OKLAHOMA HEALTH CARE AUTHORITY
REGULAR BOARD MEETING
May 19, 2021 at 3:00 P.M.
Oklahoma Health Care Authority
4345 N. Lincoln Blvd.
Oklahoma City, OK 73105

A G E N D A

This meeting will occur via videoconference, but certain parties, including CEO Corbett, Chairman Hupfeld, Vice-Chairman Yaffe, Member Boyd, Member Curry, Member Kennedy, Member Nuttle, Member Shamblin, 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

Tanya Case – Zoom videoconference

Public access via Zoom:
https://okhca.zoom.us/webinar/register/WN_NFr2NYtvS8CgFndXi1g2lw
Telephone: 1-669-900-6833 Webinar ID: 974 7924 4804

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

2. Public Comment…………………………………………………………………………………Stan Hupfeld, Chair

3. Member Moment……………………………………………………………………..Deborah Shropshire, M.D.
Director, Child Welfare Services
Oklahoma Human Services

4. Approval of the March 17, 2021 Board Meeting Minutes (Attachment "A")…………..Stan Hupfeld, Chair

5. Chief Executive Officer's Report………………………………..……….Kevin Corbett, Chief Executive Officer

6. Chief of Staff's Report…………………………………………………..............Ellen Buettner, Chief of Staff

7. Chief Operating Officer's Report………………………………....Melody Anthony, Chief Operating Officer
State Medicaid Director
   a) Managed Care Implementation Update (Attachment "B")

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

9. Discussion of Report from the……………………………………………………………..Phil Kennedy
Compliance Advisory Committee — Chair, Compliance Advisory Committee

   a) Discussion and vote regarding the Authority's ability to withstand the procurement decision made by the CEO based on the Authority's budget and available funds.
      i. Behavioral Health Home Management Software System (Attachment "C")
      ii. Recovery Audit Contractor (Attachment "D")
      iii. Third Party Liability Systems (Attachment "E")
      iv. Asset Verification System Services (Attachment "F")
      v. Managed Care Program Administration & Performance and Functional Capabilities assessment Phase 2 (Attachment "G")

10. Discussion of Report from the…………………………………………………………………Robert Boyd
Strategic Planning Advisory Committee — Chair, Strategic Planning Advisory Committee

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

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 "H"):

i. Inqovi® (Decitabine/ Cedazuridine) and Onureg® (Azacitidine)
ii. Fintepla® (Fenfluramine)
iii. Vyepti® (Eptinezumab-jjmr)
iv. Oxlumo™ (Lumasiran)
v. Zokinvy® (Lonafarnib)
vi. Monjuvi® (Tafasitamab-cxix), Tecartus™ (Brexucabtagene Autoleucel), and Ukoniq™ (Umbralisib)
vii. Sevenfact® [Coagulation Factor VIIa (Recombinant)-jncw]
viii. Bafiertam™ (Monomethyl Fumarate), Kesimpta® (Ofatumumab), and Zeposia® (Ozanimod)
ix. Orladeyo™ (Berotralstat)
x. Barhemsys® (Amisulpride)
xi. Nyvepria™ (Pegfilgrastim-apgf)

12. Discussion of Report from the……………………………………………Laura Shamblin, M.D., FAAP
Administrative Rules Advisory Committee and Administrative Rules Advisory Committee
Possible Action Regarding Agency Rulemaking (Attachment "I")

a) Consideration and Vote on a Declaration of a Compelling Public Interest for the Promulgation of the Emergency Rules in Attachment "I" 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 "I"):

i. APA WF #21-02 State Plan Personal Care Services
ii. APA WF # 21-03 Remove Reasonable Limits on Amounts for Necessary Medical and Remedial Care not covered under the Oklahoma Medicaid State Plan
iii. APA WF #21-05A Medicaid Expansion and Durable Medical Equipment
iv. APA WF #21-05B Medicaid Expansion
v. APA WF #21-06 Insure Oklahoma (IO) Program Changes and Timely Filing

13. Discussion and Possible Action…………………………………………………………Stan Hupfeld, Chair
Possible Executive Session as Recommended by the Director of Legal Services and Authorized by the Open Meeting Act, 25 O.S. § 307(B)(4) and (7), To Discuss Confidential Legal Matters, Including Pending State and Federal Litigation.

14. Adjournment…………………………………………………………………………Stan Hupfeld, Chair

NEXT BOARD MEETING
June 30, 2021
Oklahoma Health Care Authority
4345 N. Lincoln Blvd.
Oklahoma City, OK

Attachment A

MINUTES OF A SPECIAL BOARD MEETING
OF THE HEALTH CARE AUTHORITY BOARD
March 17, 2021
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 March 17, 2020 at 3:00 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 March 12, 2021 at 3:41 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 2:59 p.m.

BOARD MEMBERS PRESENT: Chairman Hupfeld, Member Case, Member Hausheer, Member Kennedy, Member Nuttle,

BOARD MEMBERS ABSENT: Vice-Chairman Yaffe, Member Boyd, Member Curry, Member Shamblin

ITEM 2 – MEMBER MOMENT
Melody Anthony, Chief Operating Officer/State Medicaid Director

Ms. Anthony introduced Tiffany Dougan, mother of Kristen Dougan, and Kristen's Case Manager, Jennifer Whitfield. Prior to being introduced, the news story which aired on KOCO 5 was played.

ITEM 3 / DISCUSSION AND POSSIBLE VOTE ON APPROVAL OF CONSENT AGENDA WHICH INCLUDES:

Chairman Hupfeld suggested that items 3a and 3bi-ii be voted on as a group and items 3b.iii be voted on separately. Member Hausheer made the motion to approve items 3a and 3bi-ii, Member Kennedy seconded, which were withdrawn when Member Case requested that item 3a be voted on separately. After clarification of what item was on the table, Chairman Hupfeld stated that the items being voted on were items 3bi-ii.

b) Discussion and vote regarding the Authority's ability to withstand the procurement decision made by the CEO based on the Authority's budget and available funds.
   i. Legal Services Contract (Attachment "B")
   ii. Consultant Contracts (Attachment "C")

MOTION: Member Hausheer moved for approval of item 3bi-ii, listed in the Consent Agenda, as published. The motion was seconded by Member Kennedy.

FOR THE MOTION: Chairman Hupfeld, Member Nuttle

AGAINST THE MOTION: Member Case

BOARD MEMBERS ABSENT: Vice-Chairman Yaffe, Member Boyd, Member Curry, Member Shamblin

a) Approval of the January 26, 2021 OHCA Board Meeting Minutes (Attachment "A")

MOTION: Member Case moved for approval of item 3a, listed in the Consent Agenda, as published. The motion was seconded by Member Kennedy.

FOR THE MOTION: Chairman Hupfeld, Member Hausheer, Member Nuttle

BOARD MEMBERS ABSENT: Vice-Chairman Yaffe, Member Boyd, Member Curry, Member Shamblin

Mr. Morris provided an overview of the Health Information Exchange contract to the board and asked Carter Kimble, Health Information Exchange Executive Director, to provide additional information. Mr. Kimble added that the reason for bringing this contract before the board again was to collapse the two contracts, as the selected vendor, Orion Health, was

the same for the HIE and the Electronic Master Patient Index. OSDH will still cover the state share cost and OHCA will cover the remainder that was already approved by the board.

b) Discussion and vote regarding the Authority's ability to withstand the procurement decision made by the CEO based on the Authority's budget and available funds.
    iii. Health Information Exchange (Attachment "D")

MOTION:	Member Nuttle moved for approval of item 3b.iii listed in the Consent Agenda, as published. The motion was seconded by Member Kennedy.
FOR THE MOTION:	Chairman Hupfeld
AGAINST THE MOTION:	Member Case, Member Hausheer
BOARD MEMBERS ABSENT:	Vice-Chairman Yaffe, Member Boyd, Member Curry, Member Shamblin

ITEM 4 / CHIEF EXECUTIVE OFFICER'S REPORT
Kevin Corbett, Chief Executive Officer

COVID Update: Mr. Corbett provided an update on OHCA staff that have been affected by COVID. He added that OHCA has collaborated with OSDH on vaccines for both OHCA and members served. The vaccination interest is high within OHCA, with some staff having been vaccinated or have appointments scheduled for their first vaccine. With that and the Governor's Executive Order to remove restrictions, OHCA is in the process of reopening the building to the public.

American Rescue Plan: The President signed the plan on March 11, 2021. Impacts to the Medicaid program are as follows:

- 5% FMAP enhancement over 2 years for expansion, in addition to the 6.2% through the end of the public health emergency.
- 100% FMAP for mandatory coverage of COVID vaccines through the end of the pandemic.
- Coverage for pregnant and postpartum women for one year. With expansion taking place on July 1, 2021, this will likely be a limited benefit.
- Option to provide mobile crisis intervention services with 85% FMAP for 3 years. OHCA staff are currently working with ODMHSAS on this.
- Additional support and 10% FMAP enhancement for medical home and community-based services through March 2022. OHCA staff are currently working with OKDHS on this.

MCO Update: All contracts have been signed with both the Medical and Dental plans. Mr. Corbett added that he has met with all 4 Medical plan local CEOs. Meetings with the Dental CEOs will take place over the next couple weeks. Expectations and operating protocols have been shared with each CEO. Monthly meetings will be scheduled with all the CEOS throughout the implementation period to track progress and performance. Mr. Corbett stated that he and the Governor have met with and will meet with the MCOs corporate CEOs to establish lines of communication. OHCA received support for implementation efforts from State Health and Value Strategies at Princeton University. Included in that is assistance from Roberts Consulting, which allows OHCA to work closely with the former Tennessee Medicaid Director and Bailit Health. Areas that are jointly being focused on are: Quality, MCO Operations and Oversight, Risk and Compliance, and Technology and Data Analysis/Intelligence.

Operations: Mr. Corbett highlighted the following Operational Metrics: Enrollment and Utilization, Out of State Cost, Expenditures, Call Center Volume, Prior Authorization Volume, and Providers. For more detailed information, see page 381 in the board packet.

Team: Mr. Corbett provided an overview of what OHCA has accomplished over the last year. OHCA has prioritized the needs of its members and providers with rule changes that make it easier and safer for Oklahomans to get the care they need. OHCA's Business Enterprises department worked hard to overcome the technical challenges of a massive and unexpected shift in the way employees work and connect. The agency also focused on the value of diversity, what it means to be an inclusive workplace and how OHCA can do it better with the Council on Diversity and Inclusion.

Member Hausheer asked for clarification on whether the MCO will be fully-capitated model, partially-capitated, ACO model, or a mix. Mr. Corbett stated the Medical and Dental plans will serve a large population of our members. The arrangement with the health plans is to be fully-capitated risk sharing model, however the arrangement with the plans and

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providers will be flexible. The minimum fee schedule will be default, but a Fee-For-Service could be entered into. Other negotiated arrangements could also be entered, which could include capitated rates.

ITEM 5 / CHIEF OF STAFF'S REPORT
Ellen Buettner, Chief of Staff

Ms. Buettner highlighted the 2020 statewide Employee Engagement Survey that OHCA staff participated in. Oklahoma has also started conducting annual employee engagement and satisfaction surveys. Overall, Oklahoma State Agencies had a 77% engagement rate, 75% job satisfaction rate and 82% intent to stay within their agencies. OHCA had an engagement rate of 86%, compared to the Health Cabinet overall rate of 77%; an employee satisfaction rate of 82%, compared to the Health Cabinet overall rate of 73%; and an intent to stay rate of 87%, compared to the Health Cabinet overall rate of 81%. Next steps include: continue to review the data with the teams, compare to other metrics used, and continue to address issues that need improvement. Things that could be improved are career advancement opportunities, which is a priority for the Organization Development Department. Another area for improvement is recognition.

OHCA will reopen to the public on April 1, 2021. OHCA will continue to recommend wearing masks, social distancing, and other precautionary procedures.

Lastly, Ms. Buettner stated she will provide an update on press releases OHCA sends out. Since the last board meeting, 3 press releases have been sent out: the announcement of the Medical MCO awards, Dental MCO awards, and the federal approval to cover and reimburse for all FDA approved medication assisted treatments.

ITEM 6 / CHIEF OPERATING OFFICER'S REPORT
Melody Anthony, Chief Operating Officer/State Medicaid Director

a) Ms. Anthony introduced Derek Lieser, Senior Director of Eligibility and Coverage Services, to provide an overview of the Member Experience. Mr. Lieser provided information on the different ways to apply for SoonerCare, how to apply, the information and/or documentation needed to apply for SoonerCare, member resources, examples of SoonerCare application documents, 2020 SoonerCare and Insure Oklahoma income guidelines, a step-by-step application guide, The Member Advisory Task Force (MATF), and member experience accomplishments. Chairman Hupfeld asked how OHCA knows its member experience is better than other states. Mr. Lieser stated that there are majors that are available from various groups that are looked at, and added that OHCA created a member experience survey. For more detailed information, see attachment "E" in the board packet.

b) Ms. Anthony also introduced Traylor Rains, Deputy State Medicaid Director. Mr. Rains provided an MCO update and highlighted 3 areas:
   - CMS Approval Process – On February 19th OHCA submitted the 1115 Waiver to CMS. The 1115 has not been posted. The Board will be made aware of the official posting date and when it will close. On March 5th, the Medical MCO contracts, rates, and the state readiness review packet was submitted to CMS. The official packet will be submitted to CMS on July 1, 2021. OHCA has had monthly meetings with CMS and will move to bi-weekly. September 1st is the Go/No Go date if CMS approval is not received.
   - Readiness Review – OHCA established and trained the readiness review team on February 25th. On March 4th, the MCO implementation partners were invited to attend the readiness training, with the dental readiness training scheduled on March 11th. OHCA will conduct desk reviews of readiness review materials from March 2nd through April 26th. Onsite reviews will take place from May 3rd through May 28th. The readiness teams will spend three days at each MCO facility. June 1st though June 30th, the readiness review results will be finalized and it will also be determined if the plans are ready to meet MCS approval and go live on October 1st.
   - Implementation – OHCA created 8 implementation workgroups and will meet weekly over the next few months. Weekly meetings with the plan CEOs, State Medicaid Director, Deputy State Medicaid Director and Dental Director to receive weekly updates on implementation progress. The plans will be required to provide weekly and monthly reports prior to and after implementation.

   For more detailed information, see attachment "F" in the board packet.

ITEM 7 / DISCUSSION OF REPORT FROM THE LEGISLATIVE ADVISORY COMMITTEE
Christina Foss, Legislative Liaison

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Ms. Foss provided an overview of the bills that OHCA is tracking. Since January's Board meeting and the first major deadline in session, the bills are down from over 3,000 to less than 1,000. To date, the Governor has signed off on two measures including SB 1031 which extends the amendments to the Open Meetings Act allowing for virtual public meetings. All OHCA bills have been heard and passed the Senate. Ms. Foss added that Mr. Corbett's nomination hearing will be heard on March 22nd during the Senate Health and Human Services Committee meeting. The next step is for all bills to be heard in the opposite chamber. Ms. Foss added that all bills must be out of their committee by April 8th. When asked how the State's budget looks, Mr. Corbett stated that as of right now, there is nothing detrimental that could affect it. For more detailed information, see attachment "G" in the board packet.

ITEM 8 / DISCUSSION OF REPORT FROM THE COMPLIANCE ADVISORY COMMITTEE
Phil Kennedy, Chair of the Compliance Advisory Committee

Committee Chairman Kennedy provided an update on the OHCA financials through January 2021. Program variances continue to be significant as they were in Fiscal Year 2020. That includes after a budget revision that decreased the assumed impact of unemployment. The increase in enrollment has not yet resulted in increased spend, however we continue to anticipate and prepare for a future scenario in which there will be a normalized per member utilization rate. Administrative expenditures are under budget in both operations and contract by about $4 million total dollars. In total, expenditures are under budget by $111 million, causing federal revenues to be under budget by $86 million. The total revenue variance is $75 million under budget and total budget variance grew about $10 million from December and through January is about $35.6 million. With the extension of the enhanced FMAP through June 30, 2021, and decreased per member utilization, OHCA continues to accumulate cash reserves.

Audit: The corrective action plan regarding the eligibility, non-eligibility, and PERM audits were discussed at the last Compliance Committee meeting. OHCA continues to work on two related findings that still need corrective action. The first one, related to pregnancy, requires system changes before implementation. The second, related to retroactive claims adjustments, is awaiting guidance from CMS. All non-eligibility findings have corrective actions that have been implemented. The member audit team will perform the post-corrective action plan audits for all eligibility finds once the corrective action is implemented to ensure that the system changes are operating effectively.

ITEM 9i-xxix / 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 on a Declaration of a Compelling Public Interest for the Promulgation of the Emergency Rule in Attachment "H" 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 Rule (see Attachment "H"):

    i. **APA WF # 21-04 Diabetes Self-Management Education and Support (DSMES) Services**

Member Case motioned to approve, but later withdrew her motion as there was no longer a quorum in the room. Once the quorum was re-established, Member Case motioned for approval of 9a.i.

MOTION:	Member Case moved for approval of Item 9a.i as published. The motion was seconded by Member Kennedy.
FOR THE MOTION:	Chairman Hupfeld, Member Hausheer, Member Nuttle,
BOARD MEMBERS ABSENT:	Vice-Chairman Yaffe, Member Boyd, Member Curry, Member Shamblin
MOTION:	Member Case moved for approval of Item 9b.i as published. The motion was seconded by Member Kennedy.
FOR THE MOTION:	Chairman Hupfeld, Member Hausheer, Member Nuttle,
BOARD MEMBERS ABSENT:	Vice-Chairman Yaffe, Member Boyd, Member Curry, Member Shamblin

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

ii. **APA WF # 20-04 Electronic Visit Verification (EVV)**
iii. **APA WF # 20-13 Child Support Cooperation Exemption for Recipients of Indian Health Services**
iv. **APA WF # 20-14 Therapy Assistants and Clinical Fellows**
v. **APA WF # 20-15A Residential Substance Use Disorder (SUD) Treatment Coverage**
vi. **APA WF # 20-16 Opioid Treatment Program (OTP) and Medication-Assisted Treatment (MAT) Services**
vii. **APA WF # 20-19A Appeals Language Cleanup**
viii. **APA WF # 20-20 Pay-for-Performance (PFP) program**
ix. **APA WF # 20-21 Employment Services Offered through Developmental Disabilities Services**
x. **APA WF # 20-06C Durable Medical Equipment (DME) and Supplies Benefit Moved under the Scope of the Home Health Benefit**
xi. **APA WF # 20-15B Residential Substance Use Disorder (SUD) Treatment Coverage**
xii. **APA WF # 20-19B Appeals and Incorrect References Language Cleanup**
xiii. **APA WF # 20-27 Specialty PRTF Staffing and Admission Revisions**
xiv. **APA WF # 20-22 Programs of All Inclusive-Care for the Elderly (PACE)**
xv. **APA WF # 20-23 Developmental Disabilities Services (DDS)**
xvi. **APA WF # 20-24 A&B ADvantage Waiver**
xvii. **APA WF # 20-25 Peer Recovery Support Specialist (PRSS) Services in Indian Health Services, Tribal Programs and Urban Indian Clinics (I/T/Us)**
xviii. **APA WF # 20-26 Applied Behavior Analysis (ABA) Services Revisions**
xix. **APA WF # 20-29 Provider Refund to Member when Copayment is Over-Collected**
xx. **APA WF # 20-31 State Treasurer's Achieving a Better Life Experience (STABLE) Accounts**
xxi. **APA WF # 20-33 Bariatric Surgery Revisions**
xxii. **APA WF # 20-34 Dental Revisions**
xxiii. **APA WF # 20-36A Lodging, Meals, and SoonerRide**
xxiv. **APA WF # 20-36B Lodging, Meals, and SoonerRide**
xxv. **APA WF # 20-37 Obstetrical (OB) Ultrasound**
xxvi. **APA WF # 20-38 Clinical Trials**
xxvii. **APA WF # 20-39 Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) Policy Revisions**
xxviii. **APA WF # 20-40 Medicaid-Funded Abortion Certification Requirements**
xxix. **APA WF # 20-41 Sunsetting of Health Homes**

Committee Chairwoman Hausheer requested that item **xviii – APA WF # 20-26 be voted on as a separate item.** Mr. Engle advised the Board to motion on consolidating the rules, with the exception of item xvii – APA WF # 20-26.

MOTION:	Chairwoman Hausheer moved to consolidate items 9c.ii-xvii, xix-xxix as published. The motion was seconded by Member Kennedy.
FOR THE MOTION:	Chairman Hupfeld, Member Case, Member Nuttle,
BOARD MEMBERS ABSENT:	Vice-Chairman Yaffe, Member Boyd, Member Curry, Member Shamblin
MOTION:	Member Nuttle moved to approve items 9c.ii-xvii, xix-xxix as published. The motion was seconded by Chairman Hupfeld.
FOR THE MOTION:	Member Case, Member Hausheer, Member Kennedy,
BOARD MEMBERS ABSENT:	Vice-Chairman Yaffe, Member Boyd, Member Curry, Member Shamblin

Chairwoman Hausheer provided an over of the changes made to APA WF # 20-26, highlighting that the following language was added, "And has professional experience in the use of ABA Therapy".

MOTION:	Chairman Hupfeld moved to approve item 9c.xviii as published. The motion was seconded by Member Nuttle.

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FOR THE MOTION: Member Case, Member Hausheer, Member Kennedy

BOARD MEMBERS ABSENT: Vice-Chairman Yaffe, Member Boyd, Member Curry, Member Shamblin

ITEM 10i-x / DISCUSSION OF REPORT FROM THE PHARMACY ADVISORY COMMITTEE AND POSSIBLE ACTION REGARDING DRUG UTILIZATION BOARD RECOMMENDATIONS
Terry Cothran D. Ph., Director of Pharmacy

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) (see Attachment "F")

i. Blenrep (Belantamab Mafodotin-blmf), Darzalex® (Daratumumab), Darzalex Faspro™ (Daratumumab/Hyaluronidase-fihj), Empliciti® (Elotuzumab), Hemady™ (Dexamethasone 20mg Tablet), Ninlaro® (Ixazomib), Sarclisa® (Isatuximab-irfc), and Xpovio® (Selinexor)
ii. Lenvima® (Lenvatinib)
iii. AirDuo® Digihaler® (Fluticasone Propionate/Salmeterol), ArmonAir® Digihaler® (Fluticasone Propionate), and Breztri Aerosphere™ (Budesonide/Glycopyrrolate/Formoterol Fumarate)
iv. Enspryng™ (Satralizumab-mwge) and Uplizna™ (Inebilizumab-cdon)
v. Ortikos™ [Budesonide Extended-Release (ER) Capsule]
vi. Pizensy™ (Lactitol)
vii. Oriahnn™ (Elagolix/Estradiol/Norethindrone and Elagolix)
viii. Nexletol® (Bempedoic Acid) and Nexlizet™ (Bempedoic Acid/Ezetimibe)
ix. Durysta™ (Bimatoprost Implant)
x. Imcivree™ (Setmelanotide)

MOTION: Member Hausheer moved to consolidate items 10i-x. The motion was seconded by Member Case.

FOR THE MOTION: Chairman Hupfeld, Member Kennedy, Member Nuttle

BOARD MEMBERS ABSENT: Vice-Chairman Yaffe, Member Boyd, Member Curry, Member Shamblin

MOTION: Member Hausheer moved for approval of Item 10i-x as published. The motion was seconded by Member Case.

FOR THE MOTION: Chairman Hupfeld, Member Kennedy, Member Nuttle

BOARD MEMBERS ABSENT: Vice-Chairman Yaffe, Member Boyd, Member Curry, Member Shamblin

ITEM 11 / 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 Hausheer moved to go into Executive Session. The motion was seconded by Member Nuttle.

FOR THE MOTION: Chairman Hupfeld, Member Case, Member Kennedy

BOARD MEMBERS ABSENT: Vice-Chairman Yaffe, Member Boyd, Member Curry, Member Shamblin

MOTION: Member Hausheer moved to leave Executive Session. The motion was seconded by Member Nuttle.

FOR THE MOTION: Chairman Hupfeld, Member Case, Member Kennedy

BOARD MEMBERS ABSENT: Vice-Chairman Yaffe, Member Boyd, Member Curry, Member Shamblin

ITEM 12 / ADJOURNMENT

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MOTION: Member Hausheer moved for approval for adjournment. The motion was seconded by Member Nuttle.

FOR THE MOTION: Chairman Hupfeld, Member Case, Member Kennedy

BOARD MEMBERS ABSENT: Vice-Chairman Yaffe, Member Boyd, Member Curry, Member Shamblin

Meeting adjourned at 5:23 p.m., 3/17/2021

NEXT BOARD MEETING
May 19, 2021
Oklahoma Health Care Authority
4345 N. Lincoln Blvd
Oklahoma City, OK 73105

Martina Ordonez
Board Secretary

Minutes Approved: _______________

*Initials:*______________

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Attachment B

OKLAHOMA
Health Care Authority

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OUTREACH AND EDUCATION

- April - May: 5 Regional Townhalls conducted across the state (Woodward, Duncan, Poteau, Kingfisher and Oklahoma City). Four additional townhalls scheduled through June and July.
- May - June: 8 virtual trainings scheduled for providers
- Expansion vs. Managed Care marketing

READINESS REVIEW

- Desk reviews of policies and procedures completed in April. Plans have until May 28 to correct any identified deficiencies.
- On-site reviews are being conducted for all seven plans throughout May.
- Weekly provider network reports as well as geo-access maps are being monitored for progress toward meeting network adequacy requirements.
- Plans are making suitable progress hiring staff and key personnel. Approximately 1,700 Oklahoma based jobs are being created.
- 10 implementation workgroups have been meeting weekly since March 15. OHCA staff have responded to over 1,400 written questions from plans.

CMS ENGAGEMENT

- CMS posted the 1115 waiver for public comment for 30 days (3/22 - 4/22). 22 comments were received. Negotiations have begun regarding the Special Terms and Conditions.
- Bi-weekly meetings with CMS managed care team to facilitate ongoing communications and timely approvals.
- CMS staff are virtually attending all of the on-site reviews.

OHCA ORGANIZATIONAL CHANGES

- A new unit has been created within SoonerCare Operations dedicated to managed care monitoring and oversight.
- 1 Senior Director of Monitoring and Oversight
- 5 Managers of Managed Care Plan Compliance

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SUBMITTED TO THE C.E.O. AND BOARD ON MAY 19, 2021
Discussion and vote regarding the Authority's ability to withstand the procurement decision made by the CEO based on the Authority's budget and available funds

BACKGROUND

Services	Behavioral Health Home Management Software System
Purpose and Scope	Oklahoma Department of Mental Health and Substance Abuse Services is seeking to extend current contract with Bertelsmann Learning LLC dba Relias LLC previously Care Management Technologies, Inc. for the services to administer a Behavioral Health Home Management Software System. The Behavioral Health Home Management Software System is providing electronic communication between the Oklahoma Health Homes, the Oklahoma Health Care Authority, the Oklahoma Department of Mental Health and Substance Abuse Services and the Centers for Medicare and Medicaid Services.
Mandate	N/A
Procurement Method	Sole Source
Award	N/A
External Approvals	OMES
Incumbent Contractor	Bertelsmann Learning LLC dba Relias LLC previously Care Management Technologies, Inc.
Name & Contract Term	07/01/2015 through 6/30/2021
New Contract Term	July 1, 2021 through June 30, 2022

BUDGET

Total Contract Not-to-Exceed Requested for Approval.	**$606,161.00**
50% Federal Match Costs within the Total Contract Not-to-Exceed (State Share paid by DMH)	**$303,080.50**

RECOMMENDATION

The Authority affirms its ability to withstand the procurement decision made by the CEO based on the budget and available funds. Board approval is requested to extend the Behavioral Health Home Management Software System described above for 1 year, not-to-exceed $606,161.00 total dollars.

Additional Information

Contract Term, Including all Optional Renewal Years (Oklahoma law limits State Agencies from encumbering funds for more than a single State Fiscal Year. As a result, all State of Oklahoma contracts are entered into for an initial year period with subsequent optional renewal years. Every OHCA professional services contract includes standard contract termination language, including immediate, 30 day for cause, 60 day without cause, and non-renewal terminations.)
Total Contract Not-to-Exceed Requested for Approval. (Actual not-to-exceed amounts are established by the competitive bid process. If the not-to-exceed amount exceeds the amount previously approved by $125,000.00 or more, the contract increase shall require additional Board approval.)
Federal Match Percentage(s) (CMS authorizes Federal Match based upon specific criteria, for example, a single Information Technology contract may qualify for 50% administrative match, 75% operational match, and 90% implementation match.)

SUBMITTED TO THE C.E.O. AND BOARD ON MAY 19, 2021
Discussion and vote regarding the Authority's ability to withstand the procurement decision made by the CEO based on the Authority's budget and available funds

BACKGROUND

Services	**Recovery Audit Contractor (RAC)**
Purpose and Scope	Oklahoma Health Care Authority is seeking to renew contract with Health Management Systems for Medicaid RAC Program to recoup overpayments for audits that were initiated prior October 1, 2017. Turnover process to recoup overpayments will take years to complete. A Medicaid RAC Program is defined as a recovery audit contractor program administered by a State to identify overpayments/underpayments and to recoup overpayments. The funding for this service is provided from the dollars the Contractor recovers in overpayments, and in order to pay the Contractor's invoices the funds must be encumber.
Mandate	Required by 42 CFR §455,
Procurement Method	Sole Source
Award	N/A
External Approvals	OMES
Incumbent Contractor Name & Contract Term	Health Management Systems 09/01/2018 through 6/30/2021
New Contract Term	July 1, 2021 through June 30, 2022

BUDGET

Total Contract Not-to-Exceed Requested for Approval.	**$350,000.00**
50% Federal Match (State Share paid by OHCA)	**$175,000.00**

RECOMMENDATION

The Authority affirms its ability to withstand the procurement decision made by the CEO based on the budget and available funds. Board approval is requested to renew the Medicaid RAC Program for the Recovery Audit Services described above for 1 year, for a total not-to-exceed $350,000.00

Additional Information

Contract Term, Including all Optional Renewal Years (Oklahoma law limits State Agencies from encumbering funds for more than a single State Fiscal Year. As a result, all State of Oklahoma contracts are entered into for an initial year period with subsequent optional renewal years. Every OHCA professional services contract includes standard contract termination language, including immediate, 30 day for cause, 60 day without cause, and non-renewal terminations.)
Total Contract Not-to-Exceed Requested for Approval. (Actual not-to-exceed amounts are established by the competitive bid process. If the not-to-exceed amount exceeds the amount previously approved by $125,000.00 or more, the contract increase shall require additional Board approval.)
Federal Match Percentage(s) (CMS authorizes Federal Match based upon specific criteria, for example, a single Information Technology contract may qualify for 50% administrative match, 75% operational match, and 90% implementation match.)

SUBMITTED TO THE C.E.O. AND BOARD ON MAY 19, 2021
Discussion and vote regarding the Authority's ability to withstand the procurement decision made by the CEO based on the Authority's budget and available funds

BACKGROUND

Services	**Third Party Liability Services**
Purpose and Scope	Oklahoma Health Care Authority is seeking to extend current contract for ninety (90) days with Health Management Systems for the services to perform Medicaid Third Party Liability (TPL) revenue collection services in accordance with 42 CRF 433.135 et. seq. Pending RFP. The Vendor is assisting OHCA in achieving the following goals: * Maximize revenues to OHCA; * Cost avoid claims before payments are generated; *Lessen the accounting and collection work required of OHCA; * Reduce call volume to onsite TPL staff
Mandate	The Medicaid TPL Program is providing revenue to Oklahoma.
Procurement Method	Amendment
Award	N/A
External Approvals	N/A
Incumbent Contractor Name & Contract Term	Health Management Systems 07/01/2015 through 6/30/2021
New Contract Term	July 1, 2021 through September 30, 2021

BUDGET

Total Contract Not-to-Exceed Requested for Approval.	**$1,125,000.00**
50% Federal Match (State Share paid by OHCA)	**$562,500.00**

RECOMMENDATION

The Authority affirms its ability to withstand the procurement decision made by the CEO based on the budget and available funds. Board approval is requested to extend the Third Party Liability Services described above for ninety (90) days, for a total not-to-exceed $1,125,000.00.

Additional Information

Contract Term, Including all Optional Renewal Years (Oklahoma law limits State Agencies from encumbering funds for more than a single State Fiscal Year. As a result, all State of Oklahoma contracts are entered into for an initial year period with subsequent optional renewal years. Every OHCA professional services contract includes standard contract termination language, including immediate, 30 day for cause, 60 day without cause, and non-renewal terminations.)
Total Contract Not-to-Exceed Requested for Approval. (Actual not-to-exceed amounts are established by the competitive bid process. If the not-to-exceed amount exceeds the amount previously approved by $125,000.00 or more, the contract increase shall require additional Board approval.)
Federal Match Percentage(s) (CMS authorizes Federal Match based upon specific criteria, for example, a single Information Technology contract may qualify for 50% administrative match, 75% operational match, and 90% implementation match.)

SUBMITTED TO THE C.E.O. AND BOARD ON MAY 19, 2021
Discussion and vote regarding the Authority's ability to withstand the procurement decision made by the CEO based on the Authority's budget and available funds

BACKGROUND

Services	**Asset Verification System Services**
Purpose and Scope	Oklahoma Health Care Authority is seeking to extend current contract for one (1) year with Public Consulting Group Inc. for the services of a Vendor to provide Asset Verification Services (AVS) in accordance with 42 USC 1396w for eligibility determination for the Oklahoma Department of Human Services (DHS). The AVS Program verify the assets of aged, blind, and disabled individuals applying or reapplying for SoonerCare: • Report the assets of the above referenced population to DHS; • Establish a network of FIs within the State of Oklahoma and the other 49 states, US possessions and territories depending on the banking laws in those various locations; and • Maintain a collegial relationship with the various financial institutions (FI).
Mandate	42 USC 1396w
Procurement Method	Sole Source
Award	N/A
External Approvals	N/A
Incumbent Contractor Name & Contract Term	Public Consulting Group Inc. 07/01/2015 through 6/30/2021
New Contract Term	July 1, 2021 through June 30, 2022

BUDGET

Total Contract Not-to-Exceed Requested for Approval.	**$600,000.00**
50% Federal Match (State share paid by OHCA)	**$300,000.00**

RECOMMENDATION

The Authority affirms its ability to withstand the procurement decision made by the CEO based on the budget and available funds. Board approval is requested to extend the Asset Verification System Services described above for 1 year, for a total not-to-exceed $600,000.00

Additional Information

Contract Term, Including all Optional Renewal Years (Oklahoma law limits State Agencies from encumbering funds for more than a single State Fiscal Year. As a result, all State of Oklahoma contracts are entered into for an initial year period with subsequent optional renewal years. Every OHCA professional services contract includes standard contract termination language, including immediate, 30 day for cause, 60 day without cause, and non-renewal terminations.)
Total Contract Not-to-Exceed Requested for Approval. (Actual not-to-exceed amounts are established by the competitive bid process. If the not-to-exceed amount exceeds the amount previously approved by $125,000.00 or more, the contract increase shall require additional Board approval.)
Federal Match Percentage(s) (CMS authorizes Federal Match based upon specific criteria, for example, a single Information Technology contract may qualify for 50% administrative match, 75% operational match, and 90% implementation match.)

SUBMITTED TO THE C.E.O. AND BOARD ON MAY 19, 2021
Discussion and vote regarding the Authority's ability to withstand the procurement decision made by the CEO based on the Authority's budget and available funds

BACKGROUND

Contractor Name	Managed Care Program Administration & Performance and Functional Capabilities Assessment Phase 2
Purpose and Scope	Address the following objectives for this project pertaining to Managed Care Program Administration and Performance and Functional Capabilities Assessment of the Gainwell MMIS: • Develop playbooks for monitoring and oversight of SoonerSelect MCO and Dental Plans. • Identify technologies needed outside MMIS for performance improvements and MCO operational needs post go live. • Analyze MMIS technology stack and develop recommendations for technology replacement priorities based on MCO operational needs post go live.
Mandate	N/A
Procurement Method	Statewide Contract
External Approvals	Not Applicable
Contractor	Ernst & Young
Contract Term	Date of signature through June 30, 2021 with one option to renew.

BUDGET

Not-to-Exceed Requested for Approval.	$700,000.00
50% Federal Match Percentage(s) within the Total Contract Not-to-Exceed (State Share paid by OHCA)	$350,000.00
Pricing Methodology	Fixed rate by deliverable

RECOMMENDATION

The Authority affirms its ability to withstand the procurement decision made by the CEO based on the budget and available funds. Board approval is requested to procure the services described above for one year, not-to-exceed $700,000.00 total dollars.

Additional Information

Contract Term, Including all Optional Renewal Years Oklahoma law limits State Agencies from encumbering funds for more than a single State Fiscal Year. As a result, all State of Oklahoma contracts are entered into for an initial year period with subsequent optional renewal years. Every OHCA professional services contract includes standard contract termination language, including immediate, 30 day for cause, 60 day without cause, and non-renewal terminations.
Competitive Bid Total Contract Not-to-Exceed Requested for Approval. Actual not-to-exceed amounts are established by the competitive bid process. If the not-to-exceed amount exceeds the amount previously approved by $125,000.00 or more, the contract increase shall require additional Board approval.
Federal Match Percentage(s) CMS authorizes Federal Match based upon specific criteria, for example, a single Information Technology contract may qualify for 50% administrative match, 75% operational match, and 90% implementation match.
Pricing Methodologies: **Hourly Rate:** Hourly Rate contracts authorize payments based on the number of hours required to perform a service within an established not-to-exceed. Hourly rate contractors cannot bill for more hours than worked, and are not guaranteed to be able to bill for the entire not-to-exceed amount. **Fixed Rate**: Fixed rate professional services contracts establish fixed prices based on services performed based on volume estimates, such as completing a prior authorization is valued at X, and costs based on established deliverables. Deliverables may be billed as all-inclusive costs, such as a report, or may include milestones with associated payments, such as a payment for a report for the first draft and another payment upon OHCA approval for the final report. Contractors cannot bill until services are completed.

Drug Utilization Review Board Meetings – March 10, 2021 and April 14, 2021

Recommendation/ Vote	Drug	Used for	Cost*	Notes
1	Inqovi® Onureg®	• Leukemia	• $7,495 per 28 days • $21,158 per 28 days	• Adults with Myelodysplastic Syndrome • Adults with Acute Myeloid Leukemia
2	Fintepla®	• Seizures associated with Dravet Syndrome	• $14,096 per 28 days	• 2 years and older
3	Vyepti®	• Migraine Headaches	• Up to $17,940 per year	• Prevention of migraines
4	Oxlumo™	• Primary Hyperoxaluria	• $660,000 per year	• Fewer than 1,000 cases expected in U.S.
5	Zokinvy™	• Progeria	• $1,548,720 per year	• 31 cases in the U.S.
6	Monjuvi® Tecartus™ Ukoniq™	• Lymphoma	• $24,000 for cycle 1 • $373,000 per 1 time treatment • $15,900 per 30 days	• None are first line treatment
7	Sevenfact®	• Hemophilia	• $144,270 per 24 hrs	• Hemophilia A or B with inhibitors
8	Bafiertam™ Kesimpta® Zeposia®	• Multiple Sclerosis	• $69,480 per year • $83,000 per year • $88,639 per year	• All are indicated in specific types of MS

9	Orladeyo™	• Hereditary Angioedema (HAE)	• $37,308 per 28 days	• First oral therapy, prevention of HAE attacks
10	Barhemsys®	• Anti-Emetic	• $42.50 per dose	• Post-operative nausea and vomiting; cheaper options available
11	Nyvepria™	• Febrile Neutrapenia	• $3,925 per dose	• Biosimilar to Neulasta

*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 Inqovi® and Onureg®

The Drug Utilization Review Board recommends the prior authorization of Inqovi® (Decitabine/ Cedazuridine) and Onureg® (Azacitidine) with the following criteria:

Inqovi® (Decitabine/Cedazuridine) Approval Criteria [Myelodysplastic Syndromes (MDS) Diagnosis]:

1. A diagnosis of MDS (intermediate-1, intermediate-2, or high risk) in adults including previously treated and untreated, de novo, and secondary MDS with the following subtypes:
   a. Refractory anemia; or
   b. Refractory anemia with ring sideroblasts; or
   c. Refractory anemia with excess blasts; or
   d. Chronic myelomonocytic leukemia (CMML).

