OKLAHOMA HEALTH CARE AUTHORITY
AMENDED BOARD MEETING
June 30, 2020 at 3:00 P.M.
Oklahoma Health Care Authority
Videoconference

A G E N D A

This meeting will occur via videoconference, but certain parties, including CEO Corbett, Chair Hupfeld, and OHCA staff, will be present at the OHCA building at 4345 N. Lincoln Blvd., Oklahoma City, OK 73105. All other OHCA Board members will participate in the videoconference from a remote location.

Videoconference Participants

Stanley Hupfeld – Zoom videoconference
Alex Yaffe – Zoom videoconference
Robert Boyd – Zoom videoconference
Tanya Case – Zoom videoconference
Jean Hausheer, M.D. – Zoom videoconference
Philip Kennedy – Zoom videoconference
Randy Curry, D. Ph. – Zoom videoconference
Laura Shamblin, M.D. – Zoom videoconference

Public access via Zoom:
https://okhca.zoom.us/webinar/register/WN_7uIAzauSRyyO0WEl3Rq3dg
Telephone: 1-669-900-6833 Meeting ID: 973 4151 1117

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

2. Consent Agenda……..Stan Hupfeld, Chair

    a) Approval of the May 18, 2020 OHCA Board Meeting Minutes(Attachment “A”)
    b) Approval of State Plan Amendment Rate Committee Rates (Attachment “B”)

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

    a) Presentation by Joe Moser, Health Management Associates

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

5. Chief Operating Officer’s Report……....Melody Anthony, Chief Operating Officer
   (Attachment “C”) State Medicaid Director

6. Discussion of Report from the Legislative……...…….Alex Yaffe
   Advisory Committee Chair, Legislative Advisory Committee

7. Discussion of Report from the……...……..Phil Kennedy
   Compliance Advisory Committee and Chair, Compliance Advisory Committee
   Possible Action Regarding State Fiscal Year
   2021 Budget Work Program

    a) Presentation of SFY 2021 Budget Work Program by Aaron Morris, Chief Financial Officer (Attachment “D”)
    b) Consideration and Vote on SFY 2021 Budget Work Program

8. Discussion of Report of Administrative……..……..…….....Jean Hausheer, M.D.

Rules Advisory Committee and Possible Action Regarding Agency Rulemaking (Attachment "E") — Chair, Administrative Rules Advisory Committee

a) Consideration and Vote on a Declaration of a Compelling Public Interest for the Promulgation of the Emergency Rules in Attachment "A" in Accordance with 75 O.S. § 253.

b) Consideration and Vote on Agency Recommended Rulemaking Pursuant to Article I of the Administrative Procedures Act. OHCA Requests the Adoption of the Following Emergency Rules (see Attachment "A") for the purpose of removal of reference to previously anticipated July 2020 expansion:

i. **APA WF # 20-06A Durable Medical Equipment (DME) and Supplies Benefit Moved under the Scope of the Home Health Benefit —** ADDING agency rules at ***OAC 317:30-5-211.20, 317:30-5-211.21, 317:30-5-211.22, 317:30-5-211.23, 317:30-5-211.24, 317:30-5-211.25, 317:30-5-211.26, 317:30-5-211.27,*** and ***317:30-5-211.28*****;** AMENDING agency rules at ***OAC 317:30-3-40, 317:30-3-57, 317:30-3-59, 317:30-5-42.16, 317:30-5-42.17, 317:30-5-133.1, 317:30-5-210, 317:30-5-210.1, 317:30-5-210.2, 317:30-5-211.1, 317:30-5-211.2, 317:30-5-211.3, 317:30-5-211.5, 317:30-5-211.6, 317:30-5-211.10, 317:30-5-211.12, 317:30-5-211.13, 317:30-5-211.14, 317:30-5-211.15, 317:30-5-211.16, 317:30-5-211.17, 317:30-5-218, 317:30-5-545, 317:30-5-546, 317:30-5-547,*** and ***317:30-5-548*****;** REVOKING agency rules at ***OAC 317:30-5-133.2, 317:30-5-211.9, 317:30-5-216,*** and ***317:30-5-549***

ii. **APA WF # 20-06B Durable Medical Equipment (DME) and Supplies Benefit Moved under the Scope of the Home Health Benefit —** AMENDING agency rules at ***OAC 317:35-18-6***

iii. **APA WF # 20-06C Durable Medical Equipment (DME) and Supplies Benefit Moved under the Scope of the Home Health Benefit —** AMENDING agency rules at ***OAC 317:40-5-104***

iv. **APA WF # 20-06D Durable Medical Equipment (DME) and Supplies Benefit Moved under the Scope of the Home Health Benefit —** AMENDING agency rules at ***OAC 317:50-1-14***

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

a) Consideration and Vote on Recommendations Made by the Drug Utilization Review Board Pursuant to 63 O.S. § 5030.3 To Add the Following Drugs to the Utilization and Scope Prior Authorization Program under OAC 317:30-5-77.2(e) (Attachment "F"):

i. Tepezza™ (Teprotumumab-trbw)
ii. Mayzent® (Siponimod), Mavenclad® (Cladribine), and Vumerity™ (Diroximel Fumarate)
iii. Aliqopa™ (Copanlisib), Brukinsa™ (Zanubrutinib), Polivy™ (Polatuzumab Vedotin-piiq), and Ruxience™ (Rituximab-pvvr)
iv. Ayvakit™ (Avapritinib), Bynfezia Pen™ (Octreotide), and Tazverik™ (Tazemetostat)
v. Pemfexy™ (Pemetrexed), Rozlytrek® (Entrectinib), and Zirabev™ (Bevacizumab-bvzr)
vi. Ziextenzo®(Pegfilgrastim-bmez)
vii. Palforzia™ (Peanut Allergen Powder-dnfp)
viii. Nourianz™ (Istradefylline Tablet

10. Adjournment……Stan Hupfeld, Chair

NEXT BOARD MEETING
September 16, 2020
TBD

Attachment A

MINUTES OF AN AMENDED BOARD MEETING
OF THE HEALTH CARE AUTHORITY BOARD
May 18, 2020
Oklahoma Health Care Authority Boardroom
Oklahoma City, Oklahoma

Manner and Time of Notice of Meeting: A statutorily required public meeting notice was placed on the front door of the Oklahoma Health Care Authority on May 15, 2020 at 2:45 p.m. Advance public meeting notice was provided to the Oklahoma Secretary of State. In addition to the posting of the statutory public notice, the agency placed its agenda on its website on May 15, 2020 at 2:45 p.m.

Pursuant to a roll call of the members, a quorum was declared to be present, and Chairman Hupfeld called the meeting to order at 3:04 p.m.

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

OTHERS PRESENT:

Victor Clay
Deirdre Flannery, Quest Diagnostics
Sandra Puebla, OHCA
Rhonda Petr, AmeriHealth Caritas
Adolph Maren, OHCA
Tara McKinley
Terry McCurre
Rebecca Cochran, OHCA
Tracy O'Shannon, OHCA
Melanie Lawrence, OHCA
Stephanie Mavredes, OHCA
Carolyn Reconnu-Shoffner, OHCA
Jesse Schroeder, Preferred Pediatrics
Fred Mensah, OHCA
Rep. Marilyn Stark
Matt Robison, OKMed
DeAnn Garrison,
Rep. Chad Caldwell
Tyler Talley, eCapitol
Aaron Morris, OHCA
David Kendrick
Will Robinson, Oklahoma Senate
Holly Rictor, OHCA
April Anonsen, OHCA
Kyle Janzen, OHCA
Jane Doss
Traylor Rains, OHCA
Mike Herndon, OHCA
Emily Crouch, OK State Chamber
Ryan Kilpatrick, FKG Consulting

OTHERS PRESENT:

Matt Glanville
Brent Wilborn, OKPCA
Natasha Kester, OHCA
Vanessa Andrade, OHCA
Paula Root, OHCA
Audrey Renegar, FKG Consulting
Kristin Pease, OHCA
Sasha Teel, OHCA
Ellen Buettner, OHCA
Fred Oraene, OHCA
Tonya McCallister, OSDH
Julie Whitworth, OKDHS
Rick Snyder, OHA
Melinda Thomason, OHCA
Karen Beam, OHCA
Brandice Walters
Harvey Reynolds, OHCA
Dennis Hogle, Quest Diagnostics
Katie Roberts, Stillwater Medical
Andy Garnand, OHCA
Jill Daugherty, Chickasaw Nation
Katelynn Burns, OHCA
Trish Harland, OHCA
Brett May, OHCA
Jonathan Cannon, OHCA
Sara Barry, OKPCA
Josh Richards, OHCA
Melody Anthony, OHCA
Nathan Valentine, OHCA
Julia Jernigan-Smith, Creative Capitol Strategies

OTHERS PRESENT:

Terry Cothran, OHCA
Audrey Rattan
Shawn Ashley, eCapitol
Wanda Furney, OKDHS
Karen Luce, OHCA
Gloria Eldridge
Josh Bouye, OHCA
Della Gregg, OHCA
Trae Rahill, OHCA
Rep. Marcus McEntire
Craig Douglas
John Gallagher
Erica Cook
Rebecca Williamson
Cheri Berry, OHCA
Nima Nabavi
Larry Dalton
Kimberly Wilson, OHCA
Christina Foss, OHCA
Susan Geyer, OHCA
Larry Jantzen
Miguel Soto, BCBS
Jill Ratterman, OHCA
Shelly Patterson, OHCA
Jimmy Witcosky, OHCA
Maria Maule, OHCA
Derek Lieser, OHCA
Beverly Murray, OKDHS
Miranda Kieffer, OKDHS

ITEM 2 / COMMENTS FROM THE SECRETARY OF HEALTH AND MENTAL HEALTH SERVICES
Jerome Loughridge, Secretary of Health and Mental Health Services

Secretary Loughridge expressed his thanks to the board and OHCA staff for all their hard work and for the work that is to come and provided a COVID-19 update.

COVID-19 Update: Based on data modeling, Oklahoma anticipated tens to hundreds of thousands of cases. As of May 18, Oklahoma has just under 5,400 positive cases and will increase, as testing increases. The first ten days, subsequent to Oklahoma's first case, there were timing issues with testing. Dr. Kasey Shrum led the effort, that eventuated in OSU's

Veterinary Science Center and their high throughput testing capabilities geared toward animal pandemics to solve the State's testing issues. Currently, Oklahoma ranks in the top 10 per capita for PCR testing. In the beginning, the state's personal protective equipment (PPE) stock was low, with only enough for 36 hours. After reaching out to those in the oil field and those oversees, the state now has three weeks' worth of PPE. A robust hospital surge plan was developed that established two COVID specific centers, Oklahoma State University in Tulsa and Integris Deaconess in Oklahoma City. Phase 1 of reopening the state began on May 1st. Key indicators used by Oklahoma include: percentage positives, hospital capacity, and number of deaths. To date, data shows that Oklahoma has flattened the curve.

ITEM 3 / PUBLIC COMMENT ON THIS MEETING'S AGENDA ITEMS BY ATTENDEES WHO GAVE 24 HOUR PRIOR WRITTEN NOTICE
Stanley Hupfeld, OHCA Board Chairman

Speakers:

- DeAnn Garrison
- Victor Clay – Mr. Clay's comments were read into the record by Ms. Maria Maule
- Larry Dalton
- Katie Roberts

ITEM 4 / DISCUSSION AND POSSIBLE VOTE ON APPROVAL OF CONSENT AGENDA WHICH INCLUDES:

a) Approval of the Minutes from March 30, 2020 OHCA board meeting
b) Approval of Expenditure of Funds Contracts
    i. Arine
    ii. Population Care Management System

MOTION:	Member Hausheer moved for approval of the items A and Bi-ii listed in the Consent Agenda, as published. The motion was seconded by Member Kennedy.
FOR THE MOTION:	Chairman Hupfeld, Vice-Chairman Yaffe, Member Case, Member Curry, Member Nuttle, Member Shamblin
ABSTAINED:	Member Boyd

ITEM 5 / CHIEF EXECUTIVE OFFICER'S REPORT
Kevin Corbett, Chief Executive Officer

Mr. Corbett thanked Secretary Loughridge for his health response update and kind words to the agency.

Agency Update: There have been no positive COVID cases at OHCA. OHCA received 300 laptops to make all employees mobile. Staff are in the process of creating provisioning process for those. It is the intent of IT staff to get those distributed to staff by mid-June to create sustainable mobility. Constant communication has been maintained by hosting weekly town hall meetings with all agency staff. As an executive team, a commitment to huddle on a daily basis to understand within each team, members, and providers. At this time, the agency is not ready to announce a broad return to the office; however when the time comes to return, it will be phased in.

COVID-19 Impacts: OHCA has been monitoring activity on a daily basis. Activities have been less than normal. Claims activity have been down over the last 7-9 weeks. As anticipated, there has been an increase of 30,000 members. The enhanced FMAP required that no members be dis-enrolled members during pandemic. The 30,000 additional members is on top of maintain membership. Call volumes are down by 20%, but answer times have improved. Prior authorizations requests are down, but at the same time, response times have been maintained. ER visits are down by 50%. Telehealth visits were at 10,000 uses prior to COVID and are now at over 200,000 uses. Since the March board meeting, OHCA has been in dialogue with providers to better understand the impact, as well as the sources of support including the support from the agency that might be available. OHCA continues to follow the actions taken at the federal level to provide financial and regulatory assistance and relief for providers, members and employees. The Family Response Act provided a temporary 6.2% increase in Medicaid matching rates beginning in January 1, 2020. The first quarter payment was received and don't anticipate challenges with the second payment. There are attempts underway to increase the FMAP to a higher percentage match. Most of the dollars being funded are difficult to track, as they are sent directly to providers without going through a clearinghouse. Overall, OHCA estimate $1.5-$1.8 billion in health care funding that has been received in the state. $50 billion was distributed in April, proportionate to a provider share of Medicare fee for service

reimbursements in 2019. The COVID-19 high impact allocation was given to specific hospitals that provided inpatient care to more than 100 COVID-19 patients, one of which received $36 million. Rural providers were provided with a $10billion fund for acute care, critical access hospitals, rural clinics, and health centers. Oklahoma had about 163 that received $300 million. Medicare advanced payments totaled about $300 million. The Health Care Enhancement Act was approved and would provide funding for eligible healthcare providers and expenses attributed to the Coranovirus.

At the state level, OHCA has provided $30 million to providers as advancements. DSH payments were moved to April and SHOPP participants were provided with $15.5 million.

SoonerCare 2.0 Update: The SHOPP bill was approved by the Legislature and is now with the Governor awaiting approval. OHCA expects the SPA approval later this month, should the Governor approve the SHOPP bill. The Health Adult Opportunity (HAO) Waiver was filed on April 20, 2020. Four virtual public hearings were held for the HAO waiver. A final public meeting was held to go over the changes that were made to the draft that was exposed for public comment. Since the submission, OHCA has remained in contact with CMS, who will post the waiver for their 30-day comment period by the end of May. As a result, OHCA has moved onto blueprinting the transformation steps that are required under the HAO waiver. OHCA is trying to simulate an internal managed care process. Transformation updates will be provided all board meetings.

Finance Update: OHCA will enter SFY 21 with surplus cash resulting from the FMAP payment. OHCA is estimating that the unemployment rate will go from 3.5% to 13.5%. OHCA is increasing its stewardship efforts to void any surprises and seeking cost efficiencies. OHCA will prepare expanded financial analysis projections each month to understand what the reality is and want to be able to respond to any adverse trends the agency may face.

Mr. Corbett expressed his thanks to Senator Hicks, Pro Tem Treat, and Senator McCortney for carrying and moving his nomination. He also expressed his thank to Gov. Stitt for this opportunity and the OHCA team for their continued hard work.

ITEM 6 / CHIEF OF STAFF'S REPORT
Ellen Buettner, Chief of Staff

Ms. Buettner provided a return to work plan and organizational culture initiatives.

Return to work: OHCA is not in a rush to get staff back into the office. This is being used as an opportunity to reimagine work spaces and how we work as agency, including additional telework opportunity and rotating shared workspaces. The current phase we're in now is evaluating what the employee preferences are. Executive staff has met with their teams to see what they're comfortable with, in terms of returning full-time or if they'd enjoy a flexible work arrangement. In doing the current space planning, the fact that the agency was not at full capacity prior to COVID-19, Secretary Budd has a team of consultants that are working of an overall state agency structure. There may be an opportunity to share space with another state agency or board.

Organizational Culture: Jennifer Lamb-Hornsby has been working closely with Communications to conduct culture surveys, surrounding organizational environment, to give leadership team a baseline about where employee perceptions stand. That feedback is being used to form certain initiatives in regards to reward recognition, professional development opportunities, and other types of communication initiatives. Public Service Recognition was celebrated two weeks ago, because of the COVID crisis, the state officially moved the celebration in September. Supervisors were asked to submit nominations for their peers surrounding OHCA's five core principles: Trust and Transparency, Empowerment and Accountability, Passion for Purpose, Best in Class and Solution Oriented, and Servant Leadership. One principle was highlighted each day and shared each person that was nominated. At the end of the week, the executive team voted to highlight one member of the team from each principle who they felt best embodied those principles.

Trust and Transparency: Kerri Williams
Empowerment and Accountability: Paula Crouch
Passions for Purpose: Lisa Cates
Best in Class: Chad Sickler,
Servant Leadership: Heather Stafford

ITEM 7 / CHIEF OPERATING OFFICER'S REPORT
Melody Anthony, Chief Operating Officer/State Medicaid Director

Ms. Anthony provided a SoonerCare Operations update. CMS has given Oklahoma flexibility, as far as telemedicine, telephonic codes, COVID testing, diagnostic and treatment. Each state was given the opportunity to request items that were unique to them. Oklahoma's request were based on comments from the provider community and were also vetted through leadership. OHCA's Population Care Management (PCM) unit conducted an evaluation of our high risk population with comorbidities. Outbound calls were made to over 3,000 African-American population that were high risk. The main concern for our members is how to find masks. A nurse from PCM was able to locate a national company that will make a mask for anyone that requests one.

SoonerCare 2.0 Update: the 90th day for the expansion SPA is June 4, 2020. Ms. Anthony contacted CMS to get a status update and was told that CMS is actively working on it. Ms. Anthony requested that the approval be sent by the end of May to accommodate system changes. An 1115 Waiver amendment was submitted and OHCA was notified the week of May 1th that the amendment was complete and currently posted on their website for public comment. OHCA is moving forward, so that on July 1, any new member that comes into our delivery system is eligible, has a provider network, and understands the rules of their current coverage. The first thing OHCA needed to know that the provider network was adequate to support the population that would come in the first year. A map was created of every county and matched it with all contracted providers, so the OHCA Data Governance team could calculate the percentage of uninsured in the specific county. Only two counties were found that would not have the capacity to support new adult members, however the surrounding counties would be able to provide adequate access. Insure Oklahoma providers were asked if they would open their capacity and do a SoonerCare Choice Addendum to their contract, so they can be a provider for the new adult population. The SoonerCare Choice Medical Home program were also asked if they would be willing to increase their panel size. Pharmacy is currently on a wait and see plan, but will be able to make changes as needed. Medical Professional Services may need new full-time employees (FTEs) starting in July, but they are also waiting to see what the demand is.

Eligibility and Coverage: Insure Oklahoma population on the individual plan will have the opportunity to be rolled into the expansion group in July. Maximus was asked to hire 20 new employees for the new adult population. OHCA is currently in the testing phase to make sure those trying to enroll can go through the rules engine for eligibility and come out as a covered member. The goal is to allow individuals to enroll for coverage starting June 1, 2020 for an effective date of July 1, 2020, SoonerPlan will qualify for full expansion and full coverage.

ITEM 8 / DISCUSSION OF REPORT FROM THE LEGISLATIVE ADVISORY COMMITTEE
Alex Yaffe, Chair of the Legislative Advisory Committee

Chairman Yaffe introduced Christina Foss, OHCA Legislative Liaison, to provide a legislative update. There were several bills that OHCA was following that were not read. The SoonerCare 2.0 funding bill passed.

SB 1046, SHOPP increase, increased it to 4% and SB 1935 made up the rest of the additional funding, using the revenue stabilization fund. Both bills are on the Governor's desk.

