90) days. Receipt by the individual is deemed to occur five (5) days after the date on the notice, unless the individual shows that the notice was not received in the five-day period. The state provides an extension of the reasonable opportunity period if the individual subject to verification is making a good faith effort to resolve any inconsistencies or obtain any necessary documentation, or the state needs more time to complete the verification process. The state begins to furnish benefits to otherwise eligible individuals on the date of application containing the declaration of citizenship or immigration status and throughout the reasonable opportunity period.
(2) The following methods of verification are the least reliable forms of verification and should only be used as a last resort:

(A) Institutional admission papers from a nursing facility, skilled care facility or other institution. Admission papers generally show biographical information for the person including place of birth; the record can be used to establish U.S. citizenship when it shows a U.S. place of birth;
(B) Medical (clinic, doctor, or hospital) record created at least five (5) years before the initial application date that indicates a U.S. place of birth. For children under the age of sixteen (16), the document must have been created near the time of birth. Medical records generally show biographical information for the person including place of birth; the record can be used to establish U.S. citizenship when it shows a U.S. place of birth. An immunization record is not considered a medical record for purposes of establishing U.S. citizenship;
(C) Written affidavit. Affidavits are only used in rare circumstances. If the verification requirements need to be met through affidavits, the following rules apply:

(i) There must be at least two (2) affidavits by two (2) individuals who have personal knowledge of the event(s) establishing the applicant's/member's claim of citizenship;
(ii) At least one (1) of the individuals making the affidavit cannot be related to the applicant/member;
(iii) In order for the affidavit to be acceptable, the persons making them must be able to provide proof of their own citizenship and identity;
(iv) If the individual(s) making the affidavit has information which explains why evidence establishing the applicant's/member's claim of citizenship does not exist or cannot be readily obtained, the affidavit must contain this information as well;
(v) The State must obtain a separate affidavit from the applicant/member or other knowledgeable individual (guardian or representative) explaining why the evidence does not exist or cannot be obtained; and

(vi) The affidavits must be signed under penalty of perjury.

(c) **Noncitizen eligibility.** SoonerCare services are provided as described to the defined groups as indicated in this subsection if they meet all other factors of eligibility, including but not limited to residency requirements, and if the relevant noncitizen status is verifiable by federally approved means.

(1) **Unauthorized resident noncitizen.** An unauthorized resident noncitizen is a foreign-born individual who is not lawfully present in the United States, regardless of having had authorization during a prior period. Unauthorized resident noncitizens have formerly been known as "illegal" or "undocumented" immigrants or "aliens". Per 8 U.S.C. 1611(a) and (b)(1)(A) an unauthorized resident noncitizen is ineligible for Title XIX Medicaid benefits except for emergency Medicaid as defined at subparagraph (e) below. However, an unauthorized resident noncitizen who is pregnant is eligible for benefits under Title XXI separate Children's Health Insurance Program (CHIP) for services that benefit the unborn child, if the unborn child meets all eligibility requirements.

(2) **Authorized resident noncitizen, not qualified.** An authorized resident noncitizen is a foreign-born individual who is lawfully present in the United States (U.S.) and is lawfully residing in the U.S., but who does not meet the definition of qualified noncitizen, per 8 U.S.C. 1611(a) and (b)(1)(A). The Oklahoma Medicaid program does not exercise the CHIPRA 214 option; therefore, an authorized resident noncitizen is ineligible for Title XIX or Title XXI Medicaid benefits except for emergency Medicaid as defined at subparagraph (e) below. However, an authorized resident noncitizen who is pregnant is eligible for benefits under Title XXI separate CHIP for services that benefit the unborn child, if the unborn child meets all eligibility requirements.

(3) **Qualified noncitizen.** A "qualified noncitizen" is an authorized resident noncitizen who, at the time of applying for Medicaid, has a "qualified noncitizen" immigration status as identified at 8 U.S.C. 1641, as may be amended from time to time. Any qualified noncitizen is eligible for full Title XIX Medicaid benefits after a five-year waiting period beginning on the date of the noncitizen's entry into the U.S. with an immigration status identified as "qualified noncitizen" if the noncitizen meets all other eligibility criteria at the end of the waiting period. During the waiting period, as per 8 U.S.C. 1613(a), any qualified noncitizen is eligible to receive emergency Medicaid as described in subparagraph (e) below if the noncitizen meets all other eligibility requirements, including but not limited to residency requirements.