Onureg® (Azacitidine) Approval Criteria [Acute Myeloid Leukemia (AML) Diagnosis]:

1. A diagnosis of AML; and
2. Used as maintenance therapy in members who have achieved first complete remission (CR) or complete remission with incomplete blood count recovery (CRi) following intensive induction chemotherapy; and
3. Member is unable to complete intensive curative therapy.

Recommendation 2: Vote to Prior Authorize Fintepla®

The Drug Utilization Review Board recommends the prior authorization of Fintepla® (Fenfluramine) with the following criteria:

Fintepla® (Fenfluramine) Approval Criteria:

1. An FDA approved indication for the treatment of seizures associated with Dravet syndrome; and
2. Member must be 2 years of age or older; and
3. Initial prescription must be written by, or in consultation with, a neurologist; and
4. Member must not be taking monoamine oxidase inhibitors (MAOIs) within 14 days of administration of Fintepla®; and
5. Prescriber must verify the member's blood pressure will be monitored; and
6. Member must not be actively suicidal or have uncontrolled depression and prescriber must verify member will be monitored for depression prior to starting Fintepla® therapy and throughout treatment; and
7. Member must have failed or be inadequately controlled with at least 2 other anticonvulsants; and

8. Pharmacy and prescriber must be certified in the Fintepla® Risk Evaluation and Mitigation Strategy (REMS) program; and
9. Member must be enrolled in the Fintepla® REMS program; and
10. 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
11. Prescriber must verify that dose titration and maximum maintenance dose will be followed according to package labeling based on member weight and concomitant medications; and
12. Initial approvals will be for the duration of 3 months. For continuation, the prescriber must include information regarding improved response/effectiveness of the medication; and
13. A quantity limit of 360mL per 30 days will apply.

Recommendation 3: Vote to Prior Authorize Vyepti®

The Drug Utilization Review Board recommends the prior authorization of Vyepti® (Eptinezumab-jjmr) with the following criteria:

Vyepti® (Eptinezumab-jjmr) Approval Criteria:

1. An FDA approved indication for the preventive treatment of migraine in adults; and
2. Member must be 18 years of age or older; and
3. Member has documented chronic migraine or episodic migraine headaches:
    a. Chronic migraine: 15 or more headache days per month with 8 or more migraine days per month; or
    b. Episodic migraine: 4 to 14 migraine days per month on average for the past 3 months; and
        i. For episodic migraine, member must have had a history of migraines for a duration of 12 months or longer; and
4. Non-migraine medical conditions known to cause headache have been ruled out and/or have been treated. This includes, but is not limited to:
    a. Increased intracranial pressure (e.g., tumor, pseudotumor cerebri, central venous thrombosis); or
    b. Decreased intracranial pressure (e.g., post-lumbar puncture headache, dural tear after trauma); and
5. Migraine headache exacerbation secondary to other medication therapies or conditions have been ruled out and/or treated. This includes, but is not limited to:
    a. Hormone replacement therapy or hormone-based contraceptives; and
    b. Chronic insomnia; and
    c. Obstructive sleep apnea; and

6. The member has failed medical migraine preventive therapy with at least 3 agents with different mechanisms of action. Trials must be at least 8 weeks in duration (or documented adverse effects) within the last 365 days. This includes, but is not limited to:
   a. Select antihypertensive therapy (e.g., beta-blocker therapy); or
   b. Select anticonvulsant therapy; or
   c. Select antidepressant therapy [e.g., tricyclic antidepressants (TCA), serotonin and norepinephrine reuptake inhibitors (SNRI)]; and
7. Member is not frequently taking medications that are known to cause medication overuse headaches (MOH or rebound headaches) in the absence of intractable conditions known to cause chronic pain. MOH are a frequent cause of chronic headaches. A list of prescription or non-prescription medications known to cause MOH includes, but is not limited to:
   a. Decongestants (alone or in combination products) (≥10 days/month for >3 months); and
   b. Combination analgesics containing caffeine and/or butalbital (≥10 days/month for >3 months); and
   c. Opioids (≥10 days/month for >3 months); and
   d. Analgesic medications including acetaminophen or non-steroidal anti-inflammatory drugs (NSAIDs) (≥15 days/month for >3 months); and
   e. Ergotamine-containing medications (≥10 days/month for >3 months); and
   f. Triptans (≥10 days/month for >3 months); and
8. Member is not taking any medications that are likely to be the cause of the headaches; and
9. Member must have been evaluated within the last 6 months by a neurologist for migraine headaches and the requested medication (e.g., Vyepti®) recommended as treatment (not necessarily prescribed by a neurologist); and
10. Member will not use requested medication concurrently with botulinum toxin for the prevention of migraine or with an alternative calcitonin gene-related peptide (CGRP) inhibitor; and
11. Other aggravating factors that are contributing to the development of episodic/chronic migraine headaches are being treated when applicable (e.g., smoking); and
12. For Vyepti®, prescriber must verify the medication will be prepared and administered according the Vyepti® *Prescribing Information*; and
13. A patient-specific, clinically significant reason why member cannot use Ajovy® (fremanezumab-vfrm) or Emgality® (galcanezumab-gnlm) must be provided; and
14. For consideration of Vyepti® at the maximum recommended dosing (300mg every 3 months), a patient-specific, clinically significant reason

why other available CGRP inhibitors for migraine prophylaxis are not appropriate for the member must be provided; and

15. Initial approvals will be for the duration of 3 months. Compliance and information regarding efficacy, such as a reduction in monthly migraine days, will be required for continued approval. Continuation approvals will be granted for the duration of 1 year; and
16. Quantity limits will apply based on FDA-approved dosing:
    a. For Vyepti®, a quantity limit of 3 vials per 90 days will apply.

Recommendation 4: Vote to Prior Authorize Oxlumo™

The Drug Utilization Review Board recommends the prior authorization of Oxlumo™ (Lumasiran) with the following criteria:

Oxlumo™ (Lumasiran) Approval Criteria:

1. An FDA approved indication for the treatment of primary hyperoxaluria type 1 (PH1) to lower urinary oxalate levels. Diagnosis of PH1 must be confirmed by:
    a. Molecular genetic testing identifying biallelic pathogenic variants in the *AGXT* gene; or
    b. Liver biopsy confirming alanine-glyoxylate aminotransferase (AGT) catalytic deficiency if the results of genetic testing are not diagnostic; and
2. Oxlumo™ must be prescribed by a nephrologist, geneticist, or other specialist with expertise in the treatment of PH1 (or an advanced care practitioner with a supervising physician who is a nephrologist, geneticist, or other specialist with expertise in the treatment of PH1); and
3. The prescriber must verify the member has an estimated glomerular filtration rate (eGFR) of ≥30mL/min/1.73m^2 prior to starting Oxlumo™ and must agree to monitor renal function regularly during treatment with Oxlumo™; and
4. The member must not have a history of liver transplant; and
5. The member must not have evidence of systemic oxalosis; and
6. The prescriber must verify that Oxlumo™ will be administered by a health care professional; and
7. 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 the Oxlumo™ *Prescribing Information*; and
8. Initial approvals will be for the duration of 6 months. Further approval may be granted if the prescriber documents that the member is responding well to treatment as indicated by a reduction in urinary oxalate excretion.

Recommendation 5: Vote to Prior Authorize Zokinvy®

The Drug Utilization Review Board recommends the prior authorization of Zokinvy® (Lonafarnib) with the following criteria:

Zokinvy™ (Lonafarnib) Approval Criteria:

1. An FDA approved indication of 1 of the following:
    a. To reduce the risk of mortality in Hutchinson-Gilford Progeria Syndrome (HGPS); or
    b. Treatment of processing-deficient Progeroid Laminopathies (PL) with either:
        i. Heterozygous *LMNA* mutation with progerin-like protein accumulation; or
        ii. Homozygous or compound heterozygous *ZMPSTE24* mutations; and
2. Member must have confirmatory mutational analysis showing mutation in the *LMNA* gene; and
3. Zokinvy™ will not be approved for other progeroid syndromes or processing-proficient PL (based upon its mechanism of action, Zokinvy™ would not be effective in these populations); and
4. Member must be 1 year of age or older; and
5. Member must have a body surface area (BSA) ≥0.39m^2; and
6. Member must have clinical signs of progeria (e.g., characteristic facial features, growth deficiency, atherosclerosis); and
7. Zokinvy™ must be prescribed by, or in consultation with, a specialist with expertise in treating HGPS or PL (or an advanced care practitioner with a supervising physician who is a specialist in treating HGPS or PL); and
8. Member must not be taking any of the following medications: strong/moderate CYP3A inhibitors, CYP2C9 inhibitors, midazolam, lovastatin, simvastatin, atorvastatin, or loperamide if younger than 2 years of age; and
9. Prior to and during treatment, the potential for drug interactions should be considered, concomitant medications reviewed, and members should be monitored for adverse reactions; and
10. Member should have ophthalmological evaluations performed at regular intervals and at the onset of any new visual changes; and
11. Prescriber must verify the member will be monitored for changes in electrolytes, complete blood counts, renal function, and liver enzymes; and
12. Member's recent BSA must be provided on the prior authorization request in order to authorize the appropriate amount of drug required according to the package labeling; and
13. The maximum approvable dose of Zokinvy™ is 300mg/m^2 per day; and

14. Initial approvals will be for 6 months. After 6 months of utilization, compliance and information regarding efficacy, such as a positive response to treatment including no new or worsening heart failure and no stroke incidence, will be required for continued approval. Subsequent approvals will be for 12 months and compliance and documentation of a positive response to Zokinvy™ therapy will be required on each continuation request.

Recommendation 6: Vote to Prior Authorize Monjuvi®, Tecartus™, and Ukoniq™

The Drug Utilization Review Board recommends the prior authorization Monjuvi® (Tafasitamab-cxix), Tecartus™ (Brexucabtagene Autoleucel), and Ukoniq™ (Umbralisib) with the following criteria:

Monjuvi® (Tafasitamab-cxix) Approval Criteria [Diffuse Large B-Cell Lymphoma (DLBCL) Diagnosis]:

1. Diagnosis of DLBCL in adults; and
2. Relapsed or refractory disease; and
3. Used in combination with lenalidomide.

Tecartus™ (Brexucabtagene Autoleucel) Approval Criteria [Lymphoma Diagnosis]:

1. Diagnosis of mantle cell lymphoma; and
2. Relapsed or refractory disease; and
3. Health care facilities must be on the certified list to administer chimeric antigen receptor (CAR) T-cells and must be trained in the management of cytokine release syndrome (CRS), neurologic toxicities, and comply with the risk evaluation and mitigation strategy (REMS) requirements.

Ukoniq™ (Umbralisib) Approval Criteria [Marginal Zone Lymphoma (MZL) Diagnosis]:

1. Diagnosis of MZL; and
2. Relapsed or refractory disease; and
3. Member must have received at least 1 prior anti-CD20-based regimen.

Ukoniq™ (Umbralisib) Approval Criteria [Follicular Lymphoma (FL) Diagnosis]:

1. Diagnosis of FL; and
2. Relapsed or refractory disease; and
3. Member must have received at least 3 prior lines of systemic therapy.

Recommendation 7: Vote to Prior Authorize Sevenfact®

The Drug Utilization Review Board recommends the prior authorization Sevenfact® [Coagulation Factor VIIa (Recombinant)-jncw] with the following criteria:

Sevenfact® [Coagulation Factor VIIa (Recombinant)-jncw] Approval Criteria:

1. An FDA approved diagnosis; and
2. Sevenfact® must be prescribed by a hematologist specializing in rare bleeding disorders or a mid-level practitioner with a supervising physician that is a hematologist specializing in rare bleeding disorders.

Recommendation 8: Vote to Prior Authorize Bafiertam™, Kesimpta®, and Zeposia®

The Drug Utilization Review Board recommends the prior authorization Bafiertam™ (Monomethyl Fumarate), Kesimpta® (Ofatumumab), and Zeposia® (Ozanimod) with the following criteria:

Bafiertam™ (Monomethyl 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, in adults; 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), including lymphocyte count, 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. Intolerable adverse effects associated with a trial of Tecfidera® (dimethyl fumarate) and Vumerity® (diroximel fumarate) that are not expected to occur with Bafiertam™ or a patient-specific, clinically significant reason why trials of Tecfidera® and Vumerity® are not appropriate for the member must be provided; and
7. Verification that CBC, including lymphocyte count, levels are acceptable to the prescriber in addition to compliance will be required for continued approval every 6 months; and
8. A quantity limit of 120 capsules per 30 days will apply.

Kesimpta® (Ofatumumab) 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, in adults; and
2. Member must have had at least 1 relapse in the previous 12 months; and
3. The prescriber must verify hepatitis B virus (HBV) screening is performed before the first dose of Kesimpta® and the member does not have an active HBV infection; and
4. Prescriber must agree to monitor quantitative serum immunoglobulin level before, during, and after discontinuation of treatment with Kesimpta® until B-cell repletion; and
5. Prescriber must verify the member has no active infection(s); and
6. Prescriber must verify the first injection of Kesimpta® will be administered by a health care professional prepared to manage injection-related adverse reactions; and
7. Kesimpta® must be shipped via cold chain supply and the member or member's caregiver must be trained on the proper storage and subcutaneous (sub-Q) administration of Kesimpta®; and
8. Female members must not be pregnant and must have a negative pregnancy test prior to initiation of treatment with Kesimpta®; and
9. Female members of reproductive potential must use an effective method of contraception during treatment and for 6 months after discontinuing Kesimpta®; and
10. A quantity limit of 1 syringe or prefilled Sensoready® Pen per month will apply. Initial dosing titration will be approved for a quantity limit override upon meeting Kesimpta® approval criteria; and
11. Compliance will be checked for continued approval every 6 months.

Zeposia® (Ozanimod) 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, in adults; and
2. Member must not have any contraindications for use of Zeposia® including:
    a. Experienced myocardial infarction (MI), unstable angina, stroke, transient ischemic attack (TIA), decompensated heart failure (HF) requiring hospitalization, or NYHA Class III/IV HF in the last 6 months; or
    b. Presence of Mobitz type II second-degree, third-degree atrioventricular (AV) block, or sick sinus syndrome, unless member has a functioning pacemaker; or
    c. Severe untreated sleep apnea; or
    d. Concurrent use of monoamine oxidase inhibitors (MAOIs); and
3. Member must not have received prior treatment with alemtuzumab; and

4. Member must not be concurrently using strong CYP2C8 inhibitors/inducers or breast cancer resistance protein (BCRP) inhibitors; 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. Prescriber must conduct an electrocardiogram (ECG) to determine whether preexisting conduction abnormalities are present before initiating Zeposia®; and
8. Liver function tests (LFTs) and verification that levels are acceptable to the prescriber; and
9. Ophthalmic evaluation and verification that member will be monitored for changes in vision throughout therapy; and
10. Verification from the prescriber that the member has been assessed for medications and conditions that cause reduction in heart rate or AV conduction delays and that the member will be followed with appropriate monitoring per package labeling; and
11. Verification from the prescriber that the member has been assessed for previous confirmed history of chickenpox or vaccination against varicella. Members without a history of chickenpox or varicella vaccination should receive a full course of the varicella vaccine prior to commencing treatment with Zeposia®; 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 Zeposia® and for at least 3 months 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. A quantity limit of 30 capsules per 30 days will apply.

Recommendation 9: Vote to Prior Authorize Orladeyo™

The Drug Utilization Review Board recommends the prior authorization Orladeyo™ (Berotralstat) with the following criteria:

Orladeyo™ (Berotralstat) Approval Criteria:

1. An FDA approved diagnosis of hereditary angioedema (HAE); and
2. Must be used for *prophylaxis* of HAE; and

3. Not currently taking an angiotensin converting enzyme (ACE) inhibitor or estrogen replacement therapy; and
4. Based on HAE attack frequency, attack severity, comorbid conditions, and member's access to emergent treatment, the prescriber has determined long-term prophylaxis is appropriate for the member; or
5. Approval consideration will be given if the member has a recent hospitalization for a severe episode of angioedema; and
6. Orladeyo™ Dosing:
    a. The recommended dose of Orladeyo™ is 150mg by mouth once daily; and
    b. A quantity limit of 28 capsules per 28 days will apply.

Recommendation 10: Vote to Prior Authorize Barhemsys®

The Drug Utilization Review Board recommends the prior authorization Barhemsys® (Amisulpride) with the following criteria:

Barhemsys® (Amisulpride) Approval Criteria:

1. An FDA approved indication of 1 of the following:
    a. Prevention of postoperative nausea and vomiting (PONV), either alone or in combination with an anti-emetic of a different class; or
    b. Treatment of PONV in members who have received anti-emetic prophylaxis with an agent of a different class or who have not received prophylaxis; and
2. Member must be 18 years of age or older; and
3. Member must not have received a preoperative dopamine-2 (D_2) antagonist (e.g., metoclopramide); and
4. A patient-specific, clinically significant reason why the member cannot use other cost-effective therapeutic alternatives for the prevention or treatment of PONV (e.g. ondansetron, dexamethasone) must be provided.

Recommendation 11: Vote to Prior Authorize Nyvepria™

The Drug Utilization Review Board recommends the prior authorization Nyvepria™ (Pegfilgrastim-apgf) with the following criteria:

Nyvepria™ (Pegfilgrastim-apgf) Approval Criteria:

1. An FDA approved diagnosis; and
2. A patient-specific, clinically significant reason why the member cannot use Granix® (tbo-filgrastim), Neulasta® (pegfilgrastim), Neupogen® (filgrastim), Zarxio® (filgrastim-sndz), or Ziextenzo® (pegfilgrastim-bmez) must be provided. Biosimilars and/or reference products are preferred

based on the lowest net cost product(s) and may be moved to either preferred or non-preferred if the net cost changes in comparison to the reference product and/or other available biosimilar products.

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May Board
Proposed Rule Changes

The following emergency rules HAVE NOT previously been approved by the Board.

i. **APA WF # 21-02 State Plan Personal Care Services —** The proposed rule revisions will revoke the State Plan Personal Care Services Eligible Provider Exception section for the purpose of complying with 42 Code of Federal Regulations (C.F.R.) § 440.167. This federal regulation does not allow a legal guardian to provide personal care services. Additional revisions will align policy with current business practice and correct grammatical errors.
Budget Impact: Budget neutral

Tribal Consultation: March 2, 2021

Medical Committee Advisory Meeting: May 13, 2021

ii. **APA WF # 21-03 Remove Reasonable Limits on Amounts for Necessary Medical and Remedial Care not covered under the Oklahoma Medicaid State Plan —** The proposed change will remove policy which set reasonable limitations on medical expenses not covered under SoonerCare from an individual's post-eligibility income and for determining the vendor payment for nursing facilities or for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID). The rules had been previously promulgated and approved but not yet implemented.
Budget Impact: Budget neutral

Tribal Consultation: March 2, 2021

Medical Advisory Committee Meeting: March 11, 2021

APA WF # 21-05A Medicaid Expansion and Durable Medical Equipment — The proposed changes will expand Medicaid eligibility for individuals defined by 42 C.F.R. § 435.119 (Expansion Adults). Additionally, the proposed changes will define Expansion Adult benefits, prior authorization requirements, and/or medically necessary criteria. Additional rule changes will be made to indicate that Expansion Adults will receive prosthetics and orthotics above the current limits to meet federal regulation requirements.

Further, the proposed rule changes will comply with the Home Health rule and CURES Act requirements. The federal regulations change medical equipment, appliances, and supplies (formerly called DMEPOS) from an optional benefit to a mandatory benefit that must be provided to all SoonerCare members who meet medically necessary criteria. Additionally, the proposed rule changes describe the new coverage criteria, renting versus purchasing equipment, and outlines prior authorization requirements.

The proposed revisions will also update organ transplant requirements and guidelines to reflect current practice.

Finally, revisions will align and better clarify policy with current practice and correct grammatical errors.

Budget Impact: To add the new eligibility group, Expansion Adults, the estimated budget impact for SFY2022 will be an increase in the total amount of $1,339,830,140; $164,138,054 in state share and $1,175,692,086 in federal share.

To comply with the home health care final rule, the estimated budget impact for SFY2021 and SFY2022 will be an increase in the total amount of $2,615,007; $1,702,631 in federal share and $912,376 in state share. This budget impact was also reflected in the previous emergency rule WF# 20-06A.

Tribal Consultation: January 7, 2020 and March 2, 2021

Medical Advisory Committee: May 14, 2020 and May 13, 2021

iii. **APA WF # 21-05B Medicaid Expansion —** The proposed changes will expand Medicaid eligibility for individuals defined by 42 C.F.R. § 435.119 (Expansion Adults). Finally, revisions will align and better clarify policy with current practice and correct grammatical errors.

Budget Impact: The budget impact is reflected in APA WF 21-05A.

Tribal Consultation: March 2, 2021

Medical Advisory Committee: May 13, 2021

iv. **APA WF # 21-06 Insure Oklahoma Program Changes and Timely Filing —** The proposed changes reflect that IO IP members and IO Employer-Sponsored Insurance (ESI) members with incomes at or below 138% of the federal poverty level (FPL) will transition to and be provided services by the SoonerCare program under the Expansion Adult option. Additionally, proposed changes will remove references to the IO IP program as the program is being terminated, add new timely filing requirements for IO ESI subsidy payments, align and clarify policy with current practice, and correct grammatical errors.

Budget Impact: The budget impact is reflected in APA WF 21-05A.

Tribal Consultation: September 1, 2020 and March 2, 2021

Medical Advisory Committee: May 13, 2021

DRAFT

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

SUBCHAPTER 15. STATE PLAN PERSONAL CARE SERVICES

317:35-15-2. State Plan Personal care services
(a) Personal care is assistance to an individual in carrying out Activities of Daily Living (ADLs) or in carrying out Instrumental Activities of Daily Living (IADLs) directly related to the member's personal care needs to prevent or minimize physical health regression or deterioration. Personal care service requires a skilled nursing assessment of need, development of a care plan to meet identified personal care needs, care plan oversight, and periodic re-assessment and updating, of the care plan, when necessary. Personal care services do not include technical services, such as suctioning, tracheal care, gastrostomy-tube feeding or care, specialized feeding due to choking risk, application of compression stockings, bladder catheterization, colostomy irrigation, wound care, application of prescription lotions or topical ointments, range of motion exercises, or the operation of equipment of a technical nature, such as a patient lift or oxygen equipment.
(b) Personal care members may receive services in limited types of living arrangements. The specific living arrangements are set forth below.

(1) Personal care members are not eligible to receive services while residing in an institutional setting including, but not limited to, licensed facilities, such as a hospital, nursing facility, licensed residential care facility or licensed assisted living facility, or in an unlicensed institutional living arrangement, such as a room and board home or facility. Personal care may not be approved when the ~~client~~member lives in the personal care assistant's home except with the approval of Oklahoma Department of Human Services ~~(DHS)~~(OKDHS) Aging Services.

(2) ~~Additional living arrangements in which members~~Members may receive personal care services ~~are~~in the member's own home, apartment, or a ~~family~~family's or friend's home or apartment. A home or apartment unit is defined as a self-contained living space having a lockable entrance to the unit including a bathroom and food storage/preparation amenities in addition to bedroom/living space.

(3) For personal care members who are full-time students, a dormitory room qualifies as an allowable living arrangement in which to receive personal care services~~ for the period during which the member is a student~~.

(4) With prior approval of the ~~DHS~~OKDHS area nurse, personal care services may be provided in an educational or employment setting to assist the member to achieve vocational goals identified in the care plan.

(c) Personal care services may be provided by an individual employed by the member, referred to as an individual personal care assistant (IPCA)~~ or~~. Personal care services may be provided by a personal care assistant (PCA) who is employed by a home care agency, provided the home care agency is certified ~~to provide personal care services~~ and contracted with the Oklahoma Health Care Authority (OHCA) to provide personal care services. ~~DHS must determine an IPCA to be~~Before providing services, OKDHS determines if the IPCA is qualified to provide personal care services and not identified as ~~formal/informal~~formal or informal support for the member~~ before they can provide services~~. Persons eligible to serve as either IPCAs or ~~PCAS~~PCAs must:

(1) ~~be~~Be at least ~~18~~eighteen (18) years of age;

(2) ~~have~~Have no pending notation related to abuse, neglect, or exploitation as reported by the Oklahoma State Department of Health Nurse Aide Registry;

(3) ~~not~~Not be included in the ~~DHS~~OKDHS Community Services Worker Registry;

(4) ~~not~~Not be convicted of a crime or have any criminal background history or registry listings that prohibit employment per ~~O.S. Title 63, Section 1-1950.1;~~Title 63 of the Oklahoma Statutes Section 1-1950.1;

(5) ~~demonstrate~~Demonstrate the ability to understand and carry out assigned tasks;

(6) ~~not~~Not be a legally responsible family member, such as a spouse, legal guardian, or parent of a minor child of the member being served~~, exceptions may be made for a legal guardian to provide services only with prior approval from DHS Aging Services~~;

(7) ~~have~~Have a verifiable work history ~~and/or~~or personal references, and verifiable identification; and

(8) ~~meet~~Meet any additional requirements outlined in the contract and certification requirements with OHCA.

(d) Eligibility for Personal Care is contingent on ~~an individual~~a member requiring one (1) or more of the services offered at least monthly that include personal care, meal preparation, housekeeping, laundry, shopping or errands, or specified special tasks to meet ADL or IADL assessed needs.

317:35-15-3. Application for State Plan Personal Care

(a) **Requests for Personal Care.** A request for Personal Care is made to the local OKDHS office or ADvantage Administration (AA). A written financial application is not required for an individual

who has an active SoonerCare case. A financial application for Personal Care is initiated when there is no active SoonerCare case. The application is signed by the applicant, parent, spouse, guardian or someone else acting on the applicant's behalf. All conditions of financial eligibility must be verified and documented in the case record. When current information already available in the local office establishes eligibility, the information may be used by recording source and date of information. If the applicant also wishes to apply for a State Supplemental Payment, either the applicant or his/her guardian must sign the application form.

(b) **Date of application.**

(1) The date of application is:

(A) ~~the~~The date the applicant or someone acting on his/her behalf signs the application in the county office;

(B) ~~the~~The date the application is stamped into the county office when the application is initiated outside the county office; or

(C) ~~the~~The date when the request for SoonerCare is made orally and the financial application form is signed later.

(2) An exception to paragraph (1) of this subsection would occur when OKDHS has contracts with certain providers to take applications and obtain documentation. After the documentation is obtained, the contract provider forwards the application and documentation to the OKDHS county office of the applicant's county of residence for SoonerCare eligibility determination. The application date is the date the applicant signed the application form for the provider.

(c) **Eligibility status.** Financial and medical eligibility must be established before services can be initiated.

317:35-15-4. Determination of medical eligibility for State Plan Personal Care

(a) **Eligibility.** The Oklahoma Department of Human Services ~~(DHS)~~(OKDHS) area nurse determines medical eligibility for personal care services based on the Uniform Comprehensive Assessment Tool (UCAT) Part III and the determination that the member has unmet care needs that require personal care services. Personal care services are initiated to support the regular care provided in the member's home. Personal care services are not intended to take the place of regular care and general maintenance tasks or meal preparation shared or done for one another by natural supports, such as spouses or other adults who live in the same household. Additionally, personal care services are not furnished when they principally benefit the family unit. To be eligible for personal care services, the individual must:

(1) ~~have~~Have adequate informal supports consisting of adult

supervision that is present or available to contribute to care, or decision-making ability as documented on the UCAT Part III, to remain in his or her home without risk to his or her health, safety, and well-being, the individual:

(A) ~~must~~Must have the decision-making ability to respond appropriately to situations that jeopardize his or her health and safety or available supports that compensate for his or her lack of ability as documented on the UCAT Part III; or

(B) ~~who~~Who has his or her decision-making ability, but lacks the physical capacity to respond appropriately to situations that jeopardize health and safety and was informed by the ~~DHS~~OKDHS nurse of potential risks and consequences, may be eligible.

(2) ~~require~~Require a plan of care involving the planning and administration of services delivered under the supervision of professional personnel;

(3) ~~have~~Have a physical impairment or combination of physical and mental impairments as documented on the UCAT Part III. An individual who poses a threat to self or others as supported by professional documentation or other credible documentation may not be approved for Personal Care services. An individual who is actively psychotic or believed to be in danger of potential harm to self or others may not be approved for personal care services;

(4) ~~not~~Not have members of the household or persons who routinely visit the household who, as supported by professional documentation or other credible documentation, pose a threat of harm or injury to the individual or other household visitors;

(5) ~~lack~~Lack the ability to meet personal care needs without additional supervision or assistance, or to communicate needs to others; and

(6) ~~require~~Require assistance, not of a technical nature, to prevent or minimize physical health regression and deterioration.

(b) **Definitions.** The following words and terms, when used in this subsection, shall have the following meaning, unless the context clearly indicates otherwise:

(1) **"Activities of Daily Living" (ADL)** means activities of daily living are activities that reflect the member's ability to perform self-care tasks essential for sustaining health and safety, such as:

(A) ~~bathing;~~Bathing;

(B) ~~eating;~~Eating;

(C) ~~dressing;~~Dressing;

(D) ~~grooming;~~Grooming;

(E) ~~transferring~~Transferring includes activities such as getting in and out of a tub or bed to chair;
(F) ~~mobility;~~Mobility;
(G) ~~toileting;~~Toileting; and
(H) ~~bowel/bladder~~Bowel/bladder control.

(2) **"ADLs score of three or greater"** means the member cannot do at least one (1) ADL at all or needs some help with two (2) or more ADLs.

(3) **"Consumer support very low need"** means the member's UCAT Part III Consumer Support score is zero (0) which indicates, in the UCAT Part III assessor's clinical judgment, the formal and informal sources are sufficient for present level of member need in most functional areas.

(4) **"Consumer support low need"** means the member's UCAT Part III Consumer Support score is five (5) which indicates, in the UCAT Part III assessor's clinical judgment, the support from formal and informal sources are nearly sufficient for present level of member need in most functional areas. The member, family, or informal supports are meeting most needs typically expected of family or household members to share or do for one another, such as general household maintenance. There is little risk of institutional placement with loss of current supports.

(5) **"Consumer support moderate need"** means the UCAT Part III Consumer score is fifteen (15) which indicates, in the UCAT Part III assessor's clinical judgment, the formal and informal support is available, but overall, it is inadequate, changing, fragile, or otherwise problematic. The member requires additional assistance that usually includes personal care assistance with one or more ADLs not available through Medicare, the Veterans Administration, or other federal entitlement programs. Support provided by informal caregivers is of questionable reliability due to one (1) or more of the following:
(A) ~~care~~Care or support is required continuously with no relief or backup available;
(B) ~~informal~~Informal support lacks continuity due to conflicting responsibilities such as work or child care;
(C) ~~care~~Care or support is provided by persons with advanced age or disability; or
(D) ~~institutional~~Institutional placement can reasonably be expected with any loss of existing support.

(6) **"Consumer support high need"** means the member's UCAT Part III Consumer score is twenty-five (25) which indicates, in the UCAT Part III assessor's clinical judgment, the formal and informal supports are not sufficient as there is very little or no support available to meet a high degree of member need.

(7) **"Community services worker"** means any non-licensed health

professional employed by or under contract with a community services provider who provides, for compensation or as a volunteer, health-related services, training, or supportive assistance to frail elderly, disabled person(s), or person(s) with developmental disabilities.

(8) **"Community Services Worker Registry"** means a registry established by the ~~DHS,~~OKDHS per Section (§) 1025.1 of Title 56 of the Oklahoma Statutes (O.S.) to list community services workers against whom a final investigative finding of abuse, neglect, or exploitation, per 43A O.S. § 10-103, involving a frail elderly, disabled person(s), or person(s) with developmental disabilities was made by ~~DHS~~OKDHS or an administrative law judge; and amended in 2002, to include the listing of SoonerCare (Medicaid) personal care assistants (PCAs) providing personal care services.

(9) **"Instrumental activities of daily living (IADL)"** means those activities that reflect the member's ability to perform household chores and tasks within the community essential for sustaining health and safety, such as:

(A) ~~shopping;~~Shopping;
(B) ~~cooking;~~Cooking;
(C) ~~cleaning;~~Cleaning;
(D) ~~managing~~Managing money;
(E) ~~using~~Using a phone;
(F) ~~doing~~Doing laundry;
(G) ~~taking~~Taking medication; and
(H) ~~accessing~~Accessing transportation.

(10) **"IADLs score is at least six (6)"** means the member needs some help with at least three (3) IADLs or cannot do two (2) IADLs at all.

(11) **"IADLs score of eight (8) or greater"** means the member needs some help with at least four (4) IADLs or the member cannot do two (2) IADLs at all and needs some help with one (1) or more other IADLs.

(12) **"MSQ"** means the mental status questionnaire.

(13) **"MSQ moderate risk range"** means a total weighted-score of seven (7) to eleven (11) that indicates an orientation-memory-concentration impairment or memory impairment.

(14) **"Nutrition moderate risk"** means the total weighted UCAT Part III Nutrition score is eight (8) or more that indicates poor appetite or weight loss combined with special diet requirements, medications, or difficulties in eating.

(15) **"Social resources score is eight (8) or more"** means the member lives alone or has no informal support when he or she is sick, needs assistance, or has little or no contact with others.

(c) **Medical eligibility minimum criteria for personal care.** The medical eligibility minimum criteria for personal care are the

minimum UCAT Part III score criteria that a member must meet for medical eligibility for personal care and are:

(1) ADLs score is five (5) or greater; or IADLs score of eight (8) or greater; or Nutrition score is eight (8) or greater; or the MSQ score is seven (7) or greater; or the ADLs score is three (3) and IADLs score is at least six (6); and

(2) Consumer Support is fifteen (15) or more; or Consumer Support score is five (5) and the Social Resources score is eight (8) or more.

(d) **Medical eligibility determination.** Medical eligibility for personal care is determined by the ~~DHS.~~OKDHS. The medical decision for personal care is made by the ~~DHS~~OKDHS area nurse utilizing the UCAT Part III.

(1) Categorical relationship must be established for determination of eligibility for personal care. When categorical relationship to Aid to the Disabled was not established but there is an extremely emergent need for personal care, and current medical information is not available, the local office authorizes a medical examination. When authorization is necessary, the county director issues Form 08MA016E, Authorization for Examination, and Form 08MA02E, Report of Physician's Examination, to a licensed medical or osteopathic health care professional, refer to Oklahoma Administrative Code (OAC) 317:30-5-1. The licensed health care professional cannot be in a medical facility internship, residency, or fellowship program or in the full time employment of the Veterans Administration, United States Public Health Service, or other agency. The ~~DHS~~OKDHS county worker submits the information to the Level of Care Evaluation Unit (LOCEU) to request a determination of eligibility for categorical relationship. LOCEU renders a decision on the categorical relationship using the Social Security Administration (SSA) definition. A follow-up is required by the ~~DHS~~OKDHS county worker with ~~(~~SSA~~)~~ to ensure the SSA disability decision is also the LOCEU decision.

(2) Approved contract agencies or the ADvantage Administration (AA) may complete UCAT Part I for intake and screening and forward the form to the county office.

(3) Upon receipt of the referral, ~~DHS~~OKDHS county staff may initiate the UCAT, Part I.

(4) The ~~DHS~~OKDHS nurse is responsible for completing the UCAT Part III assessment visit within ~~ten-business (10-business)~~ten (10) business days of the personal care referral for the applicant who is SoonerCare eligible at the time of the request. The ~~DHS~~OKDHS nurse completes the assessment visit within ~~twenty-business (20-business)~~twenty (20) business days of the referral for the applicant not determined SoonerCare eligible

at the time of the request. When the UCAT Part I indicates the request is from an individual who resides at home and an immediate response is required to ensure the health and safety of the person, emergency situation, or to avoid institutional placement, the UCAT Part III assessment visit has top-scheduling priority.
(5) During the assessment visit, the ~~DHS~~OKDHS nurse completes the UCAT Part III and reviews rights to privacy, fair hearing, provider choice, and the pre-service acknowledgement agreement with the member. The ~~DHS~~OKDHS nurse informs the applicant of medical eligibility criteria and provides information about ~~DHS~~OKDHS long-term care service options. The ~~DHS~~OKDHS nurse documents if the member wants to be considered for nursing facility level of care services or if the member is applying for a specific service program on UCAT Part III. When, based on the information obtained during the assessment, the ~~DHS~~OKDHS nurse determines if the member may be at risk for health and safety, an immediate referral is made to Adult Protective Services (APS) or Child Protective Services, as applicable. The referral is documented on the UCAT Part III.

(A) When the applicant's needs cannot be met by personal care services alone, the ~~DHS~~OKDHS nurse informs the applicant of the other community long-term care service options. The ~~DHS~~OKDHS nurse assists the applicant in accessing service options selected by the applicant in addition to, or in place of, Personal Care services.

(B) When multiple household members are applying for SoonerCare personal care services, the UCAT Part III assessment is done for all the household members at the same time.

(C) The ~~DHS~~OKDHS nurse informs the applicant of the qualified agencies in his or her local area that provide services and obtains the applicant's primary and secondary choice of agencies. When the applicant or family declines to choose a primary personal care service agency, the ~~DHS~~OKDHS nurse selects an agency from a list of all available agencies, using a round-robin system. The ~~DHS~~OKDHS nurse documents the name of the selected personal care provider agency.

(6) The ~~DHS~~OKDHS nurse completes the UCAT Part III and sends it to the ~~DHS~~OKDHS area nurse for medical eligibility determination. Personal care service eligibility is established on the date medical eligibility is approved and financial eligibility is established. This date serves as the certification date for services to be initiated.

(A) When the length of time from the initial assessment to the date of service eligibility determination exceeds ~~ninety-calendar (90-calendar)~~ninety (90) calendar days, a

new UCAT Part III and assessment visit is required.
(B) The ~~DHS~~OKDHS area nurse assigns a medical certification period of not more than thirty-six (36) months for persons eighteen (18) years of age and older or not more than twelve (12) months for persons younger than eighteen (18) years of age. The service plan period under the Service Authorization Model (SAM) is for a period of twelve (12) months and is provided by the ~~DHS~~OKDHS nurse.