SB 1937, Rate Preservation Fund, was signed by the Governor. The bill allows OHCA more flexibility with utilizing it. Currently, those funds are dependent on a decrease in FMAP, however changes to this fund would allow OHCA to access it to maintain provider rates for other circumstances.

SB 1073 is on the Governor's desk. It would expand the authority to use our revolving fund that generally funds the Insure Oklahoma Program. Funding from the cigarette and tobacco product taxes intended for that program can now be used for other areas of the Medicaid program.

SB 1944 was signed by the Governor and requires OMES to publish daily reports of the expenditures from the CARES Act.

A resolution proposed as a vote of the people for a constitutional amendment that modifies the Tobacco Settlement Endowment Trust fund and allows the legislature to appropriate money from that to draw federal matching funds for Medicaid.

Governor approvals or vetoes will be seen by Thursday, May 21, 2020.

ITEM 9 / DISCUSSION OF REPORT FROM THE COMPLIANCE ADVISORY COMMITTEE
Aaron Morris, Chief Financial Officer

Chairman Kennedy provided an update on OHCA financials through March. OHCA has a positive variance of $70 million.

Financial Update: There are no extreme variances, other than the federal revenue. Through March, other state agencies are overpaid in their receivables. OHCA has not seen significant utilization impacts due to COVID, which is expected. Utilization decline was seen in April, but it believed to ramp up. Many of the services will be deferred into FY21, which could result in state savings.

Budget Update: The Families First Coronavirus Response Act gave Medicaid programs nationwide a 6.2% increase in FMAP. Other key driver that are being focused on: unemployment, the continuous eligibility requirement, COVID costs, and the deferral of services. OHCA has done substantial amount of modeling various scenarios of impacts to FY20 budget. Models were based on early assumptions. As of May 18, 2020, OHCA's net benefit from Families First Coronavirus Act is about $88 million, which is seen in the financials. Of the $69.9 million variance, about $67 million is from the 6.2% increase of federal funds. Without the increase, OHCA's budget is flat through March. A budget revision has been filed for FY20 and wanted to make sure the acceptance of the FMAP increase were in the budget. Work on the Budget Work Program will begin and will be presented to the board in June. The FMAP increase gains about $84 million, funding: the last three months of the provider rate increases, the phasing out of the CHIP enhanced federal funding rate, the estimated 2.3% growth in utilization, and the extra claims week. OHCA estimated unemployment for SFY21 at 13.5%. For current population, there are about 7,500 new unemployment cases for every 1% increase.

Expansion funding: initially estimated about $148 million before COVID. Estimates are now at $164 million, including unemployment. SB 1046 allows OHCA to increase SHOPP fee up to 4%, which will be about $134 million to fund expansion. SB 1935 may be able to fund the additional $30 million. The FMAP Rate Stabilization fund will have about $33 million to budget for FY21, should it be needed. OHCA is participating in negotiations with third party contractors, OHCA leadership is conducting budget reviews by divisions, and evaluating reduction opportunities.

ITEM 10i-ix / DISCUSSION OF REPORT FROM THE ADMINISTRATIVE RULES ADVISORY COMMITTEE AND POSSIBLE ACTION REGARDING AGENCY RULEMAKING

Jean Hausheer, M.D., Chair of Administrative Rules Advisory Committee

a) Consideration and Vote upon a Declaration of a Compelling Public Interest for the Promulgation of the **Emergency Rules** in Attachment "A" in Accordance with 75 O.S. § 253.

b) Consideration and Vote of Agency Recommended Rulemaking Pursuant to Article I of the Administrative Procedures Act. OHCA Requests the Adoption of the Following Emergency Rules (see Attachment "A"):

i. **APA WF # 20-05 Continuation of Services Pending Appeals —** ADDING agency rules at ***Oklahoma Administrative Code (OAC) 317:2-1-2.6***

ii. **APA WF # 20-06A Durable Medical Equipment (DME) and Supplies Benefit Moved under the Scope of the Home Health Benefit —** ADDING agency rules at ***OAC 317:30-5-211.20, 317:30-5-211.21, 317:30-5-211.22, 317:30-5-211.23, 317:30-5-211.24, 317:30-5-211.25, 317:30-5-211.26, 317:30-5-211.27,*** and ***317:30-5-211.28*****;** AMENDING agency rules at ***OAC 317:30-3-40, 317:30-3-57, 317:30-3-59, 317:30-5-42.16, 317:30-5-42.17, 317:30-5-133.1, 317:30-5-210, 317:30-5-210.1, 317:30-5-210.2, 317:30-5-211.1, 317:30-5-211.2, 317:30-5-211.3, 317:30-5-211.5, 317:30-5-211.6, 317:30-5-211.10, 317:30-5-211.12, 317:30-5-211.13, 317:30-5-211.14, 317:30-5-211.15, 317:30-5-211.16, 317:30-5-211.17, 317:30-5-218, 317:30-5-545, 317:30-5-546, 317:30-5-547,*** and ***317:30-5-548*****;** REVOKING agency rules at ***OAC 317:30-5-133.2, 317:30-5-211.9, 317:30-5-216,*** and ***317:30-5-549***

iii. **APA WF # 20-06B Durable Medical Equipment (DME) and Supplies Benefit Moved under the Scope of the Home Health Benefit —** AMENDING agency rules at ***OAC 317:35-18-6***

iv. **APA WF # 20-06C Durable Medical Equipment (DME) and Supplies Benefit Moved under the Scope of the Home Health Benefit —** AMENDING agency rules at ***OAC 317:40-5-104***

v. **APA WF # 20-06D Durable Medical Equipment (DME) and Supplies Benefit Moved under the Scope of the Home Health Benefit —** AMENDING agency rules at ***OAC 317:50-1-14***

vi. **APA WF # 20-08A Medicaid Expansion —** AMENDING agency rules at ***OAC 317:30-3-1, 317:30-5-9, 317:30-5-12, 317:30-5-356,*** and ***317:30-5-664.5***

vii. **APA WF # 20-08B Medicaid Expansion —** AMENDING agency rules at ***OAC 317:35-5-2, 317:35-5-60, 317:35-5-63, 317:35-6-1, 317:35-6-15, 317:35-6-36, 317:35-6-37, 317:35-6-38, 317:35-7-1, 317:35-7-60, 317:35-10-10,*** and ***317:35-10-26;*** ADDING agency rules at ***OAC 317:35-5-9*** and ***317:35-5-48;*** REVOKING agency rules at ***OAC 317:35-5-8, 317:35-7-48*** and ***317:35-7-60.1***

viii. **APA WF # 20-09 Patient Centered Medical Home (PCMH) —** AMENDING agency rules at ***OAC 317:25-7-12***

ix. **APA WF # 20-10 Supplemental Hospital Offset Payment Program (SHOPP) —** AMENDING agency rules at ***OAC 317:30-5-58***

MOTION: Member Case moved for approval of Item 10a.ii-v as published. The motion was seconded by Member Kennedy.

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

MOTION: Vice-Chairman Yaffe moved for approval of Item 10b.ii-v as published. The motion was seconded by Member Case.

FOR THE MOTION: Chairman Hupfeld, Member Boyd, Member Curry, Member Hausheer, Member Kennedy, Member Nuttle, Member Shamblin

MOTION: Member Shamblin moved for approval of Item 10a.i, vi-ix as published. The motion was seconded by Member Curry.

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

MOTION: Member Kennedy moved for approval of Item 10b.i, vi-ix as published. The motion was seconded by Member Nuttle.

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

ITEM 11i-iv / DISCUSSION OF REPORT FROM THE PHARMACY ADVISORY COMMITTEE AND POSSIBLE ACTION REGARDING DRUG UTILIZATION BOARD RECOMMENDATIONS

Randy G. Curry, D.Ph., Chair of Pharmacy Advisory Committee

Action Item – a) Consideration and Vote Regarding Recommendations Made by the Drug Utilization Review Board Pursuant to 63 O.S. § 5030.3 to Add the Following Drugs to the Utilization and Scope Prior Authorization Program under OAC 317:30-5-77.2(e).

i. Asparlas™ (Calaspargase Pegol-mknl), Daurismo™ (Glasdegib), Idhifa® (Enasidenib), Lumoxiti® (Moxetumomab Pasudotox-tdfk), Tibsovo® (Ivosidenib), and Xospata® (Gilteritinib)
ii. Azedra® (Iobenguane I-131)
iii. Esperoct® [Antihemophilic Factor (Recombinant), Glycopegylated-exei]
iv. Xcopri® (Cenobamate)

MOTION: Member Curry moved for approval of Item 11i-iv as published. The motion was seconded by Member Boyd.

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

ITEM 12 / PROPOSED EXECUTIVE SESSION AS RECOMMENDED BY THE CHIEF OF LEGAL SERVICES AND AUTHORIZED BY THE OPEN MEETINGS ACT, 25 OKLAHOMA STATUTES §307(B) (4).

Stanley Hupfeld, OHCA Board Chairman

MOTION:	Member Boyd moved for approval to move into Executive Session. The motion was seconded by Member Hausheer.
FOR THE MOTION:	Chairman Hupfeld, Vice-Chairman Yaffe, Member Case, Member Curry, Member Kennedy, Member Nuttle, Member Shamblin
MOTION:	Member Hausheer moved for approval to move out of Executive Session. The motion was seconded by Member Boyd.
FOR THE MOTION:	Chairman Hupfeld, Vice-Chairman Yaffe, Member Case, Member Curry, Member Kennedy, Member Nuttle, Member Shamblin

ITEM 13 / ADJOURNMENT

MOTION:	Vice-Chairman Yaffe moved for approval for adjournment. The motion was seconded by Member Hausheer.
FOR THE MOTION:	Chairman Hupfeld, Member Boyd, Member Case, Member Curry, Member Kennedy, Member Nuttle, Member Shamblin

Meeting adjourned at 5:52 p.m., 5/18/2020

NEXT BOARD MEETING
June 30, 2020
Oklahoma Health Care Authority
4345 N. Lincoln Blvd
Oklahoma City, OK

Martina Ordonez
Board Secretary

Minutes Approved: _____

Initials: _____

OKLAHOMA
Health Care Authority

STATE PLAN AMENDMENT RATE COMMITTEE

REGULAR NURSING FACILITIES RATES

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

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

3. **PRESENTATION OF ISSUE – WHY IS THIS CHANGE BEING MADE?**
   The change is being made to increase the Quality of Care (QOC) Fee for Regular Nursing Facilities per 56 O.S. 2011, Section 2002. This change allows OHCA to collect additional QOC fees from providers and match them with federal funds which provides rate increases to facilities. Additionally, the change allows OHCA to calculate the annual reallocation of the pool for the "Direct Care" and "Other Cost" components of the rate as per the State Plan. Also, a one-time adjustment will be made to the base rate to account for procurement of durable medical equipment, supplies, and appliances, including oxygen from the open market. This change is to comply with the Home Health final rule.

4. **CURRENT METHODOLOGY AND/OR RATE STRUCTURE.**
   The current rate methodology for Regular Nursing Facilities calls for the establishment of a prospective rate which consists of four components. The current components are as follows:
   A. Base Rate Component is $120.57 per patient day.
   B. A Pay for Performance (PFP) Component defined as the dollars earned under this performance program with average payment of $5.00 per patient day.
   C. An "Other Cost" Component which is defined as the per day amount derived from dividing 30% of the pool of funds available after meeting the needs of the Base and PFP Components by the total estimated Medicaid days for the rate period. This component once calculated is the same for each facility.
   D. A "Direct Care "Component which is defined as the per day amount derived from allocating 70% of the pool of funds available after meeting the needs of the Base and PFP Components to the facilities. This component is determined separately and is different for each facility. The method (as approved in the State Plan) allocates the 70% pool of funds to each facility (on a per day basis) based on their relative expenditures for direct care costs.

The current combined pool amount for "Direct Care" and "Other Cost" components is $220,482,316. The current Quality of Care (QOC) fee is $12.92 per patient day.

5. **NEW METHODOLOGY OR RATE STRUCTURE.**
There is no change in methodology; however there is a rate change for Regular Nursing Facilities as a result of the required annual recalculation of the Quality of Care (QOC) fee and reallocation of the pool for "Direct Care" and "Other Cost" components of the rate as per the State Plan. In addition, there will be a one-time adjustment to the base rate to account for procurement of durable medical equipment, supplies, and appliances, including oxygen from the open market. The new Base Rate Component will be $121.30 per patient day. The new combined pool amount for "Direct Care" and "Other Cost" components will be $250,302,699. The new Quality of Care (QOC) fee will be $13.15 per patient day.

6. **BUDGET ESTIMATE.**
The estimated budget impact for SFY2021 will be an increase in the total amount of $4,202,303; with $1,365,748 in state share coming from the increased QOC Fee (which is paid by providers).

7. **AGENCY ESTIMATED IMPACT ON ACCESS TO CARE.**
The Oklahoma Health Care Authority does not anticipate any negative impact on access to care.

8. **RATE OR METHOD CHANGE IN THE FORM OF A MOTION.**
The Oklahoma Health Care Authority requests the State Plan Amendment Rate Committee to approve the following for Regular Nursing Facilities:
   - An increase to the base rate component from $120.57 per patient day to $121.30 per patient day.
   - A change to the combined pool amount for "Direct Care" and "Other Cost" Components from $220,482,316 to $250,302,699 for the annual reallocation of the Direct Care Cost Component as per the State Plan.

9. **EFFECTIVE DATE OF CHANGE.**
July 1, 2020 contingent upon CMS approval.

ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS) NURSING FACILITIES RATES

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

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

3. **PRESENTATION OF ISSUE – WHY IS THIS CHANGE BEING MADE?**
   The change is being made to increase the Quality of Care (QOC) Fee for nursing facilities serving residents with AIDS per 56 O.S. 2011, Section 2002. This change allows the Oklahoma Health Care Authority (OHCA) to collect additional QOC fees from providers and match them with federal funds which provides rate increases to the facilities. A one-time adjustment will also be made to the AIDS rate to account for procurement of durable medical equipment, supplies, and appliances, including oxygen from the open market. This change is to comply with the Home Health final rule.

4. **CURRENT METHODOLOGY AND/OR RATE STRUCTURE.**
   The current rate methodology for nursing facilities serving residents with AIDS requires the establishment of a prospective rate which is based on the reported allowable cost per day. The current rate for this provider type is $213.61 per patient day. The Quality of Care (QOC) fee is $12.92 per patient day.

5. **NEW METHODOLOGY OR RATE STRUCTURE.**
   There is no change in methodology; however there is a rate change for nursing facilities serving residents with AIDS as a result of the required annual recalculation of the Quality of Care (QOC) fee. In addition, there will be a one-time adjustment to the AIDS rate to account for procurement of durable medical equipment, supplies, and appliances, including oxygen from the open market. The rate for this provider type will be $215.00 per patient day. The recalculated Quality of Care (QOC) fee will be $13.15 per patient day.

6. **BUDGET ESTIMATE.**
   The estimated budget impact for SFY2021 will be an increase in the total amount of $10,774; with $3,501 in state share coming from the increased QOC Fee (which is paid by the facilities).

7. **AGENCY ESTIMATED IMPACT ON ACCESS TO CARE.**
   The Oklahoma Health Care Authority does not anticipate any negative impact on access to care.

8. **RATE OR METHOD CHANGE IN THE FORM OF A MOTION.**
   The Oklahoma Health Care Authority requests the State Plan Amendment Rate Committee to approve the following for nursing facilities serving residents with AIDS:
   - An increase to the AIDS rate from $213.61 per patient day to $215.00 per patient day.

9. **EFFECTIVE DATE OF CHANGE.**
   July 1, 2020 contingent upon CMS approval.

REGULAR INTERMEDIATE CARE FACILITIES FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES (ICF/IID) RATE

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

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

3. **PRESENTATION OF ISSUE – WHY IS THIS CHANGE BEING MADE?**
   The change is being made to increase the Quality of Care (QOC) Fee for Regular ICF/IID Facilities per 56 O.S. 2011, Section 2002. This change allows the Oklahoma Health Care Authority (OHCA) to collect additional QOC fees from providers and match them with federal funds which provides rate increases to facilities. A one-time adjustment will also be made to the rate to account for procurement of durable medical equipment, supplies, and appliances, including oxygen from the open market. This change is to comply with the Home Health final rule.

4. **CURRENT METHODOLOGY AND/OR RATE STRUCTURE.**
   The current rate methodology for Regular ICF/IID facilities requires the establishment of a prospective rate which is based on the reported allowable cost per day.
   The current rate for this provider type is $128.46 per patient day.
   The Quality of Care (QOC) fee is $7.58 per patient day.

5. **NEW METHODOLOGY OR RATE STRUCTURE.**
   There is no change in methodology; however there is a rate change for Regular ICF/IID facilities as a result of the annual recalculation of the Quality of Care (QOC) fee. In addition, there will be a one-time adjustment to Regular ICF/IID rate to account for procurement of durable medical equipment, supplies, and appliances, including oxygen from the open market. The proposed rate for this provider type is $128.72 per patient day. The recalculated Quality of Care (QOC) fee is $7.64 per patient day.

6. **BUDGET ESTIMATE.**
   The estimated budget impact for SFY2021 will be an increase in the total amount of $39,381; with $12,799 in state share coming from the increased QOC Fee (which is paid by providers).

7. **AGENCY ESTIMATED IMPACT ON ACCESS TO CARE.**
   The Oklahoma Health Care Authority does not anticipate any negative impact on access to care.

8. **RATE OR METHOD CHANGE IN THE FORM OF A MOTION.**
   The Oklahoma Health Care Authority requests the State Plan Amendment Rate Committee to approve the following for Regular ICF/IID facilities:
   - An increase in rate from $128.46 per patient day to $128.72 per patient day.

9. **EFFECTIVE DATE OF CHANGE.**
   July 1, 2020 contingent upon CMS approval.

ACUTE (16 BED-OR-LESS) INTERMEDIATE CARE FACILITIES FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES (ICF/IID) RATES

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

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

3. **PRESENTATION OF ISSUE – WHY IS THIS CHANGE BEING MADE?**
   A one-time rate adjustment is being made for Acute ICF/IID rate to account for procurement of durable medical equipment, supplies, and appliances, including oxygen from the open market. This change is to comply with the Home Health final rule.

4. **CURRENT METHODOLOGY AND/OR RATE STRUCTURE.**
   The current rate methodology for Acute ICF/IID facilities requires the establishment of a prospective rate which is based on the reported allowable cost per day.
   The current rate for this provider type is $163.92 per patient day.
   The Quality of Care (QOC) fee is $9.66 per patient day.

5. **NEW METHODOLOGY OR RATE STRUCTURE.**
   There is no change in methodology; however there is rate change due to the one-time adjustment of the rate to account for procurement of durable medical equipment, supplies, and appliances, including oxygen from the open market. The new rate for this provider type is $163.94. There is no change to the quality of care fee.

6. **BUDGET ESTIMATE.**
   There is no budget impact, this change will be funded using existing funds.

7. **AGENCY ESTIMATED IMPACT ON ACCESS TO CARE.**
   The Oklahoma Health Care Authority does not anticipate any negative impact on access to care.

8. **RATE OR METHOD CHANGE IN THE FORM OF A MOTION.**
   The Oklahoma Health Care Authority requests the State Plan Amendment Rate Committee to approve the following for Acute ICF/IID facilities:
   - An increase in rate from $163.92 per patient day to $163.94 per patient day.

9. **EFFECTIVE DATE OF CHANGE.**
   July 1, 2020 contingent upon CMS approval.

PRIVATE DUTY NURSING (PDN) OVERTIME RATE COVID-19 RELATED

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

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

3. **PRESENTATION OF ISSUE – WHY IS THIS CHANGE BEING MADE?**
   The Oklahoma Health Care Authority is requesting a Private Duty Nursing (PDN) global rate increase. PDN providers will receive a higher rate of pay for PDN hours that result in over-time rate of pay for nursing staff. The increase is to be applied only for persons with tracheostomies or who are ventilator dependent during the Covid-19 emergency declaration.

4. **CURRENT METHODOLOGY AND/OR RATE STRUCTURE.**
   The current reimbursement rate for PDN providers is $32.68 per hour or $8.17 per unit.

5. **NEW METHODOLOGY OR RATE STRUCTURE.**
   PDN providers will receive a supplemental payment of $7.32 per hour/$1.83 per unit for PDN hours that result in over-time rate of pay for nursing staff. The increase is to be applied only for persons with tracheostomies or who are ventilator dependent.