(A) **Qualified noncitizen immigration statuses.** Immigration statuses identified by federal law as "qualified noncitizen", as of November 2, 2021, include:

(i) A noncitizen who is lawfully admitted for permanent residence under the Immigration and Nationality Act [INA], per 8 U.S.C. 1101 et seq.;

(ii) A noncitizen who is granted asylum under INA section 208, per 8 U.S.C. 1158;

(iii) A noncitizen who is admitted to the U.S. under INA section 207 refugee, per 8 U.S.C. 1157;

(iv) A noncitizen who is paroled into the U.S. under INA section 212(d)(5), per 8 U.S.C. 1182(d)(5), for a period of at least one (1) year;

(v) A noncitizen whose deportation is being withheld under INA section 243(h), per 8 U.S.C. 1253 (as in effect immediately before the effective date of section 307 of division C of Public Law 104B208) or section 241(b)(3) of such Act, per 8 U.S.C. 1231(b)(3) (as amended by section 305(a) of division C of Public Law 104B208);

(vi) A noncitizen who is granted conditional entry before 1980 pursuant to INA section 203(a)(7), per 8 U.S.C. 1153(a)(7), as in effect prior to April 1, 1980;

(vii) A noncitizen who is a Cuban and Haitian entrant (as defined in section 501(e) of the Refugee Education Assistance Act of 1980);

(viii) A noncitizen who, or whose parent or child, has been battered or subjected to extreme cruelty in the U.S. by a U.S. citizen or lawful permanent resident spouse or parent or by a member of the spouse's or parent's family residing in the same household, except during any period in which the individual responsible for such battery or cruelty resides in the same household or family eligibility unit as the individual subjected to such battery or cruelty and only when the alien meets all of the following requirements:

(I) The noncitizen, if not the individual subjected to battery or extreme cruelty, had no active participation in the battery or cruelty;

(II) The noncitizen is a credible victim; and

(III) The noncitizen is able to show a substantial connection between the need for benefits sought and the batter or extreme cruelty; and

(IV) The noncitizen has been approved or has a petition pending which sets forth a prima facie case for one of the following: status as a spouse or child of a U.S. citizen under INA 204(a)(1)(A); classification under INA 204(a)(1)(B)(ii) or (iii); suspension of deportation under INA 244(a)(3); status as a spouse or child of a U.S. citizen under INA 204(a)(1)(A); or classification under INA 204(a)(1)(B); or cancellation of removal under INA 240A(b)(2).

(ix) A noncitizen who is or has been a victim of a severe form of trafficking in persons and who has been granted nonimmigrant status under INA 101(a)(15)(T) or who has a pending application that sets forth a prima facie case for eligibility for such immigration status; or

(x) Beginning December 27, 2020, a noncitizen who lawfully resides in the state in accordance with the Compacts of Free Association between the Government of the United States and the Governments of the Federated States of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau.

(B) **Five-year wait exception for refugees and asylees.**

(i) Excepted from the five-year waiting period per 8 U.S.C. 1612(b)(2)(A), the following qualified noncitizens are immediately eligible for a Medicaid determination upon the date:

(I) A noncitizen is admitted to the U.S. as a refugee under INA section 207 [INA 207 Refugee], per 8 U.S.C. 1157;

(II) A noncitizen is granted asylum under INA section 208, per 8 U.S.C. 1158;

(III) A noncitizen's deportation is withheld under INA section 243(h), per 8 U.S.C. 1253 (as in effect immediately before the effective date of section 307 of division C of Public Law 104B208) or section 241(b)(3) of such Act, per 8 U.S.C. 1231(b)(3) (as amended by section 305(a) of division C of Public Law 104B208);

(IV) A noncitizen is granted status as a Cuban and Haitian entrant (as defined in section 501(e) of the Refugee Education Assistance Act of 1980); or

(V) A noncitizen is admitted to the U.S. as an Amerasian immigrant under the Foreign Operations, Export Financing, and Related Programs Appropriations Act, 1988, section 584.

(ii) This exception to the five-year waiting period expires seven (7) years after the date of action indicated in the list at (c)(3)(B)(i) above. Upon expiration of the exception, the five-year waiting period must be calculated.