(7) The ~~DHS~~OKDHS area nurse notifies the ~~DHS~~OKDHS county worker via Electronic Data Entry and Retrieval System (ELDERS) of the personal care certification. The authorization line is open via automation from ELDERS.

(8) Upon establishment of personal care certification, the ~~DHS~~OKDHS nurse contacts the member's preferred provider agency, or when necessary, the secondary provider agency or the provider agency selected by the round robin system. Within ~~one-business (1-business)~~one (1) business day of provider agency acceptance, the ~~DHS~~OKDHS nurse forwards the referral information to the provider agency for SAM plan development. Refer to OAC 317:35-15-8(a).

(9) Following the SAM packet development by the provider agency, and within ~~three-business (3-business)~~three (3) business days of receipt of the packet from the provider agency, the ~~DHS~~OKDHS nurse reviews the documentation to ensure agreement with the plan. Once agreement is established, the packet is authorized by the designee or submitted to the area nurse for review.

(10) Within ~~ten-business (10-business)~~ten (10) business days of receipt of the SAM case from the ~~DHS~~OKDHS nurse, the ~~DHS~~OKDHS area nurse authorizes or denies the SAM units. If the SAM case fails to meet standards for authorization, the case is returned to the ~~DHS~~OKDHS nurse for further justification.

(11) Within ~~one-business (1-business)~~one (1) business day of knowledge of the authorization, the ~~DHS~~OKDHS nurse forwards the service plan authorization to the provider agency.

317:35-15-5. General financial eligibility requirements for State Plan Personal Care

Financial eligibility for Personal Care is determined using the rules on income and resources according to the eligibility group to which the individual is related. Income and resources are evaluated on a monthly basis for all individuals requesting payment for Personal Care who are categorically related to ABD; maximum countable monthly income and resource standards for individuals related to ABD are found on OKDHS form 08AX001E (Appendix C-1), Schedule VI (QMBP program standards).

317:35-15-6. Determining financial eligibility of categorically

needy individuals

Financial eligibility for Personal Care for categorically needy individuals is determined as follows:

(1) **Financial eligibility for MAGI eligibility groups.** See MAGI eligibility rules in Subchapter 6 of this Chapter to determine financial eligibility for MAGI eligibility groups.

(2) **Financial eligibility/categorically related to ABD.** In determining income and resources for the individual related to ABD, the "family" includes the individual and spouse, if any. To be categorically needy, the countable income must be less than the categorically needy standard as shown on the OKDHS form 08AX001E (Appendix C-1), Schedule VI (QMBP standard). If an individual and spouse cease to live together for reasons other than institutionalization or receipt of the ADvantage waiver or HCBW/MR services, income and resources are considered available to each other through the month in which they are separated. Mutual consideration ceases with the month after the month in which the separation occurs. Any amounts which are actually contributed to the spouse after the mutual consideration has ended are considered.

(3) **Determining financial eligibility for State Plan Personal Care.** For individuals determined categorically needy for Personal Care, the member will not pay a vendor payment for Personal Care services.

317:35-15-7. Certification for State Plan Personal Care

(a) **Personal Care certification period.** The first month of the Personal Care certification period must be the first month the member was determined eligible for Personal Care, both financially and medically. When eligibility or ineligibility for Personal Care is established, the local office updates the computer-generated form and the appropriate notice is mailed to the member.

(b) **Financial certification period.** The financial certification period for Personal Care services is ~~12~~twelve (12) months. Redetermination of eligibility is completed according to the categorical relationship.

(c) **Medical certification period.** A medical certification period of not more than thirty-six (36) months is assigned for an individual who is approved for Personal Care. The certification period for Personal Care is based on the Uniform Comprehensive Tool (UCAT) evaluation and clinical judgment of the Oklahoma Department of Human Services ~~(DHS)~~OKDHS area nurse or designee.

317:35-15-8. Agency State Plan personal care service authorization and monitoring

(a) Within ~~10-business~~ten (10) business days of receipt of the referral for personal care services, the personal care provider

agency nurse completes a Service Authorization Model (SAM) visit in the home to assess the member's personal care service needs, completes a SAM packet based on the member's needs and submits the packet to the ~~DHS~~OKDHS nurse. The member's SAM packet includes ~~DHS~~OKDHS Forms:

(1) 02AG044E, Personal Care Progress Notes;

(2) 02AG030E, Personal Care Planning Schedule/Service Plan; and

(3) 02AG029E, Personal Care Plan.

(b) When more than one (1) person in the household was referred to receive personal care or ADvantage services, all household members' SAM packets are discussed and developed with the eligible members so service delivery is coordinated to achieve the most efficient use of resources. The number of units of personal care service authorized for each individual is distributed between all eligible family members to ensure that the absence of one (1) family member does not adversely affect the family member(s) remaining in the home. When one (1) or more persons in the same household with a personal care member were referred to or are receiving other formal services, such as ADvantage or Developmental Disability Services, then those services are coordinated as well.

(c) The personal care provider agency receives documentation from ~~DHS~~OKDHS as authorization to begin services. The agency delivers a copy of the care plan Form 02AG029E and the Personal Care Planning Schedule/Service Plan to the member upon initiating services.

(d) Prior to placing a personal care assistant (PCA) in the member's home or other service-delivery setting by the provider agency, an Oklahoma State Bureau of Investigation (OSBI) background check, an Oklahoma State Department of Health Registry check, and an ~~DHS~~OKDHS Community Services Worker Registry check must be completed per Sections 1-1944 through 1-1948 of Title 63 of the Oklahoma Statutes. Payment is made for PCAs who provide personal care services and meet criteria OAC ~~317:35-15-2(c)(1) 1 through 8).~~317:35-15-2(c) (1) through (8).

(e) The provider agency nurse monitors the member's plan of care.

(1) The personal care provider agency contacts the member within ~~five business~~five (5) business days of receipt of the authorized document in order to ensure services were implemented according to the authorized plan of care.

(2) The provider agency nurse makes a SAM home visit at least every six (6) months to assess the member's satisfaction with his or her care and to evaluate the SAM packet for adequacy of goals and authorized units. Whenever a home visit is made, the provider agency nurse documents findings in the Personal Care Progress Notes. The provider agency forwards a copy of the Progress Notes to the ~~DHS~~OKDHS nurse for review within ~~five-~~

~~business~~five (5) business days of the visit. The monitoring visit may be conducted by a Licensed Practical Nurse (LPN) only when the PCA is not performing hands-on personal care. A Registered Nurse (RN) must also co-sign the progress notes.

(3) Requests by the provider agency nurse to change the number of units authorized in the SAM packet are submitted to ~~(DHS)~~OKDHS and are approved or denied by the ~~(DHS)~~OKDHS area nurse or designee, prior to changed number of units~~ unit~~ implementation.

(4) Annually, or more frequently when the member's needs change, the provider agency nurse re-assesses the member's need's and develops a new SAM packet to meet the member's needs. The provider agency nurse conducts a home visit and completes and submits the annual reassessment documents to the ~~DHS~~OKDHS nurse no sooner than ~~60-calendar~~sixty (60) calendar days before the existing service plan end-date, and no later than ~~14-calendar~~fourteen (14) calendar days prior to service.

(5) When the member is unstaffed, the provider agency communicates with the member and makes efforts to re-staff. It is recommended the provider agency contacts unstaffed members weekly by phone to actively monitor the health and safety of the member and documents ongoing efforts to provide staff. When the member is unstaffed for ~~30-calendar~~thirty (30) days, the provider agency notifies the ~~DHS~~OKDHS nurse on Form 02AG032E, Provider Communication Form. The ~~DHS~~OKDHS nurse contacts the member and when the member chooses, initiates a transfer of the member to another provider agency that can provide staff.

317:35-15-8.1. Agency State Plan Personal Care services; billing, and problem resolution

The ADvantage Administration (AA) certifies qualified personal care provider agencies and facilitates the execution of the agencies' SoonerCare (Medicaid) contracts on behalf of the Oklahoma Health Care Authority (OHCA). OHCA checks the list of providers barred from Medicare/SoonerCare (Medicaid) participation to ensure that the personal care services agency is not listed.

(1) **Payment for State Plan personal care.** Payment for personal care services is made for care provided in the member's ~~"own home"~~own home or in other limited types of living arrangements, per ~~OAC~~Oklahoma Administrative Code (OAC) 317:35-15-2(b)(1 through 4).

(A) **Use of provider agency.** To provide personal care services, an agency must be licensed by the Oklahoma State Department of Health, meet certification standards identified by the Oklahoma Department of Human Services ~~(DHS),~~(OKDHS), and possess a current SoonerCare (Medicaid) contract.

(B) **Reimbursement.** Personal care services payment on behalf of a member is made according to the type of service and number of ~~units of~~ personal care ~~services~~services units authorized in the Service Authorization Model (SAM) packet.

(i) The amount paid to provider agencies for each unit of service is determined according to established SoonerCare (Medicaid) rates for the ~~Personal Care~~personal care services. Only authorized units contained in each eligible member's individual SAM packet are eligible for reimbursement. Provider agencies serving more than one personal care service member residing in the same residence ensure the members' SAM packets combine units in the most efficient manner to meet the needs of all eligible persons in the residence.

(ii) Payment for personal care services is for tasks performed in accordance per OAC 317:30-5-951 only when listed on an authorized plan of care. Payment for personal care skilled nursing service is made on behalf of the member for assessment/evaluation and associated service planning per SAM nursing visit.

(iii) Service time for personal care services is documented through the use of the Electronic Visit Verification System (EVV), previously known as Interactive Voice Response Authentication (IVRA) system, when services are provided in the home.

(2) **Issue resolution.**

(A) The provider agency provides a written copy of their grievance process to each member at the commencement of services. The written grievance process includes the name and phone number of a provider agency contact person who is responsible for responding to such complaints and grievances. When the member is dissatisfied with the Personal Care provider agency or the assigned PCA and has exhausted attempts to work with the Personal Care provider agency's grievance process without resolution, the member is referred to the ~~DHS~~OKDHS State Plan Care Unit to attempt to resolve the issue(s). The member has the right to appeal to OHCA per OAC 317:2-1-2.

(B) When a PCA performance issue is identified, provider agency staff conducts a counseling conference with the member and/or the PCA as appropriate. Provider agency staff counsels the PCA regarding problems with his/her performance.

(3) **Persons ineligible to serve as PCAs.** Payment from SoonerCare funds for personal care services may not be made to an individual who is a legally responsible family member of the member, such as a spouse, legal guardian, or parent of minor child, to whom he/she

is providing personal care services~~ (exceptions may be made for legal guardians with prior approval from the Department of Human Services/Aging Services (DHS/AS)~~.

317:35-15-8.2. State Plan Personal Care Eligible Provider Exception [REVOKED]

~~The Oklahoma Department of Human Services (OKDHS) Aging Services (AS) may authorize a member's legal guardian to be eligible for SoonerCare (Medicaid) reimbursement when he or she is hired by a home care provider agency as a personal care service provider. Authorization for a legal guardian as a provider requires the criteria in (1) though (4) of this Section and monitoring provisions to be met.~~

~~(1) Authorization for a legal guardian to be the member's care provider may occur only when the member is offered a choice of providers and documentation demonstrates:~~

~~(A) Another provider is not available; or~~

~~(B) The member's needs are so extensive that the legal guardian providing the care is prohibited from obtaining employment.~~

~~(2) The service must:~~

~~(A) Fall under the State Plan Personal Care (SPPC) program guidelines;~~

~~(B) Be necessary to avoid institutionalization;~~

~~(C) Be a service and/or support specified in the person-centered service plan;~~

~~(D) Be provided by a person who meets provider qualifications;~~

~~(E) Be paid at a rate that does not exceed what would be paid to a provider of a similar service and does not exceed what is allowed by Medicaid (SoonerCare)for the payment of personal care or personal assistance services; and~~

~~(F) Not be an activity the legal guardian would ordinarily perform or is responsible to perform.~~

~~(3) The legal guardian service provider complies with:~~

~~(A) Providing no more that forty (40) hours of services in a seven (7) calendar day period;~~

~~(B) Planned work schedules that must be available in advance for the member's home care agency. Variations to the schedule must be noted and supplied to the home care agency two (2) weeks in advance unless the change is due to an emergency;~~

~~(C) Utilization of the Electronic Visit Verification System (EVV) also known as the Interactive Voice Response Authentication (IVRA) system; and~~

~~(D) Being identified and monitored by the home care agency.~~

~~(4) The home care agency is required to submit a request and obtain approval for eligible provider exceptions to OKDHS AS~~

~~prior to employing a legal guardian as a member's personal care assistant (PCA). Eligible provider exceptions require the home care agency to:~~

~~(A) Provide monitoring and complete the Eligible Provider Exception Six Month Review document, when in the member's home completing the six-month Nurse Evaluation document in the Medicaid waiver information system; and~~

~~(B) Annually complete the Eligible Provider Exception Request and submit it with the annual Service Authorization Model (SAM) documentation no later than forty-five (45) calendar days prior to the previous eligible provider exception service authorization end date.~~

317:35-15-9. Redetermination of financial eligibility for State Plan Personal Care

The OKDHS county Social Services Specialist must complete a redetermination of financial eligibility before the end of the certification period. A notice is generated only if there is a change which affects the member's financial eligibility.

317:35-15-10. Redetermination of medical eligibility for ~~personal care~~State Plan Personal Care services

(a) **Medical eligibility redetermination.** The Oklahoma Department of Human Services ~~(DHS)~~OKDHS area nurse must complete a redetermination of medical eligibility before the end of the long-term care medical certification period.

(b) **Recertification.** The ~~DHS~~OKDHS nurse re-assesses the personal care services member, eighteen (18) years of age and older, for medical re-certification based on the member's needs and level of caregiver support required, using the Uniform Comprehensive Assessment Tool (UCAT) Part III at least every thirty-six (36) months. Those members, who are younger than eighteen (18) years of age, are re-evaluated by the ~~DHS~~OKDHS nurse using the UCAT Part III on a twelve (12) month basis or sooner when needed. During this re-certification assessment, the DHS nurse informs the member of the state's other SoonerCare (Medicaid) long-term care options. The ~~DHS~~OKDHS nurse submits the re-assessment to the ~~DHS~~OKDHS area nurse for recertification. Documentation is sent to the ~~DHS~~ area nurse no later than the ~~tenth calendar (10th calendar)~~tenth (10th) calendar day of the month in which the certification expires. When the ~~DHS~~OKDHS area nurse determines medical eligibility for personal care services, a recertification review date is entered on the system.

(c) **Change in amount of units or tasks.** When the personal care provider agency determines a need for a change in the amount of units or tasks within the personal care service, a new Service Authorization Model (SAM) packet is completed and submitted to

~~DHS~~OKDHS within five (5) business days of identifying the assessed need. The change is approved or denied by the ~~DHS~~OKDHS area nurse or designee, prior to implementation.

(d) **Voluntary closure of personal care services.** When a member decides personal care services are no longer needed to meet his or her needs, a medical decision is not needed. The member and the ~~DHS~~OKDHS nurse or ~~DHS~~OKDHS county Social Services Specialist completes and signs ~~DHS~~OKDHS Form 02AG038E, State Plan Personal Care/ADvantage Program Voluntary Withdrawal Request. The ~~DHS~~OKDHS nurse submits closure notification to the provider agency.

(e) **Resuming personal care services.** When a member approved for personal care services is without personal care services for less than ~~ninety-calendar (90-calendar)~~ninety (90) calendar days but has current medical and SoonerCare (Medicaid) financial eligibility approval, personal care services may be resumed using the member's previously approved SAM packet. The personal care provider agency nurse contacts the member to determine when changes in health or service needs occurred. When changes are identified, the provider agency nurse makes a home visit and submits a personal care services skilled nursing re-assessment of need within ~~ten-business (10-business)~~ten (10) business days of the resumed plan start date, using the State Plan Personal Care Progress Notes, ~~DHS~~OKDHS Form 02AG044E. When the member's needs dictate, the personal care provider agency may submit a request for a change in authorized personal care services units with a SAM packet to ~~DHS.~~OKDHS. When no changes occur, the agency nurse documents the contact on State Plan Personal Provider Communication Form 02AG032E and forwards it to the ~~DHS~~OKDHS nurse within ~~ten-business (10-business)~~ten (10) business days of the resumed plan start date.

(f) **Financial ineligibility.** When the ~~DHS~~OKDHS determines a personal care services member does not meet SoonerCare financial eligibility criteria, the ~~DHS~~OKDHS office notifies the ~~DHS~~OKDHS area nurse to initiate the closure process due to financial ineligibility. Individuals determined financially ineligible for personal care services are notified by ~~DHS~~OKDHS in writing of the determination and of their right to appeal the decision. The ~~DHS~~OKDHS nurse submits closure notification to the provider agency.

(g) **Closure due to medical ineligibility.** Individuals determined medically ineligible for personal care services are notified by ~~DHS~~OKDHS in writing of the determination and of their right to appeal the decision. When medical eligibility redetermination is not made prior to current medical eligibility expiration, the existing medical eligibility certification is automatically extended until level of care redetermination is established. For members:

(1) ~~who~~Who are not hospitalized or in an extended medical care

facility, the existing medical eligibility certification is extended for a maximum ~~sixty-calendar (60-calendar)days~~sixty (60) calendar days from the date of the previous medical eligibility expiration date;

(2) ~~who~~Who are hospitalized or in an extended medical care facility, the existing medical eligibility certification is extended for ~~thirty-calendar (30-calendar)~~thirty (30) calendar days from the date of discharge from the facility or for ~~sixty-calendar (60-calendar)~~sixty (60) calendar days from the date of previous medical eligibility expiration date, whichever is longer;

(3) ~~whose~~Whose medical eligibility redetermination is not made by applicable extended deadline, the member is determined to be no longer medically eligible; or

(4) ~~who~~Who no longer meet medical eligibility or cannot be located to complete the redetermination assessment, the area nurse or nurse designee, updates the system's medical eligibility end date and notifies the ~~DHS~~OKDHS State Plan Care Unit (SPCU) nurse of effective end date. The ~~DHS~~OKDHS SPCU nurse submits closure notification to the provider agency.

(h) **Termination of State Plan personal care services.**

(1) Personal care services may be discontinued when:

(A) ~~the~~The member poses a threat to self or others as supported by professional documentation;

(B) ~~other~~Other members of the household or persons who routinely visit the household who, as supported by professional documentation or other credible documentation, pose a threat to the member or other household visitors;

(C) ~~the~~The member or the other household members use threatening, intimidating, degrading, or sexually inappropriate language and/or innuendo or behavior towards service providers, either in the home or through other contact or communications; and efforts to correct such behavior were unsuccessful as supported by professional documentation or other credible documentation.

(D) ~~the~~The member or family member fails to cooperate with Personal Care service delivery or to comply with Oklahoma Health Care Authority (OHCA) or ~~DHS~~OKDHS rules as supported by professional documentation;

(E) ~~the~~The member's health or safety is at risk as supported by professional documentation;

(F) ~~additional~~Additional services, either "formal" such as, paid by Sooner Care (Medicaid) or some other funding source or "informal" such as, unpaid are provided in the home eliminating the need for SoonerCare personal care services;

(G) ~~the~~The individual's living environment poses a physical threat to self or others as supported by professional

documentation where applicable, and measures to correct hazardous conditions or assist the person to move are unsuccessful or are not feasible; or

(H) ~~the~~The member refuses to select and/or accept the services of a provider agency or personal care assistant (PCA) for ~~ninety-consecutive (90-consecutive)~~ninety (90) consecutive days as supported by professional documentation.

(2) For persons receiving personal care services, the personal care provider agency submits documentation with the recommendation to discontinue services to ~~DHS.~~OKDHS. The ~~DHS~~OKDHS nurse reviews the documentation and submits it to the ~~DHS~~OKDHS area nurse for determination. The ~~DHS~~OKDHS nurse notifies the personal care provider agency or PCA and the local ~~DHS~~OKDHS county worker of the decision to terminate services. The member is sent an official closure notice informing him or her of appropriate member rights to appeal the decision to discontinue services.

317:35-15-13.1. Individual personal care assistant (IPCA) service management

(a) An Individual Personal Care Assistant (IPCA) may be utilized to provide personal care services when it is documented to be in the best interest of the member to have an IPCA or when there are no qualified personal care provider agencies available in the member's local area. Oklahoma Health Care Authority (OHCA) checks the list of providers barred from Medicare/Medicaid participation to ensure the IPCA is not listed.

(b) After personal care services eligibility is established and prior to implementation of personal care services using an IPCA, the ~~DHS~~OKDHS nurse reviews the care plan with the member and IPCA and notifies the member and IPCA to begin personal care services delivery. The ~~DHS~~OKDHS nurse maintains the original care plan and forwards a copy of the care plan to the selected IPCA and member within ~~one-business~~one (1) business day of receipt of approval.

(c) The ~~DHS~~OKDHS nurse contacts the member within ~~five-business~~five (5) business days to ensure services are in place and meeting the member's needs and monitors the care plan for members with an IPCA. For any member receiving personal care services utilizing an IPCA, the ~~DHS~~OKDHS nurse makes a home visit at least every six (6) months beginning within ~~90-calendar~~ninety (90) calendar days from the date of personal care service initiation. ~~DHS~~OKDHS assesses the member's satisfaction with his or her personal care services and evaluates the care plan for adequacy of goals and units allocated. Requests for changes in the units authorized in the care plan must be approved by the ~~DHS~~OKDHS area nurse or designee, prior to implementation of the changed number of units.

317:35-15-13.2. Individual personal care assistants (IPCA) provider contractor; billing, training, and problem resolution

While the Oklahoma Health Care Authority (OHCA) is the contractor authorized under federal law, the Oklahoma Department of Human Services ~~(DHS)~~OKDHS nurse initiates initial contracts with qualified individuals~~ for provision of~~to provide personal care services per Oklahoma Administrative Code (OAC) 317:35-15-2. ~~The~~OHCA is responsible for the IPCA contract renewal~~ for the IPCA is the responsibility of OHCA~~.

(1) **IPCA payment.** Payment for personal care services is made for care provided in the member's ~~"own home"~~own home or in other limited types of living arrangements per OAC 317:35-15-2(b)(1) through (4). Personal care may not be approved when the ~~client~~member lives in the Personal Care Assistant's ~~(PCA's)~~(PCA) home, except with the approval of ~~DHS~~OKDHS Aging Services.

(A) **Reimbursement.** Personal care payment for a member is made according to the number of personal care units~~ of service~~ identified in the service plan.

(i) The amount per unit~~ amounts~~ paid to individual contractors is determined according to the established rates. A service plan is developed for each ~~eligible individual~~member in the home and units of service are assigned to meet ~~the~~each member's needs~~ of each member~~. The service plans combine units in the most efficient manner to meet the needs of all eligible ~~persons~~members in the household.

(ii) From the total amounts billed by the IPCA in (i) of this subparagraph, the OHCA, acting as agent for the member-employer, withholds the appropriate percentage of FICA tax and sends it to the Internal Revenue Service as the individual contractor's contribution toward Social Security coverage. To ensure the individual contractor's Social Security account ~~may be~~is properly credited, ~~it is vital that~~ the individual contractor's Social Security number ~~be~~is entered correctly on each claim.

(iii) The contractor payment fee covers all personal care services included on the service and care plans developed by the ~~DHS~~OKDHS nurse. Payment is only made for eligible member's direct services and care~~ of the eligible member(s) only~~. The OKDHS area nurse, or designee, authorizes the number of units of service units the member receives.

(iv) A member may select more than one (1) IPCA. This may be necessary as indicated by the service and care plans.

(v) The IPCA may provide SoonerCare personal care services for several households during one (1) week as long as the daily number of paid service units does not exceed eight (8) hours, ~~32~~thirty-two (32) units per day. The total number of hours per week cannot exceed ~~40, 160 units.~~forty (40), one-hundred and sixty (160) units.

(B) **Release of wage ~~and/or~~or employment information for IPCAs.** Any inquiry received by the local office requesting wage ~~and/or~~or employment information for an IPCA is forwarded to~~ the~~ OHCA, Claims Resolution.

(2) **IPCA member selection.** Members ~~and/or~~or family members recruit, interview, conduct reference checks, and select the individual for IPCA consideration. Prior to placing a personal care service provider in the member's home, an ~~OSBI~~Oklahoma State Bureau of Investigation background check~~, a DHS~~ and an OKDHS Community Services Worker Registry check must be completed per Section 1-1944 through 1-1948 of Title 63 of the Oklahoma Statutes~~.~~ (O.S. 63 §§ 1-1944 through 1-948). The ~~DHS~~OKDHS nurse must also check the Certified Nurse Aide Registry. The ~~DHS~~OKDHS nurse must affirm that the applicant's name is not contained on any of the registries. The ~~DHS~~OKDHS nurse notifies OHCA when the applicant is on ~~the Registry.~~any registry.

(A) **Persons eligible to serve as IPCAs.** Payment is made for personal care services to IPCAs ~~who~~and provide personal care services who meet the criteria per OAC 317:35-15-2(c)(1) through (8).

(B) **Persons ineligible to serve as IPCAs.** Payment from SoonerCare funds for personal care services may not be made to an individual who is a legally responsible family member, such as a spouse, legal guardian, or parent of a minor child of the member being served~~, exceptions to legal guardian are made only with prior approval from Aging Services Division~~.

(i) Payment cannot be made to ~~a DHS or~~ an OKDHS or OHCA employee. Payment cannot be made to an immediate family member of a ~~DHS~~an OKDHS employee who works in the same county without ~~DHS~~OKDHS Aging Services approval. When a family member relationship exists between ~~a DHS~~an OKDHS nurse and an IPCA in the same county, the ~~DHS~~OKDHS nurse cannot manage services for a member whose IPCA is a family member of the ~~DHS~~OKDHS nurse.

(ii) If it is determined that ~~an a DHS~~an OKDHS or an OHCA employee is interfering in the process of providing services for personal or family benefit, ~~he or she~~the employee is subject to disciplinary action.

(3) **IPCA orientation.** When a member selects an IPCA, the ~~DHS~~OKDHS nurse ~~contacts~~notifies the ~~individual~~selected IPCA to

report to the county office to complete the Oklahoma State Department of Health~~ form~~(OSDH) Form 805, Uniform Employment Application for Nurse Aide Staff, and the ~~DHS~~OKDHS Form 06PE039E, Employment Application Supplement, and for a determination of qualifications and orientation~~.~~ determination. For personal care members, this process is the responsibility of the ~~DHS~~OKDHS nurse. The IPCA can begin work when:

(A) ~~he or she was interviewed~~Interviewed by the member~~,~~;

(B) ~~he or she was oriented~~Orientated by the OKDHS nurse~~,~~;

(C) ~~he or she executed a~~A contract (OHCA-0026) is executed with the OHCA~~,~~;

(D) ~~the~~The effective service date ~~was~~is established~~,~~;

(E) ~~all~~All registries ~~were~~are checked and the IPCA's name is not listed~~,~~;

(F) ~~the Oklahoma State Department of Health~~OSDH Nurse Aide Registry ~~was~~is checked and no notations ~~were~~are found~~,~~; and

(G) ~~the~~ OSBI background check ~~was~~is completed.

(4) **Training of IPCAs.** It is the responsibility of the ~~DHS~~OKDHS nurse to make sure the IPCA has the training needed to carry out the plan of care prior to service initiation for each member.

(5) **Problem resolution related to the performance of the IPCA.** When it comes to the attention of the ~~DHS~~OKDHS nurse that there is a problem related to the IPCA's performance~~ of the IPCA~~, a counseling conference is held between the member, OKDHS nurse, and ~~worker.~~IPCA. The ~~DHS~~OKDHS nurse counsels the IPCA regarding problems with his or her performance. Counseling is considered when staff believes counseling will result in improved performance.

(6) **Termination of the IPCA Provider Agreement.**

(A) A recommendation for the termination of an IPCA's contract is submitted to OHCA and IPCA services are suspended immediately when~~:~~ the:

(i) ~~an~~ IPCA's performance is such that~~ his or her~~ continued participation in the program could pose a threat to the health and safety of the member or others; or

(ii) ~~the~~ IPCA failed to comply with the expectations outlined in the PCA Provider Agreement, and counseling is not appropriate or was not effective; or

(iii) ~~an~~ IPCA's name appears on the ~~DHS~~OKDHS Community Services Worker Registry, any of the registries listed in ~~Section 1-1947 of Title~~O.S. 63 ~~of the Oklahoma Statutes,~~ § 1-1947, even ~~though his or her name may not have appeared on the Registry~~when his or her name was not on a registry at the time of application or hiring.

(B) The ~~DHS~~OKDHS nurse makes the recommendation for the termination of the IPCA to ~~DHS~~OKDHS Aging Services who notifies the OHCA Legal Division of the recommendation. When the problem is related to allegations of abuse, neglect, or exploitation, ~~DHS~~OKDHS Adult Protective Services, State Attorney General's Medicaid Unit, OHCA, and ~~the Oklahoma State Department of Health~~OSDH are notified by the ~~DHS~~OKDHS nurse.

(C) When the problem is related to allegations of abuse, neglect, or exploitation the ~~DHS~~OKDHS nurse follows the process, ~~as outlined in~~per OAC 340:100-3-39.

317:35-15-14. Billing procedures for State Plan personal care

Billing procedures for personal care services are contained in the Oklahoma Medicaid Management Information Systems (OKMMIS) Billing and Procedure Manual. Questions regarding billing procedures that cannot be resolved through a study of the manual are referred to the Oklahoma Health Care Authority (OHCA). Contractors for Personal Care bill on CMS-1500 claim form. OHCA provides instructions to an Individual personal care assistant (IPCA) contracted provider for completion of the claim at the time of the contractor orientation. The contracted provider submits a claim for each member. The contracted provider prepares claims for services provided and submits the claims to the fiscal agent responsible for ensuring claims were properly completed. All personal care contractors must have a unique provider number. New contracted providers are mailed the provider number after they are placed on the claims processing contractor's provider file. All services provided in the service recipients home, member's home including Personal Care and Nursing must be documented through the Electronic Visit Verification (EVV) system. Additionally, work completed in the provider's office is documented in the EVV system. The EVV system provides alternate backup solutions if the automated system is unavailable; however, in the event of an EVV system failure, the provider documents time in accordance with internal policy and procedures backup plan. This documentation is sufficient to account for both in-home and in-office services. The provider agency's backup procedures are only permitted when the EVV system is unavailable.

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

SUBCHAPTER 9. ICF/IID, HCBW/IID, AND INDIVIDUALS AGE 65 OR OLDER IN MENTAL HEALTH HOSPITALS

PART 7. DETERMINATION OF FINANCIAL ELIGIBILITY

317:35-9-68. Determining financial eligibility for care in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (public and private), for HCBW/IID services, and for persons age sixty-five (65) or older in mental health hospitals

(a) **Determining financial eligibility for care in an ICF/IID.** Financial eligibility and spenddown for individuals in an ICF/IID is determined according to whether or not a spouse remains in the home.

(1) **Individual without a spouse.** For an individual without a spouse, the following rules are used to determine financial eligibility for ICF/IID care.

(A) **Income eligibility.** To determine the income of the individual without a spouse, the rules in (i) - (iii) of this subparagraph apply.

(i) If payment of income is made to the individual and another person(s), the income is considered in proportion to the individual's interest.

(ii) If a legal instrument exists which specifies terms of payment, income is considered according to the terms of the instrument.

(iii) After determination of income, the gross income of the individual cannot exceed the categorically needy standard in Oklahoma Department of Human Services (OKDHS) Form 08AX001E (Appendix C-1), Schedule VIII. B. 1., to be eligible for ICF/IID services. If the individual's gross income exceeds this standard, refer to SoonerCare rules for establishing a Medicaid Income Pension Trust [OAC 317:35-5-41.6(a)(6)(B)].

(B) **Resource eligibility.** In order for an individual without a spouse to be eligible for ICF/IID services, his/her countable resources cannot exceed the maximum resource standard listed in OKDHS Form 08AX001E (Appendix C-1), Schedule VIII. D.

(C) **Vendor payment.** When eligibility for ICF/IID services has been determined, the vendor payment is computed. For an individual eligible for long-term care in an ICF/IID, the individual's share of the vendor payment is not prorated

over the month. As SoonerCare is the payer of last resort, the full amount of the member's share of the vendor payment must first be applied to the facility's charges before SoonerCare reimbursement begins. See (b) of this Section for calculation of the vendor payment after financial eligibility has been determined.

(D) **First month.** For the first month of care, the following procedures apply when determining the vendor payment:

(i) When an individual enters the facility on the first day of the month, all countable income is considered with the facility maintenance standard allowed.

(ii) When an individual enters the facility after the first day of the month, all countable income is considered with the own home standard allowed in computation of the vendor payment. Only the remaining income actually available is used to compute the vendor payment.

(E) **Equity in capital resources.** If the equity in capital resources is in excess of the standards, certification is delayed up to thirty (30) days providing plans are made for the applicant to utilize the excess resource. Certification is made at the point the excess resources have been exhausted, with the effective date of certification being shown as the date on which the resources came within the standard. If the excess capital resources, along with excess income to be considered against the vendor payment, are in excess of one (1) month's vendor payment, the application is denied.

(2) **Individual with a spouse who is institutionalized in a NF or ICF/IID, or who receives ADvantage or HCBW/IID services, or is sixty-five (65) or over and in a mental health hospital.** For an individual with a spouse who is institutionalized in a NF or ICF/IID, or who receives ADvantage or HCBW/IID services, or is sixty-five (65) or over and in a mental health hospital, resources are determined for each individual as the amount owned by each individual plus one-half of the jointly owned resources of the couple. Once this separation of assets is made, a resource of either spouse is not considered available to the other during institutionalization.

(A) **Income eligibility.** To determine income for an individual whose spouse is institutionalized in a NF or ICF/IID, or who receives ADvantage or HCBW/IID services, or is sixty-five (65) or over and in a mental health hospital, income determination is made individually. The income of either spouse is not considered as available to the other during institutionalization for determination of financial eligibility. See (b) of this Section for post-eligibility calculation of the vendor payment and the community spouse

income allowance, if applicable. The rules in (i) - (v) of this subparagraph apply in this situation.

(i) If payment of income is made solely to one (1) or the other, the income is considered available only to that individual.

(ii) If payment of income is made to both, one-half is considered for each individual.

(iii) If payment of income is made to either one (1) or both and another person(s), the income is considered in proportion to either spouse's interest (if payment is to that spouse) or one-half of the joint interest if no interest is specified.

(iv) If a legal instrument exists which specifies terms of payment, income is considered according to the terms of the instrument.

(v) After determination of income, the gross income of the individual cannot exceed the categorically needy standard in OKDHS Form 08AX001E (Appendix C-1), Schedule VIII. B. 1., to be eligible for ICF/IID care. If the individual's gross income exceeds this standard, refer to SoonerCare rules for establishing a Medicaid Income Pension Trust [Oklahoma Administrative Code (OAC) 317:35-5-41.6(a)(6)(B)].

(B) **Resource eligibility.** In order for an individual with a spouse who is institutionalized in a NF or ICF/IID, receives ADvantage or HCBW/IID services, or is sixty-five (65) or older and in a mental health hospital to be eligible for ICF/IID services, his/her countable resources cannot exceed the maximum resource standard for an individual listed in OKDHS Form 08AX001E (Appendix C-1), Schedule VIII. D.

(C) **Vendor payment.** When eligibility for ICF/IID services has been determined, the vendor payment is computed. For an individual eligible for long-term care in an ICF/IID, the individual's share of the vendor payment is not prorated over the month. As SoonerCare is the payer of last resort, the full amount of the member's share of the vendor payment must first be applied to the facility's charges before SoonerCare reimbursement begins. See (b) of this Section for calculation of the vendor payment after financial eligibility has been determined.

(D) **First month.** For the first month of care, the following procedures apply when determining the vendor payment:

(i) When an individual enters the facility on the first day of the month, all countable income is considered with the facility maintenance standard allowed.

(ii) When an individual enters the facility after the

first day of the month, all countable income is considered with the own home standard allowed in computation of the vendor payment. Only the remaining income actually available is used to compute the vendor payment.

(E) **Equity in capital resources.** If the equity in capital resources is in excess of the standards, certification is delayed up to thirty (30) days providing plans are made for the applicant to utilize the excess resource. Certification is made at the point the excess resources have been exhausted, with the effective date of certification being shown as the date on which the resources came within the standard. If the excess capital resources, along with excess income to be considered against the vendor payment, are in excess of one (1) month's vendor payment, the application is denied.

(3) **Individual with a spouse remaining in the home who does not receive ADvantage or HCBW/IID services.** When an individual and spouse are separated due to the individual entering an ICF/IID, income and resources are determined separately. However, the income and resources of the community spouse must be included on the application form. At redetermination of eligibility, the community spouse's income must be included in the review process. During any month that the individual is in the ICF/IID, income of the community spouse is not considered available to that individual. The following rules are used to determine the income and resources of each:

(A) **Income eligibility.** To determine the income of both spouses, the rules in this subparagraph apply:

(i) If payment of income is made solely to one (1) or the other, the income is considered available only to that individual.

(ii) If payment of income is made to both, one-half is considered for each individual.

(iii) If payment of income is made to either one (1) or both and another person(s), the income is considered in proportion to either the spouse's interest (if payment is to that spouse) or one-half of the joint interest if no interest is specified.

(iv) If a legal instrument exists which specifies terms of payment, income is considered according to the terms of the instrument.

(v) If the individual's gross income exceeds the categorically needy standard as shown on OKDHS Form 08AX001E (Appendix C-1), Schedule VIII. B. 1., refer to SoonerCare rules for establishing a Medicaid Income Pension Trust [OAC 317:35-5-41.6(a)(6)(B)].

(B) **Resource eligibility.** To determine resource

eligibility, it is necessary to determine the amount of resources for both spouses for the month of the individual's entry into the nursing facility. Of the resources available to the couple (both individual and joint ownership) an amount will be protected for the community spouse which will not be considered available to the spouse in the ICF/IID. OKDHS Form 08MA011E, Assessment of Assets, is used for the assessment prior to application for SoonerCare. The amount determined as the spousal share is used for all subsequent applications for SoonerCare, regardless of changes in the couple's resources. The protected spousal share cannot be changed for any reason. When application for SoonerCare is made at the same time the individual enters the ICF/IID, OKDHS Form 08MA012E, Title XIX Worksheet, is used in lieu of OKDHS Form 08MA011E.

(i) The first step in the assessment process is to establish the total amount of resources for the couple during the first month of the entry of the spouse into the ICF/IID.

(ii) The community spouse's share is equal to one-half of the total resources of the couple not to exceed the maximum amount of resource value that can be protected for the community spouse, as shown on OKDHS Appendix C-1, Section XI.

(iii) The minimum resource standard for the community spouse is found on OKDHS Appendix C-1, Schedule XI. When the community spouse's share is less than the minimum standard, an amount may be deemed from the other spouse's share to ensure the minimum resource standard for the community spouse. If the community spouse's share equals or exceeds the minimum resource standard, deeming cannot be done.

(iv) If deeming is necessary to meet the minimum resource standard for the community spouse, the amount that is deemed must be legally transferred to the community spouse within one (1) year of the effective date of certification for SoonerCare. At the first redetermination of eligibility, the worker must document that the resources have been transferred. After the first year of SoonerCare eligibility, resources of the community spouse will not be available to the other spouse and resources cannot be deemed to the community spouse.