6. **BUDGET ESTIMATE.**
   The estimated budget impact for March 1, 2020 to December 31, 2020 is an increase of $601,920; with $195,624 state share. This amount could change depending on the emergency declaration duration whether it is shorter or longer.

7. **AGENCY ESTIMATED IMPACT ON ACCESS TO CARE.**
   The Oklahoma Health Care Authority does not anticipate any negative impact on access to care.

8. **RATE OR METHOD CHANGE IN THE FORM OF A MOTION.**
   The Oklahoma Health Care Authority requests the State Plan Amendment Rate Committee approve the $7.32 per hour/$1.83 per unit Private Duty Nursing Overtime rate during Covid-19 emergency declaration.

9. **EFFECTIVE DATE OF CHANGE.**
   March 1, 2020, as per CMS approval.

Attachment C

OKLAHOMA Health Care Authority

Serving Oklahomans through SoonerCare

Chief Operating Officer Report
OHCA Board Meeting June 30, 2020

Telehealth - March to June 2020 vs 2019

When the national pandemic was declared, CMS reached out to states to remove barriers to access to care, and allow states as much flexibility as they needed to maintain the Medicaid program. Telehealth was first and foremost on providers minds. Protecting the members they service, protecting their staff and making sure necessary care was available. Based on input from you and our provider community, I wanted to give you're an update on utilization and next steps post COVID.

	March to June			
	2020	2019	Change	Percent
Total Members	78,545	6,989	71,556	1023.8%
Total Claims	337,415	11,941	325,474	2725.7%
Total Reimbursements	$ 24,095,915	$ 975,008	$ 23,120,907	2371.4%
Average Claims Per Member	4.3	1.7		
Average Reimbursement Per Member	$ 307	$ 140		
Average Reimbursement Per Claim	$ 71	$ 82		
Active Telemedicine Providers	1,815	208	1,607	772.6%

May 2020 Total Enrollment	856,777
Percent Served Telemedicine	9%

Top 10 Procedure Codes Used

Procedure Code Desc	Number of Claims (2020)	Procedure Code Desc	Number of Claims (2019)
Alcohol And/Or Drug Counseling And Therapy, Per 15 Minutes	194,917	Established Patient Office Or Other Outpatient Visit, Typically 15 Minutes	4,653
Speech, Language, Voice, And/Or Hearing Therapy	26,494	Established Patient Office Or Other Outpatient, Visit Typically 25 Minutes	3,232
Established Patient Office Or Other Outpatient Visit, Typically 15 Minutes	22,157	Alcohol And/Or Drug Counseling And Therapy, Per 15 Minutes	1,415
Psychosocial Rehabilitation Services, Per 15 Minutes	19,037	New Patient Office Or Other Outpatient Visit, Typically 45 Minutes	536

ADDRESS
4345 N. Lincoln Blvd.
Oklahoma City, OK 73105

WEBSITES
okhca.org
mysoonercare.org

PHONE
Admin: 405-522-7300
Helpline: 800-987-7767

Established Patient Office Or Other Outpatient, Visit Typically 25 Minutes	17,102	New Patient Office Or Other Outpatient Visit, Typically 30 Minutes	530
Therapeutic Activities To Improve Function, Each 15 Minutes	16,912	Established Patient Office Or Other Outpatient Visit, Typically 10 Minutes	478
Psychotherapy, 60 Minutes	5,906	Speech, Language, Voice, And/Or Hearing Therapy	175
Clinic Visit/Encounter, All-Inclusive	4,312	Psychotherapy, 30 Minutes	150
Mental Health Service Plan Development By Non-Physician	4,040	Psychiatric Diagnostic Evaluation With Medical Services	146
Psychotherapy - Interactive Complexity	3,451	Mental Health Assessment, By Non-Physician	109
Top 10 Total Claims	314,328	Top 10 Total Claims	11,424
Top 10 Percent of Total Claims	93.2%	Top 10 Percent of Total Claims	95.7%

Urban/Rural County

County Type	Members Served (2020)	Percent Members Served by County Type	May Enrollment	Percent Enrollment Served
Rural	30,124	39%	385,484	8%
Urban	46,582	61%	469,778	10%

Top 5 Counties by Members Served

County	Members Served (2020)	County Type
72 - Tulsa	16,878	Urban
55 - Oklahoma	16,755	Urban
14 - Cleveland	3,825	Urban
51 - Muskogee	2,590	Rural
09 - Canadian	2,059	Urban

Top 5 Counties by Percent of Enrolled Members Served

County	Percent May Enrollment Served	County Type
51 - Muskogee	13%	Rural
12 - Choctaw	12%	Rural
72 - Tulsa	12%	Urban
73 - Wagoner	12%	Urban
37 - Kingfisher	12%	Rural

Telemedicine - Nursing Facility Codes

Procedure Code Desc	Members Served	Number of Claims	Billing Providers	Total Reimbursement
Nursing Facility Visit, Typically 15 Minutes	112	138	15	$ 11,454
Nursing Facility Visit, Typically 25 Minutes	96	106	10	$ 8,832
Initial Nursing Facility Visit, Typically 45 Minutes	6	7	4	$ 905
Nursing Facility Visit, Typically 10 Minutes	24	24	10	$ 884
Nursing Facility Visit, Typically 35 Minutes	3	4	2	$ 597
Nursing Assessment / Evaluation	12	12	1	$ 591
Initial Nursing Facility Visit, Typically 35 Minutes	3	3	2	$ 368
TOTAL (UNDUPLICATED)	**241**	**294**	**28**	**$ 23,631**

Telemedicine - Telephone Codes

Procedure Code Desc	Members Served	Number of Claims	Billing Providers	Total Reimbursement
Physician Telephone Patient Service, 5-10 Minutes	522	556	106	$ 31,678
Physician Telephone Patient Service, 11-20 Minutes	839	897	155	$ 29,992
Telephone Assessment And Management Service, 21-30 Minutes	236	427	39	$ 17,848
Physician Telephone Patient Service, 21-30 Minutes	342	380	83	$ 15,499
Telephone Assessment And Management Service, 11-20 Minutes	240	303	29	$ 7,318
Telephone Assessment And Management Service, 5-10 Minutes	207	221	22	$ 3,207
Follow-Up Inpatient Consultation Via Telehealth, Limited, 15 Minutes	169	322	1	$ 1,160
Follow-Up Inpatient Consultation Via Telehealth, Intermediate, 25 Minutes	110	173	2	$ 1,132
Telehealth Consultation via Telehealth, Emergency Department Or Initial Inpatient, 50 Minutes	14	14	1	$ 291
Telehealth Consultation via Telehealth, Emergency Department Or Initial Inpatient, 30 Minutes	2	2	1	$ 17
TOTAL (UNDUPLICATED)	**2,470**	**3,295**	**249**	**$ 108,143**

Oklahoma Health Care Authority

2020 Telehealth Summary

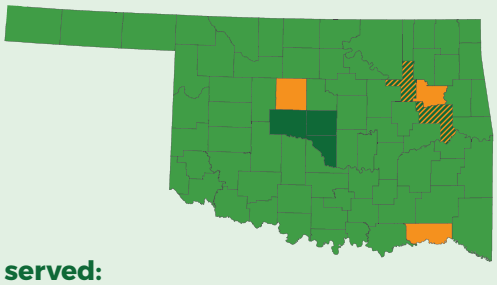
4345 N. Lincoln Blvd.
Oklahoma City, OK 73105
okhca.org | mysoonercare.org

Overview

	March-June 2019	March-June 2020
How many members used telehealth?	6,989	78,545
How many providers conducted services via telehealth?	208	1,815
How many telehealth visits were conducted?	11,941	337,415
What was the average number of telehealth visits per member utilizing this service?	1.7	4.3
What was the total cost for telehealth visits?	$975K	$24M
What was the average reimbursement per member?	$140	$307
What was the average reimbursement per claim?	$82	$71

Number of telehealth visits determined by claims in top 10 codes, which accounts for vast majority of activity.

Where was telehealth used?



Top 5 counties by
percent of enrolled members served:

- Muskogee: 13% of members served
- Choctaw: 12% of members served
- Tulsa: 12% of members served
- Wagoner: 12% of members served
- Kingfisher: 12% of members served

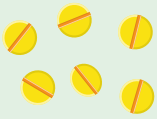
Top 5 counties by
number of members served:

- Tulsa: 16,878 (12% of members in this county)
- Oklahoma: 16,755 (9 of members in this county)
- Cleveland: 3,825 (7% of members in this county)
- Muskogee: 2,590 (13% of members in this county)
- Canadian: 2,059 (11% of members in this county)

What telehealth services were used?

2019: Top 3 Codes by Volume

- Office/outpatient visit: 7,885
- Alcohol and/or drug service: 1,415
- Total unique procedure codes used: 44



2020: Top 3 Codes by Volume

- Alcohol and/or drug service: 194,917
- Speech/hearing therapy: 26,494
- Office/outpatient visit: 22,157
- Total unique procedure codes used: 172

What was telehealth utilization in **rural vs urban** markets and **per capita?**

	Members Served 2020	Percent Members Served by County Type	May Enrollment	Percent Enrollment Served
Rural	**30,124**	**38%**	**385,484**	**8%**
Urban	**46,582**	**59%**	**469,778**	**10%**
Other	**1,839**	**2%**	**1,515**	**784%**
Grand Total	**78,545**	**100%**	**856,777**	**9%**

OKLAHOMA Health Care Authority

Serving Oklahomans through SoonerCare

Chief Operating Officer Report
OHCA Board Meeting June 30, 2020

SoonerCare Operations COVID Outreach

- Outreach list developed by DXC analyst, James Lanier, using Johns Hopkins COVID-19 ACG grouper
- We also shared the list of high risk members with our Health Access Networks. They are also doing outbound calls.
- Started outbound calls April 22
- Being conducted by staff from Health Care Systems Innovation (Health Management Program, Chronic Care Unit, PACE) and Population Care Management (including our Social Service Coordinators and SoonerRide program operations staff)
- Callers are conducting the outreach in addition to their regular duties, so outreach efforts are expected to continue through the summer.
- Focus to date: 9,348 members
    - Priority 1 = Very-High and High Risk, 55+, African American
    - Priority 2 = Very-High Risk and 65+, all other races
    - Risk levels determined by Johns Hopkins ACG grouper
- Outcomes:
    - 5,461 attempted contact thus far
    - 2,191 successfully reached
    - 40% success rate
- Further study planned:
    - At conclusion of outreach efforts, we will be able to match RIDs of members that we successfully reached against diagnoses/claims to determine possible impact of outreach effort.

Along with the outreach efforts above, we regularly survey our highest risk members regarding their care. These are members enrolled with the SoonerCare HMP and CCU. Last month, we added questions about the impact of COVID-19 on their ability to access services. We also asked about their use of telemedicine/telephonic care as a substitute for in-person visits. And we asked about how our health coach and nurse care managers and whether they could do more.

Question *(Note – Child Survey replaces "you" with "your child" throughout survey)*	**Response**
1. At any time, did you <u>delay</u> getting medical care because of the coronavirus pandemic? a. Yes b. No → [GO TO Q3]	A – 21 (20%) B – 83 (80%)
2. What type of care did you delay getting because of the coronavirus pandemic? [RECORD ALL THAT APPLY] a. Primary care visit/routine follow-up care with regular doctor b. Specialty care visit (medical) c. Mental health care visit d. Substance use disorder visit e. Physical/occupational therapy f. Prescription drug refill g. Colonoscopy h. Radiation treatment/chemotherapy for cancer i. Dental care j. Other [SPECIFY] _____	A – 11 B – 10 C – 1 E - 1 J – 1 (ER for Edema)
3. At any time, did you need medical care for something other than the coronavirus but <u>did not get it</u> because of the coronavirus pandemic? a. Yes b. No → [IF YES TO 1, GO TO Q5; IF NO TO 1 <u>AND</u> 3, GO TO 6]	A – 38 (37%) B – 66 (63%)
4. What type of care did you not get because of the coronavirus pandemic? [RECORD ALL TYPES] a. Primary care visit/routine follow-up care with regular doctor b. Specialty care visit (medical) c. Mental health care visit d. Substance use disorder visit e. Physical/occupational therapy f. Prescription drug refill g. Colonoscopy h. Radiation treatment/chemotherapy for cancer	A – 18 B – 16 C – 3 F – 3 I - 1 J – 7 Hernia surgery Fine needle aspiration Ultrasound

Question *(Note – Child Survey replaces "you" with "your child" throughout survey)*	**Response**
i. Dental care j. Other [SPECIFY] _____	ER (multiple)
5. Why did you delay getting care or not get care during the pandemic? [RECORD ALL REASONS] a. Concerned about going out in public b. Concerned about going into a medical facility/doctor's office c. Provider cancelled the appointment and rescheduled for a later date d. Provider cancelled the appointment and did not reschedule e. Other [SPECIFY]	A – 11 B – 13 C – 25 D – 11 E – 4 Was sick and was asked to stay home ER refused care/ER advised not to come Bus ride cancelled
6. Have you talked to, texted or emailed with your Health Coach (Nurse Care Manager) concerning the coronavirus pandemic? a. Yes b. No → [GO TO Q10] c. Don't Know/Not Sure → [GO TO Q10]	A – 41 (40%) B – 58 (56%) C – 4 (4%)
7. Did your Health Coach (Nurse Care Manager) provide information on how to avoid contracting the coronavirus during the pandemic? a. Yes b. No c. Have tested positive for coronavirus d. Don't Know/Not Sure	A – 37 (93%) B – 1 (3%) C – 0 D – 2 (5%)
8. Did your Health Coach (Nurse Care Manager) provide information on getting medical care during the pandemic? a. Yes b. No c. Don't Know/Not Sure	A – 31 (79%) B – 5 (13%) C – 3 (8%)

Question *(Note – Child Survey replaces "you" with "your child" throughout survey)*	**Response**
9. Did your Health Coach (NCM) help you to schedule medical care during the pandemic? a. Yes b. No c. Don't Know/Not Sure	A – 2 (5%) B – 37 (95%) C - 0
10. Some providers during the pandemic are seeing patients using telemedicine, which requires patients to have a computer, tablet device or smartphone, as well as connection to the internet. Some providers also are treating patients through telephone visits, if necessary to the health and safety of the patient, and if the service can safely and effectively be provided over the telephone. Did your Health Coach (Nurse Care Manager) or medical provider give you information about how to receive medical care through telemedicine or by telephone, rather than an in-person appointment? a. Yes – Health Coach (Nurse Care Manager) only b. Yes – Provider only c. Yes – Both d. No e. Don't Know/Not Sure	A – 2 (2%) B – 35 (34%) C – 22 (21%) D – 43 (41%) E – 2 (2%)
11. Do you have access to a computer, tablet device or smartphone, and an internet connection that would allow you to receive medical care through telemedicine? a. Yes b. No c. Don't Know/Not Sure	A – 65 (64%) B – 32 (31%) C – 5 (5%)
12. Have you had any (telemedicine or) telephone visits since the beginning of March? a. Yes – Telemedicine b. Yes – Telephone c. Yes – Both d. No → [GO TO Q15] e. Don't Know/Not Sure → [GO TO Q15]	A – 23 (26%) B – 14 (16%) C – 3 (4%) D– 47 (54%) *Q12 modified to allow for phone after survey was initiated; smaller sample as a result*

Question *(Note – Child Survey replaces "you" with "your child" throughout survey)*	**Response**
13. What was the purpose of the (telemedicine/telephone) visit or visits? [RECORD ALL THAT APPLY] a. Primary care visit/routine follow-up care with regular doctor b. Specialty care visit (medical) c. Mental health care visit d. Substance use disorder visit e. Other [SPECIFY] _____	A – 22 B – 18 C - 9
14. Overall, how satisfied are you with telemedicine (and/or the telephone) as a way to receive care? Would you say you are very satisfied, somewhat satisfied, somewhat dissatisfied or very dissatisfied? [RECORD AND GO TO Q16] a. Very satisfied b. Somewhat satisfied c. Somewhat dissatisfied d. Very dissatisfied e. Don't Know/Not Sure	A – 26 (64%) B – 12 (29%) C – 1 (2%) D – 2 (5%)
Positive comments – *Like the convenience of both telemedicine and telephone appointments (multiple respondents)* *Like telemedicine as it feels safer. Concerned about using SoonerRide* *Safer than being out during the pandemic* **Negative comments –** *Need bloodwork, which still requires a trip for care* *Prefer in-person visit (for mental health) due to hassle of telemedicine technology* *Not as good as in person but "better than nothing"*	

Question *(Note – Child Survey replaces "you" with "your child" throughout survey)*	**Response**
15. Would you be interested in using telemedicine or the telephone if your provider offered this option? a. Yes b. No c. Don't Know/Not Sure	A – 40 (70%) B – 13 (23%) C – 4 (7%)
16. Do you have any suggestions for how your Health Coach (Nurse Care Manager) could better help you with your medical needs during the coronavirus pandemic? [RECORD BELOW] *Help member to acquire masks* *Help in obtaining food* *Has tried unsuccessfully to reach health coach; would like help accessing care*	

Attachment D

OKLAHOMA HEALTH CARE AUTHORITY SFY 2021 BUDGET

MEDICAL PROGRAM

Total Budget Increase of $467,081,192 or 10.7%

*Excluding SHOPP and EHR, total budget increase of $499,210,490 or 12.89%

MEDICAL PROGRAM

Percent Change	Summary of Change	Total Dollars
5.5%	Unemployment Impact	$214,675,890
1.4%	Disenrollment Prohibition	$56,121,340
1.7%	Additional Claim Week	$67,149,882
0.4%	ITU PMPM Rate Increase	$16,400,000
1.4%	SB 1044 & SB 280 Provider Rate Increases	$53,211,118
2.4%	Growth & Utilization Increase	$91,652,259
12.89%	**SFY 2021 Overall Increase**	**$499,210,490**

INSURE OKLAHOMA

Total Budget Decrease of $9,438,582 or 9.3%

INSURE OKLAHOMA

Percent Change	Program	Total Dollars
-4.4%	Employer Sponsored Insurance (ESI)	($2,630,895)
-16.6%	Individual Plan (IP)	($6,807,687)
-9.3%	**SFY 2021 Overall Decrease**	**($9,438,582)**

OHCA ADMINISTRATION

Total budget increase of $6,285,727 or 2.9%

OHCA ADMINISTRATION

Percent Change	Division	Total Dollars
-0.7%	Operations	($360,342)
4.7%	Contracts	$1,775,783
-38.1%	Insure Oklahoma	($1,608,815)
5.6%	Business Enterprises	$6,652,845
-3.9%	Grants Management	($173,745)
2.9%	**SFY 2021 Overall Increase**	**$6,285,727**

OTHER STATE AGENCY MEDICAID PROGRAMS

Total Budget Increase of
$102,690,021 or 7.0%

OTHER STATE AGENCY MEDICAID PROGRAMS

Percent Change	Agency / Program	Total Dollars
2.4%	Department of Human Services	$14,076,011
12.5%	Department of Health	$1,641,756
36.4%	Office of Juvenile Affairs	$3,013,755
21.7%	University Hospital Authority & Trust	$59,167,878
-100%	Medical Education Program	($32,645,396)
12%	Department of Mental Health & Substance Abuse	$51,523,518
-14.3%	Department of Education	($256,889)
56.1%	Tribal Government	$1,440,074
83.6%	Department of Corrections	$1,821,947
32.3%	JD McCarty	$2,907,368
7.0%	**SFY 2021 Overall Increase**	**$102,690,021**

REVENUE

Total Budget Increase of $472,671,484 or 7.6%

Percent Change	Funding Source	Total Dollars
11%	Federal – program	$414,746,790
2.8%	Federal – administration	$4,269,507
5.9%	Drug Rebates	$22,793,498
-0.4%	Medical Refunds	($143,598)
-0.4%	NF Quality of Care	($306,031)
3.5%	Other State Agency	$18,489,809
-100%	Federal Disallowance (OU/OSU)	($17,503,932)
-3.6%	Tobacco Tax	($2,823,078)
-7.8%	Insurance Premiums	($107,781)
-51.2%	Miscellaneous Revenue	($221,679)
307.3%	Prior Year Carryover / Federal Stimulus	$61,938,982
-14%	Other Grants	($114,769)
-6.1%	Hospital Provider Fee (SHOPP)	($11,546,233)
100%	Insure Oklahoma Transfer	$8,000,000
-2.5%	State Appropriations	($24,800,000)
7.6%	**SFY 2021 Overall Increase**	**$472,671,484**

OVERVIEW

Percent Increase	Expenditures/Revenue	Increase	Total Dollars
9.2%	Expenditures	$566,618,358	$6,729,819,150
7.6%	Revenues	$472,671,484	$6,729,819,150
		$93,946,874	**$0**

OKLAHOMA
Health Care Authority

GET IN TOUCH

4345 N. Lincoln Blvd.
Oklahoma City, OK 73105

okhca.org
mysoonercare.org

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

June Board
Proposed Rule Changes

A tribal consultation regarding the following proposed changes was held on Tuesday, January 7, 2020 in the Charles Ed McFall Boardroom of the Oklahoma Health Care Authority (OHCA). Additionally, the proposed rules were presented to the Medical Advisory Committee (MAC) on Thursday, May 14, 2020.