(C) **Five-year wait exception for certain permanent resident noncitizens.** The five-year waiting period does not apply and the noncitizen is immediately eligible for a Medicaid determination per 8 U.S.C. 1612(b)(2)(B), if:

(i)_The noncitizen is lawfully admitted to the U.S. for permanent residence;

(ii) The noncitizen has either:

(I) worked forty (40) qualifying quarters of coverage as defined under the Act; or

(II) can be credited with such qualifying quarters as provided under 8 U.S.C. 1645; and

(iii) In the case of any such qualifying quarters creditable for any period beginning after December 31, 1996, the noncitizen did not receive any federal means-tested public benefit during any such period.

(D) **Five-year wait exception for veteran and active-duty noncitizens.** As per 8 U.S.C. 1612(b)(2)(C) and 1613, the five-year waiting period does not apply, and the noncitizen is immediately eligible for a Medicaid determination if the noncitizen is a qualified noncitizen who is lawfully residing in the state and is:

(i) A veteran (as defined at INA sections 101, 1101, or 1301, or as described at 38 U.S.C. section 107) with a discharge characterized as an honorable discharge and not on account of noncitizenship and who fulfills the minimum active-duty service requirements of 38 U.S.C. section 5303A(d);

(ii) On active duty (other than active duty for training) in the Armed Forces of the United States; or

(iii) The spouse or unmarried dependent child of an individual described herein as a veteran or active-duty noncitizen; or

(iv) The unremarried surviving spouse of an individual described herein as a veteran or active-duty noncitizen who is deceased, if the marriage fulfills the requirements of 38 U.S.C. section 1304.

(E) **Five-year wait exception for COFA migrants.** Per 8 U.S.C. 1613(b)(3) and as of December 27, 2020, any noncitizen who lawfully resides in the state in accordance with the Compacts of Free Association between the Government of the United States and the Governments of the Federated States of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau is, with regard to the Medicaid program, are not subject to the five-year waiting period unless and until the individual=s status is adjusted to lawful permanent resident (LPR), at which time the five year waiting period must be calculated, unless the individual meets a separate exception to the five-year waiting period:

(i) If the individual entered the U.S. before December 27, 2020, and the date of adjustment to LPR status occurred before December 27, 2020, then the waiting period begins on the date of adjustment and ends after five (5) years;

(ii) If the individual entered the U.S. before December 27, 2020, and the date of adjustment to LPR status occurred after December 27, 2020, the waiting period expires on December 27, 2025; and

(iii) If the individual entered the U.S. after December 27, 2020, and the date of adjustment to LPR status occurred after December 27, 2020, the waiting period begins on the date of entry into the U.S. and ends after five (5) years.

(F) **Five-year wait exception for qualified noncitizens receiving SSI.** Per 8 U.S.C. 1612(b)(2)(F), a qualified noncitizen who is receiving benefits under the supplemental security income program (SSI) under Title XVI of the Act shall be eligible for medical assistance under a state plan under Title XIX of the Social Security Act, per 42 U.S.C. 1396 et seq), under the same terms and conditions that apply to other recipients of SSI benefits.

(4) **Special categories of noncitizens and conferred benefits.** For the following noncitizens, federal law has expressly authorized Title XIX Medicaid benefits as described below and at law.

(A) **Certain American Indian / Alaskan Native (AI/AN) noncitizens.** The qualified noncitizen requirement and the five-year waiting period do not apply to any individual who is:

(i) An American Indian born in Canada to whom section 289 of the Immigration and Nationality Act apply, per 8 U.S.C. 1359; or

(ii) A member of a federally recognized Indian tribe as defined at 25 U.S.C. 450b(e).

(B) **Certain Iraqi nationals.**

(i) Public Law 110-181, Section 1244, while in force and as amended from time to time, created a new category of special immigrant for Iraqi nationals, including:

(I) Principal noncitizens who have provided relevant service to the U.S. government, while employed by or on behalf of the U.S. government in Iraq, for not less than 1 year beginning on or after March 20, 2003, and who have experienced or are experiencing an ongoing serious threat as a consequence of that employment; (II) The spouse or surviving spouse of a principal noncitizen; and

(III) The child of a principal noncitizen.