(v) After the month in which the institutionalized spouse and community spouse have met the resource standards and the institutionalized spouse is determined eligible for benefits, no resources of the community spouse, regardless of value, will be considered available to the

institutionalized spouse. If the resources of the community spouse grow to exceed the original deemed amount, the State cannot require the community spouse to apply any of these excess resources toward the cost of the care of the institutionalized spouse.
(vi) When determining eligibility for SoonerCare, the community spouse's share of resources is protected and the remainder considered available to the spouse in the ICF/IID.
(vii) The resources determined for the individual in the ICF/IID cannot exceed the maximum resource standard for an individual as shown in OKDHS Form 08AX001E (Appendix C-1), Schedule VIII. D.
(viii) Once the dollar value of the community spouse's share of resources is established for the month of the other spouse's entry into an ICF/IID, that amount is used when determining resource eligibility for a subsequent SoonerCare application for ICF/IID.
(ix) Once a determination of eligibility for SoonerCare is made, either spouse is entitled to a fair hearing. Any such hearing regarding the determination of the community spouse's resource allowance is held within thirty (30) days of the date of the request for the hearing. Either spouse is entitled to a fair hearing if dissatisfied with a determination of:
(I) The community spouse's monthly income allowance;
(II) The amount of monthly income otherwise available to the community spouse;
(III) Determination of the spousal share of resource;
(IV) The attribution of resources (amount deemed); or
(V) The determination of the community spouse's resource allowance.
(x) The rules on determination of income and resources are applicable only when an individual has entered an ICF/IID and is likely to remain under care for thirty (30) consecutive days. The thirty-day requirement is considered to have been met even if it is interrupted by a hospital stay or the individual is deceased before the thirty-day period ends.
(xi) The rules on resources included in this Section apply only to those cases in which an individual begins a continuous period of care in an ICF/IID on or after September 30, 1989.
(xii) If the individual was admitted prior to September 30, 1989, there is not a protected amount for the community spouse. Resources are separated according to spousal ownership with one-half of jointly owned

resources counted for each. In this instance, each spouse's resources are considered separately and the resources of the community spouse does not affect the eligibility of the spouse in the ICF/IID.

(C) **Vendor payment.** After the institutionalized spouse has been determined eligible for long-term care, the vendor payment is computed. For an individual eligible for long-term care in an ICF/IID, the individual's share of the vendor payment is not prorated over the month. As SoonerCare is the payer of last resort, the full amount of the member's share of the vendor payment must first be applied to the facility's charges before SoonerCare reimbursement begins. See (b) of this Section for calculation of the vendor payment after financial eligibility has been determined.

(D) **Excess resources.** If the equity in capital resources is in excess of the standards but less than the amount of one (1) month's vendor payment, certification is delayed up to thirty (30) days providing plans are made for the applicant to utilize the excess resource. Certification is made at the point the excess resources have been exhausted, with the effective date of certification being shown as the date on which the resources came within the standard. If the excess capital resources, along with excess income to be considered against the vendor payment, are in excess of the vendor payment, the application is denied.

(b) **Determination of the vendor payment for ICF/IID.** Calculation of the vendor payment after financial eligibility for care in an ICF/IID has been established is determined according to whether or not a spouse remains in the home. For the purpose of calculating the community spouse income allowance, spouses receiving ADvantage or HCBW/IID services are considered community spouses.~~ The formula for determining the vendor payment for individuals without a spouse or other dependents is in accordance with OAC 317:35-19-21(b).~~

(1) The formula for determining the vendor payment for individuals without a spouse or other dependents is:

(A) Countable income;

(B) Minus the institutional or own home standard; and

(C) Minus the verified countable medical expenses (only the actual monthly payments being made for medical insurance premiums including Medicare premiums).

(2) The own home standard is the categorically needy standard found on OKDHS Form 08AX001E (Appendix C-1), Schedule VI.

(3) The computation for the community spouse's share of resources for individuals with a spouse remaining in the home is the total countable resources divided by two. This amount cannot exceed the maximum resource standard. If it is less than the minimum resource standard, resources are deemed from the

institutionalized spouse to the community spouse, up to the minimum standard.

(4) The formula for determining the vendor payment for an individual with a spouse remaining in the home, regardless of whether the spouse receives ADvantage or HCBW/MR services, is:

(A) Determine the institutionalized spouse's monthly income as described in (b)(1) of this Section.

(B) Determine how much of the institutionalized spouse's income can be deemed to the community spouse:

(i) Subtract the community spouse's gross income from the maximum monthly income standard on OKDHS Form 08AX001E (Appendix C-1), Schedule XI.

(ii) The resulting amount is the maximum amount that can be deemed from the institutionalized spouse to the community spouse.

(C) The amount actually deemed from the institutionalized spouse to the community spouse is subtracted from the institutionalized spouse's monthly income as described in (b)(1) of this Section. Any amount remaining is the vendor payment if there are no minor dependent children, parents, or siblings residing with the community spouse.

(D) If there are minor dependent children, parents, or siblings residing with the community spouse, the formula for determining their allowance is:

(i) Divide the maximum monthly income standard from OKDHS Form 08AX001E (Appendix C-1), Schedule XI by 3;

(ii) Subtract the gross income of each dependent child, parent, or sibling residing with the community spouse from the amount in (i);

(iii) If there is more than one dependent, add the amounts from (ii) together;

(iv) This amount is deemed to the dependents residing with the community spouse.

(E) The amount actually deemed to the dependents residing with the community spouse is subtracted from the amount determined in (b)(4)(C) of this Section. Any amount of the institutionalized spouse's income remaining is the vendor payment.

(c) **Determining financial eligibility for HCBW/IID.** For individuals determined eligible for HCBW/IID services, there is no vendor payment. Financial eligibility for HCBW/IID services for a single individual is determined the same as for ICF/IID services as outlined in paragraph (a)(1) of this Section with the exception of the vendor payment. Financial eligibility for HCBW/IID services for an individual with a spouse who is institutionalized in a NF or ICF/IID, or who receives ADvantage or HCBW/IID services, or is sixty-five (65) or over and in a mental health hospital is

determined the same as for ICF/IID services as outlined in paragraph (a)(2) of this Section with the exception of the vendor payment. Financial eligibility for HCBW/IID services for an individual with a spouse in the home who does not receive ADvantage or HCBW/IID services is determined the same as for an individual with a community spouse according to paragraph (a)(3) of this Section. If the individual is a minor child who can be determined categorically needy and SSP eligible by considering the parent(s)' income and resources in the deeming process, the case is handled in the usual manner. If the child is not eligible for SSP only because of the deeming of parent(s)' income/resources, financial eligibility for HCBW/IID services is determined using only the child's income/resources and exempting the parent(s)' income and resources from the deeming process.

(d) **Determining financial eligibility for persons age sixty-five (65) years or older in mental health hospitals.** The eligibility determination for an individual age sixty-five (65) or older in a mental health hospital as categorically needy is the same as for any other person who is institutionalized. (Refer to subsection (a) in this Section.) The same procedure for determining excess income to be applied to the vendor payment as described in this Section is applicable.

SUBCHAPTER 19. NURSING FACILITY SERVICES

317:35-19-21. Determining financial eligibility for care in nursing facility

(a) Financial eligibility and vendor payment calculations for individuals in a nursing facility (NF) are determined according to whether or not a spouse remains in the home.

(1) **Individual without a spouse.** For an individual without a spouse, the following rules are used to determine financial eligibility.

(A) **Income eligibility.** To determine the income of the individual without a spouse, the rules in (i) - (iii) of this subparagraph apply.

(i) If payment of income is made to the individual and another person(s), the income is considered in proportion to the individual's interest.

(ii) If a legal instrument exists which specifies terms of payment, income is considered according to the terms of the instrument.

(iii) After determination of income, the gross income of the individual cannot exceed the categorically needy standard in Oklahoma Department of Human Services (OKDHS) Form 08AX001E (Appendix C-1), Schedule VIII. B. 1., to be eligible for NF services. If the individual's gross

income exceeds this standard, refer to SoonerCare rules for establishing a Medicaid Income Pension Trust [Oklahoma Administrative Code (OAC) 317:35-5-41.6(a)(6)(B)].

(B) **Resource eligibility.** In order for an individual without a spouse to be eligible for NF services, his/her countable resources cannot exceed the maximum resource standard listed in OKDHS Form 08AX001E (Appendix C-1), Schedule VIII. D.

(C) **Vendor payment.** When eligibility for NF care has been determined, the vendor payment is computed. For an individual eligible for long-term care in a NF, the individual's share of the vendor payment is not prorated over the month. As SoonerCare is the payer of last resort, the full amount of the member's share of the vendor payment must first be applied to the facility's charges before SoonerCare reimbursement begins. See (b) of this Section for calculation of the vendor payment after financial eligibility has been determined.

(D) **First month.** For the first month of care, the following procedures apply when determining the vendor payment:

(i) When an individual enters the facility on the first day of the month, all countable income is considered with the facility maintenance standard allowed.

(ii) When an individual enters the facility after the first day of the month, all countable income is considered with the own home standard allowed in computation of the vendor payment. Only the remaining income actually available is used to compute the vendor payment.

(E) **Equity in capital resources.** If the equity in capital resources is in excess of the standards, certification is delayed up to thirty (30) days providing plans are made for the applicant to utilize the excess resource. Certification is made at the point the excess resources have been exhausted, with the effective date of certification being shown as the date on which the resources came within the standard. If the excess capital resources, along with excess income to be considered against the vendor payment, are in excess of one (1) month's vendor payment, the application is denied.

(2) **Individual with a spouse who is institutionalized in a NF or ICF/IID, or who receives ADvantage or HCBW/IID services, or is sixty-five (65) or over and in a mental health hospital.** For an individual with a spouse who is institutionalized in a NF or ICF/IID, or who receives ADvantage or HCWB/IID services, or is sixty-five (65) or over and in a mental health hospital, resources are determined for each individual as the amount owned by each individual plus one-half of the jointly owned resources

of the couple. Once this separation of assets is made, a resource of either spouse is not considered available to the other during institutionalization.

(A) **Income eligibility.** To determine income for an individual whose spouse is institutionalized in a NF or ICF/IID, or who receives ADvantage or HCBW/IID services, or is sixty-five (65) or over and in a mental health hospital, income determination is made individually. The income of either spouse is not considered as available to the other during institutionalization for determination of financial eligibility. See (b) of this Section for post-eligibility calculation of the vendor payment and the community spouse income allowance, if applicable. The rules in (i) - (v) of this subparagraph apply in this situation.

(i) If payment of income is made solely to one (1) or the other, the income is considered available only to that individual.

(ii) If payment of income is made to both, one-half is considered for each individual.

(iii) If payment of income is made to either one (1) or both and another person(s), the income is considered in proportion to either spouse's interest (if payment is to that spouse) or one-half of the joint interest if no interest is specified.

(iv) If a legal instrument exists which specifies terms of payment, income is considered according to the terms of the instrument.

(v) After determination of income, the gross income of the individual cannot exceed the categorically needy standard in OKDHS Form 08AX001E (Appendix C-1), Schedule VIII. B. 1., to be eligible for Nursing Facility services. If the individual's gross income exceeds this standard, refer to SoonerCare rules for establishing a Medicaid Income Pension Trust [OAC 317:35-5-41.6(a)(6)(B)].

(B) **Resource eligibility.** In order for an individual with a spouse who is institutionalized in a NF or ICF/IID, receives ADvantage or HCBW/IID services, or is sixty-five (65) or older and in a mental health hospital to be eligible for NF services, his/her countable resources cannot exceed the maximum resource standard for an individual listed in OKDHS Form 08AX001E (Appendix C-1), Schedule VIII. D.

(C) **Vendor payment.** When eligibility for NF services has been determined, the spenddown calculation is used to compute the vendor payment. For an individual eligible for long-term care in a NF, the individual's share of the vendor payment is not prorated over the month. As SoonerCare is the payer of last resort, the full amount of the member's

share of the vendor payment must first be applied to the facility's charges before SoonerCare reimbursement begins. See (b) of this Section for calculation of the vendor payment after financial eligibility has been determined.

(D) **First month.** For the first month of care, the following procedures apply when determining the vendor payment:

(i) When an individual enters the facility on the first day of the month, all countable income is considered with the facility maintenance standard allowed.

(ii) When an individual enters the facility after the first day of the month, all countable income is considered with the own home standard allowed in computation of the vendor payment. Only the remaining income actually available is used to compute the vendor payment.

(E) **Equity in capital resources.** If the equity in capital resources is in excess of the standards, certification is delayed up to thirty (30) days providing plans are made for the applicant to utilize the excess resource. Certification is made at the point the excess resources have been exhausted, with the effective date of certification being shown as the date on which the resources came within the standard. If the excess capital resources, along with excess income to be considered against the vendor payment, are in excess of one (1) month's vendor payment, the application is denied.

(3) **Individual with a spouse remaining in the home who does not receive ADvantage or HCBW/IID services.** When an individual and spouse are separated due to the individual entering an NF, income and resources are determined separately. However, the income and resources of the community spouse must be included on the application form. At redetermination of eligibility, the community spouse's income must be included in the review process. During any month that the individual is in the NF, income of the community spouse is not considered available to that individual. The following rules are used to determine the income and resources of each:

(A) **Income eligibility.** To determine the income of both spouses, the following rules in this subparagraph apply:

(i) If payment of income is made solely to one (1) or the other, the income is considered available only to that individual.

(ii) If payment of income is made to both, one-half is considered for each individual.

(iii) If payment of income is made to either one (1) or both and another person(s), the income is considered in proportion to either the spouse's interest (if payment is to that spouse) or one-half of the joint interest if no

interest is specified.

(iv) If a legal instrument exists which specifies terms of payment, income is considered according to the terms of the instrument.

(v) If the individual's gross income exceeds the categorically needy standard as shown on OKDHS Form 08AX001E (Appendix C-1), Schedule VIII. B. 1., refer to SoonerCare rules for establishing a Medicaid Income Pension Trust [OAC 317:35-5-41.6(a)(6)(B)].

(B) **Resource eligibility.** To determine resource eligibility, it is necessary to determine the amount of resources for both spouses for the month of the individual's entry into the nursing facility. Of the resources available to the couple (both individual and joint ownership) an amount will be protected for the community spouse which will not be considered available to the spouse in the NF. OKDHS Form 08MA011E, Assessment of Assets, is used for the assessment prior to application for SoonerCare. The amount determined as the spousal share is used for all subsequent applications for SoonerCare, regardless of changes in the couple's resources. The protected spousal share cannot be changed for any reason. When application for SoonerCare is made at the same time the individual enters the NF, OKDHS Form 08MA012E, Title XIX Worksheet, is used in lieu of OKDHS Form 08MA011E.

(i) The first step in the assessment process is to establish the total amount of resources for the couple during the first month of the entry of the spouse into the NF.

(ii) The community spouse's share is equal to one-half of the total resources of the couple not to exceed the maximum amount of resource value that can be protected for the community spouse, as shown on OKDHS Form 08AX001E (Appendix C-1), Schedule XI.

(iii) The minimum resource standard for the community spouse, as established by the Oklahoma Health Care Authority (OHCA), is found on OKDHS Form 08AX001E (Appendix C-1), Schedule XI. When the community spouse's share is less than the minimum standard, an amount may be deemed from the other spouse's share to ensure the minimum resource standard for the community spouse. If the community spouse's share equals or exceeds the minimum resource standard, deeming cannot be done.

(iv) If deeming is necessary to meet the minimum resource standard for the community spouse, the amount that is deemed must be legally transferred to the community spouse within one (1) year of the effective date of

certification for SoonerCare. At the first redetermination of eligibility, the worker must document that the resources have been transferred. After the first year of SoonerCare eligibility, resources of the community spouse will not be available to the other spouse and resources cannot be deemed to the community spouse.
(v) After the month in which the institutionalized spouse and community spouse have met the resource standards and the institutionalized spouse is determined eligible for benefits, no resources of the community spouse, regardless of value, will be considered available to the institutionalized spouse. If the resources of the community spouse grow to exceed the original deemed amount, the State cannot require the community spouse to apply any of these excess resources toward the cost of the care of the institutionalized spouse.
(vi) When determining eligibility for SoonerCare, the community spouse's share of resources is protected and the remainder considered available to the spouse in the NF.
(vii) The resources determined above for the individual in the NF cannot exceed the maximum resource standard for an individual as shown in OKDHS Form 08AX001E (Appendix C-1), Schedule VIII. D.
(viii) Once the dollar value of the community spouse's share of resources is established for the month of the other spouse's entry into NF, that amount is used when determining resource eligibility for a subsequent SoonerCare application for NF.
(ix) Once a determination of eligibility for SoonerCare is made, either spouse is entitled to a fair hearing. Any such hearing regarding the determination of the community spouse's resource allowance is held within thirty (30) days of the date of the request for the hearing. Either spouse is entitled to a fair hearing if dissatisfied with a determination of:

(I) The community spouse's monthly income allowance;
(II) The amount of monthly income otherwise available to the community spouse;
(III) Determination of the spousal share of resource;
(IV) The attribution of resources (amount deemed); or
(V) The determination of the community spouse's resource allowance.

(x) The rules on determination of income and resources are applicable only when an individual has entered an NF and is likely to remain under care for thirty (30) consecutive days. The thirty (30) day requirement is

considered to have been met even if it is interrupted by a hospital stay or the individual is deceased before the thirty (30) day period ends.

(xi) The rules on resources included in this Section apply only to those cases in which an individual begins a continuous period of care in an NF on or after September 30, 1989.

(xii) If the individual was admitted prior to September 30, 1989, there is not a protected amount for the community spouse. Resources are separated according to spousal ownership with one-half of jointly owned resources counted for each. In this instance, each spouse's resources are considered separately and the resources of the community spouse do not affect the eligibility of the spouse in the NF.

(C) **Vendor payment.** After the institutionalized spouse has been determined eligible for long-term care, the vendor payment is computed. For an individual eligible for long-term care in a NF, the individual's share of the vendor payment is not prorated over the month. As SoonerCare is the payer of last resort, the full amount of the member's share of the vendor payment must first be applied to the facility's charges before SoonerCare reimbursement begins. See (b) of this Section for calculation of the vendor payment after financial eligibility has been determined.

(D) **Excess resources.** If the equity in capital resources is in excess of the standards but less than the amount of one (1) month's vendor payment, certification is delayed up to thirty (30) days providing plans are made for the applicant to utilize the excess resource. Certification is made at the point the excess resources have been exhausted, with the effective date of certification being shown as the date on which the resources came within the standard. If the excess capital resources, along with excess income to be considered against the vendor payment, are in excess of the vendor payment, the application is denied.

(b) Calculation of the vendor payment after financial eligibility for care in a NF has been determined is performed according to whether or not a spouse remains in the home. For the purpose of calculating the community spouse income allowance, spouses receiving ADvantage or HCBW/IID services are considered community spouses.

(1) The formula for determining the vendor payment for individuals without a spouse or other dependents is:

(A) Countable income;

(B) Minus the institutional or own home standard; and

(C) Minus the verified countable medical expenses (only the

actual monthly payments being made for medical insurance premiums including Medicare premiums)~~;~~. ~~and~~

~~(D) Minus incurred expenses for necessary medical and remedial care not covered under Medicaid, as set forth in the Oklahoma State Medicaid Plan.~~

~~(i) In order to be allowed to be deducted, expenses must:~~

~~(I) Have been incurred during the three (3) month period immediately preceding the month of application;~~

~~(II) Have been prescribed by a medical professional;~~

~~(III) Be certified as being medically necessary by a treating physician, physician assistant, or advanced practice registered nurse working within the scope of his or her licensure; and~~

~~(IV) Be no more than the least of the fee recognized by Medicaid, Medicare, or the average cost allowed by a commercial health insurance plan in Oklahoma.~~

~~(ii) The following expenses are not allowed to be deducted:~~

~~(I) Expenses incurred as the result of the imposition of a transfer penalty;~~

~~(II) Expenses for which a third party (including Medicaid) is liable, even if provided by an out-of-state network provider;~~

~~(III) Expenses resulting from the failure to obtain prior approval from applicable private insurance, Medicare, or Medicaid, due to the service being medically unnecessary;~~

~~(IV) Expenses that had been the subject of a prior authorization denial by Medicaid, due to lack of medical necessity; and~~

~~(V) Health insurance premiums paid by an individual who is not a financially responsible relative, for which repayment is not expected.~~

(2) The own home standard is the categorically needy standard found on OKDHS Form 08AX001E (Appendix C-1), Schedule VI.

(3) The computation for the community spouse's share of resources for individuals with a spouse remaining in the home is the total countable resources divided by two (2). This amount cannot exceed the maximum resource standard. If it is less than the minimum resource standard, resources are deemed from the institutionalized spouse to the community spouse, up to the minimum standard.

(4) The formula for determining the vendor payment for an individual with a spouse remaining in the home, regardless of whether the spouse receives ADvantage or HCBW/IID services, is:

(A) Determine the institutionalized spouse's monthly income

as described in Paragraph (b)(1) of this Section.

(B) Determine how much of the institutionalized spouse's income can be deemed to the community spouse:

(i) Subtract the community spouse's gross income from the maximum monthly income standard on OKDHS Form 08AX001E (Appendix C-1), Schedule XI.

(ii) The resulting amount is the maximum amount that can be deemed from the institutionalized spouse to the community spouse.

(C) The amount actually deemed from the institutionalized spouse to the community spouse is subtracted from the institutionalized spouse's monthly income as described in Paragraph (b)(1) of this Section. Any amount remaining is the vendor payment if there are no minor dependent children, parents, or siblings residing with the community spouse.

(D) If there are minor dependent children, parents, or siblings residing with the community spouse, the formula for determining their allowance is:

(i) Divide the maximum monthly income standard from OKDHS Form 08AX001E (Appendix C-1), Schedule XI by 3;

(ii) Subtract the gross income of each dependent child, parent, or sibling residing with the community spouse from the amount in (i);

(iii) If there is more than one (1) dependent, add the amounts from (ii) together;

(iv) This amount is deemed to the dependents residing with the community spouse.

(E) The amount actually deemed to the dependents residing with the community spouse is subtracted from the amount determined in Subparagraph (b)(4)(C) of this Section. Any amount of the institutionalized spouse's income remaining is the vendor payment.

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

SUBCHAPTER 1. GENERAL PROVISIONS

317:30-1-4. Definitions

The following words and terms, when used in this Chapter, shall have the following meaning, unless the context clearly indicates otherwise:

"Adult" means an individual twenty-one (21) years of age or older, unless otherwise specified by statute, regulation, and/or policy adopted by the Oklahoma Health Care Authority (OHCA). For eligibility criteria policy for children and adults, please refer to Oklahoma Administrative Code (OAC) 317:35-5-2.

"Child" means an individual under twenty-one (21) years of age, unless otherwise specified by statute, regulation, and/or policy adopted by the OHCA. For eligibility criteria policy for children and adults, please refer to OAC 317:35-5-2.

"Expansion Adult" means an individual defined by 42 Code of Federal Regulations § 435.119 who is age nineteen (19) or older and under sixty-five (65), at or below 133 percent of the federal poverty level (FPL), and who are not categorically related to the aged, blind, and disabled.

SUBCHAPTER 3. GENERAL PROVIDER POLICIES

PART 1. GENERAL SCOPE AND ADMINISTRATION

317:30-3-1. Creation and implementation of rules; applicability

(a) Medical rules of the Oklahoma Health Care Authority (OHCA) are set by the ~~Oklahoma Health Care Authority~~OHCA Board. The rules are based upon the recommendations of the Chief Executive Officer of the Authority, ~~the Deputy Administrator for Health Policy~~the Deputy State Medicaid Director, the ~~Medicaid Operations~~ State Medicaid Director, OHCA Tribal partners and the ~~Advisory Committee on Medical Care for Public Assistance Recipients~~OHCA Medical Advisory Committee. The ~~Medicaid Operations~~ State Medicaid Director is responsible for implementing medical policies and programs and directing the Fiscal Agent ~~with regard to~~regarding proper payment of claims.

(b) Payment to practitioners under Medicaid is made for services clearly identifiable as personally rendered services performed on behalf of a specific ~~patient~~member. There are no exceptions to personally rendered services unless specifically set out in coverage guidelines.

(c) Payment is made on behalf of Medicaid eligible individuals for services within the scope of the Authority medical programs. Services cannot be paid under Medicaid for ineligible individuals or for services not covered under the scope of medical programs or that do not meet documentation requirements. These claims will be denied, or in some instances upon post-payment review, payment will be recouped.

(d) Payment to practitioners on behalf of Medicaid eligible individuals is made only for services that are medically necessary and essential to the diagnosis and treatment of the patient's presenting problem. ~~Well patient~~Wellness examinations and diagnostic testing are not covered for adults unless specifically set out in coverage guidelines.

(e) The scope of the medical program for eligible children is the same as for adults except as further set out under ~~EPSDT~~Early and Periodic Screening, Diagnostic and Treatment (EPSDT) service guidelines.

(f) Services, provided within the scope of the Oklahoma Medicaid ~~Program~~program, shall meet medical necessity criteria. Requests by qualified providers for services 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. Service limits listed within OAC 317:30 can be exceeded for expansion adults, upon meeting medical necessity as determined by OHCA and in alignment with the Oklahoma State Plan. Physical therapy, occupational therapy and speech language pathology have hard limits, which are set at forty-five (45) cumulative visits- fifteen (15) visits of each therapy. Members must meet medical necessity criteria, prior authorization, and all other documentation requirements. Medical necessity is established through consideration of the following standards:

(1) Services must be medical in nature and must be consistent with accepted health care practice standards and guidelines for the prevention, diagnosis or treatment of symptoms of illness, disease or disability;

(2) Documentation submitted in order to request services or substantiate previously provided services must demonstrate through adequate objective medical records and other supporting records, evidence sufficient to justify the ~~client's~~member's need for the service;

(3) Treatment of the ~~client's~~member's condition, disease or injury must be based on reasonable and predictable health outcomes;

(4) Services must be necessary to alleviate a medical condition and must be required for reasons other than convenience for the member, family, or medical provider;

(5) Services must be delivered in the most cost-effective manner and most appropriate setting; and

(6) Services must be appropriate for the ~~client's~~member's age and health status and developed for the ~~client~~member to achieve, maintain, or promote functional capacity.

(g) Emergency medical condition means a medical condition including injury manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected, by a reasonable and prudent layperson, to result in placing the patient's health in serious jeopardy, serious impairment to bodily function, or serious dysfunction of any bodily organ or part.

(h) Verbal or written interpretations of policy and procedure in singular instances is made on a ~~case by case~~case-by-case basis and shall not be binding on this Agency or override its policy of general applicability.

(i) The rules and policies in this ~~part~~Part apply to all providers of service who participate in the program.

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~~.

(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~~freestanding dialysis facility.

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

(5) Outpatient surgical services - facility payment for selected ~~outpatient surgical~~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 services and other ambulatory services furnished by rural health clinic.

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

(9) Maternity clinic services.

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

examinations for eligible children by a medical or osteopathic physician, physician assistant, or advanced practice nurse practitioner.

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

(C) Immunizations.

(D) Outpatient care.

(E) Dental services as outlined in OAC 317:30-3-65.8.

(F) Optometrists' services. The EPSDT periodicity schedule provides for at least one (1) visual screening and glasses each twelve (12) months. In addition, payment is made for glasses for children with congenital aphakia or following cataract removal. Interperiodic screenings and glasses at intervals outside the periodicity schedule for optometrists are allowed when a visual condition is suspected. Payment is limited to two (2) glasses per year. Any glasses beyond this limit must be prior authorized and determined to be medically necessary.

(G) Hearing services as outlined in OAC 317:30-3-65.9.

(H) Prescribed drugs.

(I) Outpatient psychological services as outlined in OAC 317:30-5-275 through 317:30-5-278.

(J) Inpatient psychiatric services as outlined in OAC ~~317:30-5-95~~317:30-5-94 through 317:30-5-97.

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

(L) Inpatient hospital services.

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

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

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

(15) Physicians' services whether furnished in the office, the member's home, a hospital, a ~~nursing~~long-term care facility, ~~Intermediate Care Facilities for Individuals with Intellectual Disabilities~~intermediate care facilities for individuals with intellectual disabilities (ICF/IID), or elsewhere. For adults,

payment is made for compensable hospital days described at OAC 317:30-5-41. Office visits for adults are limited to four (4) per month except when in connection with conditions as specified in OAC 317:30-5-9(b).

(16) Medical care and any other type of remedial care recognized under state law, furnished by licensed practitioners within the scope of their practice as defined by state law. See applicable provider section for limitations to covered services for:

(A) Podiatrists' services<u>;</u>

(B) Optometrists' services<u>;</u>

(C) Psychologists' services<u>;</u>

(D) Certified ~~Registered Nurse Anesthetists~~<u>registered nurse anesthetists;</u>

(E) Certified ~~Nurse Midwives~~<u>nurse midwives;</u>

(F) Advanced ~~Practice Nurses~~<u>practice registered nurses; and</u>

(G) Anesthesiologist ~~Assistants~~<u>assistants.</u>

(17) ~~Free-standing~~<u>Freestanding</u> 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~~<u>Unlimited</u> medically necessary monthly prescriptions for:

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

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

(B) ~~seven~~<u>Seven</u> (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)~~<u>home and community-based services (HCBS) waivers</u>. 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.~~<u>medical supplies, equipment, and appliances.</u>

(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) <u>For non-expansion adults, </u>prosthetic devices<u> are</u> limited to catheters and catheter accessories, colostomy and urostomy bags and accessories, tracheostomy accessories, nerve stimulators, hyperalimentation and accessories, home dialysis equipment and supplies, external breast prostheses and support

accessories, oxygen/oxygen concentrator equipment and supplies, respirator or ventilator equipment and supplies, and those devices inserted during the course of a surgical procedure. There is no coverage for orthotic devices for adults.
(23) Orthotics and prosthetics are covered for expansion adult members, above the limitations within (22) of this Section, when prescribed by the treating provider (physician, physician assistant, or an advanced practice registered nurse) and medical necessity is documented in accordance with OAC 317:30-5-211.13.
~~(23)~~ (24) Standard medical supplies.
~~(24)~~ (25) Eyeglasses under EPSDT for members under age twenty-one (21). Payment is also made for glasses for children with congenital aphakia or following cataract removal. Payment is limited to two (2) glasses per year. Any glasses beyond this limit must be prior authorized and determined to be medically necessary.
~~(25)~~ (26) Blood and blood fractions for members when administered on an outpatient basis.
~~(26)~~ (27) Inpatient services for members age sixty-five (65) or older in institutions for mental diseases, limited to those members whose Medicare, Part A benefits are exhausted for this particular service and/or those members who are not eligible for Medicare services.
~~(27)Nursing~~(28) Long-term care facility services, limited to members preauthorized and approved by OHCA for such care.
~~(28)~~ (29) 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)~~ (30) Transportation and subsistence (room and board) to and from providers of medical services to meet member's needs (ambulance or bus, etc.), to obtain medical treatment.
~~(30)~~ (31) Extended services for pregnant women including all pregnancy-related and postpartum services to continue to be provided, as though the women were pregnant, for sixty (60) days after the pregnancy ends, beginning on the last date of pregnancy.
~~(31) Nursing~~(32) Long-term care facility services for members under twenty-one (21) years of age.
~~(32)~~ (33) Personal care in a member's home, prescribed in accordance with a plan of treatment and rendered by a qualified person under supervision of a ~~Registered Nurse~~registered nurse (RN).
~~(33) Part A deductible and Part B Medicare Coinsurance and/or deductible~~(34) Medicare Part A, Part B, and Part C deductibles, coinsurance, and copays.

~~(34)~~ (35) HCBS for the intellectually disabled.
~~(35)~~ (36) Home health services ~~limited to~~can be provided without a PA for the first thirty-six (36) visits ~~per year and standard supplies for one (1) month in a twelve (12) month period~~. A PA will be required beyond the 36th visit. The visits are limited to any combination of ~~Registered Nurse~~RN and nurse aide visits~~, not to exceed thirty-six (36) per year~~.
~~(36)~~ (37) Medically necessary solid organ and bone marrow/stem cell transplantation services for children and adults are covered services based upon the conditions listed in (A)-(D) of this paragraph:

~~(A) 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. For more information regarding experimental or investigational including clinical trials, see OAC 317:30-3-57.1; and
(E) Donor search and procurement services are covered for transplants consistent with the methods used by the Medicare program for organ acquisition costs.

~~(37)~~ (38) HCBS for intellectually disabled members who were determined to be inappropriately placed in a ~~nursing~~long-term care facility (Alternative Disposition Plan - ADP).
~~(38)~~ (39) Case management services for the chronically and/or ~~severely~~seriously mentally ill.
~~(39)~~ (40) Emergency medical services, including emergency labor and delivery for ~~illegal~~undocumented or ineligible aliens.
~~(40)~~ (41) Services delivered in Federally Qualified Health Centers (FQHCs). Payment is made on an encounter basis.
~~(41)~~ (42) Early intervention services for children ages zero (0) to three (3).
~~(42)~~ (43) 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.
(50) Residential substance use disorder (SUD) services.
(51) Medication-assisted treatment (MAT) services.
(52) Diabetes self-management education and support (DSMES).

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. For more information regarding coverage of clinical trials, see Oklahoma Administrative Code (OAC) 317:30-3-57.1.
(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 and/or Occupational Therapist.~~Services of an independent licensed physical therapist and/or licensed physical therapist assistant. Per OAC 317:30-5-291.
(13) Services of an independent licensed occupational therapist and/or occupational therapist assistant. Per OAC 317:30-5-296.
~~(13)~~(14) Services of a ~~Psychologist.~~psychologist.
~~(14)~~(15) Services of an independent licensed ~~Speech and Hearing Therapist.~~speech-language pathologist, speech-language pathology assistant (SLPA), and/or speech-language clinical fellow. Per OAC 317:30-5-675.
~~(15)~~(16) 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)~~(17) Payment for more than ~~two nursing~~two (2) long-term care facility visits per month.
~~(17)~~(18) More than one (1) inpatient visit per day per physician.
~~(18)~~(19) Payment for removal of benign skin lesions.
~~(19)~~(20) 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)~~(21) Charges for completion of insurance forms, abstracts, narrative reports or telephone calls.
~~(21)~~(22) 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)~~(23) Mileage.
~~(23)~~(24) A routine hospital visit on the date of discharge unless the member expired.
~~(24)~~(25) 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 Oklahoma 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. For more information regarding coverage of clinical trials, see OAC 317:30-3-57.1.
(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~~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~~determine 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~~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~~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<u> (1)</u> rebase and/or one<u> (1)</u> reline is considered appropriate every three<u> (3)</u> years. It is the responsibility of the ~~nursing~~<u>long-term care</u> facility to ensure that the member has adequate assistance in the proper care, maintenance, identification and replacement of these items. The ~~nursing~~<u>long-term care</u> facility cannot set up payment limits which result in barriers to obtaining denture services. However, the ~~nursing~~<u>long-term care</u> 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~~<u>long-term care</u> 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~~<u>services</u>. 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~~<u>admission plan of care and on the annual plan of care</u>. 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~~<u>Long-term care facility</u> 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~~<u>twenty-one (21)</u> to ~~40~~<u>forty (40)</u> years of age are eligible for one<u> (1)</u> routine eye examination and one <u>(1)</u> pair of glasses every ~~36~~<u>thirty-six (36)</u> months ~~(~~<u>[</u>three <u>(3)</u> years~~)~~<u>]</u>.

(ii) Individuals ~~41~~<u>forty-one (41)</u> to ~~64~~<u>sixty-four (64)</u>

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~~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. 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.~~Code of Federal Regulations (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.

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.

~~(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~~Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services.** ~~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.~~ 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 the Oklahoma Medicaid 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. For more information regarding clinical trials, see Oklahoma Administrative Code 317:30-3-57.1.

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~~member 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 loss of 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, nurse practitioner, clinical nurse specialist or physician assistant, working in accordance with State law, 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 provider. Nursing services and home health aide services provided by a home health agency must be reviewed every sixty (60) days by the ordering provider.
(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,~~medical supplies, equipment, and appliances, 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 registered 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~~the Centers for Medicare and Medicaid Services (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):**~~The following services require PA:

(1) ~~services~~Services that exceed quantity/frequency limits;

(2) ~~medical~~Medical need for an item that is beyond OHCA's standards of coverage;

(3) ~~use~~Use of a Not Otherwise Classified (NOC) code or miscellaneous codes;

(4) ~~services~~Services for which a less costly alternative may exist; and

(5) ~~procedures~~Procedures indicating that a PA is required on the OHCA fee schedule.

(c) ~~**Prior authorization (PA)**~~**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 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 (OHCA) 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 ~~replacedalong~~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 (OHCA) 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 Code of Federal Regulations (C.F.R.) § 440.70 and Oklahoma Administrative Code (OAC) 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 (OAC) 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 Code of Federal Regulations (C.F.R.) § 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 (4) 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) Coverage of prosthetics for ~~adults~~non-expansion 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~~qualified provider and as specified in this section are covered items for ~~adults~~non-expansion adults. There is no coverage of orthotics for ~~adults~~non-expansion 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~~One (1) prosthetic garment with mastectomy form every ~~12~~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~~Two (2) mastectomy bras per year; and

(iii) ~~one~~One (1) silicone or equal breast prosthetic per side every ~~24~~twenty-four (24) months; or

(iv) ~~one~~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 ~~12~~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~~Lost;

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

(iii) ~~the~~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) Orthotics and prosthetics are covered for expansion adults services when:

(1) Orthotics are medically necessary when required to correct or prevent skeletal deformities, to support or align movable body parts, or to preserve or improve physical function.

(2) Prosthetics are medically necessary as a replacement for all or part of the function of a permanently inoperative, absent, or malfunctioning body part. The member shall require the prosthesis for mobility, daily care, or rehabilitation purposes.

(3) In addition, orthotics and prosthetics must be:

(A) A reasonable and medically necessary part of the member's treatment plan;

(B) Consistent with the member's diagnosis and medical condition, particularly the functional limitations and symptoms exhibited by the member; and

(C) Of high quality, with replacement parts available and obtainable.

(c) Refer to Oklahoma Administrative Code (OAC) 317:30-5-211.1 for definitions of orthotics and prosthetics.

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(2)(C). 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 are 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. Orthotics and prosthetics are paid separately from the per diem rate in accordance with the Oklahoma Medicaid State Plan. Refer to Oklahoma Administrative Code (OAC) 317:30-5-211.13 for orthotics and prosthetics 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~~computer-generated model of the member (e.g., CAD-CAM technology), or the detailed measurements of the member to create either:

(A) ~~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~~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 care 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 provider to be medically necessary and documented in the member's plan of care as medically necessary and used for medical purposes. Requests by qualified 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 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 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 qualified 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 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 prescription by a provider 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 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 qualified 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 provider, 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 qualified 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 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 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

qualified provider for PN 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 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 PN.

(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 qualified 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 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 qualified provider;

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

(d) **Reimbursement.**
(1) Sleep studies for children must be performed in a sleep diagnostic testing facility to be reimbursable.
(2) Sleep studies for adults age twenty-one (21) and older must be performed in a sleep diagnostic testing facility or as a home sleep study to be reimbursable.
(3) 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 reimburse 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 ~~pickup~~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 35. RURAL HEALTH CLINICS

317:30-5-356. Coverage for adults

Payment is made to rural health clinics (RHC) for adult services as set forth in this Section.