APA work folders 20-06A, B, C, and D were posted on the OHCA public website for a public comment period.

The following emergency rules HAVE previously been approved by the Board. These emergency rules were withdrawn before approval by the Governor and have since been revised.

A. **APA WF # 20-06A, B, C & D Durable Medical Equipment (DME) and Supplies Benefit Moved under the Scope of the Home Health Benefit —** The proposed rule changes comply with federal Home Health rule and CURES Act requirements. The federal regulations change medical equipment, appliances and supplies (formerly known as DME) from an optional benefit to a mandatory benefit that must be provided to all SoonerCare members who meet the medical necessity criteria. Additionally, the proposed rule changes describe the new coverage criteria including renting versus purchasing equipment along with outlining reimbursement methodology and prior authorization requirements.

Finally, the proposed revisions will update organ transplant requirements and guidelines to reflect current practice.

Budget Impact: The estimated budget impact for SFY2021 and SFY2022 will be an increase in the total amount of $2,615,007, with $912,376 state share.

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

SUBCHAPTER 3. GENERAL PROVIDER POLICIES

PART 3. GENERAL MEDICAL PROGRAM INFORMATION

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

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

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

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

(3) HCBS waiver services:

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

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

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

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

(4) HCBS waiver services must be:

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

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

(i) The IP:

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

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

provide services.

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

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

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

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

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

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

(2) Providers who do not meet program standards in the review process are not approved for a provider agreement.

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

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

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

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

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

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

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

(2) Emergency department services.

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

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

(5) Outpatient surgical services - facility payment for selected ~~outpatient surgical~~outpatient-surgical procedures to

hospitals which have a contract with the Oklahoma Health Care Authority (OHCA).
(6) Outpatient mental health services for medical and remedial care including services provided on an outpatient basis by certified ~~hospital based~~hospital-based facilities that are also qualified mental health clinics.
(7) Rural health clinic (RHC) services and other ambulatory services furnished by ~~rural health clinic~~an RHC.
(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) ~~Nursing~~Long-term care facility services (other than services in an institution for tuberculosis or mental diseases).
(13) Early and Periodic Screening, ~~Diagnosis~~Diagnostic and Treatment Services (EPSDT) are available for members under twenty-one (21) years of age to provide access to regularly scheduled examinations and evaluations of the general physical and mental health, growth, development, and nutritional status of infants, children, and youth. Federal regulations also require that diagnosis and treatment be provided for conditions identified during a screening whether or not they are covered under the State Plan, as long as federal funds are available for these services. These services must be necessary to ameliorate or correct defects and physical or mental illnesses or conditions and require prior authorization. EPSDT/OHCA ~~Child Health~~child-health services are outlined in OAC 317:30-3-65.2 through ~~317:30-3-65.4~~317:30-3-65.12.

(A) ~~Child health screening examinations~~EPSDT screenings 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~~Outpatient-psychological services as outlined in OAC 317:30-5-275 through 317:30-5-278.

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

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

(L) ~~Inpatient hospital~~Inpatient-hospital services.

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

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

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

(15) Physicians' services whether furnished in the office, the member's home, a hospital, a ~~nursing~~long-term care facility, Intermediate Care Facilities for Individuals with Intellectual Disabilities (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~~Section for limitations to covered services for:

(A) Podiatrists' services;

(B) Optometrists' services;

(C) Psychologists' services;

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

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

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

(G) Anesthesiologist ~~Assistants~~assistants.

(17) Free-standing ambulatory surgery centers.

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

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

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

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

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

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

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

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

(22) ~~Prosthetic devices 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.~~Orthotic and prosthetic devices for members under age twenty-one (21). For adults, orthotics and prosthetics are limited to breast prosthesis and support accessories. See OAC 317:30-5-210.1 and 317:30-5-211.13.

(23) Standard medical supplies.

(24) Eyeglasses under EPSDT for members under age twenty-one (21). Payment is also made for glasses for children with

congenital aphakia or following cataract removal. Payment is limited to two (2) glasses per year. Any glasses beyond this limit must be prior authorized and determined to be medically necessary.
(25) Blood and blood fractions for members when administered on an outpatient basis.
(26) Inpatient services for members age sixty-five (65) or older in institutions for mental diseases, limited to those members whose Medicare, Part A benefits are exhausted for this particular service and/or those members who are not eligible for Medicare services.
(27) ~~Nursing~~Long-term care facility services, limited to members preauthorized and approved by OHCA for such care.
(28) Inpatient psychiatric facility admissions for members under twenty-one (21) are limited to an approved length of stay effective July 1, 1992, with provision for requests for extensions.
(29) Transportation and subsistence (room and board) to and from providers of medical services to meet member's needs (ambulance or bus, etc.), to obtain medical treatment.
(30) Extended services for pregnant women including all pregnancy-related and postpartum services to continue to be provided, as though the women were pregnant, for sixty (60) days after the pregnancy ends, beginning on the last date of pregnancy.
(31) ~~Nursing~~Long-term care facility services for members under twenty-one (21) years of age.
(32) 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).
(33) Part A deductible and Part B Medicare Coinsurance and/or deductible.
(34) HCBS for the intellectually disabled.
(35) Home-health services limited to thirty-six (36) visits per year and standard supplies for one (1) month in a twelve (12) month period. The visits are limited to any combination of ~~Registered Nurse~~an RN and nurse aide visits, not to exceed thirty-six (36) per year.
(36) Medically necessary solid organ and bone marrow/stem cell transplantation services for children and adults are covered services based upon the conditions listed in (A)-(D) of this paragraph:

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

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

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

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

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

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

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

(D) Procedures considered experimental or investigational are not covered; and

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

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

(38) Case management services for the chronically and/or severely mentally ill.

(39) Emergency medical services including emergency labor and delivery for illegal or ineligible aliens.

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

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

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

(43) Birthing center services.

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

(45) HCBS for aged or physically disabled members.

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

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

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

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

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

The following are excluded from SoonerCare coverage for adults:

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

(2) Services or any expense incurred for cosmetic surgery.

(3) Services of two (2) physicians for the same type of service to the same member on the same day, except when supplemental skills are required and different specialties are involved.

(4) Refractions and visual aids.

(5) Pre-operative care within ~~24~~twenty-four (24) hours of the day of admission for surgery and routine post-operative care as defined under the global surgery guidelines promulgated by Current Procedural Terminology (CPT) and the Centers for Medicare and Medicaid Services (CMS).

(6) Sterilization of members who are under ~~21~~twenty-one (21) years of age, mentally incompetent, or institutionalized or reversal of sterilization procedures for the purposes of conception.

(7) Non-therapeutic hysterectomies.

(8) Induced abortions, except when certified in writing by a physician that the abortion was necessary due to a physical disorder, injury or illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would place the woman in danger of death unless an abortion is performed, or that the pregnancy is the result of an act of rape or incest~~. (Refer to OAC 317:30-5-6 or 317:30-5-50.)~~

(9) Medical services considered experimental or investigational.

(10) Services of a ~~Certified Surgical Assistant.~~certified surgical assistant.

(11) Services of a ~~Chiropractor~~chiropractor. Payment is made for ~~Chiropractor~~chiropractor services on ~~Crossover~~crossover claims for coinsurance and/or deductible only.

(12) Services of an independent licensed ~~Physical~~physical and/or ~~Occupational Therapist.~~occupational therapist.

(13) Services of a ~~Psychologist.~~psychologist.

(14) Services of an independent licensed ~~Speech and Hearing Therapist.~~speech and hearing therapist.

(15) Payment for more than four (4) outpatient visits per month (home or office) per member, except those visits in connection with family planning or related to emergency medical conditions.

(16) Payment for more than ~~two nursing~~two (2) long-term care facility visits per month.

(17) More than one (1) inpatient visit per day per physician.
(18) Payment for removal of benign skin lesions.
(19) Physician services which are administrative in nature and not a direct service to the member including such items as quality assurance, utilization review, treatment staffing, tumor board review or multidisciplinary opinion, dictation, and similar functions.
(20) Charges for completion of insurance forms, abstracts, narrative reports or telephone calls.
(21) Payment for the services of social workers, licensed family counselors, registered nurses or other ancillary staff, except as specifically set out in ~~OHCA~~the Oklahoma Health Care Authority (OHCA) rules.
(22) Mileage.
(23) A routine hospital visit on the date of discharge unless the member expired.
(24) Direct payment to perfusionist as this is considered part of the hospital reimbursement.
(25) Inpatient chemical dependency treatment.
(26) Fertility treatment.
(27) Payment to the same physician for both an outpatient visit and admission to hospital on the same date.
~~(28) Sleep studies.~~

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 3. HOSPITALS

317:30-5-42.16. Related services

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

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

~~(1) Payment is made for home health services provided in a member's residence to all categorically needy individuals.~~

~~(2) Payment is made for a maximum of 36 visits per year for eligible members 21 years of age or older. Payment for any~~

~~combination of skilled and home health aide visits can not exceed 36 visits per year.~~

~~(3) Payment is made for standard medical supplies.~~

~~(4) Payment is made on a rental or purchase basis for equipment and appliances suitable for use in the home.~~

~~(5) Non-covered items include sales tax, enteral therapy and nutritional supplies, and electro-spinal orthosis systems (ESO).~~

~~(6) Payment may be made to home health agencies for prosthetic devices.~~

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

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

~~(C) Sterile tracheotomy trays are covered.~~

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

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

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

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

~~(c) **Hospice Services.** Hospice is defined as palliative and/or comfort care provided to the member family when a physician certifies that the member has a terminal illness and has a life expectancy of six months or less. A hospice program offers palliative and supportive care to meet the special needs arising out of the physical, emotional and spiritual stresses which are experienced during the final stages of illness and death. Hospice services must be related to the palliation and management of the member's illness, symptom control, or to enable the individual to maintain activities of daily living and basic functional skills.~~

~~(1) Payment is made for home based hospice services for terminally ill individuals under the age of 21 with a life expectancy of six months or less when the member and/or family~~

~~has elected hospice benefits. Hospice services are available to eligible members without forgoing any other service to which the member is entitled under SoonerCare for curative treatment of the terminal illness. Once the member has elected hospice care, the hospice medical team assumes responsibility for the member's medical care for the terminal illness in the home environment. Hospice providers are not responsible for curative treatments for members that elect such services while on hospice. Hospice care includes nursing care, physician services, medical equipment and supplies, drugs for symptom control and pain relief, home health aide and personal care, physical, occupational and/or speech therapy, medical social services, dietary counseling and grief and bereavement counseling to the member and/or family.~~

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

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

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

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

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

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

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

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

(4) Medical services considered experimental or investigational.
(5) Payment for removal of benign skin lesions for adults.
(6) Visual aids.
(7) Charges incurred while the member is in a skilled nursing or swing bed.
~~(8) Sleep studies for adults.~~

PART 9. LONG-TERM CARE FACILITIES

317:30-5-133.1. Routine services

(a) ~~Nursing~~Long-term care facility care includes routine items and services that must be provided directly or through appropriate arrangement by the facility when required by SoonerCare residents. Charges for routine services may not be made to resident's personal funds or to resident family members, guardians, or other parties who have responsibility for the resident. If reimbursement is available from Medicare or another public or private insurance or benefit program, those programs are billed by the facility. In the absence of other available reimbursement, the facility must provide routine services from the funds received from the regular SoonerCare vendor payment and the SoonerCare resident's applied income, or spend down amount.
(b) The ~~OHCA~~Oklahoma Health Care Authority (OHCA) will review the listing periodically for additions or deletions, as indicated. Routine services are member specific and provided in accordance with standard medical care. Routine services include, but are not limited to:
(1) Regular room.
(2) Dietary ~~Services~~services:
(A) ~~regular~~Regular diets;
(B) ~~special~~Special diets;
(C) ~~salt~~Salt and sugar substitutes;
(D) ~~supplemental~~Supplemental feedings;
(E) ~~special~~Special dietary preparations;
(F) ~~equipment~~Equipment required for preparing and dispensing tube and oral feedings; and
(G) ~~special~~Special feeding devices (furnished or arranged for).
(3) Medically related social services to attain or maintain the highest practicable physical, mental and psycho-social well-being of each resident, nursing care, and activities programs (costs for a private duty nurse or sitter are not allowed).
(4) Personal services - personal laundry services for residents (does not include dry cleaning).
(5) Personal hygiene items (personal care items required to be

provided does not include electrical appliances such as shavers and hair dryers, or individual personal batteries), to include:

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

(B) ~~bath~~Bath soap;

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

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

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

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

(6) Routine oral hygiene items, including:

(A) ~~toothbrushes~~Toothbrushes;

(B) ~~toothpaste~~Toothpaste;

(C) ~~dental~~Dental floss;

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

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

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

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

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

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

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

(C) If the member, family, or other responsible party (excluding the ~~nursing~~long-term care facility) prefers a specific type or brand of non-legend drug rather than the ones furnished by the facility, the member, family or

responsible party may be charged the difference between the cost of the brand the resident requests and the cost of the brand generally provided by the facility. (Facilities are not required to provide an unlimited variety of brands of these items and services. It is the required assessment of resident needs, not resident preferences, that will dictate the variety of products facilities need to provide);

(D) Before purchasing or charging for the preferred items, the facility must secure written authorization from the member, family member, or responsible party indicating his or her desired preference, as well as the date and signature of the person requesting the preferred item. The signature may not be that of an employee of the facility. The authorization is valid until rescinded by the maker of the instrument.

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

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

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

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

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

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

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

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

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

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

(18) Vision ~~Services~~services. Routine eye examinations for the purpose of medical screening or prescribing or changing glasses and the cost of glasses are included in the daily rate for routine services. This does not include follow-up or treatment of known eye disease such as diabetic retinopathy, glaucoma, conjunctivitis, corneal ulcers, iritis, etc. Treatment of known eye disease is a benefit of the member's medical plan. The projected schedule for routine vision care must be documented on the Admission Plan of Care and on the Annual Plan of Care. The medical record must contain documentation of the steps that have been taken to access the service. When vision services are not appropriate, documentation of why vision services are not medically appropriate must be included in the treatment plan. For example, the member is comatose, unresponsive, blind, etc. Nursing Home providers may contract with individual eye care providers, providers groups or a vision plan to provide routine vision services to their members. The member cannot be expected to pay any co-payments and/or deductibles.

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

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

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

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

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

(19) An attendant to accompany SoonerCare eligible members during SoonerRide ~~Non-Emergency Transportation~~non-emergency

transportation (NET). Please refer to ~~OAC~~Oklahoma Administrative Code (OAC) 317:30-5-326 through OAC 317:30-5-327.9 for SoonerRide rules regarding members residing in a ~~nursing~~long-term care facility~~. And~~; and

(20) Influenza and pneumococcal vaccinations.

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

~~(a) Ancillary services are those items which are not considered routine services. Ancillary services may be billed separately to the SoonerCare program, unless reimbursement is available from Medicare or other insurance or benefit programs. Coverage criteria, utilization controls and program limitations are specified in Part 17 of OAC 317:30-5. Ancillary services are limited to the following services:~~

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

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

~~(B) Ventilators and supplies.~~

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

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

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

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

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

~~(C) Tracheostomy supplies.~~

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

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

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

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

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

~~(1) Diapers.~~

~~(2) Underpads.~~

~~(3) Medicine cups.~~

~~(4) Eating utensils.~~

~~(5) Personal comfort items.~~

PART 17. MEDICAL SUPPLIERS

317:30-5-210. Eligible providers

All eligible medical suppliers must have a current contract with the Oklahoma Health Care Authority (OHCA). The supplier must comply with all applicable ~~State and Federal~~state and federal laws. Effective January 1, 2011, all suppliers of ~~durable medical equipment, prosthetics, orthotics and supplies (DMEPOS)~~medical supplies, equipment, and appliances must be accredited by a Medicare deemed accreditation organization for quality standards for ~~DMEPOS~~durable medical equipment (DME) suppliers in order to bill the SoonerCare program. For coverage of orthotics and prosthetics, refer to Oklahoma Administrative Code (OAC) 317:30-5-211.13. OHCA may make exceptions to this standard based on the exemptions provided by the Centers for Medicare and Medicaid Services (CMS) for Medicare accreditation, if the provider is a government-owned entity, or at a provider's request and at the discretion of OHCA based on access issues and/or agency needs for SoonerCare members. Additionally, unless an exception is granted from the OHCA, all ~~DMEPOS~~DME providers must meet the following criteria:

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

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

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

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

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

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

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

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

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

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

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

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

317:30-5-210.1. Coverage for adults

~~Coverage of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) for adults is specified in OAC 317:30-5-211.1 through OAC 317:30-5-211.18.~~Coverage of medical supplies, equipment, and appliances for adults complies with 42 Code of Federal Regulations (C.F.R.) § 440.70 and is specified in Oklahoma Administrative Code (OAC) 317:30-5-211.1 through OAC 317:30-5-211.19. Orthotics and prosthetics are not a covered service for adults with the exception of breast prosthetics and support acessories (Refer to OAC 317:30-5-211.13).

317:30-5-210.2. Coverage for children

(a) **Coverage.** ~~Coverage of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) for children includes the specified coverage for adults found in OAC 317:30-5-211.1 through OAC 317:30-5-211.18. In addition the following are covered items for children only:~~Medical supplies, equipment, and appliances are covered for children. In addition, orthotics and prosthetics are covered items for children only, except as specified in OAC 317:30-5-211.3.

~~(1) Orthotics and prosthetics.~~

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

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

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

~~(ii) the impairment that prevents adequate nutrition by~~

~~conventional means;~~
~~(iii) the member's weight history before initiating enteral nutrition that demonstrates oral intake without enteral nutrition is inadequate;~~
~~(iv) the percentage of the member's average daily nutrition taken by mouth and by tube; and~~
~~(v) prescribed daily caloric intake.~~
~~(B) Enteral nutrition products that are administered orally and related supplies are not covered.~~
~~(3) Continuous positive airway pressure devices (CPAP).~~

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

(c) **Medical necessity.** Federal regulations require ~~OHCA~~the Oklahoma Health Care Authority (OHCA) to make the determination as to whether the service is medically necessary and do not require the provision of any items or services that the State determines are not safe and effective or that are considered experimental.

317:30-5-211.1. Definitions

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

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

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

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

~~**"Basic activities of daily living"** means a series of activities performed on a day-to-day basis that are necessary to care for~~

~~oneself (e.g., personal hygiene, dressing, eating, maintaining continence and transferring).~~

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

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

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

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

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

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

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

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

"~~Durable medical equipment (DME)~~Equipment and/or appliances" means ~~equipment that can withstand repeated use (e.g. a type of item that could normally be rented), is used to serve a medical~~

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

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

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

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

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

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

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

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

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

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

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

317:30-5-211.2. Medical necessity

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

(1) Routine personal hygiene;

(2) Education;

(3) Exercise;

(4) Convenience, safety, or restraint of the member, or his or

her family or caregiver;
(5) Participation in sports; and/or
(6) Cosmetic purposes.