(ii) Public Law 111-118, Section 8120, while in force and as amended from time to time, extended Iraqi special immigrant eligibility for medical assistance to the same extent as INA 207 Refugees are eligible for medical assistance [see subparagraph (c)(3)(B) above] as of December 19, 2009.

(iii) As of August 3, 2021, pursuant to the Office of Refugee Resettlement Policy Letter 21-07, while in force and as may be amended, Iraqi nationals granted special immigrant parole, noncitizens with applications pending for special immigrant status, are also eligible for medical assistance to the same extent as INA 207 Refugees are eligible for medical assistance [see subparagraph (c)(3)(B) above];

(C) **Certain Afghan nationals.**

(i) Public Law 111-8, Section 602, while in force and as amended from time to time, created a new category of special immigrant for Afghan nationals, including:

(I) Principal noncitizens who have provided relevant service to the U.S. government or the International Security Assistance Force, while employed by or on behalf of the U.S. government in Afghan, for not less than one (1) year beginning on or after October 7, 2001, and who have experienced or are experiencing an ongoing serious threat as a consequence of that employment;

(II) The spouse or surviving spouse of a principal noncitizen; and

(III) The child of a principal noncitizen.

(ii) Public Law 111-118, Section 8120, while in force and as amended from time to time, amended Public Law 111-8, Section 602, to extend Afghan special immigrant eligibility for medical assistance to the same extent as INA 207 Refugees are eligible

for medical assistance [see subparagraph (c)(3)(B) above] as of December 19, 2009;
(iii) As of August 3, 2021, pursuant to the Office of Refugee Resettlement Policy Letter 21-07, while in force and as may be amended, Afghan nationals granted special immigrant parole, noncitizens with applications pending for special immigrant status, are also eligible for medical assistance to the same extent as INA 207 Refugees are eligible for medical assistance [see subparagraph (c)(3)(B) above];
(iv) Pursuant to Public Law 117-43, Section 2502, while in force and as may be amended from time to time, "applicable individuals" have time-limited eligibility for medical assistance to the same extent as INA 207 Refugees are eligible for medical assistance [See subsection (c)(3)(B) above], until March 21, 2023, or the term of parole, whichever is later. In this subparagraph, the term "applicable individual" includes only:

(I) A citizen or national of Afghanistan or a person with no nationality who last habitually resided in Afghanistan, if the individual is paroled into the U.S. between July 31, 2021, and September 30, 2022;
(II) The spouse or child of an individual described at (c)(3)(C)(iv)(I) of this section, if the spouse or child is paroled into the U.S. after September 30, 2022; and
(III) The parent or legal guardian of an individual described at (c)(3)(C)(iv)(I) who is determined to be an unaccompanied child, if the parent or legal guardian is paroled into the U.S. after September 30, 2022.

(D) **Certain Ukrainian nationals**

(i) Public Law 117-128, Section 401, while in force and as amended from time to time, created a new category of special immigrant for Ukraine nationals, including:

(I) A citizen or national of Ukraine, or a person who last habitually resided in Ukraine, who was paroled into the United States between February 24, 2022 and September 30, 2023; or
(II) A citizen or national of Ukraine, or a person who last habitually resided in Ukraine, who was paroled into the United States after September 30, 2023, and is the spouse or child of an individual described in (D)(i)(I) above, or is the parent, legal guardian, or primary caregiver of an individual described in (D)(i)(I) above who is determined to be an unaccompanied child; and
(III) The individual's parole has not been terminated by the Secretary of Homeland Security.

(d) **Continuing conformance with federal law.** Notwithstanding any other provision of this section, any noncitizen population that federal law or authority, as amended from time to time, identifies as eligible for medical assistance under Title XIX is eligible for such benefits to the same extent, under the same conditions, and for the same period of time as indicated in the relevant federal law or official federal guidance documents, including any amendments to the law or guidance.

(e) **Emergency Medicaid.** Emergency Medicaid in this section means medical assistance provided to a noncitizen under Title XIX for care and services that are necessary for the treatment of an emergency medical condition, as defined by section 1903(v)(3) of the Act and including labor and delivery but not related to organ transplant procedure, of the noncitizen involved if the noncitizen otherwise meets eligibility requirements for medical assistance under the state plan, including but not limited to residency requirements.