(1) **RHC services.** Payment is made for ~~one~~(1) encounter per

member per day. Payment is also limited to four (4) visits per member per month. Refer to ~~OAC~~Oklahoma Administrative Code (OAC) 317:30-1, General Provisions, and OAC 317:30-3-65.2 for exceptions to the four (4) visit limit for children under the Early and Periodic Screening, ~~Diagnosis~~Diagnostic and Treatment Program (EPSDT). Additional preventive service exceptions include: obstetrical care and family planning.

(A) ~~**Obstetrical care**. A Rural Health Clinic~~An RHC should have a written contract with its physician, certified nurse midwife (CNM), advanced practice registered nurse (APRN), or physician assistant (PA) that specifically identifies how obstetrical care will be billed to SoonerCare, in order to avoid duplicative billing situations. The agreement should also specifically identify the physician's compensation for rural health and non-rural health clinic (other ambulatory) services. Obstetrical care is exempted from the four (4) visit limitation.

(i) If the clinic compensates the physician, ~~certified nurse midwife or advanced practice nurse~~CNM, or APRN to provide obstetrical care, then the clinic must bill the SoonerCare program for each prenatal visit using the appropriate CPT evaluation and management codes.

(ii) If the clinic does not compensate its practitioners to provide obstetrical care, then the independent practitioner must bill the OHCA for prenatal care according to the global method described in the SoonerCare provider specific rules for physicians, ~~certified nurse midwives, physician assistants, and advanced practice nurses~~CNMs, PAs, and APRNs (refer to OAC 317:30-5-22).

(iii) Under both billing methods, payment for prenatal care includes all routine or minor medical problems. No additional payment is made to the prenatal provider except in the case of a major illness distinctly unrelated to pregnancy.

(B) **Family planning services.** Family planning services are available only to members with reproductive capability. Family planning visits ~~do not count as one of the four RHC visits per month.~~are exempted from the four (4) visit limitation.

(2) **Other ambulatory services.** Services defined as "other ambulatory" services are not considered a part of ~~a~~an RHC visit and are therefore billable to the SoonerCare program by the RHC or provider of service on the appropriate claim forms. Other ambulatory services are subject to the same scope of coverage as other SoonerCare services billed to the program, i.e., limited adult services and some services for ~~under~~

~~21~~individuals under twenty-one (21) are subject to the same prior authorization process. Refer to OAC 317:30-1, General Provisions, and OAC 317:30-3-57, 317:30-5-59, and 317:30-3-60 for general coverage and exclusions under the SoonerCare program. Some specific limitations are applicable to other ambulatory services as set forth in specific provider rules and excerpted as follows: Coverage under optometrists for adults is limited to treatment of eye disease not related to refractive errors. There is no coverage for eye exams for the purpose of prescribing eyeglasses, contact lenses or other visual aids. (See OAC 317:30-5-431.)

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 by a home health agency 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 the thirty-sixth (36) visit will 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~~pick up 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.~~

PART 75. FEDERALLY QUALIFIED HEALTH CENTERS

317:30-5-664.5. Health Center encounter exclusions and limitations

(a) Service limitations governing the provision of all services apply pursuant to ~~OAC~~Oklahoma Administrative Code (OAC) 317:30. Excluded from the definition of reimbursable encounter core services are:

(1) Services provided by an independently ~~CLIA~~Clinical Laboratory Improvement Amendments (CLIA) certified and enrolled laboratory.

(2) Radiology services including nuclear medicine and diagnostic ultrasound services.

(3) Venipuncture for lab tests is considered part of the encounter and cannot be billed separately. When a member is seen at the clinic for a lab test only, use the appropriate CPT code. A visit for "lab test only" is not considered a Center encounter.

(4) ~~Durable medical equipment or medical supplies~~Medical supplies, equipment and appliances are not generally provided during the course of a Center visit such as diabetic supplies. However, gauze, band-aids, or other disposable products used during an office visit are considered as part of the cost of an encounter and cannot be billed separately under SoonerCare.

(5) Supplies and materials that are administered to the member are considered a part of the physician's or other health care practitioner's service.

(6) Drugs or medication treatments provided during a clinic visit are included in the encounter rate. For example, a member has come into the Center with high blood pressure and is treated

at the Center with a hypertensive drug or drug samples provided to the Center free of charge are not reimbursable services and are included in the cost of an encounter. Prescriptions are not included in the encounter rate and must be billed through the pharmacy program by a qualified enrolled pharmacy.

(7) Administrative medical examinations and report services;

(8) Emergency services including delivery for pregnant members that are eligible under the ~~Non-Qualified~~non-qualified (ineligible) provisions of OAC 317:35-5-25;

(9) ~~SoonerPlan family planning services;~~Family planning services;

(10) Optometry and podiatric services other than for dual eligible for Part B of Medicare; and

(11) Other services that are not defined in this rule or the State Plan.

(b) In addition, the following limitations and requirements apply to services provided by Health Centers:

(1) Physician services are not covered in a hospital.

(2) Behavioral health case management and psychosocial rehabilitation services are limited to Health Centers enrolled under the provider requirements in OAC 317:30-5-240 and contracted with ~~OHCA~~the Oklahoma Health Care Authority (OHCA) as an outpatient behavioral health agency.

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

SUBCHAPTER 1. GENERAL PROVISIONS

317:35-1-2. Definitions

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

"Acute Care Hospital" means an institution that meets the requirements defined in Section (') 440.10 of Title 42 of the Code of Federal Regulations (C.F.R.) and:

(A) ~~is~~Is maintained primarily for the care and treatment of patients with disorders other than mental diseases;

(B) ~~is~~Is formally licensed or formally approved as a hospital by an officially designated authority for state standard setting; and

(C) ~~meets~~Meets the requirements for participation in Medicare as a hospital.

"Adult" means an individual twenty-one (21) years of age or older, unless otherwise specified by statute, regulation, and/or policy adopted by the Oklahoma Health Care Authority (OHCA). For eligibility criteria policy for children and adults, please refer to Oklahoma Administrative Code (OAC) 317:35-5-2.

"ADvantage Administration (AA)" means the Oklahoma Department of Human Services (OKDHS) which performs certain administrative functions related to the ADvantage Waiver.

"Aged" means an individual whose age is established as sixty-five (65) years or older.

"Agency partner" means an agency or organization contracted with the OHCA that will assist those applying for services.

"Aid to Families with Dependent Children (AFDC)" means the group of low income families with children described in Section 1931 of the Social Security Act. The Personal Responsibility and Work Opportunity Act of 1996 established the new eligibility group of low income families with children and linked eligibility income and resource standards and methodologies and the requirement for deprivation for the new group to the State plan for AFDC in effect on July 16, 1996. Oklahoma has elected to be less restrictive for all SoonerCare members related to AFDC. ~~Effective January 1, 2014, children~~Children covered under Section 1931 are related to the children's group, and adults covered under Section 1931 are related to the parent and caretaker relative group. The Modified Adjusted Gross Income (MAGI) methodology is used to determine eligibility for these groups.

"Area nurse" means a registered nurse in the OKDHS Aging

Services Division, designated according to geographic areas who evaluates the Uniform Comprehensive Assessment Tool (UCAT) and determines medical eligibility for Personal Care, ADvantage Waiver, and Nursing Facility services. The area nurse also approves care plan and service plan implementation for Personal Care services.

"Area nurse designee" means a registered nurse selected by the area nurse who evaluates the UCAT and determines medical eligibility for Personal Care, ADvantage Waiver, and Nursing Facility services.

"Authority" means the OHCA.

"Blind" means an individual who has central visual acuity of 20/200 or less in the better eye with the use of a correcting lens.

"Board" means the OHCA Board.

"Buy-in" means the procedure whereby the OHCA pays the member's Medicare premium.

(A) **"Part A Buy-in"** means the procedure whereby the OHCA pays the Medicare Part A premium for individuals determined eligible as Qualified Medicare Beneficiaries Plus (QMBP) who are enrolled in Part A and are not eligible for premium free enrollment as explained under Medicare Part A. This also includes individuals determined to be eligible as Qualified Disabled and Working Individuals (QDWI).

(B) **"Part B Buy-in"** means the procedure whereby the OHCA pays the Medicare Part B premium for categorically needy individuals who are eligible for Part B Medicare. This includes individuals who receive TANF or the State Supplemental Payment to the Aged, Blind or Disabled, and those determined to be Qualified Medicare Beneficiary Plus (QMBP), Specified Low Income Medicare Beneficiaries (SLMB) or Qualifying Individual-1 (QI-1). Also included are individuals who continue to be categorically needy under the PICKLE amendment and those who retain eligibility after becoming employed.

"Caretaker relative" means a person other than the biological or adoptive parent with whom the child resides who meets the specified degree of relationship within the fifth degree of kinship.

"Case management" means the activities performed for members to assist them in accessing services, advocacy and problem solving related to service delivery.

"Categorically needy" means that income and, when applicable, resources are within the standards for the category to which the individual is related.

"Categorically related" or **"related"** means the individual meets basic eligibility requirements for an eligibility group.

"Certification period" means the period of eligibility

extending from the effective date of certification to the date of termination of eligibility or the date of the next periodic redetermination of eligibility.

"Child" means an individual under twenty-one (21) years of age, unless otherwise specified by statute, regulation, and/or policy adopted by the OHCA. For eligibility criteria policy for children and adults, please refer to OAC 317:35-5-2.

"County" means the Oklahoma OKDHS' office or offices located in each county within the State.

"Custody" means the custodial status, as reported by OKDHS.

"Deductible/Coinsurance" means the payment that must be made by or on behalf of an individual eligible for Medicare before Medicare payment is made. The coinsurance is that part of the allowable medical expense not met by Medicare, which must be paid by or on behalf of an individual after the deductible has been met.

(A) For Medicare Part A (Hospital Insurance), the deductible relates to benefits for inpatient services while the patient is in a hospital or nursing facility. After the deductible is met, Medicare pays the remainder of the allowable cost.

(B) For Medicare Part B (Medical Insurance), the deductible is an annual payment that must be made before Medicare payment for medical services. After the deductible is met, Medicare pays eighty percent (80%) of the allowable charge. The remaining twenty percent (20%) is the coinsurance.

"Disabled" means an individual who is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death, or which has lasted (or can be expected to last) for a continuous period of not less than twelve (12) months.

"Disabled child" means for purposes of Medicaid Recovery a child of any age who is blind, or permanently and totally disabled according to standards set by the Social Security Administration.

"Estate" means all real and personal property and other assets included in the member's estate as defined in Title 58 of the Oklahoma Statutes.

"Expansion adult" means an individual defined by 42 Code of Federal Regulations (C.F.R.) § 435.119 who is age nineteen (19) or older and under sixty-five (65), at or below 133 percent of the federal poverty level (FPL), and who are not related to the aged, blind, or disabled.

"Gatekeeping" means the performance of a comprehensive assessment by the OKDHS nurse utilizing the UCAT for the determination of Medical eligibility, care plan development, and the determination of Level of Care for Personal Care, ADvantage Waiver and Nursing Facility services.

"Ineligible Spouse" means an individual who is not eligible for Supplemental Security Income (SSI) but is the husband or wife of

someone who is receiving SSI.

"Local office" means the Oklahoma OKDHS' office or offices located in each county within the State.

"LOCEU" means the Oklahoma Health Care Authority's Level of Care Evaluation Unit.

"MAGI eligibility group" means an eligibility group whose financial eligibility is determined through the Modified Adjusted Gross Income (MAGI) methodology. The groups subject to MAGI are defined in 42 C.F.R. ' 436.603 and listed in OAC 317:35-6-1.

"Modified Adjusted Gross Income (MAGI)" means the financial eligibility determination methodology established by the Patient Protection and Affordable Care Act (PPACA) in 2009.

"Medicare" means the federally funded health insurance program also known as Title XVIII of the Social Security Act. It consists of four (4) separate programs. Part A is Hospital Insurance, Part B is Medical Insurance, Part C is Medicare Advantage Plans, and Part D is Prescription Drug Coverage.

(A) **"Part A Medicare"** means Hospital Insurance that covers services for inpatient services while the patient is in a hospital or nursing facility. Premium free enrollment is provided for all persons receiving OASDI or Railroad Retirement income who are age sixty-five (65) or older and for those under age sixty-five (65) who have been receiving disability benefits under these programs for at least twenty-four (24) months.

(i) Persons with end stage renal disease who require dialysis treatment or a kidney transplant may also be covered.

(ii) Those who do not receive OASDI or Railroad Retirement income must be age sixty-five (65) or over and pay a large premium for this coverage. Under Authority rules, these individuals are not required to enroll for Part A to be eligible for SoonerCare benefits as categorically needy. They must, however, enroll for Medicare Part B. Individuals eligible as a QMBP or as a QDWI under Medicaid are required to enroll for Medicare Part A. The Authority will pay Part A premiums for QMBP individuals who do not qualify for premium free Part A and for all QDWI's.

(B) **"Part B Medicare"** means Supplemental Medical Insurance that covers physician and related medical services other than inpatient or nursing facility care. Individuals eligible to enroll in Medicare Part B are required to do so under OHCA policy. A monthly premium is required to keep this coverage in effect.

"Minor child" means a child under the age of eighteen (18).

"Nursing Care" for the purpose of Medicaid Recovery is care received in a nursing facility, an intermediate care facility for

individuals with intellectual disabilities (ICF/IIDs) or other medical institution providing nursing and convalescent care, on a continuing basis, by professional personnel who are responsible to the institution for professional medical services.

"OCSS" means the OKDHS' Oklahoma Child Support Services (formerly Child Support Enforcement Division).

"OHCA" means the Oklahoma Health Care Authority.

"OHCA Eligibility Unit" means the group within the OHCA that assists with the eligibility determination process.

~~**"OKDHS"** means the Oklahoma Department of Human Services.~~**"OKDHS"** means the Oklahoma Department of Human Services which is also referenced in rules as Department of Human Services (DHS) and Office of Human Services (OHS).

"OKDHS nurse" means a registered nurse in the OKDHS Aging Services Division who meets the certification requirements for UCAT Assessor and case manager, and who conducts the uniform assessment of individuals utilizing the UCAT for the purpose of medical eligibility determination. The OKDHS nurse also develops care plans and service plans for Personal Care services based on the UCAT.

"Qualified Disabled and Working Individual (QDWI)" means individuals who have lost their Title II OASDI benefits due to excess earnings, but have been allowed to retain Medicare coverage.

"Qualified Medicare Beneficiary Plus (QMBP)" means certain aged, blind or disabled individuals who may or may not be enrolled in Medicare Part A, meet the Medicaid QMBP income and resource standards and meet all other Medicaid eligibility requirements.

"Qualifying Individual" means certain aged, blind or disabled individuals who are enrolled in Medicare Part A, meet the Medicaid Qualifying Individual income and resource standards and meet all other Medicaid eligibility requirements.

"Qualifying Individual-1" means a Qualified Individual who meets the Qualifying Individual-1 income and resource standards.

"Reasonably compatible" means that there is no significant discrepancy between information declared by a member or applicant and other information available to the agency. More specific policies and procedures for determining whether a declaration is reasonably compatible are detailed in Oklahoma's Verification Plan.

"Recipient lock-in" means when a member is restricted to one primary physician and/or one pharmacy. It occurs when the OHCA determines that a SoonerCare member has used multiple physicians and/or pharmacies in an excessive manner over a twelve (12) month period.

"Scope" means the covered medical services for which payment is made to providers on behalf of eligible individuals. The OHCA Provider Manual (OAC 317:30) contains information on covered

medical services.

"Specified Low Income Medicare Beneficiaries (SLMB)" means individuals who, except for income, meet all of the eligibility requirements for QMBP eligibility and are enrolled in Medicare Part A.

"TEFRA" means the Tax Equity and Fiscal Responsibility Act of 1982 (Public Law 97-248). TEFRA provides coverage to certain disabled children living in the home who would qualify for SoonerCare if residents of nursing facilities, ~~ICF/IIDs~~Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IIDs), or inpatient acute care hospital stays are expected to last not less than sixty (60) days.

"Worker" means the OHCA or OKDHS worker responsible for assisting in eligibility determinations.

SUBCHAPTER 5. ELIGIBILITY AND COUNTABLE INCOME

PART 1. DETERMINATION OF QUALIFYING CATEGORICAL RELATIONSHIPS

317:35-5-2. Categorically related programs

(a) In order to be eligible for SoonerCare, an individual must first meet the description of a member eligibility group. For individuals related to the aged, blind, or disabled groups, categorical relationship is established using the same definitions of age, disability and blindness as used by the Social Security Administration (SSA) in determining eligibility for Supplemental Security Income (SSI) or SSA benefits. If the individual is ~~a~~an SSA/SSI recipient in current payment status (including presumptive eligibility), a ~~TANF~~Temporary Assistance for Needy Families (TANF) recipient, an adoption assistance or kinship guardianship assistance recipient, or is under age nineteen (19), categorical relationship is automatically established. For individuals related to expansion adults the categorical relationship is established and defined by 42 Code of Federal Regulations (C.F.R.) § 435.119. Categorical relationship to the pregnancy group is established when the determination is made by medical evidence that the individual is or has been pregnant. ~~Effective January 1, 2014, verification~~Verification of pregnancy is only required if the individual's declaration that she is pregnant is not reasonably compatible with other information available to the agency. Pregnancy-related services include all medical services provided within the scope of the program during the prenatal, delivery and postpartum periods for women in this pregnancy group; see Subchapter 22 of this Chapter for services for unborn children covered under Title XXI. For an individual age nineteen (19) or over to be related to the parent and caretaker relative group, the individual must have a minor dependent child. For an individual to

be related to the former foster care children group, the individual must not be eligible for the Title XIX pregnancy or parent or caretaker relative groups, must be aged ~~19-26~~nineteen (19) to twenty-six (26), and must have been receiving SoonerCare as a foster care child when he/she aged out of foster care in Oklahoma. There is no income or resource test for the former foster care children group. Categorical relationship to ~~Refugee~~refugee services is established in accordance with OAC 317:35-5-25. Categorical relationship for the Breast and Cervical Cancer (BCC) ~~Treatment~~treatment program is established in accordance with ~~OAC 317:35-21~~Subchapter 21 of this Chapter. Categorical relationship for the SoonerPlan ~~Family Planning Program~~family planning program is established in accordance with OAC 317:35-5-8. Categorical relationship for pregnancy related benefits covered under Title XXI is established in accordance with ~~OAC 317:35-22~~Subchapter 22 of the Chapter. Benefits for pregnancies covered under Title XXI medical services are provided within the scope of the program during the prenatal, delivery and postpartum care when included in the global delivery payment. To be eligible for SoonerCare benefits, an individual must be related to one (1) of the following eligibility groups and as defined above in this Section:

(1) Aged;
(2) Disabled;
(3) Blind;
(4) Pregnancy;
(5) Children, including newborns deemed eligible;
(6) Parents and ~~Caretaker Relatives~~caretaker relatives;
(7) Refugee;
(8) ~~Breast and Cervical Cancer Treatment~~BCC treatment program;
(9) SoonerPlan ~~Family Planning Program~~family planning program;
(10) Benefits for pregnancies covered under Title XXI;
(11) Former foster care children; or
(12) Expansion adults.

(b) The Authority may provide SoonerCare to reasonable categories of individuals under age twenty-one (21).

(1) Individuals eligible for SoonerCare benefits include individuals between the ages of nineteen (19) and twenty-one (21):

(A) ~~for~~For whom a public agency is assuming full or partial financial responsibility who are in custody as reported by ~~the Oklahoma Department of Human Services (OKDHS)~~OKDHS and in foster homes, private institutions or public facilities; or

(B) ~~in~~In adoptions subsidized in full or in part by a public agency; or

(C) ~~individuals~~Individuals under age ~~twenty one~~twenty-one (21) receiving active treatment as inpatients in public

psychiatric facilities or programs if inpatient psychiatric services for individuals under age ~~twenty one~~twenty-one (21) are provided under the State Plan and the individuals are supported in full or in part by a public agency; or

(2) Individuals eligible for SoonerCare benefits include individuals between the ages of eighteen (18) and ~~twenty one~~twenty-one (21) if they are in custody as reported by OKDHS on their ~~18th~~eighteenth (18th) birthday and living in an ~~out of home~~out-of-home placement.

317:35-5-9. Determining the categorical relationship to expansion adults

(a) To be eligible for SoonerCare under expansion adults, individuals shall meet the following requirements:

(1) Are age nineteen (19) years or older, and under age sixty-five (65);

(2) Are not pregnant;

(3) Are not entitled to or enrolled for Medicare benefits under part A or B;

(4) Are not eligible for SoonerCare in another mandatory eligibility group under Oklahoma's Medicaid State Plan;

(5) Have household income that is at or below 133 percent of the federal poverty level (FPL) for their household size; and

(6) Meet general SoonerCare program eligibility requirements described in Oklahoma Administrative Code (OAC) 317:35, including but not limited to citizenship and residence requirements.

(b) An individual whose household's modified adjusted gross income (MAGI) exceeds the income standard for participation under the parent and caretaker relative group, including those eligible for transitional medical assistance per 317:35-6-64.1, may participate in expansion adults if:

(1) The individual resides with and assumes primary responsibility for the care of a child under nineteen (19) years of age; and

(2) The child is enrolled in SoonerCare or other minimum essential coverage, as described by the Affordable Care Act.

PART 5. COUNTABLE INCOME AND RESOURCES

317:35-5-48. Determination of income and resources for categorical relationship to expansion adults

Income is determined in accordance with the Modified Adjusted Gross Income (MAGI) methodology for individuals related to expansion adults. See Subchapter 6 of this Chapter for MAGI rules.

PART 7. APPLICATION AND ELIGIBILITY DETERMINATION PROCEDURES

317:35-5-60. Application for SoonerCare; forms

(a) **Application.** An application for ~~Medical Services~~medical services consists of the ~~Medical Assistance Application~~SoonerCare application. The application form is signed by the individual, parent, spouse, guardian or someone else acting on the individual's behalf. An individual does not have to have received a medical service nor expect to receive one to be certified for SoonerCare. ~~Effective January 1, 2014, the~~The application form is available as an online application, as a paper form, and is available to be completed by telephone with the assistance of the agency.

(1) An application may be made in a variety of locations, for example, a physician's office, a hospital or other medical facility or in the county OKDHS office. An application may be made online by individuals who are pregnant~~,~~ or have children or are applying for family planning services only. A ~~face to face~~face-to-face interview is not required. Only SoonerCare applications for women who are pregnant, and families with children and for family planning services are mailed to the OHCA Eligibility Unit. Applications for other medical services may be mailed or faxed to the local county OKDHS office. If faxed, it is not necessary to send the original application. When an individual indicates a need for health benefits, the physician or facility may forward an application or 08MA005E to the OKDHS county office of the patient's residence for processing. The physician or facility may forward an application or OKDHS form 08MA005E for individuals who are pregnant~~,~~ or have children or are applying for family planning services only to the OHCA Eligibility Unit for processing. If the applicant is unable to sign the application, someone acting on his/her behalf may sign the application. ~~Effective October 1, 2013, an~~An application for SoonerCare may also be submitted through the Health Insurance Exchange.

(2) OKDHS form 08MA005E, Notification of Needed Medical Services, is required only for preauthorization of medical services. Although not required, the form may be submitted by the physician or facility as notification of a need for medical services. The form also may be accepted as medical verification of pregnancy.

(3) Receipt of the SoonerCare Application form or OKDHS form 08MA005E constitutes an application for SoonerCare.

(4) If OKDHS form 08MA005E is received and an application cannot be completed, receipt of OKDHS form 08MA005E constitutes an application which must be registered and subsequently denied. The applicant and provider are notified by computer-generated notice.

(5) If the applicant also wishes to apply for a State Supplemental Payment, either the applicant or his/her guardian must sign the Medical Assistance Application form.

(b) **Date of application.** When an application is made online, the date of application is the date the application is submitted online. The date of application for a paper application is the date a signed application is received and stamped in by contracted agency partners or OHCA. When a request for SoonerCare is made orally, and that request is followed within ~~20~~twenty (20) days by a signed application, the documented date of the oral request is the date of application. When OKDHS form 08MA005E is received by OKDHS, or received by OHCA and forwarded to OKDHS, the earliest of the date stamps is considered the date of request and should be honored when followed within ~~20~~twenty (20) days by a signed application for SoonerCare.

317:35-5-63. Agency responsible for determination of eligibility

(a) **Determination of eligibility by Oklahoma Health Care Authority (OHCA).** OHCA is responsible for determining eligibility for the following eligibility groups:

(1) ~~children~~Children;
(2) ~~newborns~~Newborns deemed eligible;
(3) ~~pregnant~~Pregnant women;
(4) ~~pregnancy-related~~Pregnancy-related services under Title XXI;
(5) ~~parents~~Parents and caretaker relatives;
(6) ~~former~~Former foster care children;
(7) ~~Oklahoma Cares~~ Breast and Cervical Cancer ~~program~~(BCC) treatment program;
(8) SoonerPlan ~~Family Planning~~family planning program~~.~~;
(9) Programs of All-Inclusive Care for the Elderly (PACE); and
(10) Expansion adults.

(b) **Determination of eligibility by ~~DHS~~OKDHS.** ~~DHS~~OKDHS is responsible for determining eligibility for the following eligibility groups:

(1) TANF recipients;
(2) ~~recipients~~Recipients of adoption assistance or kinship guardianship assistance;
(3) ~~state~~State custody;
(4) Refugee ~~Medical Assistance~~medical assistance;
(5) ~~aged~~Aged;
(6) ~~blind~~Blind;
(7) ~~disabled~~Disabled;
(8) Tuberculosis;
(9) ~~QMBP~~Qualified Medicare Beneficiary Plus (QMBP);
(10) ~~QDWI~~Qualified Disabled Working Individual (QDWI);
(11) ~~SLMB~~Specified Low-Income Medicare Beneficiary (SLMB);

(12) ~~QI-1~~Qualifying Individual (QI-1);
(13) ~~Long term~~Long-term care services; and
(14) ~~alien~~Alien emergency services.

(c) **Determination of eligibility for programs offered through the Health Insurance Exchange.** ~~Effective October 1, 2013,~~ OHCA assesses applicants who are found to be ineligible for SoonerCare for potential eligibility for affordable insurance programs offered through the Health Insurance Exchange. OHCA does not determine eligibility or ineligibility for those programs. OHCA facilitates the determination for those affordable insurance programs by forwarding applicants' electronic applications to the Health Insurance Exchange.

SUBCHAPTER 6. SOONERCARE FOR PREGNANT WOMEN AND FAMILIES WITH CHILDREN

PART 1. GENERAL

317:35-6-1. Scope and applicability

(a) The rules in this Subchapter apply when determining financial eligibility for SoonerCare ~~Health Benefits~~health benefits for groups whose eligibility is determined using Modified Adjusted Gross Income (MAGI). These rules apply to the following groups:

(1) Children~~,~~;
(2) Pregnant women~~,~~;
(3) Pregnancy-related services under Title XXI~~,~~;
(4) Parents and caretaker relatives~~,~~;
(5) SoonerPlan ~~Family Planning~~family planning program~~,~~;
(6) Independent foster care adolescents~~,~~;
~~(7) Inpatients in public psychiatric facilities under 21, and~~
(7) Individuals under age twenty-one (21) in public psychiatric facilities;
(8) Tuberculosis~~.~~;
(9) Former foster care children;
(10) Children with non-IV-E adoption assistance;
(11) Individuals in adoptions subsidized in full or part by a public agency; and
(12) Expansion adults.

(b) See ~~42 Code of Federal Regulation, Sec. 435.603~~42 C.F.R. § 435.603 to determine whether MAGI applies to a group not specifically listed in this Section.

(c) MAGI rules ~~take~~took effect on October 1, 2013.

PART 3. APPLICATION PROCEDURES

317:35-6-15. ~~Application for SoonerCare for Pregnant Women and Families with Children~~SoonerCare application for pregnant women, families with children, and expansion adults; forms

(a) **Application.** An application for pregnant women~~ and~~, families with children, and expansion adults consists of the SoonerCare application. The application form is signed by the individual, parent, spouse, guardian, or someone else acting on the individual's behalf. An individual does not have to have received a medical service nor expect to receive one to be certified for SoonerCare. ~~Effective October 1, 2013, individuals~~Individuals who wish to use a paper application form to apply for coverage under a MAGI eligibility group must submit the federal Single Streamlined Application to apply for SoonerCare.

(1) An application may be made in a variety of locations, for example, a physician's office, a hospital or other medical facility, ~~Health Department, in the county OKDHS office~~Oklahoma Department of Health, in the individual's county Oklahoma Department of Human Services (OKDHS) office, or online. A ~~face to face~~face-to-face interview is not required. Applications are mailed to the OHCA Eligibility Unit. When an individual indicates a need for SoonerCare, the physician or facility may forward an application to the OHCA Eligibility Unit for processing. If the applicant is unable to sign the application, someone acting on his/her behalf may sign the application. ~~Effective October 1, 2013, an~~An application for SoonerCare may also be submitted through the Health Insurance Exchange.

(2) OKDHS form 08MA005E, Notification of Needed Medical Services, is required only for preauthorization of medical services. Although not required, the form may be submitted by the physician or facility as notification of a need for medical services. The form also may be accepted as medical verification of pregnancy.

(3) Receipt of the SoonerCare ~~Application~~application form or OKDHS form 08MA005E constitutes an application for SoonerCare.

(4) If OKDHS form 08MA005E is received and a SoonerCare application cannot be completed, receipt of OKDHS form 08MA005E constitutes an application which must be registered and subsequently denied. The applicant and provider are notified by computer-generated notice.

(5) A hospital providing services may file an electronic Notification of Date of Service (NODOS) form with OHCA up to five (5) days from the date services are rendered. The hospital, applicant, or someone acting on the applicant's behalf has fifteen (15) days from the date the NODOS form was received by OHCA to submit a completed SoonerCare application. Filing a ~~Notification of Date of Service~~NODOS does not guarantee coverage and if a completed application is not submitted within fifteen (15) days, the NODOS is void.

(b) **Date of application.** When an application is made online, the date of application is the date the application is submitted

online. The date of application for a paper application is the date a signed application is received and stamped in by contracted agency partners or OHCA. When a request for SoonerCare is made orally, and that request is followed within ~~20~~twenty (20) days by a signed application, the documented date of the oral request is the date of application. When OKDHS form 08MA005E is received by OKDHS, or received by OHCA and forwarded to OKDHS, the earliest of the date stamps is considered the date of request and should be honored when followed within ~~20~~twenty (20) days by a signed application for SoonerCare.

(c) **Other application and signature requirements.** For additional rules regarding other application and eligibility determination procedures, see Part 7 of Subchapter 5 of this Chapter.

PART 5. DETERMINATION OF ELIGIBILITY FOR SOONERCARE HEALTH BENEFITS FOR PREGNANT WOMEN AND FAMILIES WITH CHILDREN

317:35-6-36. Financial eligibility of individuals categorically related to ~~AFDC or pregnancy-related services~~aid to families with dependent children (AFDC), pregnancy-related services or expansion adults

(a) ~~**Prior to October 1, 2013.** In determining~~When determining financial eligibility for an individual related to AFDC ~~or~~, pregnancy-related services or expansion adults, the income of the following persons (if living together or if living apart as long as there has been no break in the family relationship) are considered. These persons include the:

(1) ~~the individual~~Individual;

(2) ~~the spouse~~Spouse of the individual;

(3) ~~the biological~~Biological or adoptive parent(s) of the individual who is a minor dependent child. For ~~Health Benefits~~health benefits only, income of the stepparent of the minor dependent child is determined according to OAC 317:35-5-45;

(4) ~~minor~~Minor dependent children of the individual if the children are being included in the case for ~~Health Benefits~~health benefits. If the individual is ~~19~~nineteen (19) years or older and not pregnant, at least one (1) minor dependent child must be living in the home and included in the case for the individual to be related to AFDC;

(5) ~~blood~~Blood related siblings, of the individual who is a minor child, if they are included in the case for ~~Health Benefits;~~health benefits; or

(6) ~~a caretaker~~Caretaker relative and spouse (if any) and minor dependent children when the caretaker relative is to be included for coverage.

(b) ~~**Prior to October 1, 2013.** The family has the option to exclude~~

~~minor dependent children or blood related siblings [OAC 317:35-6-36(a)(4) and (5)] and their income from the eligibility process. However, for the adult to be eligible, at least one minor child and his/her income must be included in the case. The worker has the responsibility to inform the family of the most advantageous consideration in regard to coverage and income.~~The MAGI methodology is used to determine eligibility for MAGI eligibility groups. See OAC 317:35-6-39 through 317:35-6-54.
~~(c) **Effective October 1, 2013.** The MAGI methodology is used to determine eligibility for MAGI eligibility groups. See OAC 317:35-6-39 through OAC 317:35-6-54.~~
~~(d)~~(c) ~~**Effective October 1, 2013.**~~ Individuals who are determined to be part of a MAGI household cannot be excluded from the household; likewise, income of individuals determined to be part of a MAGI household cannot be excluded unless the exclusion is expressly required under MAGI rules.
~~(e) When determining financial eligibility for an individual related to the children, parent or caretaker relative, or pregnancy groups, consideration is not given to income of any person who is aged, blind or disabled and receives SSI or is determined to be categorically needy.~~

317:35-6-37. Financial eligibility of categorically needy individuals related to ~~AFDC or pregnancy-related services~~aid to families with dependent children (AFDC), pregnancy-related services, parent/caretaker relatives, families with children, and expansion adults

Individuals whose income is less than the SoonerCare ~~Income Guidelines~~income guidelines for the applicable eligibility group are financially eligible for SoonerCare.

(1) **Categorically related to pregnancy-related services.** For an individual related to pregnancy-related services to be financially eligible, the countable income must be less than the appropriate standard according to the family size on the SoonerCare ~~Income Guidelines~~income guidelines. In determining the household size, the pregnant woman and her unborn child(ren) are included.

(2) **Categorically related to ~~children's and parent/caretakers' groups~~the children and parent/caretaker relative groups.**

(A) **Parent/~~caretakers'~~caretaker relative group.** For the individual in the parent/~~caretakers'~~caretaker relative group to be considered categorically needy, the SoonerCare ~~Income Guidelines~~income guidelines must be used.

(i) ~~**SoonerCare Income Guidelines.**~~ Individuals age ~~19~~nineteen (19) years or older, other than pregnant women, are determined categorically needy if countable income is ~~less~~equal to or less than the ~~Categorically~~

~~Needy Standard~~categorically needy standard, according to the family size.

(ii) ~~**SoonerCare Income Guidelines.**~~ All individuals under ~~19~~nineteen (19) years of age are determined categorically needy if countable income is equal to or less than the ~~Categorically Needy Standard~~categorically needy standard, according to the size of the family.

(B) **Families with children.** Individuals who meet financial eligibility criteria for the ~~children's~~children and parent/~~caretakers'~~caretaker relative groups are:

(i) All persons included in an active TANF case.

(ii) Individuals related to the ~~children's~~children or parent/~~caretakers'~~caretaker relative groups whose countable income is within the current appropriate income standard, but who do not receive TANF assistance.

(iii) All persons in a TANF case in ~~Work Supplementation~~work supplementation status who meet TANF eligibility conditions other than earned income.

(iv) Those individuals who continue to be eligible for Medicaid in a TANF case after they become ineligible for a TANF payment. These individuals will continue to be considered categorically needy if the TANF case was closed due to child or spousal support, the loss or reduction of earned income exemption by any member of the assistance unit, or the new or increased earnings of the parent/caretaker relative.

(3) **Expansion adults.** Individuals who meet financial eligibility criteria for expansion adults are established and defined by 42 C.F.R. § 435.119 and by the Oklahoma Medicaid State Plan.

317:35-6-38. Hospital ~~Presumptive Eligibility~~presumptive eligibility (HPE)

(a) **General.** ~~Hospital Presumptive Eligibility (HPE)~~HPE is a limited period of SoonerCare eligibility for individuals who are categorically related to certain MAGI eligibility groups listed in OAC 317:35-6-38(a)(1)(A)(i) through (vi) and are also determined by a qualified hospital ~~(see OAC 317:35-6-38(a)(2)(A) through (L)) for the conditions of a qualified hospital)~~[see OAC 317:35-6-38(a)(2)(A) through (L) for the conditions of a qualified hospital], on the basis of preliminary information provided by the applicant on a completed HPE application, to be eligible for SoonerCare services. The rules in this ~~section~~Section apply only to those individuals applying for, or qualified hospitals determining eligibility under, the HPE program.

(1) **Individuals eligible to participate in the HPE program.** To be eligible to participate in the HPE program, an individual

must be categorically related to a MAGI eligibility group (see OAC 317:35-5-2 for categorical relationship criteria) and also meet the income standard and non-medical eligibility specified in this ~~section~~Section.

(A) **MAGI ~~Eligibility Groups~~eligibility groups.** The following MAGI eligibility groups are eligible to have a presumptive eligibility (PE) determination made by a qualified hospital participating in the HPE program:

(i) ~~children~~Children;

(ii) ~~pregnant~~Pregnant women;

(iii) ~~parents and caretaker relatives~~Parent/caretaker relative;

(iv) ~~former~~Former foster care children;

(v) Breast and Cervical Cancer~~ Treatment~~ (BCC) treatment program; and

(vi) SoonerPlan ~~Family planning~~family planning program.

(B) **Income standard.** The income that is counted in determining PE for an individual is that individual's household income. The income limit for the MAGI eligibility groups covered under the HPE program is the same as defined in OAC 317:35-6-39(b)(8) and is listed on the HPE application. The calculation of countable household income for an individual covered under the HPE program is the same as OAC 317:35-6-39, except that, in determining the individual's household composition, only the MAGI household composition non-filer rules listed under OAC 317:35-6-43 apply for all individuals applying for the HPE program regardless of whether or not the individual is a tax filer, plans on filing taxes, or is a tax dependent.

(C) **Non-medical eligibility requirements.** Individuals covered under the HPE program must also meet the non-medical eligibility requirements described in OAC 317:35-5-25.

(D) **Pregnant women covered under the HPE program.** Coverage for pregnant women who are covered under the HPE program is limited to ambulatory prenatal care only, and the number of PE periods that may be authorized for pregnant women is one per pregnancy. Pregnant women who may be covered for the benefit of the unborn child(ren) under Title XXI are not eligible for the HPE program.

(E) **Other individuals covered under the HPE program.** Coverage for other individuals listed under OAC 317:35-6-38(a)(1)(A)(i) through (vi) who are covered under the HPE program, except for pregnant women, is the same as covered under the State Plan. The number of PE periods that may be authorized is one period every ~~365~~three hundred sixty-five (365) days beginning on the date the individual is enrolled in HPE.