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

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

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

~~(b)~~(c) **Prescription requirements.** All ~~DME~~prosthetics and orthotics, as those terms are defined by 42 C.F.R. § 440.120 and OAC 317:30-5-211.1, except for hearing aid batteries and equipment repairs with a cost per item of less than ~~$250.00~~$1,000.00 total parts and labor ~~and hearing aid batteries~~, require a prescription signed by a physician, a physician assistant, or an advanced practice nurse. Except as otherwise stated in state or federal law, the prescription must be in writing, or given orally and later reduced to writing by the provider filling the order. Prescriptions are valid for no more than one (1) year from the date written. The prescription must include the following information:

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

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

~~(c)~~(d) **Certificate of medical necessity (CMN).** For certain items

or services, the supplier must receive a signed CMN/OHCA CMN from the treating physician, non-physician practitioner, or dentist. The supplier must have a signed CMN/OHCA CMN in their records before they submit a claim for payment. The CMN/OHCA CMN may be ~~faxed, copied~~faxed copy, electronic copy, or the original hardcopy.

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

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

(2) ~~For members residing in a nursing facility, most medical supplies and/or DME are considered part of the facility's per diem rate. Refer to coverage for nursing facility residents at OAC 317:30-5-211.16.~~For members residing in a hospital, long-term care facility, intermediate care facility for individuals with intellectual disabilities, or any other setting in which payment is or could be made under Medicaid for inpatient services that include room and board, medical supplies, equipment, and appliances are considered part of the facility's per diem rate.

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

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

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

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

(1) services that exceed quantity/frequency limits;

(2) medical need for an item that is beyond OHCA's standards of coverage;
(3) use of a Not Otherwise Classified (NOC) code or miscellaneous codes;
(4) services for which a less costly alternative may exist; and
(5) procedures indicating that a PA is required on the OHCA fee schedule.

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

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

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

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

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

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

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

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

(6) **PA of manually-priced items.** Manually-priced items must be

prior authorized. For reimbursement of manually priced items, see OAC 317:30-5-218.

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

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

(b) **Maintenance.** Routine periodic servicing, such as testing, cleaning, regulating, and checking the member's equipment is considered maintenance and not a separate covered service. ~~DMEPOS~~DME suppliers must provide equipment-related services consistent with the manufacturer's specifications and in accordance with all federal, state, and local laws and regulations. Equipment-related services may include, but are not limited to, checking oxygen system purity levels and flow rates, changing and cleaning filters, and assuring the integrity of equipment alarms and back-up systems. However, more extensive maintenance, as recommended by the manufacturer and performed by authorized technicians, is considered repairs. This may include breaking down sealed components and performing tests that require specialized testing equipment not available to the member. The supplier of a capped rental item that supplied the item the ~~13th~~thirteenth (13th) month must provide maintenance and service for the item. In very rare circumstances of malicious damage, culpable neglect, or wrongful disposition, the supplier may document the circumstances and be relieved of the obligation to provide maintenance and service.

(c) **Replacement.**

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

(2) Replacement parts must be billed with the appropriate ~~HCPCS~~Healthcare Common Procedure Coding System (HCPCS) code that represents the item or part being replaced along with a pricing modifier and replacement modifier. If a part that has

not been assigned a HCPCS code is being replaced, the provider should use a miscellaneous HCPCS code to bill each part. Each claim that contains miscellaneous codes for replacement parts must include a narrative description of the item, the brand name, model name/number of the item, and an invoice.

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

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

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

delivered via mail may be at a reduced rate.

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

317:30-5-211.6. General documentation requirements

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

(b) Payment is made for Durable Medical Equipment as set forth in this section when a face-to-face encounter has occurred in accordance with provisions of 42 CFR 440.70 and Oklahoma Administrative Code 317:30-5-211.1.

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

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

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

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

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

(b) **Certificate of medical necessity (CMN)**. Certain items of ~~DME~~medical supplies, equipment, and appliances require a CMN/OHCA CMN which should be submitted with the request for prior

authorization. These items include, but are not limited to:

~~(1) hospital beds;~~

~~(2) support surfaces;~~

~~(3) patient lift devices;~~

~~(4) external infusions pumps;~~

~~(5) enteral and parenteral nutrition;~~

~~(6) Oxygen and oxygen related products; and~~

~~(7) pneumatic compression devices.~~

(1) External infusion pumps;

(2) Hospital beds;

(3) Oxygen and oxygen related products;

(4) Pneumatic compression devices;

(5) Support surfaces;

(6) Enteral and parenteral nutrition; and

(7) Osteogenesis stimulator.

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

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

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

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

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

~~(e)~~(f) **Home modification.** ~~Equipment used for home modification is not a covered service.~~Home modifications that require permanent installation are not covered services as they are not removable and therefore do not meet the definition of medical supplies,

equipment, and appliances per 42 CFR 440.70. Refer to Title 317, Chapters 40 and 50 for home modifications covered under Home and Community Based Services Waivers including the ADvantage Waiver.

317:30-5-211.12. Oxygen rental

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

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

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

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

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

(a) Orthotics and prosthetics are classified as an optional benefit by the Center for Medicare and Medicaid Services (CMS) and are administered as per 42 CFR §440.120. Refer to Oklahoma Administrative Code (OAC) 317:30-5-211.1 for definitions of orthotics and prosthetics.

~~(b) Coverage of prosthetics for adults is limited to (1) home dialysis equipment and supplies, (2) nerve stimulators, (3) external breast prosthesis and support accessories, and (4) implantable devices inserted during the course of a surgical procedure. Prosthetics prescribed by an appropriate medical~~

~~provider and as specified in this section are covered items for adults. There is no coverage of orthotics for adults.~~

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

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

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

~~(A) Payment is limited to:~~

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

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

~~(iii) one silicone or equal breast prosthetic per side every 24 months; or~~

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

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

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

~~(D) A breast prosthesis can be replaced if:~~

~~(i) lost;~~

~~(ii) irreparably damaged (other than ordinary wear and tear); or~~

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

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

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

(b) There is no coverage of orthotics for adults.

(c) Coverage of prosthetics for adults is limited to one (1) breast prosthesis and support accessories and two (2) prosthetic devices insurted during surgery.

(1) **Breast prosthesis and support accessories.**

(A) Payment is limited to:

(i) one (1) prosthetic garment with mastectomy form every twelve (12) months for use in the postoperative period prior to a permanent breast prosthesis or as an alternative to a mastectomy bra and breast prosthesis;
(ii) two (2) mastectomy bras per year; and
(iii) one (1) silicone or equal breast prosthetic per side every twenty-four (24) months; or
(iv) one (1) foam prosthetic per side every six (6) months.

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

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

(D) A breast prosthesis can be replaced if:
(i) lost;
(ii) irreparably damaged (other than ordinary wear and tear); or
(iii) the member's medical condition necessitates a different type of item and the physician provides a new prescription explaining the need for a different type of prosthesis.

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

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

317:30-5-211.14. Nutritional support

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

~~(a)~~(b) **Parenteral nutrition.** The member must require intravenous feedings to maintain weight and strength commensurate with the member's overall health status. Adequate nutrition must not be possible by dietary adjustment and/or oral supplements.

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

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

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

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

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

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

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

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

~~(1) **Intravenous therapy.** Supplies for intravenous therapy are~~

~~covered items. Drugs for IV therapy are covered items only as specified by the Vendor Drug program.~~

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

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

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

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

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

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

~~(A) ventilators and supplies;~~

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

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

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

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

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

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

~~(C) tracheostomy supplies;~~

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

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

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

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

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

~~(1) diapers;~~

~~(2) underpads;~~

~~(3) medicine cups;~~

~~(4) eating utensils; and~~

~~(5) personal comfort items.~~

317:30-5-211.17. Wheelchairs

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

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

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

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

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

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

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

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

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

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

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

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

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

(d) **Coverage and limitations.**

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

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

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

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

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

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

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

members who reside in a long-term careg facility or intermediate care facility for individuals with intellectual disabilities, ~~All~~all standard manual and power wheelchairs~~ are the responsibility of the facility and~~ are considered part of the facility's per diem rate. Repairs and maintenance~~, except for custom seating systems, are not covered items~~ for wheelchairs ~~and~~ are considered part of the facility's per diem rate.

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

(f) **Documentation.**

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

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

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

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

317:30-5-211.20. Enteral nutrition

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

(b) **Medical necessity.** Enteral nutrition supplies must be determined by a physician to be medically necessary and documented in the member's plan of care as medically necessary and used for medical purposes. Requests by medical providers for enteral nutrition supplies in and of itself shall not constitute medical necessity. The Oklahoma Health Care Authority (OHCA) shall serve as the final authority pertaining to all determinations of medical necessity. Refer to Oklahoma Administrative Code (OAC) 317:30-5-211.2 and OAC 317:30-3-1(f) for policy on medical necessity.

(c) **Documentation.** All documentation submitted to request services must demonstrate, through adequate objective medical records, evidence sufficient to justify the member's need for the service, in accordance with OAC 317:30-3-1(f)(2). Documentation must include:

(1) Diagnosis;

(2) Certificate of Medical Necessity (CMN);

(3) Ratio data;

(4) Route;

(5) Caloric intake; and
(6) Prescription.
(7) For full guidelines, please refer to www.okhca.org/mau.

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

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

317:30-5-211.21. Incontinence supplies

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

(b) **Medical necessity.** Incontinence supplies must be determined by a physician to be medically necessary and documented in the member's plan of care as medically necessary and used for medical purposes. A request by a medical provider for incontinence supplies in and of itself shall not constitute medical necessity. The Oklahoma Health Care Authority (OHCA) shall serve as the final authority pertaining to all determinations of medical necessity. Refer to Oklahoma Administrative Code (OAC) 317:30-5-211.2 and OAC 317:30-3-1(f) for policy on medical necessity.

(c) **Documentation.** All documentation submitted to request services must demonstrate, through adequate objective medical records, evidence sufficient to justify the member's need for the service, in accordance with OAC 317:30-3-1(f)(2). Documentation must include:
(1) A signed provider prescription specifying the requested item;
(2) A documented diagnosis of an underlying chronic medical condition that involves loss of bladder or bowel control;
(3) Documentation must include the height and weight of the member, the type of incontinence (bowel/bladder/combined), and expected length of need;
(4) Requests submitted for underwear/pull-on(s) the member must be ambulatory or in toilet training;

(5) The member may qualify for incontinence supplies for a short period of time when the member has documented full-skin thickness injuries;

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

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

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

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

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

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

(3) Reusable briefs and/or reusable diapers;

(4) Diaper service for reusable diapers;

(5) Feminine hygiene products;

(6) Disposable penile wraps; and

(7) Shipping costs.

317:30-5-211.22. Pulse oximeter

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

(b) **Medical necessity.** Pulse oximeters must be determined by a physician to be medically necessary and documented in the member's plan of care as medically necessary and used for medical purposes. A request by a medical provider for pulse oximeters in and of itself shall not constitute medical necessity. The Oklahoma Health Care Authority (OHCA) shall serve as the final authority pertaining to all determinations of medical necessity. Refer to Oklahoma Administrative Code (OAC) 317:30-5-211.2 and OAC 317:30-3-1(f) for policy on medical necessity.

(c) **Documentation.** All documentation submitted to request services must demonstrate, through adequate objective medical records, evidence sufficient to justify the member's need for the service, in accordance with OAC 317:30-3-1(f)(2). Documentation must include:

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

(2) Pertinent information relating to the member's underlying diagnosis and condition which results in the need for the oximeter and supplies, including documentation of unstable

airway events and documentation of current monitor readings if available; and

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

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

(d) **Reimbursement.**

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

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

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

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

(b) **Medical necessity.** CPM must be determined by a provider to be medically necessary and documented in the member's plan of care as medically necessary and used for medical purposes. A request by a medical provider for CPM in and of itself shall not constitute medical necessity. The Oklahoma Health Care Authority (OHCA) shall serve as the final authority pertaining to all determinations of medical necessity. Refer to Oklahoma Administrative Code (OAC) 317:30-5-211.2 and OAC 317:30-3-1(f) for policy on medical necessity.

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

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

(c) **Documentation.** All documentation submitted to request services must demonstrate, through adequate objective medical records, evidence sufficient to justify the member's need for the service, in accordance with OAC 317:30-3-1(f)(2).

(1) Documentation must include:

(A) Type of surgery performed;

(B) Date of surgery;

(C) Date of application of CPM;

(D) Date of discharge from the hospital; and

(E) Written prescription issued by a licensed prescriber that is signed and dated no more than thirty (30) days prior to the first date of service and that defines the specific

"from" and "to" dates that reflect the actual days the CPM device is to be utilized.

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

(d) **Reimbursement.**

(1) Separate reimbursement will not be made for use of device while member is hospitalized or in a long-term care facility.

(2) Billing for dates of service when the patient is no longer actively using the CPM device is not appropriate and is not reimbursable.

317:30-5-211.24. Parenteral nutrition

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

(b) **Medical necessity.** PN must be determined by a provider to be medically necessary and documented in the member's plan of care as medically necessary and used for medical purposes. A request by a medical provider for parenteral nutrition in and of itself shall not constitute medical necessity. The Oklahoma Health Care Authority (OHCA) shall serve as the final authority pertaining to all determinations of medical necessity. Refer to Oklahoma Administrative Code (OAC) 317:30-5-211.2 and OAC 317:30-3-1(f) for policy on medical necessity.

(c) **Documentation.** All documentation submitted to request services must demonstrate, through adequate objective medical records, evidence sufficient to justify the member's need for the service, in accordance with OAC 317:30-3-1(f)(2).

(1) Hospital records that have objective medical evidence supporting the clinical diagnosis; if applicable;

(2) A certificate of medical necessity;

(3) A prescription; and

(4) Caloric Intake.

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

(d) **Reimbursement.**

(1) Supply kits are all inclusive, unbundled supplies (e.g. gloves, tubing, etc.) are not reimbursable for parenteral nutrition.

(2) Pumps are rented as a capped rental.

317:30-5-211.25. Continuous glucose monitoring

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

(b) **Medical necessity.** CGM must be determined by a provider to be medically necessary and documented in the member's plan of care as medically necessary and used for medical purposes. A request by a

medical provider for CGM in and of itself shall not constitute medical necessity. The Oklahoma Health Care Authority (OHCA) shall serve as the final authority pertaining to all determinations of medical necessity. Refer to Oklahoma Administrative Code (OAC) 317:30-5-211.2 and OAC 317:30-3-1(f) for policy on medical necessity. CGM devices must be approved by the U.S. Food and Drug Administration (FDA) as non-adjunctive and must be used for therapeutic purposes. Devices may only be used for members within the age range for which the devices have been FDA approved.

(c) **Documentation.** All documentation submitted to request services must demonstrate, through adequate objective medical records, evidence sufficient to justify the member's need for the service, in accordance with OAC 317:30-3-1(f)(2). Requests for CGM must include all of the following documentation:

(1) Prescription by a physician, physician assistant, or an advanced practice registered nurse;

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

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

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

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

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

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

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

317:30-5-211.26. Bathroom equipment

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

(b) **Medical necessity.** Bathroom Equipment must be determined by a provider to be medically necessary and documented in the member's plan of care as medically necessary and used for medical purposes. A request by a medical provider for bathroom equipment in and of itself shall not constitute medical necessity. The Oklahoma Health Care Authority (OHCA) shall serve as the final authority pertaining to all determinations of medical necessity. Refer to Oklahoma Administrative Code (OAC) 317:30-5-211.2 and OAC 317:30-3-1(f) for policy on medical necessity.

(c) **Documentation.** All documentation submitted to request services must demonstrate, through adequate objective medical records, evidence sufficient to justify the member's need for the service, in accordance with OAC 317:30-3-1(f)(2).

(1) Current written prescription for specific medical supply, equipment, and appliance item;
(2) Letter of Medical Necessity;
(3) Product Information;
(4) Manufacturer's Suggested Retail Price (MSRP) for each item requested
(5) For full guidelines, please refer to www.okhca.org/mau.

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

(a) **PAP devices.** PAP devices are both a single level continuous positive airway pressure device (CPAP), and/or a bi-level respiratory assist device with or without back-up rate when it is used in the treatment of obstructive sleep apnea.
(b) **Medical Necessity.** PAP devices must be determined by a provider to be medically necessary and documented in the member's plan of care as medically necessary and used for medical purposes. A request by a medical provider for PAP devices in and of itself shall not constitute medical necessity. The Oklahoma Health Care Authority (OHCA) shall serve as the final authority pertaining to all determinations of medical necessity. Refer to Oklahoma Administrative Code (OAC) 317:30-5-211.2 and OAC 317:30-3-1(f) for policy on medical necessity.
(c) **Documentation.** All documentation submitted to request services must demonstrate, through adequate objective medical records, evidence sufficient to justify the member's need for the service, in accordance with OAC 317:30-3-1(f)(2).

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

317:30-5-211.28. Sleep studies

(a) **Sleep studies.** Sleep studies are the continuous and simultaneous monitoring and recording of specified physiological and pathophysiological parameters during a period of sleep for six (6) or more hours. The study is used to diagnose a variety of sleep

disorders and to evaluate a patient's response to therapies such as continuous positive airway pressure (CPAP). A sleep study requires physician review, interpretation, and report.

(b) **Medical necessity.** Sleep studies must be determined by a provider to be medically necessary and documented in the member's plan of care as medically necessary and used for medical purposes. A request by a medical provider for sleep studies in and of itself shall not constitute medical necessity. The Oklahoma Health Care Authority (OHCA) shall serve as the final authority pertaining to all determinations of medical necessity. Refer to Oklahoma Administrative Code (OAC) 317:30-5-211.2 and OAC 317:30-3-1(f) for policy on medical necessity.

(c) **Documentation.** All documentation submitted to request services must demonstrate, through adequate objective medical records, evidence sufficient to justify the member's need for the service, in accordance with OAC 317:30-3-1(f)(2). Documentation requirements include:

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

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

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

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

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

(d) **Reimbursement.**

(1) Only sleep studies performed in a sleep diagnostic testing facility may be reimbursable.

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

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

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

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

~~(2) **Certificate of medical necessity.** The prescribing provider must complete the medical necessity section of the CMN. This section cannot be completed by the supplier. The medical necessity section can be completed by any health care clinician; however, only the member's treating provider may sign the CMN. By signing the CMN, the physician is validating the completeness~~

~~and accuracy of the medical necessity section. The member's medical records must contain documentation substantiating that the member's condition meets the coverage criteria and the answers given in the medical necessity section of the CMN. These records may be requested by OHCA or its representatives to confirm concurrence between the medical records and the information submitted with the prior authorization request.~~

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

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

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

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

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

317:30-5-218. Reimbursement

(a) **Medical ~~equipment and~~ supplies, equipment and appliances.**

(1) Reimbursement for ~~durable medical equipment and supplies~~medical supplies, equipment, and appliances will be made using an amount derived from the lesser of the ~~OHCA~~Oklahoma Health Care Authority (OHCA) maximum allowable fee or the provider's usual and customary charge. The maximum allowable fee is the maximum amount that the OHCA will pay a provider for an allowable procedure. When a code is not assigned a maximum allowable fee for a unit of service, a fee will be established. ~~The fee schedule will be reviewed annually and adjustments to the fee schedule may be made at any time based on efficiency, budget considerations, and quality of care as determined by the OHCA.~~

(2) The fee schedule will be reviewed annually. Adjustments to the fee schedule may be possible at any time based on efficiency, budget considerations, federal regulations, and quality of care as determined by the OHCA.

(3) Payment for medical supplies, equipment, and appliances will be calculated using the rate methodologies found in the Oklahoma Medicaid state plan.

(4) Payment is not made for medical supplies, equipment, and appliances that are not deemed as medically necessary or considered over the counter.

(5) OHCA does not pay medical supplies, equipment, and appliances providers separately for services that are included as part of the payment for another treatment program. For example, all items required during inpatient stays are paid through the inpatient payment structure.

(6) Medical supplies, equipment, and appliance products purchased at a pharmacy are paid the equivalent to Medicare Part B, Average Sales Price (ASP) + six percent (6%). When ASP is not available, an equivalent price is calculated using Wholesale Acquisition Cost (WAC). If no Medicare, ASP, or WAC pricing is available, then the price will be calculated based on invoice cost.

(b) **Manually-priced medical equipment and supplies.** There may be instances when manual pricing is required. When it is, the following pricing methods will be used:

(1) **Invoice pricing.** Reimbursement is at the provider's documented Manufacturer's Suggested Retail Price (MSRP) minus thirty percent (30%) or at the provider's invoice cost plus thirty percent (30%), whichever is the lesser of the two.