(2) **Qualified hospital.** The decision that a hospital is qualified to make PE determinations is made by the OHCA. In order to participate in the HPE program and make PE determinations, a qualified hospital must:

(A) Meet all the conditions of an eligible provider under OAC 317:30-5-40;

(B) Elect to participate in the HPE program by:

(i) Completing and submitting a HPE Statement of Intent and Memorandum of Understanding to the OHCA and agreeing to all the terms and conditions of the HPE program;

(ii) Amending its current contract with the OHCA to include participation in the HPE program;

(C) Assign and designate a hospital employee to serve as the HPE program administrator and point of contact;

(D) Assign and designate hospital employees to make PE determinations. The term ~~Authorized Hospital Employee(s) (AHE)~~"authorized hospital employee(s) (AHE)" means all individuals making PE determinations on behalf of a hospital participating in the HPE program. The AHE must meet the following conditions:

(i) Be an employee of the hospital (i.e. the AHE may not be a third party contractor);

(ii) Attend, complete, and pass the HPE program training course provided and assessed by the OHCA;

(iii) The AHE certificate of HPE course completion must be kept in the worker's file at the hospital and must be made available to the OHCA upon request;

(iv) Follow state and federal privacy and security requirements regarding patient confidentiality;

(v) Agree to abide by all the rules and guidelines of the HPE program established by the OHCA under this ~~section~~Section.

(E) Notify the OHCA of any changes in the AHE's employment status or in the designation of that individual as the hospital's AHE;

(F) Abide by the rules and regulations of the Uniform Electronic Transaction Act as outlined in OAC 317:30-3-4.1;

(G) Keep internal records of all individuals for whom a PE determination was made and make those records available to the OHCA upon request;

(H) Agree to submit all completed HPE applications and PE determinations to the OHCA within ~~5~~five (5) days of the PE determination;

(I) Notify the applicant in writing, or in cases where the HPE application was made on behalf of a child, notify the child's parent or caretaker of the PE determination outcome and provide and explain to eligible members the "HPE Program

Policy and Enrollment" form;

(J) Assist HPE applicants with the completion of a full SoonerCare application within ~~15~~fifteen (15) days of the HPE application submission to the OHCA;

(K) Agree to adhere to the processes and procedures established by the OHCA regarding the operation and oversight of the HPE program; and

(L) Cooperate with the OHCA regarding audit and quality control reviews on PE determinations the hospital makes. The agency may terminate the HPE agreement with the hospital if the hospital does not meet the standards and quality requirements set by the OHCA.

(3) **Limited hospital PE determinations.** The agency limits the PE determinations that a hospital may make to only those eligibility groups described in OAC 317:35-6-38(a)(1)(A) using the MAGI methodology rules established for the HPE program. Additionally, PE determinations made for individuals categorically related to the Breast and Cervical Cancer ~~Treatment~~(BCC) treatment program are limited to qualified hospitals that are also qualified entities through the ~~NBCCEDP~~National Breast and Cervical Cancer Early Detection Program (NBCCEDP).

(b) **General provisions of the HPE program.** The agency provides SoonerCare coverage to eligible individuals covered during a period of PE.

(1) **PE period.** The PE period begins on the date a qualified hospital determines an individual to be eligible under the HPE program. A qualified hospital has ~~5~~five (5) days to notify the agency of its PE determination. The PE period ends with the earlier of:

(A) The day the agency receives the SoonerCare application form as described in OAC 317:35-5-60 and an eligibility determination is made by the agency; or

(B) If a SoonerCare application is not received, the last day of the month following the month in which the PE determination was made.

(2) **Agency approval of PE.** When the OHCA receives a timely and completed HPE application, a case number and, if needed, SoonerCare member ID is assigned to the member by the agency. Qualified hospitals will be able to review member enrollment and eligibility, once those members have been entered into the system by the OHCA, for claims billing and member eligibility verification.

(3) **Incomplete HPE applications.** Upon receiving a HPE ~~Application~~application, the OHCA reviews it for completeness and correctness. The HPE application is considered incomplete if it is not filled out in its entirety (e.g., the applicant's

first or last name is not provided on the application) or if the application is not filed timely with the OHCA. When the HPE application is determined to be incomplete, the HPE application is returned to the AHE or the HPE program administrator at the qualified hospital to correct the application errors or amend the HPE application. To maintain the original PE certification period, the qualified hospital must return the completed or corrected HPE application to the agency within five (5) working days.

(4) **Applicant appeal.** The HPE applicant cannot appeal the PE determination made by a qualified hospital or the expiration date of the PE period.

(5) **Applicant ineligibility.** Applicants ineligible for the HPE program are individuals who do not meet the HPE criteria, individuals who have previously been enrolled in the HPE program within the last ~~365~~three hundred sixty-five (365) days, and individuals currently enrolled in SoonerCare. Individuals currently enrolled in SoonerPlan ~~Family Planning~~family planning are not eligible for HPE family planning services, but may be eligible for other programs under HPE. When the OHCA receives a HPE application from a qualified hospital for an ineligible applicant ~~(e.g., the applicant has been previously enrolled in the HPE program within the last 365 days)~~[e.g., the applicant has been previously enrolled in the HPE program within the last three hundred sixty-five (365) days], the OHCA will disenroll the individual from the HPE program immediately and notify the hospital of the error. The hospital will be responsible for following up with that individual to notify them of their disenrollment from the HPE program. If the applicant is not currently enrolled into SoonerCare, the applicant may submit a full SoonerCare application and receive a full eligibility determination by the OHCA. HPE services provided to ineligible applicants, other than persons currently enrolled into SoonerCare or SoonerPlan ~~Family Planning~~family planning program, may not be eligible for reimbursement by the OHCA.

SUBCHAPTER 7. MEDICAL SERVICES

PART 1. GENERAL

317:35-7-1. Scope and applicability

~~The rules in this Subchapter apply when determining eligibility for Medical Services under Medicaid.~~ The rules in this Subchapter apply when determining eligibility for medical services for children who are reported by OKDHS as being in custody and individuals categorically related to: Aged, Blind and Disabled (ABD); Tuberculosis; SoonerPlan family planning program; Qualified

Medicare Beneficiary Plus (QMBP); Qualified Disabled Working Individual (QDWI); Specified Low-Income Medicare Beneficiary (SLMB); Qualifying Individual (QI-1); and TEFRA.

PART 7. CERTIFICATION, REDETERMINATION AND NOTIFICATION

317:35-7-60. Certification for SoonerCare

~~(a) The rules in this Section apply to all categories of eligibles **EXCEPT:**~~

~~(1) categorically needy SoonerCare members who are categorically related to AFDC or Pregnancy Related Services, AND~~

~~(2) who if eligible, would be enrolled in SoonerCare, or~~

~~(3) individuals categorically related to the Family Planning Program.~~

~~(b) An individual determined eligible for SoonerCare may be certified for a medical service provided on or after the first day of the third month prior to the month of application if all eligibility criteria are met during the three month period. The certification period is determined beginning with the month the medical service was received or expected to be received or the month of application for categorically needy cases in which a medical service has not been received. The period of certification may cover retroactive or future months.~~

~~(1) **Certification as categorically.** A categorically needy individual who is categorically related to ABD is assigned a certification period of 12 months. A categorically needy individual who is determined eligible for a State Supplemental Payment (SSP) is certified effective the month of application. If the individual is also eligible for payment for medical services received during the three months preceding the month of application, the SoonerCare benefit is certified for the appropriate months. If the individual is not eligible for SSP, the first month of certification is the month that a medical service was provided or, if no medical service was provided, the month of application.~~

~~(1) **Certification of individuals categorically needy and categorically related to ABD.** The certification period for the individual categorically related to ABD can be assigned for up to 12 months. The individual must be determined as categorically needy for each month of the certification period. The certification period is 12 months unless the individual:~~

~~(i) is certified as eligible in a money payment case during the 12 month period;~~

~~(ii) is certified for long-term care during the 12 month period;~~

~~(iii) becomes ineligible for medical assistance after the~~

~~initial month;~~
~~(iv) becomes ineligible as categorically needy; or~~
~~(v) is deceased.~~
~~(B) **Certification period.** If any of the situations listed in subparagraph (A) of this paragraph occur after the initial month, the case is closed by the worker.~~
~~(i) If income and/or resources change after certification causing the case to exceed the categorically needy maximums, the case is closed.~~
~~(ii) A pregnant individual included in an ABD case which closes continues to be eligible for pregnancy related services through the postpartum period.~~

(a) **General.** The rules in this Section apply to the following categories of eligibles:
(1) Categorically needy SoonerCare members who are categorically related to Aged, Blind, and Disabled (ABD);
(2) Categorically needy SoonerCare members who are categorically related to ABD, and are eligible for one of the following:
(A) Qualified Medicare Beneficiary Plus (QMBP);
(B) Qualified Disabled and Working Individual (QDWI);
(C) Specified Low-Income Medicare Beneficiary (SLMB);
(D) Tuberculosis (TB) related services;
(E) Qualifying Individual (QI); or
(F) Tax Equity and Fiscal Responsibility Act (TEFRA).

(b) **Certification of individuals categorically needy and categorically related to ABD.** The certification period for the categorically needy individual who is categorically related to ABD can be up to twelve (12) months from the date of certification. The individual must meet all factors of eligibility for each month of the certification period. The certification can be for a retroactive period of coverage, during the three (3) months directly before the month of application, if the individual received covered medical services at any time during those three (3) months and would have been eligible for SoonerCare at the time he or she received the services. The cash payment portion of the State Supplemental Payment (SSP) may not be paid for any period prior to the month of application.
(1) The certification period is twelve (12) months unless the individual:
(A) Is certified as eligible in a money payment case during the twelve (12) month period;
(B) Is certified for long-term care during the twelve (12) month period;
(C) Becomes ineligible for medical assistance after the initial month;
(D) Becomes ineligible as categorically needy; or

(E) Is deceased.

(2) If any of the situations listed in subparagraph (1) of this paragraph occur after the initial month, the case is closed by the worker.

(A) If income and/or resources change after certification causing the case to exceed the categorically needy maximums, the case is closed.

(B) A pregnant individual included in an ABD case which closes continues to be eligible for pregnancy related services through the postpartum period.

~~(2)~~(c) **Certification of individuals categorically related to ABD and eligible as ~~Qualified Medicare Beneficiaries Plus~~QMBP.** The SoonerCare benefit may be certified on the first day of the third month prior to the month of application or later. If the individual receives Medicare and is eligible for SSP, the effective date of certification for the Medicare Part B premium buy-in is the month of certification for SSP. If the individual receives Medicare and is not eligible for SSP, the effective date of certification for the Medicare Part B premium buy-in is the first day of the month following the month in which the eligibility determination is made (regardless of when application was made).

~~(A)~~(1) An individual determined eligible for QMBP benefits is assigned a certification period of ~~12~~twelve (12) months. At any time during the certification period that the individual becomes ineligible, the case is closed using regular negative action procedures.

~~(B)~~(2) At the end of the certification period a redetermination of QMBP eligibility is required, using the same forms and procedures as for ABD categorically needy individuals.

~~(3)~~(d) **Certification of individuals categorically related to ABD and eligible as ~~Qualified Disabled and Working Individual~~QDWI.** The Social Security Administration (SSA) is responsible for referrals of individuals potentially eligible for QDWI. Eligibility factors verified by the SSA are Medicare Part A eligibility and discontinuation of disability benefits due to excessive earnings. When the OKDHS State ~~Office~~office receives referrals from the SSA, the county will be notified and is responsible for obtaining an application and establishing other factors of eligibility. If an individual contacts the county office stating he/she has been advised by SSA that he/she is a potential QDWI, the county takes a SoonerCare application. The effective date of certification for QDWI benefits is based on the date of application and the date all eligibility criteria, including enrollment for Medicare Part A, are met. For example, if an individual applies for benefits in October and is already enrolled in Medicare Part A, eligibility can be effective October 1 ~~(~~[or up to three (3) months prior to October 1, if all eligibility criteria

are met during the three (3) month period~~)~~]. However, if in the example, the individual's enrollment for Part A is not effective until November 1, eligibility cannot be effective until that date. Eligibility can never be effective prior to July 1, 1990, the effective date of this provision. These cases will be certified for a period of ~~12~~twelve (12) months. At the end of the ~~12-month~~twelve (12) month period, eligibility redetermination is required. If the individual becomes ineligible at any time during the certification period, the case is closed.

~~(4)~~(e) **Certification of individuals categorically related to ABD and eligible as ~~Specified Low-Income Medicare Beneficiary (SLMB)~~SLMB.** The effective date of certification of SLMB benefits may begin on the first day of the third month prior to the month of application or later. A certification can never be earlier than the date of entitlement of Medicare Part A. An individual determined eligible for SLMB benefits is assigned a certification period of ~~12~~twelve (12) months. At any time during the certification period the individual becomes ineligible, the case is closed using standard negative action procedures. At the end of the certification period a redetermination of SLMB eligibility is required. A redetermination of SLMB eligibility must also be done at the same time a dually eligible individual has a redetermination of eligibility for other SoonerCare benefits such as long-term care.

~~(5)~~(f) **Certification of individuals categorically related to disability and eligible for TB related services.**

~~(A)~~(1) An individual determined eligible for TB related services may be certified the first day of the third month prior to the month of application or later, but no earlier than the first day of the month the TB infection is diagnosed.

~~(B)~~(2) A certification period of ~~12~~twelve (12) months will be assigned. At any time during the certification period that the individual becomes ineligible, the case is closed using the regular negative action procedures.

~~(C)~~(3) At the end of the certification period a new application will be required if additional treatment is needed.

~~(6)~~(g) **Certification of individuals categorically related to ABD and eligible as ~~Qualifying Individuals~~QI.** The effective date of certification for the QI-1 may begin on the first day of the third month prior to the month of application or later. A certification can never be earlier than the date of entitlement of Medicare Part A. An individual determined eligible for QI benefits is assigned a certification period of ~~12~~twelve (12) months. At any time during the certification period the individual becomes ineligible, the case is closed using standard negative action procedures. At the end of the certification period, a redetermination of QI eligibility is required.

~~(A)~~(1) Since the State's allotment to pay Medicare premiums for this group of individuals is limited, the State must limit the number of QIs so that the amount of assistance provided during the year does not exceed the State's allotment for that year.

~~(B)~~(2) Persons selected to receive assistance are entitled to receive assistance with their Medicare premiums for the remainder of the federal fiscal year, but not beyond, as long as they continue to qualify. The fact that an individual is selected to receive assistance at any time during the year does not entitle the individual to continued assistance for any succeeding year.

~~(7)~~(h) **Certification of individuals ~~Related~~related to Aid to the Disabled for TEFRA.** The certification period for individuals categorically related to the Disabled for TEFRA is ~~12~~twelve (12) months.

SUBCHAPTER 10. OTHER ELIGIBILITY FACTORS FOR FAMILIES WITH CHILDREN AND PREGNANT WOMEN

PART 3. RESOURCES

317:35-10-10. Capital resources

Capital resources are disregarded for individuals related to the children, parent and caretaker relative, former foster care children, SoonerPlan family planning program, expansion adults, or pregnancy eligibility groups, including pregnancies covered under Title XXI. Countable income generated from any resource is considered in accordance with Part 6 of Subchapter 6 of this Chapter.

PART 5. INCOME

317:35-10-26. Income

(a) **General provisions regarding income.**

(1) The income of categorically needy individuals who are related to the children, ~~parent or caretaker relative~~parent/caretaker relative, SoonerPlan family planning program, ~~or~~ Title XIX and XXI pregnancy eligibility groups or expansion adults does not require verification, unless questionable. If the income information is questionable, it must be verified. If there appears to be a conflict in the information provided, the worker must investigate the situation to determine if income verification is necessary.

(2) All available income, except that required to be disregarded by law or ~~OHCA's~~Oklahoma Health Care Authority's (OHCA's) policy, is taken into consideration in determining need. Income is considered available both when it is actually available and

when the applicant or member has a legal interest in a liquidated sum and has the legal ability to make such sum available for support and maintenance. When an individual's income is reduced due to recoupment of an overpayment or garnishment, the gross amount before the recoupment or garnishment is counted as income. The member is responsible for reporting all income, the source, amount and how often received.

(A) Income received on behalf of a member of the benefit group by another individual such as, but not limited to, a guardian or conservator, is considered available to the benefit group.

(B) Money received and used for the care and maintenance of a third party who is not included in the benefit group is not counted as income if it can be identified and verified as intended for third party use.

(C) If it appears any member of the benefit group or an individual whose income is considered when determining eligibility is eligible for any type of income or benefits, the benefit group must be notified in writing by the ~~Oklahoma Health Care Authority (OHCA)~~OHCA. The notice must contain the information that failure to apply for and take all appropriate steps to obtain such benefits within ten (10) days from the date of the notice will result in a determination of ineligibility. An application for Supplemental Security Income (SSI) is not required.

(D) If the member and spouse are living together or they are living apart but there has not been a clear break in the family relationship, income received by either spouse and income received jointly is considered as family income. Income cannot be diverted to a household member who is not included in the household size for health benefits. Consideration is not given to ~~a~~an SSI recipient's income in computing eligibility for the AFDC or Pregnancy related unit. The ~~MAGI~~Modified Adjusted Gross Income (MAGI) methodology rules determine whose income is considered in a particular household for MAGI eligibility groups as defined in ~~OAC~~Oklahoma Administrative Code (OAC) 317:35-6-1.

(E) Income which can reasonably be anticipated to be received is considered to be available for the month its receipt is anticipated.

(F) Income produced from resources must be considered as unearned income.

(3) Income that must be verified is verified by the best available information such as pay stubs presented by the member or an interview with the employer. If OHCA is unable to verify income through the Oklahoma Employment Securities Commission, then pay stubs may only be used for verification if they have

the member's name and/or social security number indicating that the pay stubs are in fact the member's wages. The stubs should also include the date(s) of the pay period and the amount of income before deductions. If this information is not included, employer verification is required. The worker verifies medical insurance which may be available at the same time that income is verified. When a member of the benefit group accepts employment and has not received any wages, verification (if necessary) of the amount of income to be considered and the anticipated date of receipt must be obtained from the employer and provided to OHCA within ten (10) days. Income which is expected to be received during a month is considered available to the benefit group and is counted in determining eligibility for the month of receipt.

(4) Monies received in a lump sum from any source are considered income in the month received, with the exception of certain lottery or gambling winnings as specified in OAC 317:35-6-55. Changing a resource from one form to another, such as converting personal property to cash, is not considered a lump sum payment. Exception: lump sum payments used to establish dedicated bank accounts by representative payees in order to receive and maintain retroactive SSI benefits for disabled/blind children under age eighteen (18) are excluded as income. The interest income generated from dedicated bank accounts is also excluded.

(A) Whether a source of income is countable for MAGI eligibility groups is determined in accordance with Part 6 of Subchapter 6 of this Chapter.

(B) Whether a source of income is countable is determined in accordance with Part 6 of Subchapter 6 of this Chapter.

(C) When a lump sum is received by a stepparent not included in the household size, only the stepparent's contribution is considered in accordance with the stepparent's liability policy. Income received by a stepparent is considered in accordance with MAGI household and income counting rules.

(D) When a third party reveals that a lump sum payment has been received or is expected to be received by the applicant or member, adverse action notification is given or mailed to the applicant/member and appropriate action taken.

(E) Recurring lump sum income received from any source for a period covering more than one (1) month, that is received in a lump sum recurrently (such as annual rentals from surface or minerals, Windfall Profits tax refund, etc.) is prorated over a period of time it is intended to cover, beginning with the month of receipt of a lump sum payment.

(F) Net income from oil and gas production (gross minus production taxes withheld), received in varying amounts on a regular or irregular basis for the past six (6) months,

will be averaged and considered as income for the next six (6) months. In instances where an applicant or a member receives new income from oil and gas production and verification for the past six (6) months is not available, the worker accepts the available verification and averages over the period of time intended to cover. Net income may be verified by seeing the individual's production check stub, or by contacting the oil and gas company. Whether a source of income is countable is determined in accordance with Part 6 of Subchapter 6 of this Chapter.

(5) Income that is based on the number of hours worked, as opposed to income based on regular monthly wages, must be computed as irregular income. The income received irregularly or in varying amounts will be averaged using the past two (2) months to establish the amount to be anticipated and considered for prospective budgeting.

(6) MAGI household rules are used to determine whether a caretaker relative or stepparent is included in a household.

(A) MAGI household and income counting rules are used to determine whether a caretaker relative and his/her spouse or a stepparent are included in the household and whether their income is considered for the children.

(B) MAGI household and income counting rules are used to determine whose income is considered and whether that income is counted. If an individual is eligible in the parent or caretaker relative group, his/her spouse, if living with him/her, is also related to the parent or caretaker relative group.

(7) A stepparent, if living with the parent or caretaker relative, can also be related to the parent or caretaker relative group, regardless of whether the parent is incapacitated or not in the home.

(8) MAGI household and income counting rules are used to determine whose income is considered and whether that income is counted.

(b) **Earned income.** The term "earned income" refers to monies earned by an individual through the receipt of wages, salary, commission or profit from activities in which the individual is engaged as self-employed or as an employee. Whether income is countable for MAGI eligibility groups is determined using MAGI income counting rules in Part 6 of Subchapter 6 of this Chapter.

(1) **Earned income from self-employment.** For MAGI eligibility groups, the calculation of countable self-employment income is determined in accordance with MAGI income counting rules in Part 6 of Subchapter 6 of this Chapter.

(2) **Earned income from wages, salary or commission.** Countable income for MAGI eligibility groups is determined in accordance

with MAGI income counting rules in Part 6 of Subchapter 6 of this Chapter.

(3) **Earned income from work and training programs.** Countable income for MAGI eligibility groups is determined in accordance with MAGI income counting rules in Part 6 of Subchapter 6 of this Chapter.

(4) **No individual earned income exemptions.** No earned income exemptions are subtracted to determine countable income for MAGI eligibility groups. The only deduction applied to determine net countable income under the MAGI methodology is the deduction of five percent (5%) of the ~~FPL~~Federal Poverty Level (FPL) for the individual's household size as defined in OAC 317:35-6-39.

(5) **Formula for determining the individual's net earned income for MAGI eligibility groups.** To determine net income, see MAGI rules in OAC 317:35-6-39.

(c) **Unearned income.** Countable earned and unearned income for MAGI eligibility groups is determined in accordance with MAGI income counting rules in Part 6 of Subchapter 6 of this Chapter.

(d) **Income disregards.** For MAGI eligibility groups, whether a source of income is disregarded is determined in accordance with MAGI income counting rules in Part 6 of Subchapter 6 of this Chapter.

~~(g)~~(e) **Computing monthly income.** In computing monthly income, cents will be rounded down at each step. Income which is received monthly but in irregular amounts is averaged using two (2) month's income, if possible, to determine income eligibility. Less than two (2) month's income may be used when circumstances (e.g., new employment, unpaid sick leave, etc.) would indicate that previous income amounts would not be appropriate to use in determining future income amounts. Income received more often than monthly is converted to monthly amounts as follows:

(1) **Daily.** Income received on a daily basis is converted to a weekly amount then multiplied by 4.3.

(2) **Weekly.** Income received weekly is multiplied by 4.3.

(3) **Twice a month.** Income received twice a month is multiplied by two (2).

(4) **Biweekly.** Income received every two (2) weeks is multiplied by 2.15.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 45. INSURE OKLAHOMA

SUBCHAPTER 1. GENERAL PROVISIONS

317:45-1-1. Purpose and general program provisions

The purpose of this Chapter is to provide rules, in compliance with all applicable federal and state regulations, for the Insure Oklahoma program that establishes access to affordable health coverage for low-income working adults~~,~~ their dependents, and their spouses; foster parents; and qualified college students.

317:45-1-2. Program limitations

(a) The Insure Oklahoma program is contingent upon federal waiver approval and sufficient funding that is collected and dispersed through a revolving fund within the State Treasury designated as the "Health Employee and Economy Improvement Act (HEEIA) Revolving Fund". This fund is a continuing fund, not subject to fiscal year limitations.

(1) All monies accruing to the credit of the fund are budgeted and expended by the ~~OHCA~~Oklahoma Health Care Authority (OHCA) to implement the program.

(2) The program is funded through a portion of monthly proceeds from the Tobacco Tax, ~~Okla. Stat. '68-302-5~~Title 68 of the Oklahoma Statutes (O.S.) § 302-5 et seq., collected and dispersed through the HEEIA revolving fund, pursuant to ~~Title 68, Section 302-5 (B.1. and D.1.) and Section 402-3 (B.1 and C.1.) of the Oklahoma Statutes~~68 O.S. §§ 302-5 (B)(1) & (C)(1) and 402-3 (B)(1) & (D)(1).

(3) The program is limited in scope such that available funding is not exceeded. Available funding includes the estimated annual deposits from tax collections, accrued interest, federal matching funds and any other revenue source deposited in the HEEIA Revolving Fund for the purpose of this program. If at any time it becomes apparent there is risk the available funding may be exceeded, OHCA must take action to ensure the Insure Oklahoma program continues to operate within its fiscal capacity.

(A) Insure Oklahoma may limit eligibility based on:

(i) ~~the federally-approved Health Insurance Flexibility and Accountability (HIFA) Waiver/1115 Waiver~~The 1115 Waiver;

(ii) Tobacco ~~Tax~~tax collections; and

(iii) ~~the~~The State Child Health Plan for the State Children's Health Insurance Program (CHIP) under Title XXI of the Social Security Act.

(B) The Insure Oklahoma program may limit eligibility when

the utilization of services is projected to exceed the spending authority, or, may suspend new eligibility determinations instead, establishing a waiting list.

(i) Applicants, not previously enrolled and participating in the program, submitting new applications for the Insure Oklahoma program ~~are~~may be placed on a waiting list. Applications, with the exception of college students, are identified by region ~~and Insure Oklahoma program~~. Regions are established based on population density statistics as determined through local and national data and may be periodically adjusted to assure statewide availability. Insure Oklahoma program size is determined by OHCA and may be periodically adjusted.

(ii) The waiting list utilizes a "first in - first out" method of selecting eligible applicants by region and program.

(iii) When an applicant is determined eligible and moves from the waiting list to active participation, the applicant must submit a new application.

(iv) Enrolled applicants who are currently participating in the program are not subject to the waiting list.

(v) For approved employers, if the employer hires a new employee after the employer's program eligibility begins, the new employee is allowed to participate.

(vi) For approved employers, if the employer has an employee who has a qualifying event after the employer's program eligibility begins, the employee is allowed to make changes pertaining to the qualifying event.

(b) College student eligibility and participation in the Insure Oklahoma program is contingent upon sufficient funding from the Oklahoma legislature. This funding is separate from the funding described in subsection (a) of this Section.

317:45-1-3. Definitions

The following words or terms, when used in this Chapter, will have the following meanings unless the context clearly indicates otherwise:

"Carrier" means:

(A) ~~an~~An insurance company, insurance service, insurance organization, or group health service, which is licensed to engage in the business of insurance in the State of Oklahoma and is subject to State law which regulates insurance, or Health Maintenance Organization (HMO) which provides or arranges for the delivery of basic health care services to enrollees on a prepaid basis, except for copayments or deductibles for which the enrollee is responsible, or both and is subject to State law which regulates Health

Maintenance Organizations (HMOs);

(B) ~~a~~A Multiple Employer Welfare Arrangement (MEWA) licensed by the Oklahoma Insurance Department;

(C) ~~a~~A domestic MEWA exempt from licensing pursuant to Title 36 ~~O.S., Section~~of the Oklahoma Statutes (O.S.) § 634(B) that otherwise meets or exceeds all~~ of~~ the licensing and financial requirements of MEWAs as set out in ~~Article 6A of Title 36~~Title 36 O.S.; or

(D) ~~any~~Any entity organized pursuant to the Interlocal Cooperation Act, ~~Section 1001 et seq. of Title 74 of the Oklahoma Statutes~~74 O.S. § 1001 et seq. as authorized by ~~Title 36 Section 607.1 of the Oklahoma Statutes~~36 O.S. § 607.1 and which is eligible to qualify for and hold a certificate of authority to transact insurance in this State and annually submits on or before March 1st a financial statement to the Oklahoma Insurance Department in a form acceptable to the Insurance Commissioner covering the period ending December 31st of the immediately preceding fiscal year.

"Child ~~Care Center~~care center" means a facility licensed by the Oklahoma Department of Human Services (DHS) which provides care and supervision of children and meets all the requirements in OAC ~~340:110-3-1 through OAC 340:110-3-33.3~~340:110-3-275 through 340:110-3-311.

"College ~~Student~~student" means an Oklahoma resident between the age of nineteen (19) through twenty-two (22) that is a full-time student at an Oklahoma accredited ~~University~~university or ~~College~~college.

~~**"DHS"** means the Oklahoma Department of Human Services.~~

"Dependent" means the spouse of the approved applicant and/or child under nineteen (19) years of age or his or her child nineteen (19) years through twenty-two (22) years of age who is attending an Oklahoma qualified institution of higher education and relying upon the insured employee or member for financial support.

"Eligibility period" means the period of eligibility extending from an approval date to an end date.

"Employee" means a person who works for an employer in exchange for earned income. This includes the owners of a business.

"Employer" means the business entity that pays earned income to employees.

"Employer Sponsored Insurance (ESI)" means the program that provides premium assistance to qualified businesses for approved applicants.

"Explanation of Benefit (EOB)" means a statement issued by a carrier that indicates services rendered and financial responsibilities for the carrier and Insure Oklahoma member.

"Full-time ~~Employer~~employer" means the employer who employs an

employee per Federal and State regulations, to perform work in exchange for wages or salary.

"**Full-time ~~Employment~~employment**" means a normal work week per Federal and State regulations.

~~"**Individual Plan (IP)**" means the safety net program for those qualified individuals who do not have access to Insure Oklahoma ESI.~~

"**In-network**" means providers or health care facilities that are part of a benefit plan's network of providers with which it has negotiated a discount, and services provided by a physician or other health care provider with a contractual agreement with the insurance company paid at the highest benefit level.

"**Insure Oklahoma (IO)**" means a benefit plan purchasing strategy in which the State uses public funds to pay for a portion of the costs of benefit plan coverage for eligible populations.

"**Member**" means an individual enrolled in the Insure Oklahoma ESI ~~or IP~~ program.

"**Modified Adjusted Gross Income (MAGI)**" means the financial eligibility determination methodology established by the Patient Protection and Affordable Care Act (PPACA) in 2009.

"**OAC**" means the Oklahoma Administrative Code.

"**OESC**" means the Oklahoma Employment Security Commission.

"**OHCA**" means the Oklahoma Health Care Authority.

"**OKDHS**" means the Oklahoma Department of Human Services which is also referenced in rules as Department of Human Services (DHS) and Office of Human Services (OHS).

"**Premium**" means a monthly payment to a carrier for benefit plan coverage.

"**Primary ~~Care Provider~~care provider (PCP)**" means a provider under contract with the OHCA to provide primary care services, including all medically necessary referrals.

"**Professional ~~Employer Organization~~employer organization (PEO)**" means any person engaged in the business of providing professional employer services shall be subject to registration under the Oklahoma Professional Employer Organization Recognition and Registration Act as provided in ~~Title 40, Chapter 16 of Oklahoma Statutes, Section 600.1 et. seq~~40 O.S. § 600.1 et. seq.

"**Qualified ~~Benefit Plan~~benefit plan (QBP)**" means a benefit plan that has been approved by the OHCA for participation in the Insure Oklahoma program.

"**Qualifying ~~Event~~event**" means the occurrence of an event that permits individuals to join a group benefit plan outside of the "open enrollment period" and/or that allows individuals to modify the coverage they have had in effect. Qualifying events are defined by the employer's benefit plan and meet federal requirements under Public Law 104-191 (HIPAA), and 42 U.S.C. 300bb-3.

"**State**" means the State of Oklahoma, acting by and through the

OHCA.

317:45-1-4. Reimbursement for out-of-pocket expenses

(a) Out-of-pocket expenses for all approved and eligible members (and/or their approved and eligible dependents) will be limited to five (5) percent of their annual gross household income. The OHCA will provide reimbursement for out-of-pocket expenses in excess of the five (5) percent annual gross household income. An expense must be for an allowed and covered service by a ~~qualified benefit plan (QBP)~~QBP to be eligible for reimbursement. For the purpose of this Section, an allowed and covered service is defined as an in-network service covered in accordance with a QBPs benefit summary and policies. For instance, if a QBP has multiple in-network reimbursement percentage methodologies (~~80%~~eighty (80) percent for level 1 provider and ~~70%~~seventy (70) percent for level 2 provider) the OHCA will only reimburse expenses related to the highest percentage network.

(b) For all eligible expenses as defined above in OAC 317:45-1-4(a), the member must submit the OHCA required form and all OHCA required documentation to support that the member incurred and paid the out-of-pocket expense. The OHCA required documentation must substantiate that the member actually incurred and paid the eligible out-of-pocket expense. The OHCA may request additional documentation at any time to support a member's request for reimbursement of eligible out-of-pocket expenses.

SUBCHAPTER 7. INSURE OKLAHOMA ESI EMPLOYER ELIGIBILITY

317:45-7-5. Reimbursement

In order to receive a premium subsidy, the employer must submit all pages of the current benefit plan invoice. Due to timely filing requirements, subsidy payments will not be paid on invoices older than six (6) months.

SUBCHAPTER 9. INSURE OKLAHOMA ESI EMPLOYEE ELIGIBILITY

317:45-9-1. Employee eligibility requirements

(a) Employees must complete and submit the OHCA required forms and application to be considered for participation in the program.

(b) The eligibility determination will be processed within thirty (30) days from the date the application is received. The employee will be notified in writing of the eligibility decision.

(c) All eligible employees described in this section must be enrolled in their employer's qualified benefit plan. Eligible employees must:

(1) ~~have~~Have countable income at or below the appropriate

standard according to the family size on the Insure Oklahoma ESI Income Guidelines form;

(A) ~~Effective January 1, 2016, financial~~Financial eligibility for Insure Oklahoma ESI benefits is determined using the MAGI methodology. Unless questionable, the income of applicants does not require verification. See OAC 317:35-6-39 through ~~OAC 317:35-6-54~~317:35-6-55 for the applicable MAGI rules for determining household composition and countable income.

(B) Income is evaluated on a monthly basis for all individuals included in the case for Insure Oklahoma ESI Benefits.

(2) ~~be~~Be a US citizen or alien as described in OAC 317:35-5-25;

(3) ~~be~~Be Oklahoma residents;

(4) ~~furnish~~Furnish, or show documentation of an application for, a Social Security number at the time of application for Insure Oklahoma ESI benefits;

(5) ~~not~~Not be receiving benefits from SoonerCare or Medicare;

(6) ~~be~~Be employed with a qualified employer at a business location in Oklahoma;

(7) ~~be~~Be age nineteen (19) through age sixty-four (64);

(8) ~~be~~Be eligible for enrollment in the employer's ~~qualified benefit plan~~QBP;

(9) ~~not~~Not have full-time employment with any employer who does not meet the eligible employer guidelines listed in OAC 317:45-7-1(a)(1)-(2);

(10) ~~select~~Select one of the ~~qualified benefit plans~~QBPs the employer is offering; and

(11) ~~provide~~Provide in a timely manner any and all documentation that is requested by the Insure Oklahoma program by the specified due date.

(d) An employee's dependents are eligible when:

(1) ~~the~~The employer's benefit plan includes coverage for dependents;

(2) ~~the~~The employee is eligible;

(3) ~~if~~If employed, the spouse may not have full-time employment with any employer who does not meet the eligible employer guidelines listed in OAC 317:45-7-1 (a) (1)-(2); and

(4) ~~the~~The dependents are enrolled in the same benefit plan as the employee.

(e) If an employee or their dependents are eligible for multiple ~~qualified benefit plans~~QBPs, each may receive a subsidy under only one benefit plan.

(f) College students may enroll in the Insure Oklahoma ESI program as dependents. ~~Effective January 1, 2016, financial~~Financial eligibility for Insure Oklahoma ESI benefits for college students

is determined using the MAGI methodology. See OAC 317:35-6-39 through ~~OAC 317:35-6-54~~317:35-6-55 for the applicable MAGI rules for determining household composition and countable income. Dependent college students must enroll under their parents and all annual gross household income (including parent income) must be included in determining eligibility. Independent college students may apply on their own without parent income included in the household. College student status as dependent or independent is determined by the student's current Free Application for Federal Student Aid (FAFSA) or the university's financial aid office. College students must also provide a copy of their current student schedule to prove full-time student status.

(g) Working dependent children must have countable income at the appropriate standard according to the family size on the Insure Oklahoma ESI Income Limits Guidelines form. ~~Effective January 1, 2016, financial~~Financial eligibility for Insure Oklahoma ESI benefits is determined using the MAGI methodology. See OAC 317:35-6-39 through ~~OAC 317:35-6-54~~317:35-6-55 for the applicable MAGI rules for determining household composition and countable income. Children found to be eligible for SoonerCare may not receive coverage through Insure Oklahoma.

(h) ESI approved individuals must notify the OHCA of any changes, including household status and income, that might impact individual and/or dependent eligibility in the program within ten (10) days of the change.

(i) When the agency responsible for determining eligibility for the member becomes aware of a change in the member's circumstances, the agency will promptly redetermine eligibility for all household members whose eligibility is affected by the change.

SUBCHAPTER 11. INSURE OKLAHOMA IP [REVOKED]

PART 1. INDIVIDUAL PLAN PROVIDERS [REVOKED]

317:45-11-1. Insure Oklahoma Individual Plan providers [REVOKED]

~~Insure Oklahoma Individual Plan (IP) providers must comply with existing SoonerCare rules found at 317:25 and 317:30. In order to receive reimbursement, the IP provider:~~

~~(1) must enter into a SoonerCare contract; and~~

~~(2) must complete Insure Oklahoma IP addendum if provider wants to provide primary care services as a PCP.~~

317:45-11-2. Insure Oklahoma Individual Plan (IP) provider payments [REVOKED]

~~Payment for covered benefits rendered to Insure Oklahoma IP members is made to contracted Insure Oklahoma IP healthcare providers for medical and surgical services within the scope of~~

~~OHCA's medical programs, provided the services are medically necessary as defined in Oklahoma Administrative Code 317:30-3-1(f).~~

~~(1) Coverage of certain services requires prior authorization and may be based on a determination made by a medical consultant in individual circumstances; and~~

~~(2) The provider may collect the member's co-payment in addition to the SoonerCare reimbursement for services provided.~~

PART 3. INSURE OKLAHOMA IP MEMBER HEALTH CARE BENEFITS [REVOKED]

317:45-11-10. Insure Oklahoma IP adult benefit [REVOKED]

~~(a) All IP adult benefits are subject to rules delineated in OAC 317:30 except as specifically set out in this Section. The scope of IP adult benefits described in this Section is subject to specific non-covered services listed in OAC 317:45-11-11.~~

~~(b) A PCP referral is required to see any other provider with the exception of the following services:~~

~~(1) behavioral health services;~~

~~(2) prenatal and obstetrical supplies and services, meaning prenatal care, delivery and 60 days of postpartum care;~~

~~(3) family planning supplies and services, meaning an office visit for a comprehensive family planning evaluation, including obtaining a Pap smear;~~

~~(4) women's routine and preventive health care services;~~

~~(5) emergency medical condition as defined in OAC 317:30-3-1; and~~

~~(6) services delivered to American Indians at Indian Health Service, tribal, or urban Indian clinics.~~

~~(c) IP covered adult benefits for in-network services and limits are listed in this subsection. Member cost sharing related to premium and co-payments cannot exceed federal maximums with the exception of emergency room visits, in which case the State establishes the maximum for member cost share. Native American adults providing documentation of ethnicity who receive items and services furnished by the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization or through referral under contract health services are exempt from co-payments. Coverage for IP services includes:~~

~~(1) Anesthesia/Anesthesiologist Standby. Covered in accordance with OAC 317:30-5-7. Eligible services are covered for covered illness or surgery including services provided by a Certified Registered Nurse Anesthetist (CRNA) or Anesthesiologist Assistant (AA).~~

~~(2) Blood and Blood Products. Processing, storage, and administration of blood and blood products in inpatient and~~

~~outpatient settings.~~
~~(3) Chelation Therapy. Covered for heavy metal poisoning only.~~
~~(4) Diagnostic X-ray, including Ultrasound. Covered in accordance with OAC 317:30-5-22(b)(2). PCP referral is required.~~
~~(5) Emergency Room Treatment, services and supplies for treatment in an emergency. Contracted provider services are subject to a $30 co-pay per occurrence. The emergency room co-pay will be waived if the member is admitted to the hospital or death occurs before admission.~~
~~(6) Inpatient Hospital Benefits. Covered in accordance with OAC 317:30-5-41, OAC 317:30-5-47 and OAC 317:30-5-95.~~
~~(7) Preventive Office Visit. For services of evaluation and medical management (wellness exam); one visit per year. This visit counts as an office visit.~~
~~(8) Office Visits/Specialist Visits. Covered in accordance with OAC 317:30-5-9, OAC 317:30-5-10, and OAC 317:30-5-11. For services of evaluation and medical management; up to four visits are covered per month; PCP referral required for specialist visits.~~
~~(9) Outpatient Hospital/Facility Services.~~
~~(A) Includes hospital surgery services in an approved outpatient facility including outpatient services and diagnostic services. Prior authorization required for certain procedures.~~
~~(B) Therapeutic radiology or chemotherapy on an outpatient basis without limitation to the number of treatments per month for persons with proven malignancies or opportunistic infections.~~
~~(C) Physical, Occupational and Speech Therapy services. Coverage is limited to one evaluation/re-evaluation visit (unit) per discipline per calendar year and 15 visits (units) per discipline per date of service per calendar year. Must be hospital based.~~
~~(10) Maternity (Obstetric). Covered in accordance with OAC 317:30-5-22.~~
~~(11) Laboratory/Pathology. Covered in accordance with OAC 317:30-5-20.~~
~~(12) Mammogram (Radiological or Digital). Covered in accordance with OAC 317:30-5-901.~~
~~(13) Immunizations. Covered in accordance with OAC 317:30-5-2.~~
~~(14) Assistant Surgeon. Covered in accordance with OAC 317:30-5-8.~~
~~(15) Dialysis, Kidney dialysis, and services and supplies, either at home or in a facility.~~
~~(16) Oral Surgery. Services are limited to the removal of tumors or cysts.~~

~~(17) Behavioral Health (Mental Health and Substance Abuse) Treatment (Inpatient). Covered in accordance with OAC 317:30-5-95.1.~~

~~(18) Behavioral Health (Mental Health and Substance Abuse) Treatment (Outpatient). Outpatient benefits are limited to 48 visits per calendar year. Additional visits may be approved as medically necessary.~~

~~(A) Agency services. Covered in accordance with OAC 317:30-5-241 and OAC 317:30-5-596.~~

~~(B) Individual provider services. Licensed Behavioral Health Professionals (LBHPs) are defined as follows for the purpose of Outpatient Behavioral Health Services and Outpatient Substance Abuse Treatment:~~

~~(i) Allopathic or Osteopathic Physicians with a current license and board certification in psychiatry or board eligible in the state in which services are provided, or a current resident in psychiatry practicing as described in OAC 317:30-5-2.~~

~~(ii) Practitioners with a license to practice in the state in which services are provided.~~

~~(I) Psychology,~~

~~(II) Social Work (clinical specialty only),~~

~~(III) Professional Counselor,~~

~~(IV) Marriage and Family Therapist,~~

~~(V) Behavioral Practitioner, or~~

~~(VI) Alcohol and Drug Counselor.~~

~~(iii) Advanced Practice Nurse (certified in a psychiatric mental health specialty), licensed as a registered nurse with a current certification of recognition from the board of nursing in the state in which services are provided.~~

~~(iv) A Physician's Assistant who is licensed in good standing in this state and has received specific training for and is experienced in performing mental health therapeutic, diagnostic, or counseling functions.~~

~~(v) LBHPs must have a valid Insure Oklahoma contract in order to bill for services rendered.~~

~~(vi) LBHP services require prior authorization and are limited to four (4) therapy services per month per member and eight (8) testing units per year per member.~~

~~(19) Durable Medical Equipment and Supplies. Covered in accordance with OAC 317:30-5-210 through OAC 317:30-5-218. A PCP referral and prior authorization is required for certain items.~~

~~(20) Diabetic Supplies. Covered in accordance with OAC 317:30-5-211.15.~~

~~(21) Oxygen. Covered in accordance with OAC 317:30-5-211.11~~

through OAC 317:30-5-211.12.

(22) Pharmacy. Covered in accordance with OAC 317:30-5-72.1 and OAC 317:30-5-72. Prenatal vitamins and smoking cessation products do not count against monthly prescription limits.

(23) Smoking Cessation Products. Products do not count against monthly prescription limits. Covered in accordance with OAC 317:30-5-72.1.

(24) Nutrition Services. Covered in accordance with OAC 317:30-5-1076.

(25) External Breast Prosthesis, Bras and Prosthetic Garments. Covered in accordance with OAC 317:30-5-211.13.

(26) Surgery. Covered in accordance with OAC 317:30-5-8.

(27) Home Dialysis. Covered in accordance with OAC 317:30-5-211.13.

(28) Parenteral Therapy. Covered in accordance with OAC 317:30-5-211.14.

(29) Family Planning Services and Supplies, including Sterilizations. Covered in accordance with OAC 317:30-3-57.

(30) Home Health and Medications, Intravenous (IV) Therapy and Supplies. Covered in accordance with OAC 317:30-5-211.15 and OAC 317:30-5-42.16(b)(3).

(31) Fundus photography.

(32) Emergency ground ambulance transportation. Covered in accordance with OAC 317:30-5-336.

317:45-11-11. Insure Oklahoma IP adult non-covered services [REVOKED]

Certain health care services are not covered in the Insure Oklahoma IP adult benefit package listed in OAC 317:45-11-10. These services include, but are not limited to:

(1) services not considered medically necessary;

(2) any medical service when the member refuses to authorize release of information needed to make a medical decision;

(3) organ and tissue transplant services;

(4) weight loss intervention and treatment including, but not limited to, bariatric surgical procedures or any other weight loss surgery or procedure, drugs used primarily for the treatment of weight loss including appetite suppressants and supplements, and/or nutritional services prescribed only for the treatment of weight loss;

(5) procedures, services and supplies related to sex transformation;

(6) supportive devices for the feet (orthotics) except for the diagnosis of diabetes;

(7) cosmetic surgery, except as medically necessary and as covered in OAC 317:30-3-59(19);

(8) over-the-counter drugs, medicines and supplies except

~~contraceptive devices and products, and diabetic supplies;~~
~~(9) experimental procedures, drugs or treatments;~~
~~(10) dental services (preventive, basic, major, orthodontia, extractions or services related to dental accident);~~
~~(11) vision care and services (including glasses), except services treating diseases or injuries to the eye;~~
~~(12) physical medicine including chiropractic and acupuncture therapy;~~
~~(13) hearing services;~~
~~(14) non-emergency transportation and emergency air transportation;~~
~~(15) allergy testing and treatment;~~
~~(16) hospice regardless of location;~~
~~(17) Temporomandibular Joint Dysfunction (TMD) (TMJ);~~
~~(18) genetic counseling;~~
~~(19) fertility evaluation/treatment/and services;~~
~~(20) sterilization reversal;~~
~~(21) Christian Science Nurse;~~
~~(22) Christian Science Practitioner;~~
~~(23) skilled nursing facility;~~
~~(24) long-term care;~~
~~(25) stand-by services;~~
~~(26) thermograms;~~
~~(27) abortions (for exceptions, refer to OAC 317:30-5-6);~~
~~(28) services of a Lactation Consultant;~~
~~(29) services of a Maternal and Infant Health Licensed Clinical Social Worker;~~
~~(30) enhanced services for medically high risk pregnancies as found in OAC 317:30-5-22.1;~~
~~(31) ultraviolet treatment-actinotherapy;~~
~~(32) private duty nursing;~~
~~(33) payment for removal of benign skin lesions;~~
~~(34) sleep studies;~~
~~(35) prosthetic devices; and~~
~~(36) continuous positive airway pressure devices (CPAP).~~

PART 5. INSURE OKLAHOMA IP MEMBER ELIGIBILITY [REVOKED]

317:45-11-20. Insure Oklahoma IP eligibility requirements [REVOKED]

~~(a) Oklahoma employed working adults not eligible to participate in an employer's qualified benefit plan, employees of non-participating employers, self-employed, unemployed seeking work, workers with a disability, and qualified college students may apply for the Individual Plan. Applicants, unless a qualified college student, must be: considered "employed" in accordance with State law, including, but not limited to, Title 40 O.S. ' 1-210; engaged~~

~~in routine, for-profit activity, if self-employed; or considered "unemployed" in accordance with State law, including, but not limited to Title 40 O.S. ' 1-217. Applicants cannot obtain IP coverage if they are eligible for ESI.~~

~~(b) The eligibility determination will be processed within thirty (30) days from the date the complete application is received. The applicant will be notified of the eligibility decision.~~

~~(c) In order to be eligible for the IP, the applicant must:~~

~~(1) choose a valid PCP according to the guidelines listed in OAC 317:45-11-22, at the time he/she completes application;~~

~~(2) be a US citizen or alien as described in OAC 317:35-5-25;~~

~~(3) be an Oklahoma resident;~~

~~(4) furnish, or show documentation of an application for, a Social Security number at the time of application for Insure Oklahoma IP benefits;~~

~~(5) be not currently enrolled in, or have an open application for SoonerCare or Medicare;~~

~~(6) be age 19 through 64;~~

~~(7) make premium payments by the due date on the invoice;~~

~~(8) not have full-time employment with any employer who does not meet the eligible employer guidelines listed in OAC 317:45-7-1(a) (1)-(2);~~

~~(9) be not currently covered by a private insurance policy or plan; and~~

~~(10) provide in a timely manner any and all documentation that is requested by the Insure Oklahoma program by the specified due date.~~

~~(d) If employed and working for an approved Insure Oklahoma employer who offers a qualified benefit plan, the applicant must meet the requirements in subsection (c) of this Section and:~~

~~(1) have countable income at or below the appropriate standard according to the family size on the Insure Oklahoma IP Income Guidelines form.~~

~~(A) Effective January 1, 2016, financial eligibility for Insure Oklahoma IP benefits is determined using the MAGI methodology. Unless questionable, the income of applicants do not require verification. See OAC 317:35-6-39 through OAC 317:35-6-54 for the applicable MAGI rules for determining household composition and countable income.~~

~~(B) Income is evaluated on a monthly basis for all individuals included in the case for Insure Oklahoma IP Benefits;~~

~~(2) be ineligible for participation in their employer's qualified benefit plan due to number of hours worked.~~

~~(e) If employed and working for an employer who does not offer a qualified benefit plan, the applicant must meet the requirements in subsection (c) of this Section and have countable income at or~~

~~below the appropriate standard according to the family size on the Insure Oklahoma IP Income Guidelines form.~~

~~(1) Effective January 1, 2016, financial eligibility for Insure Oklahoma IP benefits is determined using the MAGI methodology. Unless questionable, the income of applicants does not require verification. See OAC 317:35-6-39 through OAC 317:35-6-54 for the applicable MAGI rules for determining household composition and countable income.~~

~~(2) Income is evaluated on a monthly basis for all individuals included in the case for Insure Oklahoma IP Benefits.~~

~~(f) If self-employed, the applicant must meet the requirements in subsection (c) of this Section and:~~

~~(1) have countable income at or below the appropriate standard according to the family size on the Insure Oklahoma IP Income Guidelines form.~~

~~(A) Effective January 1, 2016, financial eligibility for Insure Oklahoma IP benefits is determined using the MAGI methodology. Unless questionable, the income of applicants does not require verification. See OAC 317:35-6-39 through OAC 317:35-6-54 for the applicable MAGI rules for determining household composition and countable income.~~

~~(B) Income is evaluated on a monthly basis for all individuals included in the case for Insure Oklahoma IP Benefits.~~

~~(2) must not have full-time employment with any employer who does not meet the eligible employer guidelines listed in OAC 317:45-7-1(a)(1)-(2).~~

~~(3) must verify self-employment by completing and submitting to Insure Oklahoma the Self-Employment Attestation Form. In addition,~~

~~(A) for any applicant who filed a Federal tax return for the tax year immediately preceding the date of application, he or she must provide a copy of such tax return with all supporting schedules and forms, or~~

~~(B) for any applicant exempt from filing a Federal tax return for the previous tax year in accordance with Federal law, including, but not limited to, 26 Code of Federal Regulation, Section 1.6017-1, he or she must submit a completed 12-Month Profit and Loss Worksheet to Insure Oklahoma, as well as any other information requested by Insure Oklahoma that could reasonably be used to substantiate the applicant's regular, for-profit business activity.~~

~~(g) If unemployed seeking work, the applicant must meet the requirements in subsection(c) of this Section and the following:~~

~~(1) Applicants must have countable income at or below the appropriate standard according to the family size on the Insure Oklahoma IP Income Guidelines form.~~

(2) Effective January 1, 2016, financial eligibility for Insure Oklahoma IP benefits is determined using the MAGI methodology. Unless questionable, the income of applicants does not require verification. See OAC 317:35-6-39 through OAC 317:35-6-54 for the applicable MAGI rules for determining household composition and countable income.

(3) Income is evaluated on a monthly basis for all individuals included in the case for Insure Oklahoma IP Benefits. Applicant must verify eligibility by providing a most recent copy of their monetary OESC determination letter and a most recent copy of at least one of the following:

(A) A OESC eligibility letter;

(B) A OESC weekly unemployment payment statement, or;

(C) A bank statement showing state treasurer deposit.

(h) If working with a disability, the applicant must meet the requirements in subsection (c) of this Section and the following:

(1) Applicants must have countable income at or below the appropriate standard according to the family size on the Insure Oklahoma IP Income Guidelines form.

(2) Applicants may need to verify eligibility of their enrollment in the Ticket to Work program.

(3) Effective January 1, 2016, financial eligibility for Insure Oklahoma IP benefits is determined using the MAGI methodology. Unless questionable, the income of applicants does not require verification. See OAC 317:35-6-39 through OAC 317:35-6-54 for the applicable MAGI rules for determining household composition and countable income.

(4) Income is evaluated on a monthly basis for all individuals included in the case for Insure Oklahoma IP Benefits.

(i) IP approved individuals must notify the OHCA of any changes, including household status and income, that might impact individual and/or dependent eligibility in the program within 10 days of the change.

(j) When the agency responsible for determining eligibility for the member becomes aware of a change in the member's circumstances, the agency will promptly redetermine eligibility for all household members whose eligibility is affected by the change.

(k) College students may enroll in the Insure Oklahoma IP program as dependents. Effective January 1, 2016, financial eligibility for Insure Oklahoma IP benefits for college students is determined using the MAGI methodology. See OAC 317:35-6-39 through OAC 317:35-6-54 for the applicable MAGI rules for determining household composition and countable income. Dependent college students must enroll under their parents and all annual gross household income (including parent income) must be included in determining eligibility. Independent college students may apply on their own without parent income included in the household. College student

~~status as dependent or independent is determined by the student's current Free Application for Federal Student Aid (FAFSA) or the university's financial aid office. College students must also provide a copy of their current student schedule to prove full-time student status.~~

~~(l) Any misleading or false representation, or omission of any material fact or information required or requested by OHCA as part of the Insure Oklahoma application process, may result in, among other things, closure of eligibility pursuant to OAC 317:45-11-27.~~

317:45-11-21. Dependent eligibility [REVOKED]

~~(a) If the spouse of an Insure Oklahoma IP approved individual is eligible for Insure Oklahoma ESI, they must apply for Insure Oklahoma ESI. Spouses cannot obtain Insure Oklahoma IP coverage if they are eligible for Insure Oklahoma ESI.~~

~~(b) The employed or self-employed spouse of an approved applicant must meet the guidelines listed in 317:45-11-20 (a) through (g) to be eligible for Insure Oklahoma IP.~~

~~(c) The dependent of an applicant approved according to the guidelines listed in 317:45-11-20(h) does not become automatically eligible for Insure Oklahoma IP.~~

~~(d) The applicant and the dependents' eligibility are tied together. If the applicant no longer meets the requirements for Insure Oklahoma IP, then the associated dependent enrolled under that applicant is also ineligible.~~

~~(e) College students may enroll in the Insure Oklahoma IP program. Effective January 1, 2016, financial eligibility for Insure Oklahoma IP benefits for college students' are determined using the MAGI methodology. See OAC 317:35-6-39 through OAC 317:35-6-54 for the applicable MAGI rules for determining household composition and countable income.~~

~~(f) IP approved individuals must notify the OHCA of any changes, including household status and income, that might impact individual and/or dependent eligibility in the program within 10 days of the change.~~

~~(g) When the agency responsible for determining eligibility for the member becomes aware of a change in the dependents circumstances, the agency will promptly redetermine eligibility for all household members whose eligibility is affected by the change.~~

317:45-11-21.1. Certification of newborn child deemed eligible [REVOKED]

~~(a) A newborn child is deemed eligible on the date of birth for SoonerCare benefits when the child is born to a member of Insure Oklahoma Individual Plan (IP) and the annual gross household income~~

~~does not exceed SoonerCare requirements. The newborn child is deemed eligible for SoonerCare benefits through the last day of the month the child attains the age of one (1) year.~~

~~(b) The newborn child's SoonerCare eligibility is not dependent on the mother's continued eligibility in Insure Oklahoma IP. The child's SoonerCare eligibility is based on the original eligibility determination of the mother for Insure Oklahoma IP and consideration is not given to any income or resource changes that occur during the deemed eligibility period.~~

~~(c) The newborn child's certification period for SoonerCare is shortened only in the event the child:~~

~~(1) Loses Oklahoma residence; or~~

~~(2) Expires.~~

~~(d) No other conditions of eligibility are applicable, including social security number enumeration and citizenship and identity verification. However, it is recommended that social security number enumeration be completed as soon as possible after the child's birth.~~

317:45-11-22. Primary Care Physician (PCP) choices [REVOKED]

~~(a) The applicant and any covered dependent(s) are required to select a valid PCP.~~

~~(b) The applicant and any covered dependent(s) must make a PCP selection though their mysoonercare.org account.~~

~~(c) After initial enrollment in Insure Oklahoma Individual Plan the applicant any covered dependent(s) may change their PCP selection through their mysoonercare.org account or by calling the Insure Oklahoma helpline.~~

~~(d) To ensure members have access to their Patient Centered Medical Home, Insure Oklahoma staff may facilitate enrollment as applicable.~~

317:45-11-23. Member eligibility period [REVOKED]

~~(a) The rules in this subsection apply to member's eligibility according to OAC 317:45-11-20(a) through (c).~~

~~(1) The member's eligibility period begins only after approval of the application and receipt of the premium payment.~~

~~(A) If the application is approved and the premium payment is made by the last day of the same month, eligibility will begin the first day of the next month.~~

~~(B) If the application is approved and the premium payment is made between the first and 15th day of the next month, eligibility will begin the first day of the second consecutive month.~~

~~(C) If the application is approved and the premium payment is not made within 45 days, eligibility will not begin.~~

~~(2) Employee eligibility is contingent upon the employer~~

~~meeting the program guidelines.~~

~~(3) The employee's eligibility is determined using the eligibility requirements listed in OAC 317:45-9-1 or OAC 317:45-11-20 (a) through (c).~~

~~(4) If the employee is determined eligible for Insure Oklahoma IP, he/she is approved for a period not greater than 12 months.~~

~~(b) The rules in this subsection apply to applicants eligible according to OAC 317:45-11-20(a) through (c) and OAC 317:45-11-20(f) through (h).~~

~~(1) The applicant's eligibility is determined using the eligibility requirements listed in OAC 317:45-11-20(a) through (c) and OAC 317:45-11-20(f) through (h).~~

~~(2) If the applicant is determined eligible for Insure Oklahoma IP, he/she is approved for a period not greater than twelve (12) months.~~

~~(3) The applicant's eligibility period begins only after receipt of the premium payment.~~

317:45-11-24. Member cost sharing [REVOKED]

~~(a) Members are given monthly invoices for their benefit plan premiums. IP health plan premiums are established by the OHCA. The premiums are due monthly and must be paid in full.~~

~~(1) Members are responsible for their monthly premiums, in an amount not to exceed four percent (4%) of their monthly gross household income.~~

~~(2) Working disabled individuals are responsible for their monthly premiums in an amount not to exceed four percent (4%) of their monthly gross household income, based on a family size of one and capped at one-hundred percent (100%) of the Federal Poverty Level.~~

~~(3) Cost-sharing, including premium payments and copayments, are not required of American Indian and Alaska Native members, as is established in the federally-approved Oklahoma Medicaid State Plan.~~

~~(b) IP coverage is not provided until the premium and any other amounts due are paid in full. Other amounts due may include but are not limited to any fees, charges, or other costs incurred as a result of returned payments.~~

317:45-11-26. Reviews [REVOKED]

~~Members participating in the Insure Oklahoma program are subject to reviews related to their eligibility, subsidy payments, premium payments and out-of-pocket reimbursements. Eligibility may be reversed at any time if inconsistencies are found. Any monies paid in error will be subject to recoupment.~~

317:45-11-27. Closure [REVOKED]

~~(a) Members are mailed a notice 10 days prior to closure of eligibility.~~

~~(b) The employer and employees' eligibility are tied together. If the employer no longer meets the requirements for Insure Oklahoma then eligibility for the associated employees enrolled under that employer are also ineligible.~~

~~(c) The employee's certification period may be terminated when:~~

~~(1) the member requests closure;~~
~~(2) the member moves out-of-state;~~
~~(3) the covered member dies;~~
~~(4) the employer's eligibility ends;~~
~~(5) a review indicates a discrepancy that makes the member or employer ineligible;~~
~~(6) the employer is terminated from Insure Oklahoma;~~
~~(7) the member fails to pay their premium;~~
~~(8) the qualified benefit plan or carrier no longer meets the requirements set forth in this chapter;~~
~~(9) the member begins receiving SoonerCare or Medicare benefits;~~
~~(10) the member begins receiving coverage by a private benefit policy or plan;~~
~~(11) the member or employer reports any change affecting eligibility; or~~
~~(12) the member no longer meets the eligibility criteria set forth in this Chapter.~~

~~(d) This subsection applies to applicants eligible according to 317:45-11-20(a) through (c) and 317:45-11-20(f) through (h). The member's certification period may be terminated when:~~

~~(1) the member requests closure;~~
~~(2) the member moves out-of-state;~~
~~(3) the covered member dies;~~
~~(4) the employer's eligibility ends;~~
~~(5) a review indicates a discrepancy that makes the member or employer ineligible;~~
~~(6) the member fails to pay their premium;~~
~~(7) the member becomes eligible for SoonerCare or Medicare;~~
~~(8) the member begins receiving coverage by a private benefit policy or plan;~~
~~(9) the member or employer reports any change affecting eligibility; or~~
~~(10) the member no longer meets the eligibility criteria set forth in this Chapter.~~

317:45-11-28. Appeals [REVOKED]

~~Member appeal procedures based on denial of eligibility due to income are described at 317:2-1-2.~~

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OPERATIONAL METRICS

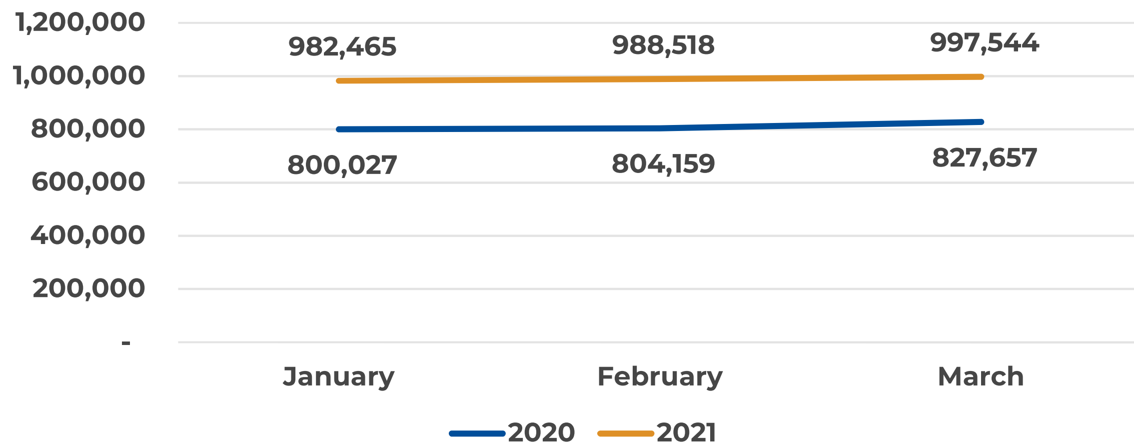
May 2021 Board Meeting

OKLAHOMA HEALTH CARE AUTHORITY

4345 N. LINCOLN BLVD. | OKHCA.ORG |

Enrollment & Utilization

Total Enrolled Members

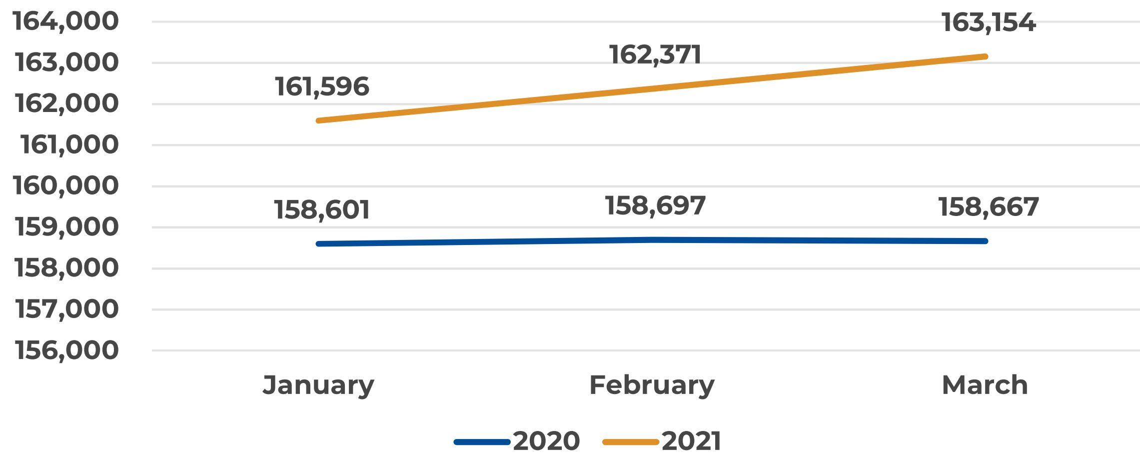


Month	2020	2021
January	800,027	982,465
February	804,159	988,518
March	827,657	997,544

Month	Count Change	Percent Change
January	182,438	23%
February	184,359	23%
March	169,887	21%

Quarterly Percent Change	20%

Aged/Blind/Disabled Enrolled



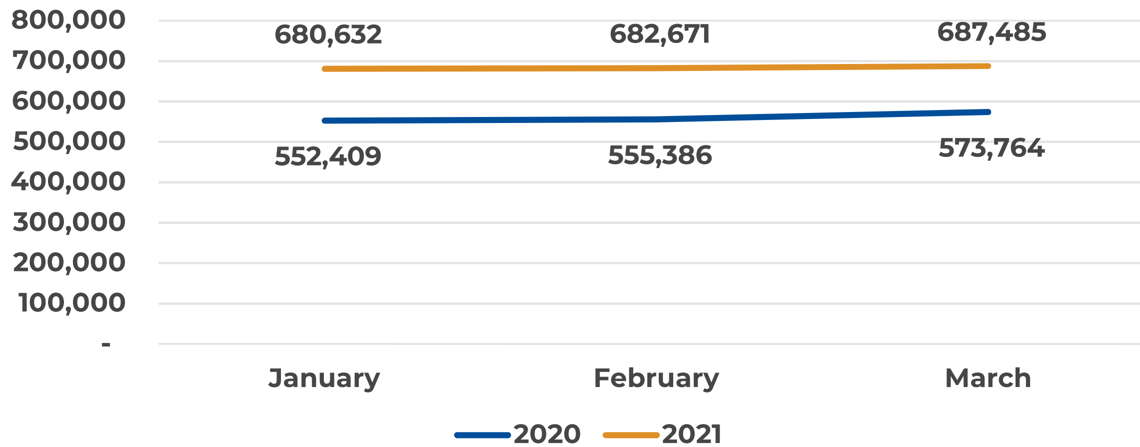
Month	2020	2021
January	158,601	161,596
February	158,697	162,371
March	158,667	163,154

Month	Count Change	Percent Change
January	2,995	2%
February	3,674	2%
March	4,487	3%

Quarterly Percent Change	1%

Enrollment & Utilization (Cont.)

Children & Parent/Caretaker Enrolled

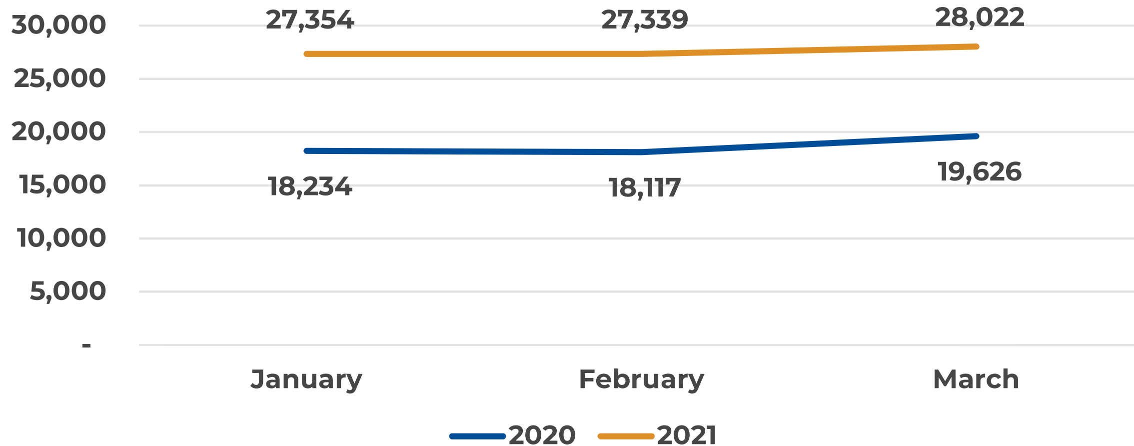


Month	2020	2021
January	552,409	680,632
February	555,386	682,671
March	573,764	687,485

Month	Count Change	Percent Change
January	128,223	23%
February	127,285	23%
March	113,721	20%

Quarterly Percent Change	21%

Pregnant (Full Scope) Enrolled



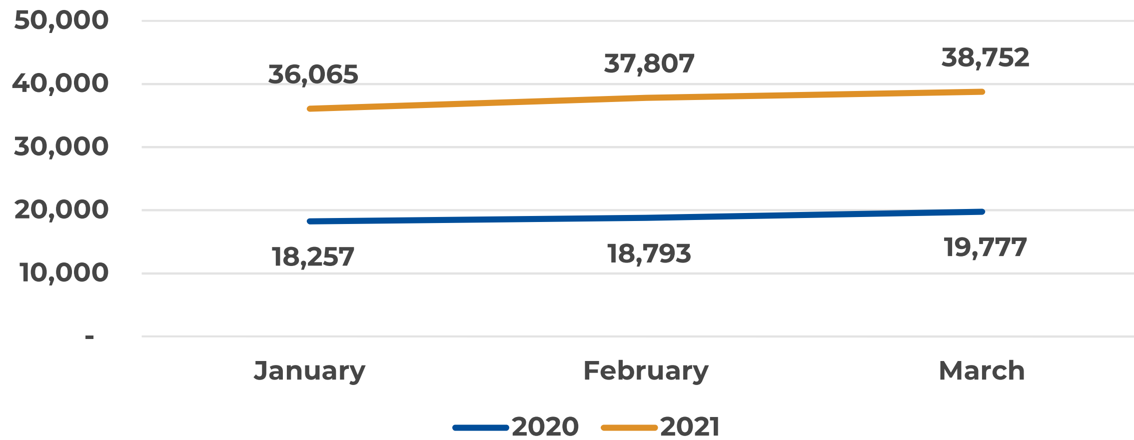
Month	2020	2021
January	18,234	27,354
February	18,117	27,339
March	19,626	28,022

Month	Count Change	Percent Change
January	9,120	50%
February	9,222	51%
March	8,396	43%

Quarterly Percent Change	48%

Enrollment & Utilization (Cont.)

Insure Oklahoma Enrolled

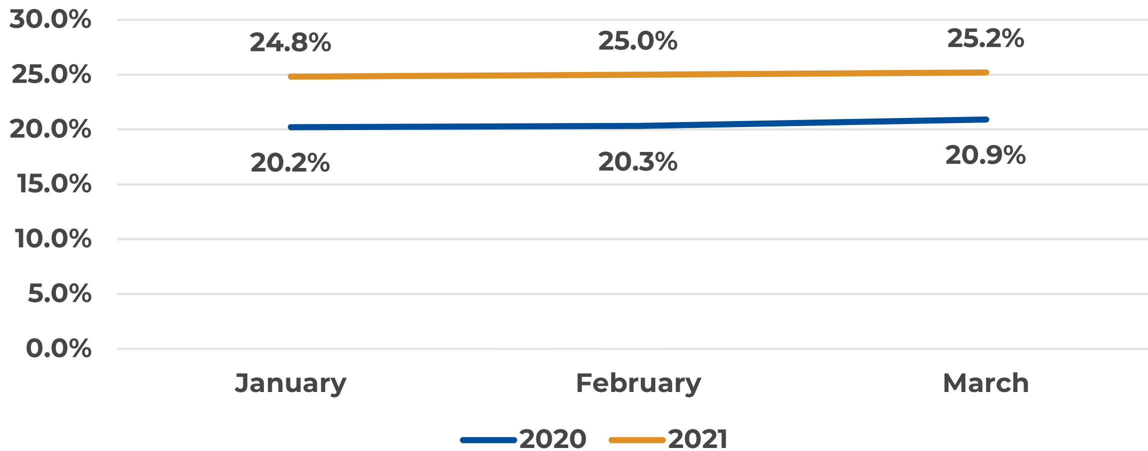


Month	2020	2021
January	18,257	36,065
February	18,793	37,807
March	19,777	38,752

Month	Count Change	Percent Change
January	17,808	98%
February	19,014	101%
March	18,975	96%

Quarterly Percent Change	96%

Percent of OK Population Enrolled



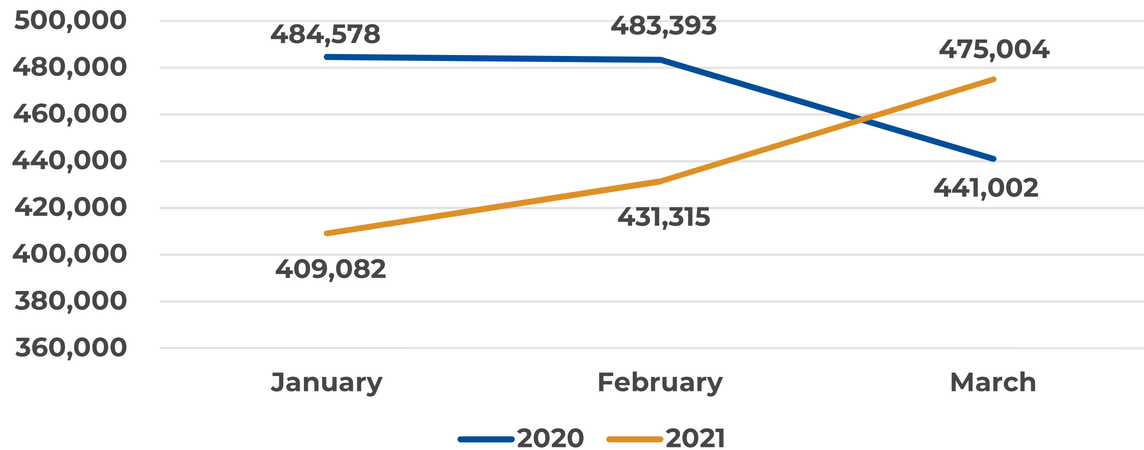
Month	2020	2021
January	20.2%	24.8%
February	20.3%	25.0%
March	20.9%	25.2%

Month	Count Change	Percent Change
January	4.6%	23%
February	4.7%	23%
March	4.3%	21%

Quarterly Percent Change	22%

Enrollment & Utilization (Cont.)

Total Members Utilization

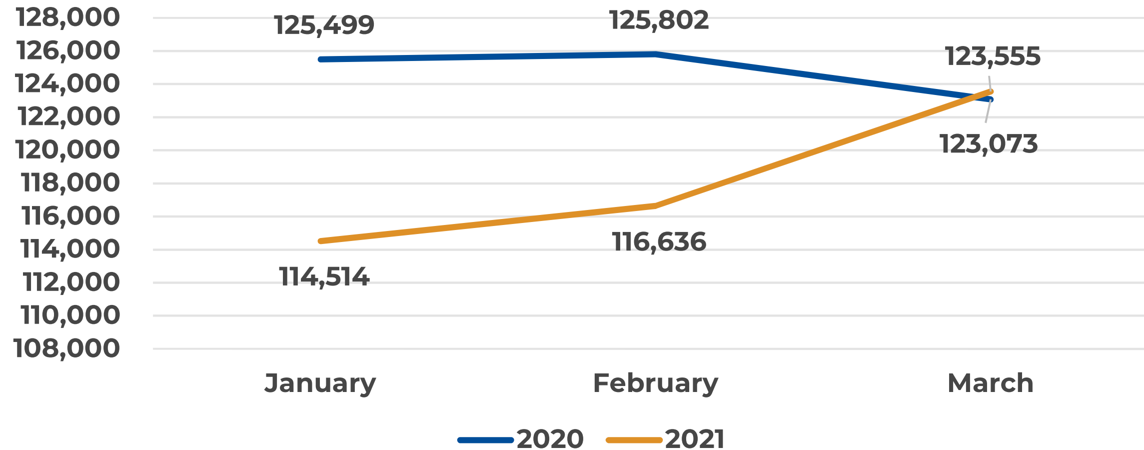


Month	2020	2021
January	484,578	409,082
February	483,393	431,315
March	441,002	475,004

Month	Count Change	Percent Change
January	(75,496)	-16%
February	(52,078)	-11%
March	34,002	8%

Quarterly Percent Change	-4%

Aged/Blind/Disabled Utilization



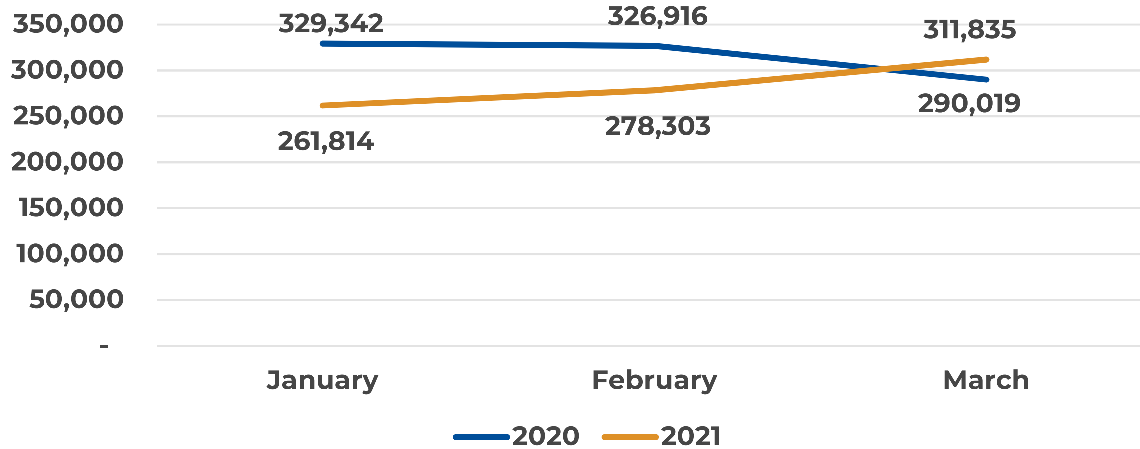
Month	2020	2021
January	125,499	114,514
February	125,802	116,636
March	123,073	123,555

Month	Count Change	Percent Change
January	(10,985)	-9%
February	(9,166)	-7%
March	482	0.4%

Quarterly Percent Change	-4%

Enrollment & Utilization (Cont.)