(2) **Fair market pricing.** OHCA may establish a fair market price through claims review and analysis. For a list of medical equipment and supplies that are fair market-priced, refer to the OHCA website at www.okhca.org for the Fair Market Value List (Selected medical supplies, equipment, and appliance items priced at Fair Market Price).

~~(b)~~ (c) **Oxygen equipment and supplies.**

(1) Payment for stationary oxygen systems (liquid oxygen systems, gaseous oxygen systems, and oxygen concentrators) is based on continuous rental, i.e., a continuous monthly payment that is made as long as it is medically necessary. The rental payment includes all contents and supplies, e.g. regulators, tubing, masks, etc. Portable oxygen systems are considered continuous rental. Ownership of the equipment remains with the supplier.

(2) Separate payment will not be made for maintenance, servicing, delivery, or for the supplier to pick up the

equipment when it is no longer medically necessary. In addition, the provider/supplier will not be reimbursed for mileage.

(3) Payment for oxygen and oxygen equipment and supplies will not exceed the Medicare fee for the same procedure code. ~~Reimbursement for members who reside in a nursing facility may be at a reduced rate. The fee schedule will be reviewed annually and adjustments to the fee schedule may be made at any time based on efficiency, budget considerations, and quality of care as determined by the OHCA.~~

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

PART 61. HOME HEALTH AGENCIES

317:30-5-545. Eligible providers

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

317:30-5-546. Coverage by category

Payment is made for home health services as set forth in this section when a ~~face to face~~face-to-face encounter has occurred in accordance with provisions of ~~42 CFR 440.70~~42 Code of Federal Regulations (C.F.R.) § 440.70. Payment is made for home health services provided in the member's residence and in any setting in which normal life activities take place except for a hospital, long-term care facility, or intermediate care facility for individuals with intellectual disabilities. For individuals eligible for Part B of Medicare, payment is made utilizing the Medicaid allowable for comparable services.

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

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

~~(i) Part-time or intermittent nursing services;~~

~~(ii) Home health aide services;~~

~~(iii) Standard medical supplies;~~

~~(iv) Durable medical equipment (DME) and appliances; and~~

~~(v) Items classified as prosthetic devices.~~

~~(B) **Non-covered items.** The following are not covered:~~

~~(i) Sales tax;~~

~~(ii) Enteral therapy and nutritional supplies;~~

~~(iii) Electro-spinal orthosis system (ESO); and~~

~~(iv) Physical therapy, occupational therapy, speech pathology, or audiological services.~~

~~(2) **Children.** Home Health Services are covered for persons under age 21.~~

~~(3) **Individuals eligible for Part B of Medicare.** Payment is made utilizing the Medicaid allowable for comparable services.~~

317:30-5-547. Reimbursement

(a) Nursing services and home health aide services are covered services on a per visit basis. ~~Reimbursement for any combination of nursing or home aid service shall not exceed 36 visits per calendar year per member. Additional visits for children must be prior authorized when medically necessary.~~Thirty-six (36) visits per calendar year of nursing and/or home health aide services for any member do not require prior authorization; however, any visit surpassing thirty-six (36) would require prior authorization and medical review.

(b) Reimbursement for durable medical equipment and supplies will be made using the amount derived from the lesser of the ~~OHCA~~Oklahoma Health Care Authority (OHCA) fee schedule or the provider's usual and customary charge. ~~The maximum allowable fee is the maximum amount that OHCA will pay a provider for an allowable procedure code.~~ When a procedure code is not assigned a maximum allowable fee for a unit of service, a fee will be established. Once the service has been provided, the supplier is required to include a copy of the invoice documenting the supplier's cost of the item with the claim.

(c) Reimbursement for oxygen and oxygen supplies is as follows:

(1) Payment for oxygen systems (stationary, liquid and oxygen concentrators) is based on continuous rental, i.e., a continuous monthly payment is made as long as it is medically necessary. The rental payment includes all contents and supplies, i.e., regulators, tubing, masks, etc. Portable oxygen systems are also considered continuous rental. Ownership of the equipment remains with the supplier.

(2) Separate payment will not be made for maintenance,

servicing, delivery, or for the supplier to pickup the equipment when it is no longer medically necessary.
(3) Payment for oxygen and oxygen equipment and supplies will not exceed the Medicare fee for the same procedure code. ~~Reimbursement for members who reside in a nursing facility may be at a reduced rate.~~ The fee schedule will be reviewed annually and adjustments to the fee schedule may be made at any time based on efficiency, budget considerations, and quality of care as determined by the OHCA.
(4) Physical therapy, occupational therapy, and/or speech pathology and audiology services, are not covered when provided by a home health agency.

317:30-5-548. Procedure codes

~~Procedure codes for home health services are assigned HCPCS codes for supplies and durable medical equipment.~~All home health services are billed using Healthcare Common Procedure Coding System (HCPCS) codes.

317:30-5-549. Prosthetic devices [REVOKED]

~~Payment may be made to home health agencies for prosthetic devices. Refer to the Medical Suppliers Provider Rules for further information.~~

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

SUBCHAPTER 18. PROGRAMS OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)

317:35-18-6. PACE program benefits

(a) The PACE program offers a comprehensive benefit plan. A provider agency must provide a participant all the services listed in ~~42 CFR 460.92~~Section (§) 460.92 of Title 42 of the Code of Federal Regulations (C.F.R.) that are approved by the ~~IDT.~~interdisciplinary team (IDT). The PACE benefit package for all participants, regardless of the source of payment, must include but is not limited to the following:

(1) All SoonerCare-covered services, as specified in the State's approved ~~SoonerCare plan.~~Medicaid State Plan;

(2) ~~Interdisciplinary assessment~~IDT and treatment planning~~.~~;

(3) Primary care, including physician and nursing services~~.~~;

(4) Social work services~~.~~;

(5) Restorative therapies, including physical therapy, occupational therapy, and speech-language pathology services~~.~~;

(6) Personal care and supportive services~~.~~;

(7) Nutritional counseling~~.~~;

(8) Recreational therapy~~.~~;

(9) Transportation~~.~~;

(10) Meals~~.~~;

(11) Medical specialty services including, but not limited to the following:

(A) Anesthesiology~~.~~;

(B) Audiology~~.~~;

(C) Cardiology~~.~~;

(D) Dentistry~~.~~;

(E) Dermatology~~.~~;

(F) Gastroenterology~~.~~;

(G) Gynecology~~.~~;

(H) Internal medicine~~.~~;

(I) Nephrology~~.~~;

(J) Neurosurgery~~.~~;

(K) Oncology~~.~~;

(L) Ophthalmology~~.~~;

(M) Oral surgery~~.~~;

(N) Orthopedic surgery~~.~~;

(O) Otorhinolaryngology~~.~~;

(P) Plastic surgery~~.~~;

(Q) Pharmacy consulting services~~.~~;

(R) Podiatry~~.~~;

(S) Psychiatry~~.~~;
(T) Pulmonary disease~~.~~;
(U) Radiology~~.~~;
(V) Rheumatology~~.~~;
(W) General surgery~~.~~;
(X) Thoracic and vascular surgery~~.~~; and
(Y) Urology.
(12) Laboratory tests, x-rays, and other diagnostic procedures~~.~~;
(13) Drugs and biologicals~~.~~;
(14) Prosthetics, orthotics, ~~durable medical equipment,~~medical supplies, equipment, and appliances, corrective vision devices, such as eyeglasses and lenses, hearing aids, dentures, and repair and maintenance of these items~~.~~;
(15) Acute inpatient care, including the following:
(A) Ambulance~~.~~;
(B) Emergency room care and treatment room services~~.~~;
(C) Semi-private room and board~~.~~;
(D) General medical and nursing services~~.~~;
(E) Medical surgical/intensive care/coronary care unit~~.~~;
(F) Laboratory tests, x-rays, and other diagnostic procedures~~.~~;
(G) Drugs and biologicals~~.~~;
(H) Blood and blood derivatives~~.~~;
(I) Surgical care, including the use of anesthesia~~.~~;
(J) Use of oxygen~~.~~;
(K) Physical, occupational, respiratory therapies, and speech-language pathology services~~.~~; and
(L) Social services.
(16) Nursing facility (NF) care, including:
(A) Semi-private room and board;
(B) Physician and skilled nursing services;
(C) Custodial care;
(D) Personal care and assistance;
(E) Drugs and biologicals;
(F) Physical, occupational, recreational therapies, and speech-language pathology, if necessary;
(G) Social services; and
(H) Medical supplies, equipment, and appliances.
(17) Other services determined necessary by the ~~interdisciplinary team~~IDT to improve and maintain the participant's overall health status.

(b) The following services are excluded from coverage under PACE:
(1) Any service that is not authorized by the ~~interdisciplinary team,~~IDT, even if it is a required service, unless it is an emergency service.

(2) In an inpatient facility, private room and private duty nursing (PDN) services (unless medically necessary), and non-medical items for personal convenience such as telephone charges and radio or television rental (unless specifically authorized by the ~~interdisciplinary team~~IDT as part of the participant's plan of care).

(3) Cosmetic surgery, which does not include surgery that is required for improved functioning of a malformed part of the body resulting from an accidental injury or for reconstruction following mastectomy.

(4) Experimental medical, surgical, or other health procedures.

(5) Services furnished outside of the United States, except as follows:

(A) ~~in~~In accordance with 42 ~~CFR~~C.F.R. § 424.122 through 42 ~~CFR~~ C.F.R. § 424.124, and

(B) ~~as~~As permitted under the State's approved Medicaid ~~plan.~~State Plan.

(c) In the event that a PACE participant is in need of permanent placement in a ~~nursing facility,~~NF, a Medicaid premium will be imposed. OKDHS will calculate a vendor co-payment for those participants using the same methodology as is used for any Oklahoma Medicaid member who is accessing ~~nursing facility~~NF level of care. However, for a PACE participant, the ~~participants~~participant's responsibility will be to make payment directly to the PACE provider~~;~~, the amount to be specified by the OKDHS worker. There are no other share of costs requirements for PACE.

(d) All PACE ~~Program Benefits~~program benefits are offered through the duration of the PACE participant's enrollment in the PACE program. PACE enrollment does not cease once a participant's condition necessitates or the PACE IDT recommends that ~~they~~he or she be institutionalized.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 40. DEVELOPMENTAL DISABILITIES SERVICES

SUBCHAPTER 5. MEMBER SERVICES

PART 9. SERVICE PROVISIONS

317:40-5-104. Specialized medical supplies

(a) **Applicability.** The rules in this ~~section~~Section apply to ~~specialized medical supplies~~medical supplies, equipment, and appliances provided through ~~Home and Community Based Services (HCBS) Waivers~~home and community-based waiver services operated by the Oklahoma Department of Human Services (OKDHS) Developmental Disabilities Services ~~Division (DDSD).~~(DDS).

(b) **General information.** ~~Specialized medical supplies~~Medical supplies, equipment, and appliances include supplies specified in the plan of care that enable the member to increase his or her ability to perform activities of daily living. ~~Specialized medical supplies~~Medical supplies, equipment, and appliances include the purchase of ancillary supplies not available through SoonerCare.

(1) ~~Specialized medical supplies~~Medical supplies, equipment, and appliances must be included in the member's plan and arrangements for this service must be made through the member's case manager. Items reimbursed with ~~Home and Community Based Services~~home and community-based waiver services (HCBS) funds are in addition to any supplies furnished by SoonerCare.

(2) ~~Specialized medical supplies~~Medical supplies, equipment, and appliances meet the criteria for service necessity given in OAC 340:100-3-33.1.

(3) All items meet applicable standards of manufacture, design, and installation.

(4) ~~Specialized medical supplies~~Medical supplies, equipment, and appliance providers must hold a current SoonerCare Durable Medical Equipment (DME) and/or Medical Supplies Provider Agreement with the Oklahoma Health Care Authority, and be registered to do business in Oklahoma or the state in which they are domiciled. Providers must enter into the agreement giving assurance of ability to provide products and services and agree to the audit and inspection of all records concerning goods and services provided.

(5) Items that can be purchased as ~~specialized~~ medical supplies, equipment, and appliances include:

(A) ~~incontinence~~Incontinence supplies, as described in subsection (b) of this Section;

(B) ~~nutritional~~Nutritional supplements;

(C) ~~supplies~~Supplies for respirator or ventilator care;

(D) ~~decubitus~~Decubitus care supplies;

(E) ~~supplies~~Supplies for catheterization; and

(F) ~~supplies~~Supplies needed for health conditions.

(6) Items that cannot be purchased as ~~specialized~~ medical supplies, equipment, and appliances include:

(A) ~~over the counter~~Over-the-counter medications(s);

(B) ~~personal~~Personal hygiene items;

(C) ~~medicine~~Medicine cups;

(D) ~~items~~Items that are not medically necessary; and

(E) ~~prescription~~Prescription medication(s).

(7) ~~Specialized medical supplies~~Medical supplies, equipment, and appliances must be:

(A) ~~necessary~~Necessary to address a medical condition;

(B) ~~of~~Of direct medical or remedial benefit to the member;

(C) ~~medical~~Medical in nature; and

(D) ~~consistent~~Consistent with accepted health care practice standards and guidelines for the prevention, diagnosis, or treatment of symptoms of illness, disease, or disability.

(c) **Limited coverage.** Items available in limited quantities through ~~specialized~~ medical supplies, equipment, and appliances include:

(1) ~~incontinence~~Incontinence wipes, ~~300~~three-hundred (300) wipes per month;

(2) ~~non-sterile~~Non-sterile gloves, as approved by the Team;

(3) ~~disposable~~Disposable underpads, ~~60~~sixty (60) pads per month; and

(4) ~~incontinence~~Incontinence briefs, ~~180~~one-hundred and eighty (180) briefs per month.

(A) Adult briefs are purchased only in accordance with the implementation of elimination guidelines developed by the ~~Team.~~team.

(B) Exceptions to the requirement for implementation of elimination guidelines may be approved by the ~~DDSD~~DDS nurse when the member has a medical condition that precludes implementation of elimination guidelines, such as atonic bladder, neurogenic bladder, or following a surgical procedure.

(d) **Exceptions.** Exceptions to the requirements of this Section are explained in this subsection.

(1) When a member's ~~Team~~team determines that the member needs medical supplies that:

(A) ~~are~~Are not available through SoonerCare and for which no ~~Health Care Procedure Code~~healthcare common procedure code exists, the case manager e-mails pertinent information regarding the member's medical supply need to the programs manager responsible for ~~Specialized Medical Supplies.~~medical supplies, equipment, and appliances. The e-mail includes all pertinent information that supports the need for the supply,

including but not limited to, quantity and purpose; or

(B) ~~exceed~~Exceed the limits stated in subsection(c) of this Section, the case manager documents the need in the ~~Individual Plan~~individual plan for review and approval per OAC 340:100-33.

(2) Approval or denial of exception requests is made on a ~~case by case~~case-by-case basis and does not override the general applicability of this Section.

(3) Approval of a ~~specialized medical supplies~~medical supplies, equipment, and appliances exception does not exceed one (1) plan of care year.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 50. HOME AND ~~COMMUNITY BASED SERVICES WAIVERS~~COMMUNITY-BASED WAIVER SERVICES

SUBCHAPTER 1. MEDICALLY FRAGILE WAIVER SERVICES

317:50-1-14. Description of services

Services included in the Medically Fragile ~~Waiver~~waiver program are as follows:

(1) **Case Management.**

(A) Case ~~Management~~management services are services that assist a member in gaining access to medical, social, educational or other services, regardless of payment source of services, that may benefit the member in maintaining health and safety. Case managers initiate and oversee necessary assessments and reassessments to establish or reestablish waiver program eligibility. Case managers develop the member's comprehensive service plan, listing only services which are necessary to prevent institutionalization of the member, as determined through assessments. Case managers initiate the addition of necessary services or deletion of unnecessary services, as dictated by the member's condition and available support. Case managers monitor the member's condition to ensure delivery and appropriateness of services and initiate service plan reviews. If a member requires hospital or skilled nursing facility (NF) services, the case manager assists the member in accessing institutional care and, as appropriate, periodically monitors the member's progress during the institutional stay and helps the member transition from institution to home by updating the service plan and preparing services to start on the date the member is discharged from the institution. Case managers must meet Medically Fragile ~~Waiver~~waiver program minimum requirements for qualification and training prior to providing services to members. Prior to providing services to members choosing to self-direct their services, case managers are required to receive training and demonstrate knowledge regarding the self-directed service delivery model.

(B) Providers may only claim time for billable case management activities described as follows:

(i) A billable case management activity is any task or function defined under ~~OAC~~Oklahoma Administrative Code (OAC) 317:50-1-15(1)(A), that only a Medically Fragile case manager because of skill, training, or authority, can perform on behalf of a member;

(ii) Ancillary activities such as clerical tasks like mailing, copying, filing, faxing, drive time, or supervisory/administrative activities are not billable case management activities, although the administrative cost of these activities and other normal and customary business overhead costs have been included in the reimbursement rate for billable activities. Payment is not allowed for written reports or record documentation.

(C) Case ~~Management~~management services are prior authorized and billed per ~~fifteen-minute~~fifteen (15) minute unit of service using the rate associated with the location of residence of the member served.

(i) ~~Standard rate: ~~Case Management services are billed using a standard rate for reimbursement for billable service activities provided to a member who resides in a county with population density greater than twenty-five (25) persons per square mile.

(ii) ~~Very rural/difficult service area rate: ~~Case management services are billed using a very ~~rural/difficult~~rural/outside providers' service rate for billable service activities provided to a member who resides in a county with population density equal to or less than twenty-five (25) persons per square mile. An exception would be services to members that reside in OHCA-identified zip codes in Osage county adjacent to metropolitan areas of Tulsa and Washington counties. Services to these members are prior authorized and billed using the standard rate.

(iii) The latest United States Census, Oklahoma Counties population data is the source for determination of whether a member resides in a county with a population density equal to or less than twenty-five (25) persons per square mile, or resides in a county with a population density greater than twenty-five (25) persons per square mile.

(D) Case managers providing case management services to Medically Fragile waiver members must submit monthly monitoring case notes on a monthly basis to the OHCA Medically Fragile ~~Waiver~~waiver staff.

(E) Providers of Home and ~~Community Based Services~~Community-Based waiver services (HCBS) for the member, or those who have an interest in or are employed by a provider of HCBS for the member, must not provide case management or develop the person-centered service plan, except when the State demonstrates that the only willing and qualified entity to provide case management and/or develop person-centered service plans in a geographic area also provides HCBS.

(2) **Institutional transitional case management.**

(A) Institutional Transition case management services are required by the member's service plan, which are necessary to ensure the health, welfare, and safety of the member, or to enable the member to function with greater independence in the home, and without which, the member would continue to require institutionalization.

(B) Institutional transition case management services assist institutionalized members that are eligible to receive waiver services in gaining access to needed waiver and other state plan services, as well as needed medical, social, educational, and other services to assist the transition, regardless of the funding source for the services which access is gained.

(C) Institutional transition case management services may be authorized for periodic monitoring of a waiver member's progress during an institutional stay, and for assisting the member's transition from institution to home by updating the services plan, including preparing for necessary services and supports to be in place or to start on the date the member is discharged from the institution.

(3) **Respite.**

(A) Respite services are provided to members who are unable to care for themselves. They are provided on a short-term basis because of the absence or need for relief of the primary caregiver. Payment for respite care does not include room and board costs unless more than seven (7) hours are provided in a nursing facility~~.~~ (NF). Respite care will only be utilized when other sources of care and support have been exhausted. Respite care will only be listed on the service plan when it is necessary to prevent institutionalization of the member. Units of services are limited to the number of units approved on the service plan.

(B) ~~In-Home Respite~~In-home respite services are billed per fifteen (15) minute unit service. Within any ~~one-day~~one (1) day period, a minimum of eight (8) units must be provided with a maximum of ~~28~~twenty-eight (28) units provided. The service is provided in the member's home.

(C) ~~Facility-Based Extended Respite~~Facility-based extended respite is filed for a per diem rate, if provided in ~~Nursing Facility.~~a NF. Extended ~~Respite~~respite must be at least eight (8) hours in duration.

(D) In-Home Extended ~~Respite~~respite is filed for a per diem rate. A minimum of eight (8) hours must be provided in the member's home.

(4) **Environmental ~~Modifications.~~modifications.**

(A) Environmental ~~Modifications~~modifications are physical

adaptations to the home, required by the member's service plan, which are necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence in the home and without which, the member would require institutionalization. Adaptations or improvements to the home which are not of direct medical or remedial benefit to the ~~Waiver~~waiver member are excluded.

(B) All services require prior authorization.

(C) All services shall be provided in accordance with applicable state and local building codes and conform to the Americans with Disabilities Act Accessibility Guidelines, Title 28 of the Code of Federal Regulations Part 36 Appendix A.

(D) Payment for these services is made on an individual basis following a uniform process approved by the Medicaid agency.

(5) **~~Specialized Medical Equipment and Supplies.~~Medical Supplies, Equipment, and Appliances.**

(A) ~~Specialized medical equipment and supplies are devices, controls, or appliances~~Medical supplies, equipment, and supplies are specified in the service plan, which enable members to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live. Also included are items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment and supplies not available under the ~~Medicaid state plan~~Medicaid State Plan. This service excludes any equipment and/or supply items which are not of direct medical or remedial benefit to the Waiver member. This service is necessary to prevent institutionalization.

(B) ~~Specialized medical equipment and supplies~~Medical supplies, equipment, and supplies are billed using the appropriate ~~HCPC~~healthcare common procedure code~~.~~ (HCPC). Reoccurring supplies which are shipped to the member are compensable only when the member remains eligible for ~~Waiver~~waiver services, continues to reside in the home and is not institutionalized in a hospital, skilled ~~nursing facility~~(NF) or nursing home. It is the provider's responsibility to verify the member's status prior to shipping these items. Payment for ~~medical supplies~~medical supplies, equipment, and supplies is limited to the Medicare rate, or the SoonerCare rate, or is determined through manual pricing. If manual pricing is used, the provider is reimbursed at the provider's documented ~~Manufacturer's Suggested Retail Price~~manufacturer's suggested retail price

(MSRP) minus thirty (30) percent or invoice cost plus thirty (30) percent, whichever is the lesser of the two~~.~~ (2). OHCA may establish a fair market price through claims review and analysis.

(6) **Advanced ~~Supportive/Restorative Assistance.~~supportive/restorative assistance.**

(A) Advanced ~~Supportive/Restorative Assistance~~supportive/restorative assistance services are maintenance services to assist a member who has a chronic, yet stable, condition. These services assist with activities of daily living which require devices and procedures related to altered body functions. This service is for maintenance only and is not utilized as a treatment service.

(B) Advanced ~~Supportive/Restorative Assistance~~supportive/restorative assistance service is billed per fifteen (15) minute unit of service. The number of units of this service a member may receive is limited to the number of units approved on the service plan.

(7) **Nursing.**

(A) Nursing services are services listed in the service plan which are within the scope of the Oklahoma Nursing Practice Act and are provided by a registered professional nurse, or licensed practical or vocational nurse under the supervision of a registered nurse, licensed to practice in the State. Nursing services includes skilled nursing and/or private duty nursing. Skilled nursing is provided on an intermittent or part-time basis. Private duty nursing is individual and continuous care provided to a participant at home by licensed nurses. The provision of the nursing service will work to prevent or postpone the institutionalization of the member.

(B) Nursing services are services of a maintenance or preventive nature provided to members with stable, chronic conditions. These services are not intended to treat an acute health condition and may not include services which would be reimbursable under either Medicaid or Medicare's Home Health program. This service primarily provides nurse supervision to the Personal Care Assistant or to the Advanced Supportive/Restorative Assistance Aide and assesses the member's health and prescribed medical services to ensure that they meet the member's needs as specified in the service plan. A skilled nursing assessment/evaluation on-site visit is made to each member for whom Advanced Supportive/Restorative Assistance services are authorized to evaluate the condition of the member and medical appropriateness of services. An assessment/evaluation visit report will be made to the Medically Fragile Waiver case manager in accordance with review schedule determined in

consultation between the Case Manager and the Skilled Nurse, to report the member's condition or other significant information concerning each advanced supportive/restorative care member.

(i) The case manager may recommend authorization of Skilled Nursing services as part of the interdisciplinary team planning for the member's service plan and/or assessment/evaluation of:

(I) the member's general health, functional ability and needs and/or

(II) the adequacy of personal care and/or advanced supportive/restorative assistance services to meet the member's needs including providing on-the-job training and competency testing for personal care or advanced supportive/restorative care aides in accordance with rules and regulations for delegation of nursing tasks as established by the Oklahoma Board of Nursing.

(ii) In addition to assessment/evaluation, the case manager may recommend authorization of Skilled Nursing services for the following:

(I) preparing a one (1) week supply of insulin syringes for a blind diabetic, who can safely self-inject the medication but cannot fill his/her own syringe. This service would include monitoring the member's continued ability to self-administer the insulin;

(II) preparing oral medications in divided daily compartments for a member who self-administers prescribed medications but needs assistance and monitoring due to a minimal level of disorientation or confusion;

(III) monitoring a member's skin condition when a member is at risk for skin breakdown due to immobility or incontinence, or the member has a chronic stage II decubitus ulcer requiring maintenance care and monitoring;

(IV) providing nail care for the diabetic member or member with circulatory or neurological compromise;

(V) providing consultation and education to the member, member's family and/or other informal caregivers identified in the service plan, regarding the nature of the member's chronic condition. Provide skills training (including return skills demonstration to establish competency) to the member, family and/or other informal caregivers as specified in the service plan for preventive and rehabilitative care procedures.

(C) Nursing service can be billed for service plan development and/or assessment/evaluation services or, for other services within the scope of the Oklahoma Nursing Practice Act including private duty nursing. Nursing services are billed per fifteeen (15) minute unit of service. A specific procedure code is used to bill for assessment/evaluation/service plan development skilled nursing services and other procedure codes are used to bill for all other authorized nursing services. A maximum of eight (8) units per day of skilled nursing for assessment/evaluation and/or service plan development are allowed. An agreement by a provider to perform a nurse evaluation is also an agreement, to provide the nurse assessment identified in the Medicaid in-home care services for which the provider is certified and contracted. Reimbursement for a nurse evaluation is denied if the provider that produced the nurse evaluation fails to provide the nurse assessment identified in the Medicaid in-home care services for which the provider is certified and contracted.

(8) **Home Delivered Meals.**

(A) Home Delivered Meals provide one (1) meal per day. A home delivered meal is a meal prepared in advance and brought to the member's home. Each meal must have a nutritional content equal to at least one third (1/3) of the recommended daily allowance as established by the Food and Nutrition Board of the National Academy of Sciences. Meals are only provided to members who are unable to prepare meals and lack an informal provider to do meal preparation.

(B) Home Delivered Meals are billed per meal, with one meal equaling one unit of service. The limit of the number of units a member is allowed to receive is limited on the member's service plan. The provider must obtain a signature from the member or the member's representative at the time the meals are delivered. In the event that the member is temporarily unavailable (i.e., doctor's appointment, etc.) and the meal is left, the provider must document the reason a signature is not obtained. The signature logs must be available for review.

(9) **Occupational Therapy services.**

(A) Occupational Therapy services are those services that increase functional independence by enhancing the development of adaptive skills and performance capacities of members with physical disabilities and related psychological and cognitive impairments. Services are provided in the member's home and are intended to help the member achieve greater independence to reside and participate in the community. Treatment involves the therapeutic use of self-

care, work and play activities and may include modification of the tasks or environment to enable the member to achieve maximum independence, prevent further disability, and maintain health. Under a physician's order, a licensed occupational therapist evaluates the member's rehabilitation potential and develops an appropriate written therapeutic regimen. The regimen utilizes paraprofessional occupational therapy assistant services, within the limits of their practice, working under the supervision of the licensed occupational therapist. The regimen includes education and training for informal caregivers to assist with and/or maintain services, where appropriate. The therapist will ensure monitoring and documentation of the member's rehabilitative progress and will report to the member's case manager and physician to coordinate necessary addition and/or deletion of services, based on the member's condition and ongoing rehabilitation potential.

(B) Occupational Therapy services are billed per fifteen (15) minute unit of service. Payment is not allowed solely for written reports or record documentation.

(10) **Physical Therapy services.**

(A) Physical Therapy services are those services that prevent physical disability through the evaluation and rehabilitation of members disabled by pain, disease or injury. Services are provided in the member's home and are intended to help the member achieve greater independence to reside and participate in the community. Treatment involves use of physical therapeutic means such as massage, manipulation, therapeutic exercise, cold or heat therapy, hydrotherapy, electrical stimulation and light therapy. Under a physician's order, a licensed physical therapist evaluates the member's rehabilitation potential and develops an appropriate, written therapeutic regimen. The regimen utilizes paraprofessional physical therapy assistant services, within the limits of their practice, working under the supervision of the licensed physical therapist. The regimen includes education and training for informal caregivers to assist with and/or maintain services, where appropriate. The therapist will ensure monitoring and documentation of the member's rehabilitative progress and will report to the member's case manager and physician to coordinate necessary addition and/or deletion of services, based on the member's condition and ongoing rehabilitation potential.

(B) Physical Therapy services are billed per fifteen (15) minute units of service. Payment is not allowed solely for written reports or record documentation.

(11) **Speech and Language Therapy services.**

(A) Speech/Language Therapy services are those that prevent speech and language communication disability through the evaluation and rehabilitation of members disabled by pain, disease or injury. Services are provided in the member's home and are intended to help the member achieve greater independence to reside and participate in the community. Services involve use of therapeutic means such as evaluation, specialized treatment, and/or development and oversight of a therapeutic maintenance program. Under a physician's order, a licensed Speech/Language Pathologist evaluates the member's rehabilitation potential and develops an appropriate, written therapeutic regimen. The regimen utilizes paraprofessional therapy assistant services within the limits of their practice, working under the supervision of the licensed Speech/Language Pathologist. The regimen includes education and training for informal caregivers to assist with and/or maintain services, where appropriate. The Pathologist will ensure monitoring and documentation of the member's rehabilitative progress and will report to the member's case manager and physician to coordinate necessary addition and/or deletion of services, based on the member's condition and ongoing rehabilitation potential.

(B) Speech/Language Therapy services are billed per fifteen (15) minute unit of service. Payment is not allowed solely for written reports or record documentation.

(12) **Respiratory Therapy Services.**

(A) Respiratory therapy services are provided for a member who, but for the availability of in-home respiratory services, would require respiratory care as an inpatient in a hospital or nursing facility. Services are provided in the member's home under the care of a physician who is familiar with the technical and medical components of home ventilator support and the physician must determine medically that in-home respiratory care is safe and feasible for the member. Treatment involves use of therapeutic means such as: evaluation, respiratory treatments, chest physiotherapy, and/or development and oversight of a therapeutic maintenance program. Under a physician's order, a registered respiratory therapist evaluates the member and develops an appropriate, written therapeutic regimen. The regimen includes education and training for informal caregivers to assist with and/or maintain services, where appropriate. The therapist will ensure monitoring and documentation of the member's progress and will report to the member's case manager and physician to coordinate necessary addition

and/or deletion of services, based on the member's condition and ongoing rehabilitation potential.

(B) Respiratory ~~Therapy~~therapy services are billed per fifteen (15) minute unit of service. Payment is not allowed solely for written reports or record documentation.

(13) **Hospice Services.**

(A) Hospice is palliative and/or comfort care provided to the member and his/her family when a physician certifies that the member has a terminal illness and has six (6) months or less to live and orders hospice care. Medically Fragile Waiver hospice care is authorized for a six (6) month period and requires a physician certification of a terminal illness and orders of hospice care. If the member requires more than six months of hospice care, a physician or nurse practitioner must have a face-to-face visit with the member thirty (30) days prior to the initial hospice authorization end date and re-certify that the member has a terminal illness and has six months or less to live and orders additional hospice care. After the initial authorization period, additional periods of hospice may be authorized for a maximum of sixty (60) days increments with physician certification that the member has a terminal illness and has six months or less to live. A member's service plan that includes hospice care must comply with waiver requirements to be within total service plan cost limits.

(B) A hospice program offers palliative and supportive care to meet the special needs arising out of the physical, emotional and spiritual stresses which are experienced during the final stages of illness and during dying and bereavement. The member signs a statement choosing hospice care instead of routine medical care that has the objective to treat and cure the member's illness. Once the member has elected hospice care, the hospice medical team assumes responsibility for the member's medical care for the terminal illness in the home environment. Hospice care services include nursing care, physician services, medical equipment and supplies, drugs for symptom control and pain relief, home health aide and personal care services, physical, occupational and/or speech therapy, medical social services, dietary counseling and grief and bereavement counseling to the member and/or family. A hospice plan of care must be developed by the hospice team in conjunction with the member's case manager before hospice services are provided. The hospice services must be related to the palliation or management of the member's terminal illness, symptom control, or to enable the individual to maintain activities of daily living and basic functional skills.

Hospice may be provided to the member in a Nursing Facility (NF) only when the member is placed in the NF for Medically Fragile Facility Based Extended Respite. Hospice provided as part of Facility Based Extended Respite may not be reimbursed for more than five days during any thirty (30) day period. A member that is eligible for Medicare Hospice provided as a Medicare Part A benefit, is not eligible to receive Medically Fragile hospice services.

(C) Hospice services are billed per diem of service for days covered by a hospice plan of care and during which the hospice provider is responsible for providing hospice services as needed by the member or member's family.

(14) **Personal Care.**

(A) Personal Care is assistance to a member in carrying out activities of daily living such as bathing, grooming and toileting, or in carrying out instrumental activities of daily living, such as preparing meals and doing laundry, to assure personal health and safety of the individual or to prevent or minimize physical health regression or deterioration. Personal Care services do not include service provision of a technical nature, i.e. tracheal suctioning, bladder catheterization, colostomy irrigation, and operation/maintenance of equipment of a technical nature.

(B) Medically Fragile Home Care Agency Skilled Nursing staff working in coordination with a case manager are responsible for development and monitoring of the member's Personal Care plan.

(C) Personal Care services are prior authorized and billed per fifteen (15) minute unit of service with units of service limited to the number of units on the approved service plan.

(15) **Personal Emergency Response System.**

(A) Personal Emergency Response System (PERS) is an electronic device which enables certain individuals at high risk of institutionalization to secure help in an emergency. The individual may also wear a portable help button to allow for mobility. The system is connected to the person's phone and programmed to signal, in accordance with member preference, a friend, a relative or a response center once a help button is activated. The response center is staffed by trained professionals. For an Medically Fragile program member to be eligible to receive PERS service, the member must meet all of the following service criteria:

(i) ~~a~~A recent history of falls as a result of an existing medical condition that prevents the individual from getting up from a fall unassisted;

(ii) ~~lives~~Lives alone and has no regular caregiver, paid or unpaid, and therefore is left alone for long periods of time;

(iii) ~~demonstrates~~Demonstrates capability to comprehend the purpose of and activate the PERS;

(iv) ~~has~~Has a health and safety plan detailing the interventions beyond the PERS to assure the member's health and safety in his/her home;

(v) ~~has~~Has a disease management plan to implement medical and health interventions that reduce the possibility of falls by managing the member's underlying medical condition causing the falls; and,

(vi) ~~the~~The service avoids premature or unnecessary institutionalization of the member.

(B) PERS services are billed using the appropriate health care procedure codes for installation, monthly service or purchase of PERS. All services are prior authorized in accordance with the Medically Fragile approved service plan.

(16) **Prescription drugs.** Members are eligible for a maximum of six (6) prescriptions per month with a limit of three (3) brand-name prescriptions. Seven (7) additional generic prescriptions per month are allowed if medically necessary. Medically necessary prescriptions beyond the three (3) brand-name or thirteen (13) total prescriptions will be covered with prior authorization. More information on prescription drugs is provided at OAC 317:30-5-72.

(17) **Self-Direction.**

(A) Self-Direction is a method of service delivery that allows waiver members to determine supports and services they need to live successfully in a home or community based setting. A member choosing Self-Direction is the employer of record for his/her Personal Care and Advanced Supportive/Restorative Care service providers and must have an approved service plan prior to initiation of any Self-Directed activities.

(B) The OHCA uses the following criteria to determine a member's eligibility to participate in the Self-Directed option:

(i) ~~have~~Have an existing need for Self-Directed services to prevent institutionalization;

(ii) ~~member's~~Member's health and safety with Self-Directed services can reasonably be assured based on a review of service history records and a review of member capacity and readiness to assume employer responsibilities under Self-Direction with any one of the following findings as basis to deny a request for Self-

Direction due to inability to assure member health and safety;

(I) ~~the~~The member does not have the ability to make decisions about his/her care or service planning and the member's authorized representative is not willing to assume Self-Directed services responsibilities~~,~~; or

(II) ~~the~~The member is not willing to assume responsibility, or to enlist an authorized representative to assume responsibility, in one (1) or more areas of Self-Direction such as in service planning, or in assuming the role of employer of the Personal Care Assistant (PCA) or Advanced Supportive/Restorative (ASR) service provider, or in monitoring and managing health or in preparation for emergency backup~~,~~; or

(III) ~~the~~The member has a recent history of self-neglect or self-abuse as evidenced by Adult Protective Services intervention within the past ~~12~~twelve (12) months and does not have an authorized representative with capacity to assist with Self-Direction responsibilities~~,~~.

(C) The member voluntarily makes an informed choice to Self-Direct services. As part of the informed choice, decision making process for Self-Direction, the OHCA staff or the case manager provides consultation and assistance as the member completes a self-assessment of preparedness to assume the role of employer for their ~~Personal Care Assistant~~PCA. The orientation and enrollment process will provide the member with a basic understanding of what will be expected of them under Self-Direction, the supports available to assist them to successfully perform employer responsibilities and an overview of the potential risks involved.

(D) The OHCA uses the following criteria to determine that based upon documentation, a person is no longer able to participate in the Self-Directed services option:

(i) ~~the~~The member does not have the ability to make decisions about his/her care or service planning and the member's authorized representative is not willing to assume Self-Direction responsibilities; or

(ii) ~~the~~The member is not willing to assume responsibility, or to enlist an authorized representative to assume responsibility, in one or more areas of Self-Direction such as in service planning, or in assuming the role of employer of the PCA or ASR service providers, or in monitoring and managing health or in preparation for emergency backup; or

(iii) ~~the~~The member has a recent history of self-neglect or self-abuse as evidenced by Adult Protective Services intervention and does not have an "authorized representative" with capacity to assist with Self-Direction responsibilities; or

(iv) ~~the~~The member abuses or exploits their employee; or

(v) ~~the~~The member falsifies time-sheets or other work records; or

(vi) ~~the~~The member, even with case manager and financial management services assistance, is unable to operate successfully within their Individual Budget Allocation (IBA); or

(vii) ~~inferior~~Inferior quality of services provided by member/employer's employee, or the inability of the member/employer's employee to provide the number of service units the member requires, jeopardizes the member's health and/or safety.

(E) The member may designate a family member or friend as an "authorized representative" to assist in the service planning process and in executing member employer responsibilities. If the member chooses to designate an "authorized representative", the designation and agreement identifying the "willing adult" to assume this role and responsibility is documented with dated signatures of the member, the designee and the member's case manager or the OHCA staff.

(i) A person having guardianship or legal power of attorney or other court sanctioned authorization to make decisions on behalf of the member has legal standing to be the member's designated "authorized representative".

(ii) An individual hired to provide Personal Services Assistance to a member may not be designated the "authorized representative" for the member.

(F) Self-Directed Services are delivered as authorized on the service plan and are limited to Personal Care, Respite and Advanced Supportive/Restorative Care. The member employs the ~~Respite~~respite or PCA and/or the ASR provider and is responsible, with assistance from the Administrative Financial Management Services (FMS), for ensuring that the employment complies with state and federal labor law requirements. The member:

(i) ~~recruits~~Recruits, hires and, as necessary, discharges the PCA and ASR;

(ii) ~~provides~~Provides instruction and training to the PCA or ASR on tasks to be done and works with the case manager to obtain skilled nursing services assistance with training when necessary. Prior to performing an ASR

provider task for the first time, the ASR must demonstrate competency in the tasks in an on-the-job training session conducted by the member and the member must document the attendant's competency in performing each task in the ASR provider personnel file;

(iii) ~~determines~~Determines where and how the PCA or ASR works, hours of work, what is to be accomplished and, within IBA limits, wages to be paid for the work;

(iv) ~~supervises~~Supervises and documents employee work time; and~~,~~

(v) ~~provides~~Provides tools and materials for work to be accomplished.

(G) FMS are program administrative services provided to participating Self-Directed Service employer/members by agencies contracted with the OHCA. FMS are employer related assistance that provides Internal Revenue Service (IRS) fiscal reporting agent and other financial management tasks and functions including, but not limited to:

(i) ~~employer~~Employer payroll, at a minimum of semi monthly, and associated withholding for taxes, or for other payroll withholdings performed on behalf of the member as employer of the PCA or ASR provider;

(ii) ~~other~~Other employer related payment disbursements as agreed to with the member and in accordance with the member's IBA;

(iii) ~~responsibility~~Responsibility for obtaining criminal and abuse registry background checks, on behalf of the member, on prospective hires for PCA or ASR provider;

(iv) ~~providing~~Providing to the member, as needed, assistance with employer related cognitive tasks, decision-making and specialized skills that may include assistance with IBA planning and support for making decisions including training and providing reference material and consultation regarding employee management tasks such as recruiting, hiring, training and supervising the member's respite or PCA or ASR provider; and

(H) The service of ~~Respite~~respite or PCA is billed per fifteen (15) minute unit of service. The number of units of PCA a member may receive is limited to the number of units approved on the Service Plan.

(I) ASR services are billed per fifteen (15) minute unit of service. The number of units of ASR a member may receive is limited to the number of units approved on the Service Plan.

(J) Self-Directed Services rates are determined using the IBA expenditure accounts determination process for each

member. The IBA expenditure accounts determination process includes consideration and decisions about the following:

(i) The IBA expenditure accounts determination constrains total SoonerCare reimbursement for Self-Directed services to be less than expenditures for equivalent services using agency providers.

(ii) The PCA and ASR service unit rates are calculated by the OHCA during the Self-Directed service eligibility determination process. The allocation of portions of the PCA and/or ASR rate to cover salary, mandatory taxes, and optional benefits (including worker's compensation insurance, if available) is determined individually for each member using the Self-Directed services IBA expenditure accounts determination process.

(iii) The IBA Expenditure Accounts Determination process defines the level of program financial resources required to meet the member's need for Self-Directed services. If the member's need for services changes due to a change in health/disability status and/or a change in the level of support available from other sources, the case manager, based upon an updated assessment, amends the service plan to increase Self-Directed service units appropriate to meet additional member need. The OHCA, upon favorable review, authorizes the amended plan and updates the member's IBA. Service amendments based on changes in member need for services do not change an existing PCA or ASR rate. The member, with assistance from the FMS, reviews and revises the IBA expenditure accounts calculation annually or more often to the extent appropriate and necessary.

(18) **Self-Directed Goods and Services (SD-GS).**

(A) Self-Directed Goods and Services (SD-GS) are incidental, non-routine goods and services that promote the member's self-care, daily living, adaptive functioning, general household activity, meal preparation and leisure skills needed to reside successfully in the community and do not duplicate other services authorized in the member's service plan.

(B) These goods and services are purchased from the self-directed budget. All goods and services must be approved by the Medically Fragile wavier staff. Documentation must be available upon request.

(19) **Transitional case management.**

(A) Transitional case management are one-time billable expenses for members who transition from within the community to the Medically Fragile waiver.

(B) Transitional case management must be reasonable and necessary as determined through the transition plan development process and must be clearly identified in the plan.
(C) Transitional case management assist members that are eligible to receive waiver services in gaining access to needed waiver and other state plan services, as well as needed medical, social, educational, and other services to assist the transition, regardless of the funding source for the services which access is gained.
(D) Transitional case management may be authorized for assisting the member transition to the Medically Fragile Waiver by updating the service plan, including preparing for necessary services and supports to be in place or to start on the date the member is effective with the waiver.

Attachment F

Oklahoma Health Care Authority Board Meeting – Drug Summary

Drug Utilization Review Board Meetings – May 13, 2020 and June 10, 2020

Recommendation/ Vote	Drug	Used for	Cost*	Notes
1	Aliqopa™ Brukinsa™ Polivy™ Ruxience™	• Lymphoma	• $13,995 per 28 days • $12,934 per 30 days • $90,000 per 6 cycles • $47,308 per 6 cycles	• Adults with Follicular Lymphoma • Adults Mantle Cell Lymphoma • Adults with Diffuse Large B-cell Lymphoma • Non-Hodgkin's Lymphoma, Chronic Lymphocytic Leukemia, Wegener's Granulomatosis, and Microscopic Polyangitis
2	Mayzant® Mavenclad® Vumerity™	• Multiple Sclerosis	• $92,088 • $284,285 • $86,788	• Relapsing forms of MS • Relapsing forms of MS • Relapsing forms of MS
3	Tepezza™	• Grave's eye disease	• $342,700 per treatment course	• Surgery is only other treatment
4	Ayvakit™ Bynfezia Pen™ Tazverik™	• Sacrcoma	• $32,000 per 30 days • NA • $15,499 per 30 days	• Adults w/ Gastrointestinal Stromal Tumors • Vasoactive Intestinal Peptide-secreting Tumors, Carcinoid Tumors, and Acromegaly • ≥ 16 years with epithelioid sarcoma

5	Pemfexy™ Rozlytrek® Zirabev™	• Lung Cancer	• NA • $16,800 per 30 days • $63,778 - $114,660 per year depending on diagnosis	• Non-small Cell Lung Cancer (NSCL) and Malignant Pleural Mesothelioma • NSCL and specific solid tumors • Colorectal Cancer, NSCL, Glioblastoma, Renal Cell Carcinoma, Cervical Caner
6	Ziextenzo®	• Prevent infections post chemotherapy	• $3,925 per chemotherapy cycle	• Cheaper net cost products available without a PA
7	Palforzia™	• Peanut Allergies	• $10,680 per year	• Lifetime treatment
8	Nourianz™	• Parkinson's Disease	• $18,000 per year	• Increases "on" time

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

Recommendation 1: Vote to Prior Authorize Tepezza™

The Drug Utilization Review Board recommends the prior authorization of Tepezza™ (Teprotumumab-trbw) with the following criteria:

Tepezza™ (Teprotumumab-trbw) Approval Criteria:

1. An FDA approved indication for the treatment of thyroid eye disease in adult members 18 years of age and older; and
    a. Member must be experiencing eye symptoms related to thyroid eye disease; and
    b. Member must have thyroid blood levels in the normal range or must be undergoing active treatment working toward normal range; and
2. Female members must not be pregnant and must have a negative pregnancy test prior to initiation of therapy; and
3. Female members of reproductive potential must be willing to use effective contraception prior to initiation, during treatment with Tepezza™, and for at least 6 months after the last dose of Tepezza™; and
4. Member must not have had prior surgical treatment for thyroid eye disease; or
    a. A prior authorization request with patient-specific information may be submitted for consideration of Tepezza™ for members who have had prior surgical treatment for thyroid eye disease, including but not limited to patient-specific, clinically significant information regarding the member's prior surgery and the need for Tepezza™; and
5. Medical supervision by an ophthalmologist in conjunction with an endocrinologist for the treatment of thyroid eye disease; and
    a. The name of the ophthalmologist and endocrinologist recommending treatment with Tepezza™ must be provided on the prior authorization request; and
6. Tepezza™ must be administered as an intravenous (IV) infusion at the recommended infusion rate per package labeling, with appropriate pre-medication(s) based on the member's risk of infusion reactions; and
7. Tepezza™ must be administered by a health care professional. Prior authorization requests must indicate how Tepezza™ will be administered; and

   a. Tepezza™ must be shipped via cold chain supply to the facility where the member is scheduled to receive treatment; or
   b. Tepezza™ must be shipped via cold chain supply to the member's home and administered by a home health care provider and the member (or the member's caregiver) must be trained on the proper storage of Tepezza™; and
8. The member's current weight must be provided on the prior authorization request in order to authorize the appropriate amount of drug required according to package labeling; and
9. Approvals will be for a maximum of 8 total infusions.

Recommendation 2: Mayzent®, Mavenclad®, and Vumerity™

The Drug Utilization Review Board recommends the prior authorization of Mayzent® (Siponimod), Mavenclad® (Cladribine), and Vumerity™ (Diroximel Fumarate) with the following criteria:

Mayzent® (Siponimod) Approval Criteria:

1. An FDA approved diagnosis of relapsing forms of multiple sclerosis (MS), to include clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease; and
2. Member must have been assessed for CYP2C9 genotype:
   a. Members with a CYP2C9*3/*3 genotype will not generally be approved; or
   b. Members with a CYP2C9*1/*3 or *2/*3 genotype will not be approved for doses exceeding 1mg per day; or
   c. All other genotypes (CYP2C9*1/*1, *1/*2, or *2/*2) will be approved for 2mg per day; and
3. Member must not have any contraindication for use of siponimod including:
   a. CYP2C9*3/*3 genotype; or
   b. Experienced myocardial infarction (MI), unstable angina, stroke, transient ischemic attack (TIA), decompensated heart failure (HF) requiring hospitalization, or class III/IV HF in the last 6 months; or
   c. Presence of Mobitz type II second-degree, third-degree atrioventricular (AV) block, or sick sinus syndrome, unless member has a functioning pacemaker; and
4. Member must not have received prior treatment with alemtuzumab; and

5. Verification from the prescriber that member has no active infection(s); and
6. Complete blood counts (CBC) and verification that levels are acceptable to the prescriber; and
7. Liver function tests (LFTs) and verification that levels are acceptable to the prescriber; and
8. Ophthalmic evaluation and verification that member will be monitored for changes in vision throughout therapy; and
9. Verification from the prescriber that the member has been assessed for medications and conditions that cause reduction in heart rate (HR) or AV conduction delays and that the member will be followed with appropriate monitoring per package labeling; and
10. Verification from the prescriber that the member has been assessed for previous confirmed history of chickenpox or vaccination against varicella. Members without history of chickenpox or varicella vaccination should receive a full course of the varicella vaccine prior to commencing treatment with Mayzent®; and
11. Verification from the prescriber that members with sinus bradycardia (HR <55 beats per minute), first- or second-degree AV block (Mobitz type I), or a history of HF or MI will be monitored following the first dose for a minimum of 6 hours; and
12. Female members of reproductive potential must not be pregnant and must have a negative pregnancy test prior to initiation of therapy; and
13. Female members of reproductive potential must be willing to use effective contraception during treatment with Mayzent® and for at least 10 days after discontinuing treatment; and
14. Member must have had an inadequate response to Gilenya® (fingolimod) or a patient-specific, clinically significant reason why fingolimod is not appropriate for the member must be provided; and
15. Compliance will be checked for continued approval every 6 months; and
16. Quantity limits according to package labeling will apply.

Mavenclad® (Cladribine) Approval Criteria:

1. An FDA approved diagnosis of relapsing forms of multiple sclerosis (MS), to include relapsing remitting disease and active secondary progressive disease in adults; and
2. Requests for use in patients with clinically isolated syndrome will not generally be approved; and

3. Member must have had at least 1 relapse in the previous 12 months; and
4. Member must have had an inadequate response to 2 or more medications indicated for the treatment of MS; and
5. Prescriber must confirm that the member does not have any contraindications for use of cladribine; and
6. Prescriber must confirm that the member does not have an active malignancy; and
7. Prescriber must confirm that females members of reproductive potential must not be pregnant and must have a negative pregnancy test prior to initiation of therapy; and
8. Prescriber must attest that female and male members of reproductive potential plan to use effective contraception during cladribine dosing and for 6 months after the last dose in each treatment course; and
9. Complete blood counts (CBC) and verification that levels are acceptable to the prescriber; and
10. Verification from the prescriber that member has no active infection(s); and
11. Liver function tests (LFTs) and verification that levels are acceptable to the prescriber; and
12. The member's recent weight must be provided on the prior authorization request in order to authorize the appropriate amount of drug required according to package labeling; and
13. Quantity limits according to package labeling will apply.

Vumerity® (Diroximel Fumarate) Approval Criteria:

1. An FDA approved diagnosis of relapsing forms of multiple sclerosis (MS), to include clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease; and
2. Approvals will not be granted for concurrent use with other disease-modifying therapies; and
3. Verification from the prescriber that member has no serious active infection(s); and
4. Complete blood counts (CBC) and verification that levels are acceptable to the prescriber; and
5. Serum aminotransferase, alkaline phosphatase, and total bilirubin levels and verification that levels are acceptable to the prescriber; and
6. Verification from the prescriber that member does not have moderate or severe renal impairment; and

7. Verification from the prescriber that the member has been counseled on proper administration of Vumerity® including caloric and fat intake limits at the time of dosing; and
8. Compliance will be checked for continued approval every 6 months; and
9. A quantity limit of 120 capsules per 30 days will apply.

Recommendation 3: Vote to Prior Authorize Aliqopa™, Brukinsa™, Polivy™, and Ruxience™

The Drug Utilization Review Board recommends the prior authorization of Aliqopa™ (Copanlisib), Brukinsa™ (Zanubrutinib), Polivy™ (Polatuzumab Vedotin-piiq), and Ruxience™ (Rituximab-pvvr) with the following criteria:

Aliqopa™ (Copanlisib) Approval Criteria [Follicular Lymphoma (FL) Diagnosis]:

1. A diagnosis of relapsed/refractory FL; and
2. Member must have failed at least 2 prior systemic therapies.

Brukinsa™ (Zanubrutinib) Approval Criteria [Mantle Cell Lymphoma (MCL) Diagnosis]:

1. Adult members with a diagnosis of MCL; and
2. Member must have received at least 1 prior therapy.

Polivy™ (Polatuzumab Vedotin-piiq) Approval Criteria [Diffuse Large B-Cell Lymphoma (DLBCL) or High Grade B-Cell Lymphoma Diagnosis]:

1. Relapsed/refractory DLBCL or high grade B-cell lymphoma after at least 2 prior therapies; and
2. Used in combination with bendamustine and rituximab; and
3. Member is not a candidate for transplant.

Ruxience™ (Rituximab-pvvr) Approval Criteria:

a. An FDA approved diagnosis; and
b. A patient-specific, clinically significant reason why the member cannot use Rituxan® (rituximab) must be provided.

Recommendation 4: Vote to Prior Authorize Ayvakit™, Bynfezia Pen™, and Tazverik™

The Drug Utilization Review Board recommends the prior authorization of Ayvakit™ (Avapritinib), Bynfezia Pen™ (Octreotide), and Tazverik™ (Tazemetostat) with the following criteria:

Ayvakit™ (Avapritinib) Approval Criteria [Gastrointestinal Stromal Tumor (GIST) Diagnosis]:

1. A diagnosis of unresectable or metastatic GIST in adult members; and
2. Member has a *PDGFRA* exon 18 mutation (including *PDGFRA* D842V mutations).

Tazverik™ (Tazemetostat) Approval Criteria [Epithelioid Sarcoma Diagnosis]:

1. A diagnosis of metastatic or locally advanced epithelioid sarcoma; and
2. Member is not eligible for complete resection; and
3. Member must be 16 years of age or older.

Bynfezia Pen™ (Octreotide) Approval Criteria [Metastatic Carcinoid Tumor or Vasoactive Intestinal Peptide-Secreting Tumors (VIPoma) Diagnosis]:*

1. A diagnosis of advanced metastatic carcinoid tumor or VIPoma; and
2. Presence of severe diarrhea or flushing; and
3. A patient-specific, clinically significant reason why the member cannot use other available short-acting injectable formulations of octreotide must be provided.

Bynfezia Pen™ (Octreotide) Approval Criteria [Acromegaly Diagnosis]:*

1. A diagnosis of acromegaly; and
2. Documentation of inadequate response to or cannot be treated with surgical resection, pituitary irradiation, and bromocriptine mesylate or cabergoline at maximally tolerated doses; and
3. A patient-specific, clinically significant reason why the member cannot use other available short-acting injectable formulations of octreotide must be provided.

Recommendation 5: Vote to Prior Authorize Pemfexy™, Rozlytrek®, and Zirabev™

The Drug Utilization Review Board recommends the prior authorization of Pemfexy™ (Pemetrexed), Rozlytrek® (Entrectinib), and Zirabev™ (Bevacizumab-bvzr) with the following criteria:

Pemfexy™ (Pemetrexed) Approval Criteria:

1. An FDA approved diagnosis; and
2. A patient-specific, clinically significant reason the member cannot use Alimta® (pemetrexed) must be provided.

Rozlytrek® (Entrectinib) Approval Criteria [Non-Small Cell Lung Cancer (NSCLC) Diagnosis]:

1. Diagnosis of metastatic NSCLC; and
2. *ROS1*-positive.

Rozlytrek® (Entrectinib) Approval Criteria [Solid Tumor Diagnosis]:

1. Diagnosis of solid tumors; and
2. Member must be 12 years of age or older; and
3. Neurotrophic tyrosine receptor kinase (NTRK) gene fusion without a known acquired resistance mutation; and
4. Metastatic or not a surgical candidate; and
5. Progressed following treatment or have no satisfactory alternative therapy.

Zirabev™ (Bevacizumab-bvzr) Approval Criteria:

1. A patient-specific, clinically significant reason why the member cannot use Avastin® (bevacizumab) must be provided.

Recommendation 6: Vote to Prior Authorize Ziextenzo®

The Drug Utilization Review Board recommends the prior authorization of Ziextenzo®(Pegfilgrastim-bmez) with the following criteria:

Ziextenzo® (Pegfilgrastim-bmez) Approval Criteria:

1. An FDA approved diagnosis; and
2. A patient-specific, clinically significant reason why the member cannot use Neulasta® (pegfilgrastim) or Neupogen® (filgrastim) must be provided.

Recommendation 7: Vote to Prior Authorize Palforzia™

The Drug Utilization Review Board recommends the prior authorization of Palforzia™ (Peanut Allergen Powder-dnfp) with the following criteria:

Palforzia™ (Peanut Allergen Powder-dnfp) Approval Criteria:

1. Member must be 4 to 17 years of age to initiate initial dose escalation (maintenance dosing may be continued for members 4 years of age and older); and
2. Member must have a diagnosis of peanut allergy confirmed by a positive skin test, positive *in vitro* test for peanut-specific IgE, or positive clinician-supervised oral food challenge; and
3. Prescriber must confirm member will use Palforzia™ with a peanut-avoidant diet; and
4. Member must not have severe uncontrolled asthma; and
5. Member must not have a history of eosinophilic esophagitis or other eosinophilic gastrointestinal disease; and
6. Member must not have had severe or life-threatening anaphylaxis within the previous 60 days; and
7. Member or caregiver must be trained in the use of an auto-injectable epinephrine device and have such a device available for immediate use at all times; and
8. Prescriber must be an allergist, immunologist, or be an advanced care practitioner with a supervising physician that is an allergist or immunologist; and
9. Prescriber, health care setting, and pharmacy must be certified in the Palforzia™ Risk Evaluation and Mitigation Strategy (REMS) program; and
10. Member must be enrolled in the Palforzia™ REMS program; and
11. Palforzia™ must be administered under the direct observation of a health care provider in a REMS certified health care setting with an observation duration in accordance with the prescribing information; and
12. After successful completion of initial dose escalation and all levels of up-dosing as documented by the prescriber, initial approvals of maintenance dosing will be for 6 months. For continued approval, the member must be compliant and prescriber must verify the member is responding well to treatment.

Recommendation 8: Vote to Prior Authorize Nourianz™

The Drug Utilization Review Board recommends the prior authorization of Nourianz™ (Istradefylline Tablet) with the following criteria:

Nourianz™ (Istradefylline Tablet) Approval Criteria:

1. An FDA approved diagnosis of Parkinson's disease (PD); and

2. Member must be taking carbidopa/levodopa in combination with istradefylline (istradefylline has not been shown to be effective as monotherapy for the treatment of PD); and
3. Prescriber must verify that the dose is appropriate for the member based on degree of hepatic impairment, concomitant strong CYP3A4 inhibitors, and smoking status of the member; and
4. Member must be experiencing at least 2 hours of “off” time per day; and

A quantity limit of 1 tablet per day will apply.