Children & Parent/Caretaker Utilization

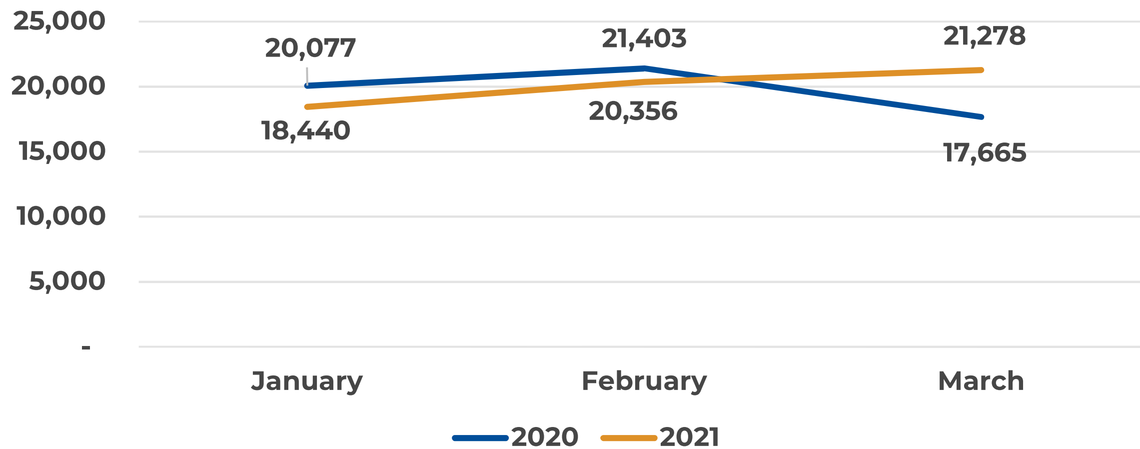


Month	2020	2021
January	329,342	261,814
February	326,916	278,303
March	290,019	311,835

Month	Count Change	Percent Change
January	(67,528)	-21%
February	(48,613)	-15%
March	21,816	8%

Quarterly Percent Change	-6%

Pregnant (Full Scope) Utilization



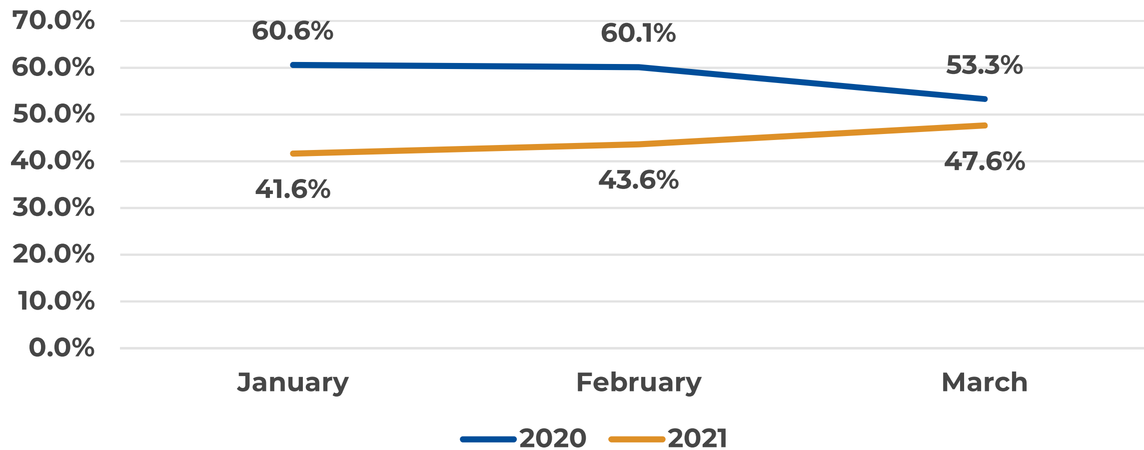
Month	2020	2021
January	20,077	18,440
February	21,403	20,356
March	17,665	21,278

Month	Count Change	Percent Change
January	(1,637)	-8%
February	(1,047)	-5%
March	3,613	20%

Quarterly Percent Change	-3%

Enrollment & Utilization (Cont.)

Percent of Total Enrolled Members Utilization

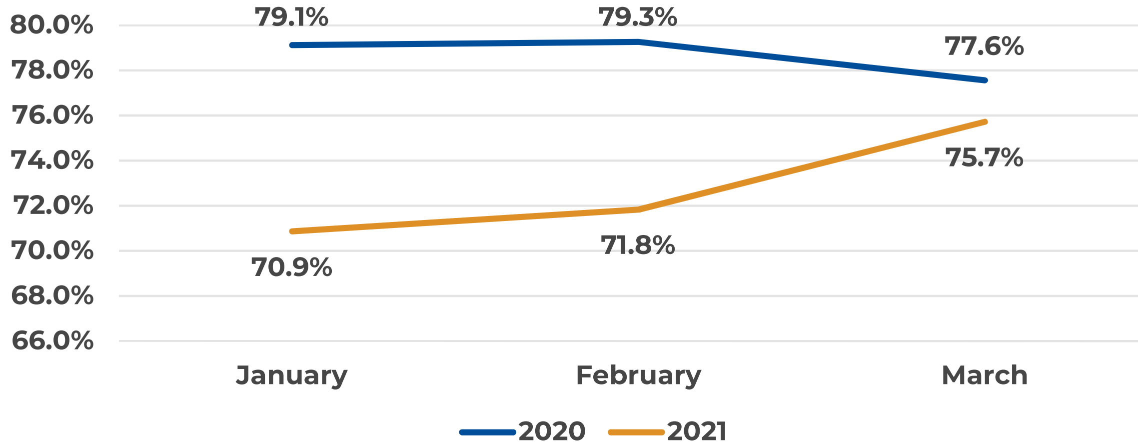


Month	2020	2021
January	60.6%	41.6%
February	60.1%	43.6%
March	53.3%	47.6%

Month	Count Change	Percent Change
January	-18.9%	-31%
February	-16.5%	-27%
March	-5.7%	-11%

Quarterly Percent Change	-24%

Percent of Aged/Blind/Disabled Enrolled Members Utilization



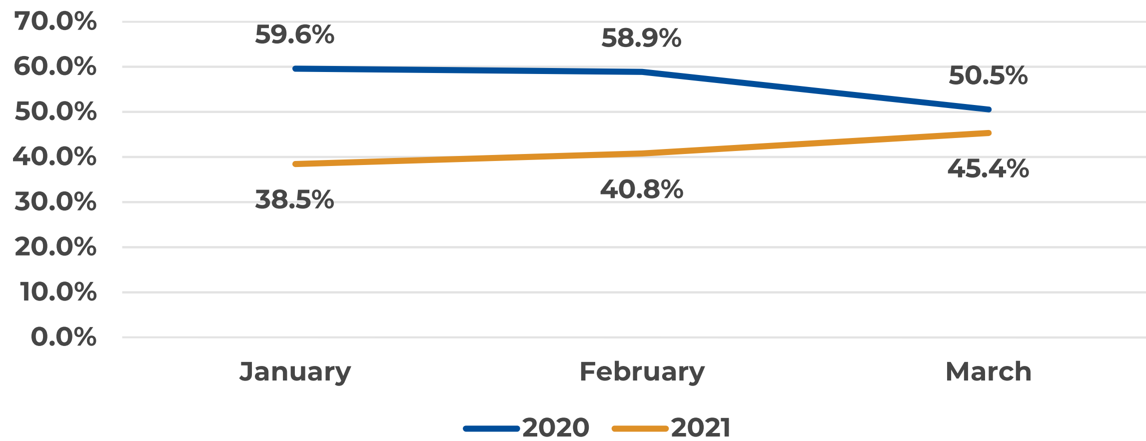
Month	2020	2021
January	79.1%	70.9%
February	79.3%	71.8%
March	77.6%	75.7%

Month	Count Change	Percent Change
January	-8.3%	-10%
February	-7.4%	-9%
March	-1.8%	-2%

Quarterly Percent Change	-7%

Enrollment & Utilization (Cont.)

Percent of Children & Parent/Caretaker Enrolled Members Utilization

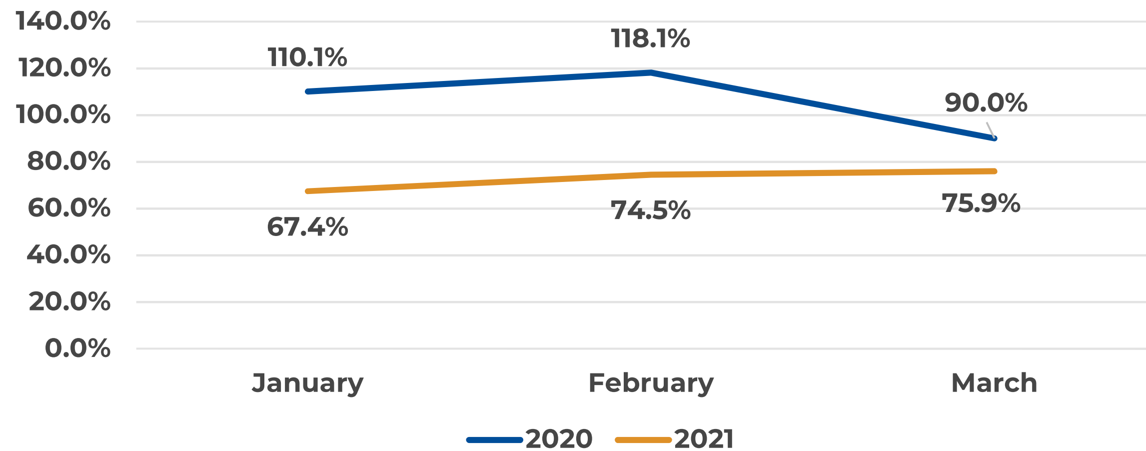


Month	2020	2021
January	59.6%	38.5%
February	58.9%	40.8%
March	50.5%	45.4%

Month	Count Change	Percent Change
January	-21.2%	-35%
February	-18.1%	-31%
March	-5.2%	-10%

Quarterly Percent Change	-26%

Percent of Pregnant (Full Scope) Enrolled Members Utilization



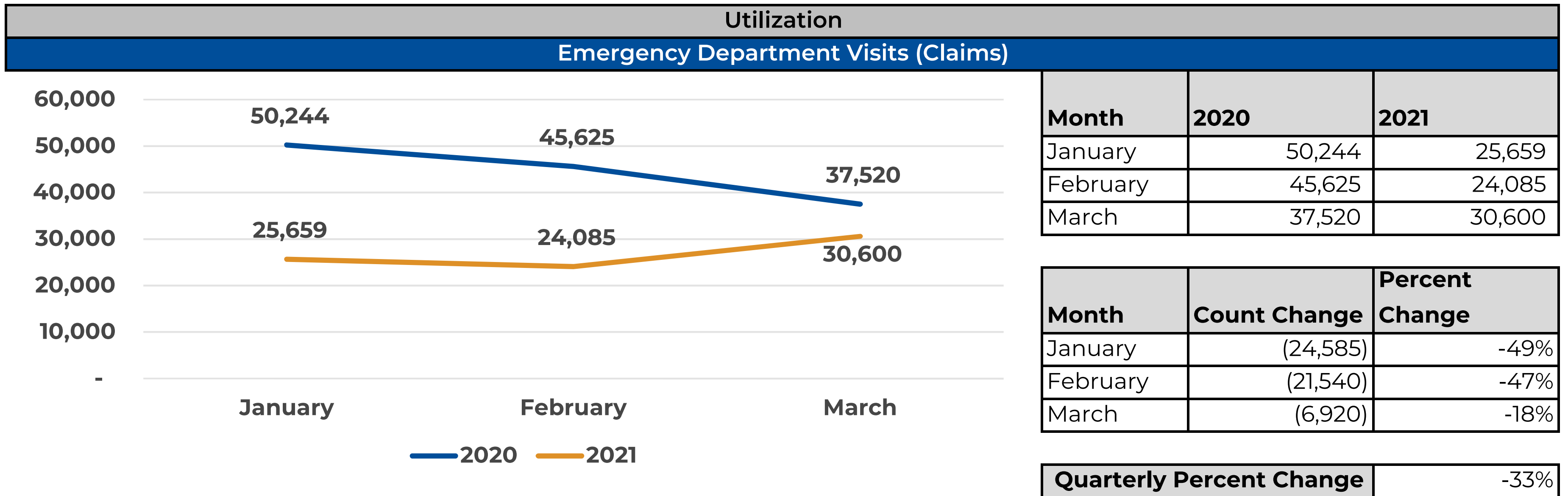
Month	2020	2021
January	110.1%	67.4%
February	118.1%	74.5%
March	90.0%	75.9%

Month	Count Change	Percent Change
January	-42.7%	-39%
February	-43.7%	-37%
March	-14.1%	-16%

Quarterly Percent Change	-32%

Utilization

Emergency Department Visits (Claims)

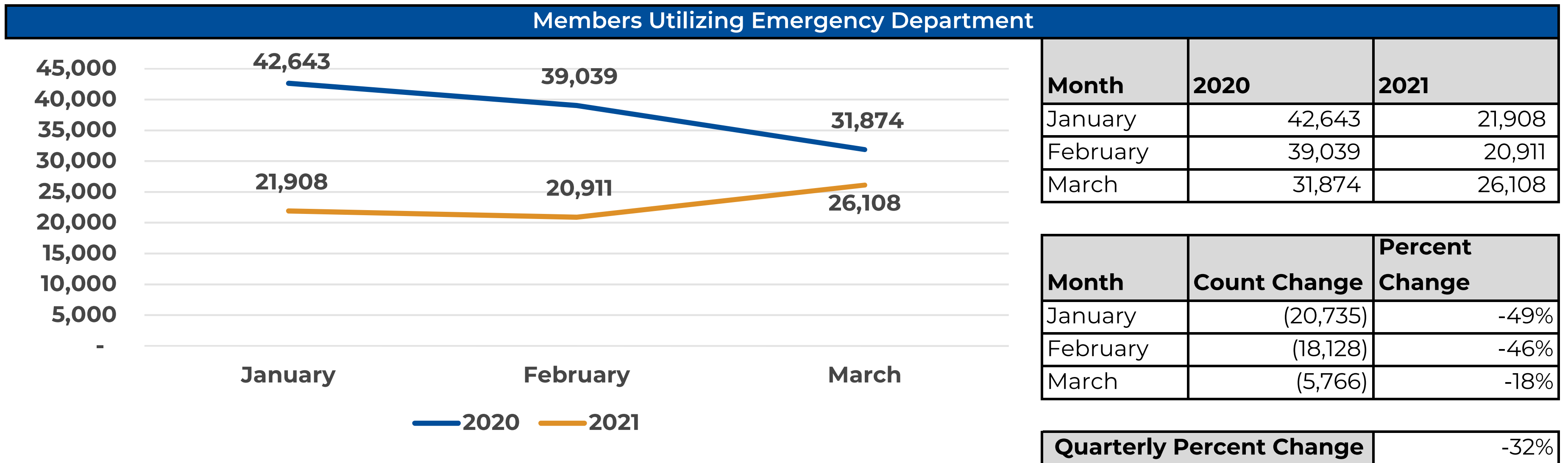


Month	2020	2021
January	50,244	25,659
February	45,625	24,085
March	37,520	30,600

Month	Count Change	Percent Change
January	(24,585)	-49%
February	(21,540)	-47%
March	(6,920)	-18%

Quarterly Percent Change	-33%

Members Utilizing Emergency Department



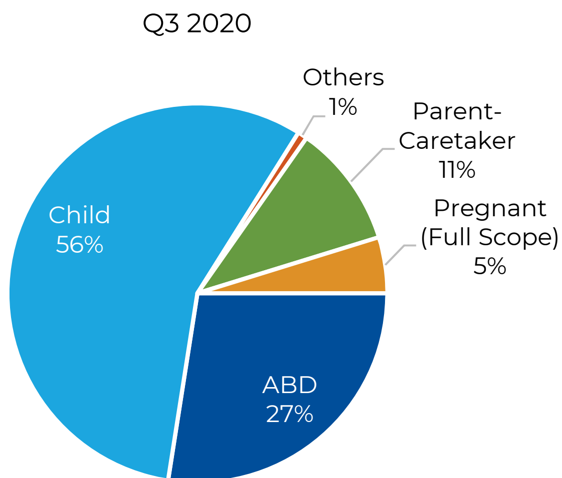
Month	2020	2021
January	42,643	21,908
February	39,039	20,911
March	31,874	26,108

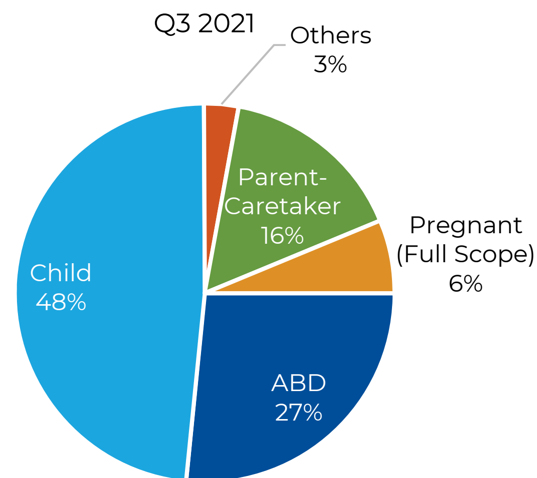
Month	Count Change	Percent Change
January	(20,735)	-49%
February	(18,128)	-46%
March	(5,766)	-18%

Quarterly Percent Change	-32%

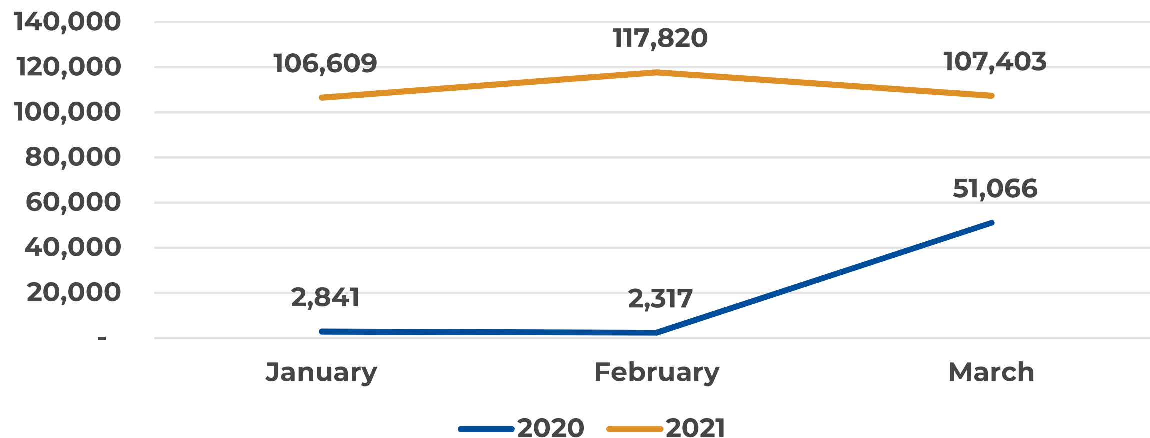
Utilization (Cont.)

Members Utilizing Emergency Department By Qualifying Group





Telemedicine - Total Visits



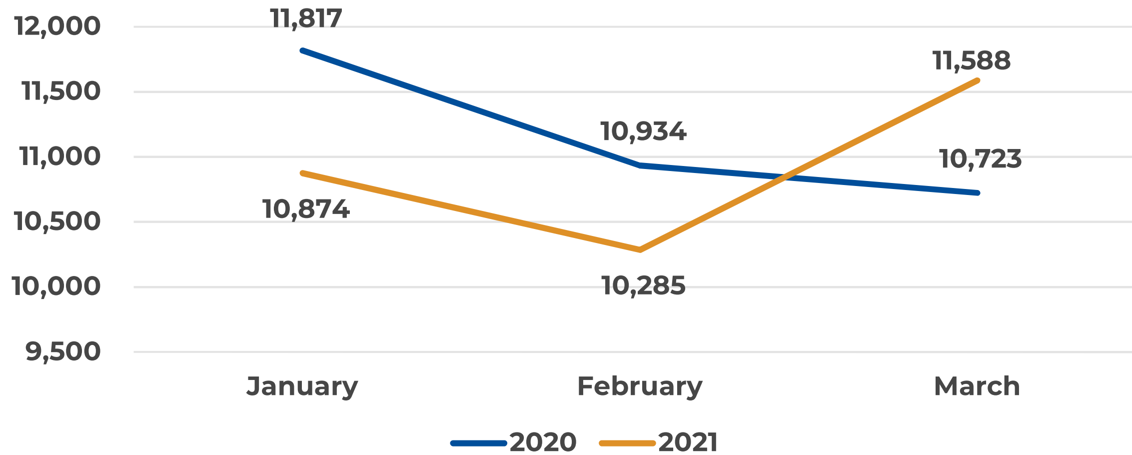
Month	2020	2021
January	2,841	106,609
February	2,317	117,820
March	51,066	107,403

Month	Count Change	Percent Change
January	103,768	3653%
February	115,503	4985%
March	56,337	110%

Quarterly Percent Change	490%

Utilization (Cont.)

Members With Opioid Claims

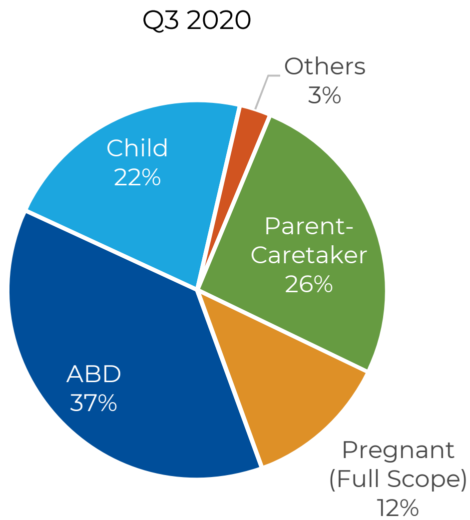


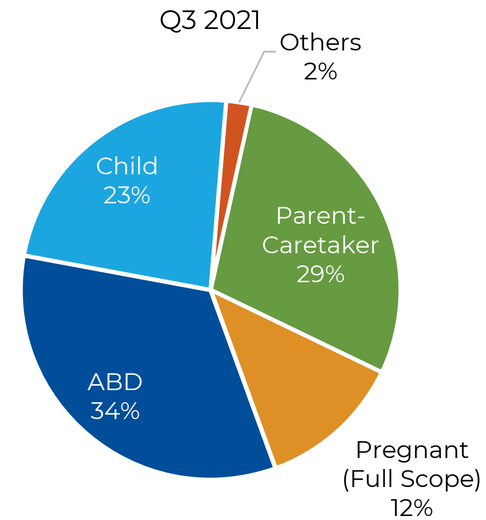
Month	2020	2021
January	11,817	10,874
February	10,934	10,285
March	10,723	11,588

Month	Count Change	Percent Change
January	(943)	-8%
February	(649)	-6%
March	865	8%

Quarterly Percent Change	0%

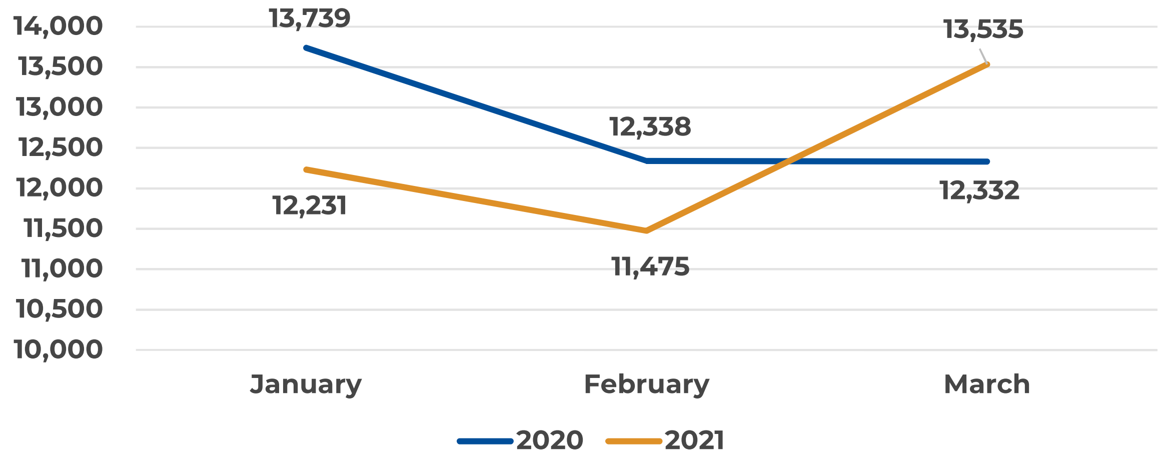
Members With Opioid Claims By Qualifying Group





Utilization (Cont.)

Total Opioid Claims

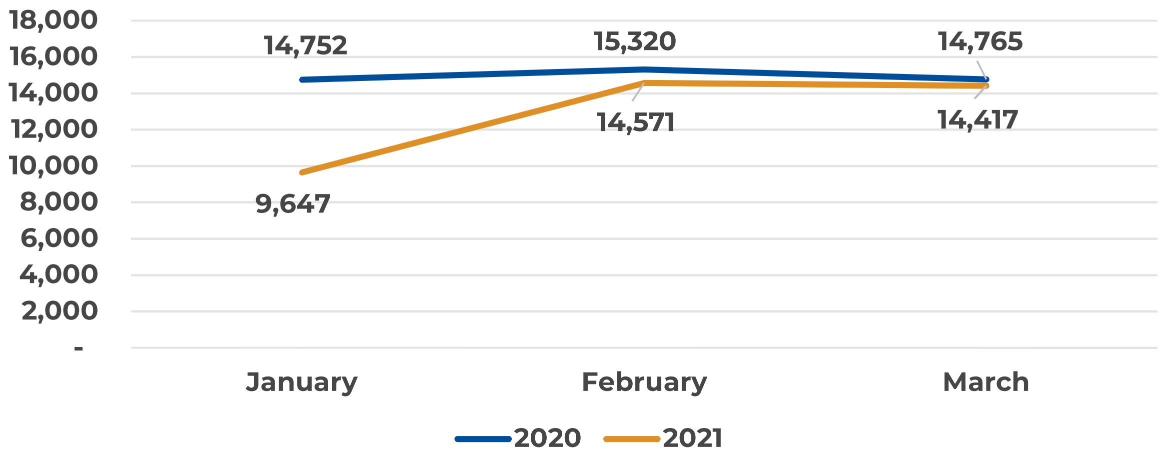


Month	2020	2021
January	13,739	12,231
February	12,338	11,475
March	12,332	13,535

Month	Count Change	Percent Change
January	(1,508)	-11%
February	(863)	-7%
March	1,203	10%

Quarterly Percent Change	-3%

Out of State Services - Total Members Utilization



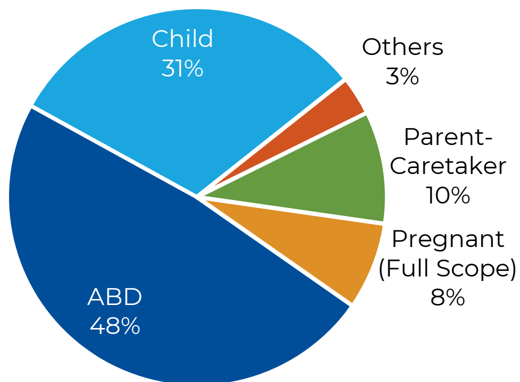
Month	2020	2021
January	14,752	9,647
February	15,320	14,571
March	14,765	14,417

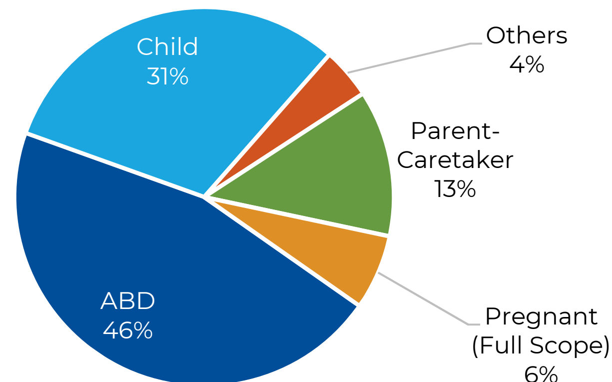
Month	Count Change	Percent Change
January	(5,105)	-35%
February	(749)	-5%
March	(348)	-2%

Quarterly Percent Change	-4%

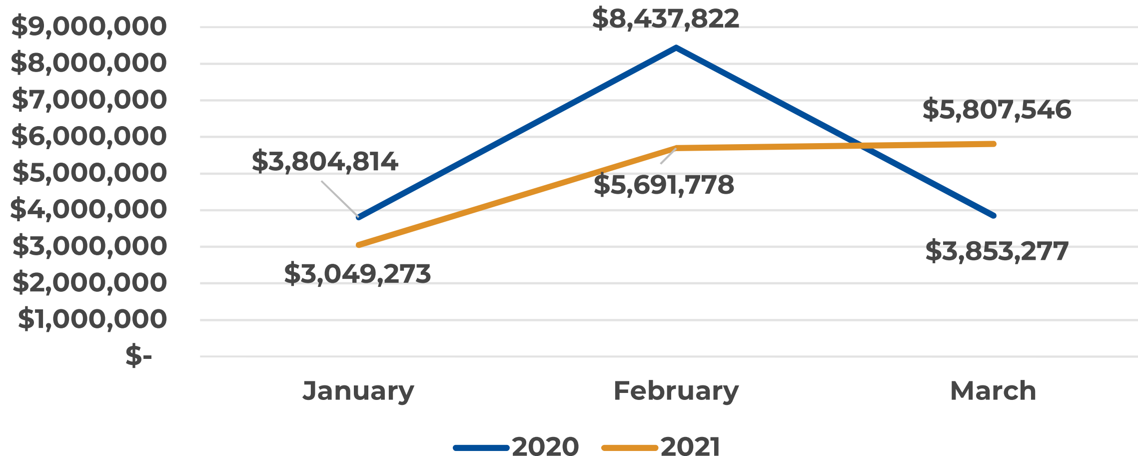
Utilization (Cont.)

Out of State Services - Total Members Utilization By Qualifying Group





Out of State Services - Total Reimbursements



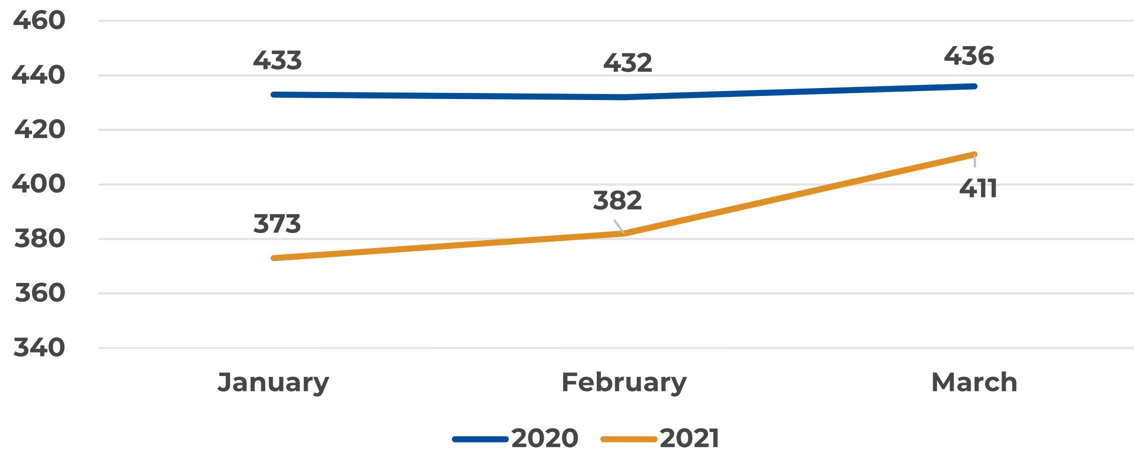
Month	2020	2021
January	$ 3,804,814	$ 3,049,273
February	$ 8,437,822	$ 5,691,778
March	$ 3,853,277	$ 5,807,546

Month	Count Change	Percent Change
January	(755,541)	-20%
February	(2,746,044)	-33%
March	1,954,269	51%

Quarterly Percent Change	-10%

Utilization (Cont.)

Out of State Services - Total Active Billing Providers



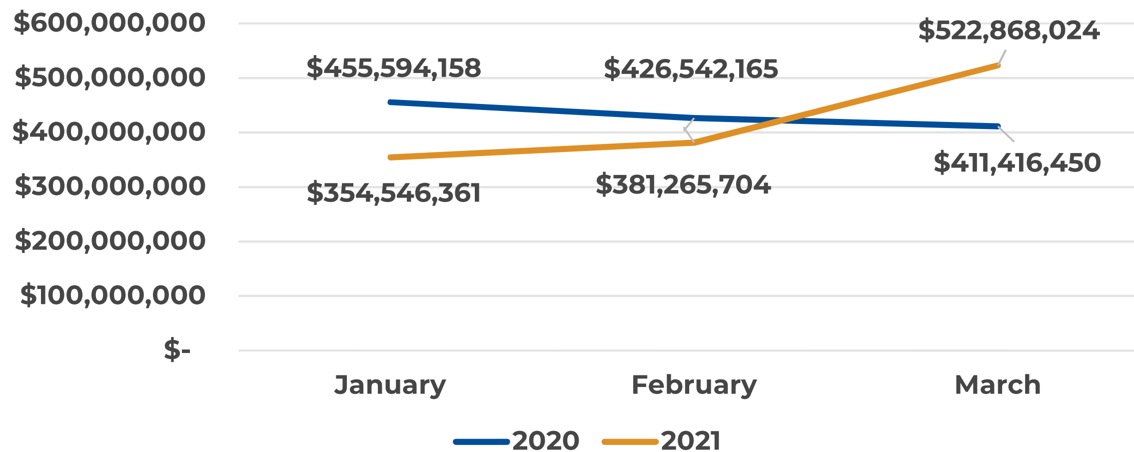
Month	2020	2021
January	433	373
February	432	382
March	436	411

Month	Count Change	Percent Change
January	(60)	-14%
February	(50)	-12%
March	(25)	-6%

Quarterly Percent Change	-11%

Financials

Total Agency Expenditures



Month	2020	2021
January	$ 455,594,158	$ 354,546,361
February	$ 426,542,165	$ 381,265,704
March	$ 411,416,450	$ 522,868,024

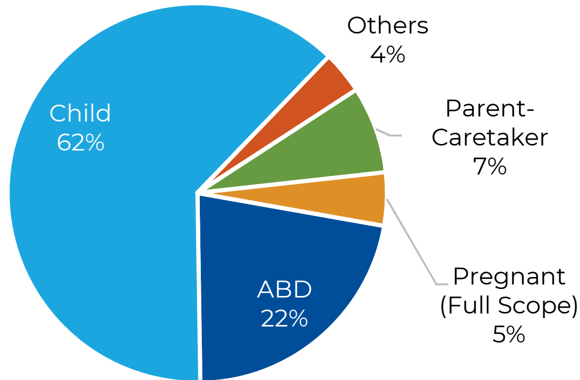
Month	Count Change	Percent Change
January	$ (101,047,797)	-22%
February	$ (45,276,462)	-11%
March	$ 111,451,574	27%

Quarterly Percent Change	-3%

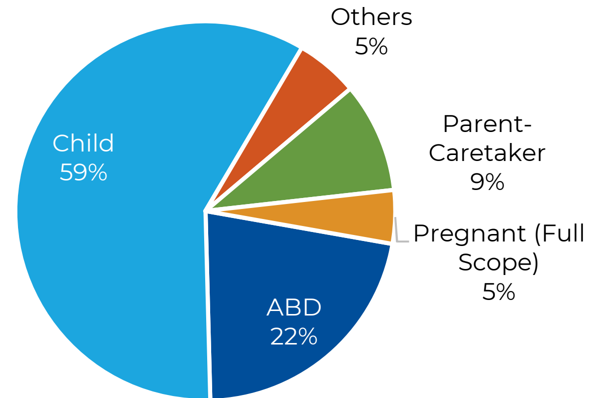
Financials (Cont.)

Total Agency Members Utilization by Qualifying Group

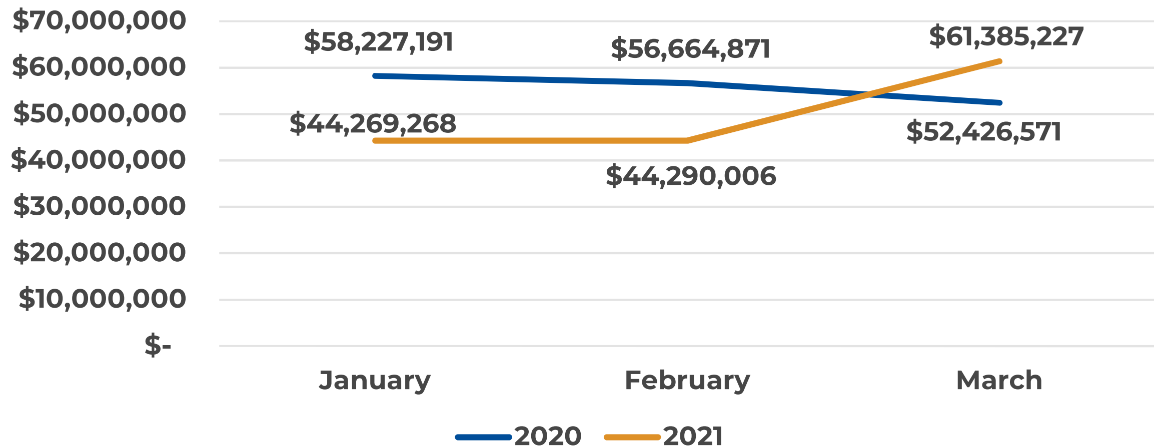
Q3 2020



Q3 2021



Inpatient Services Expenditures



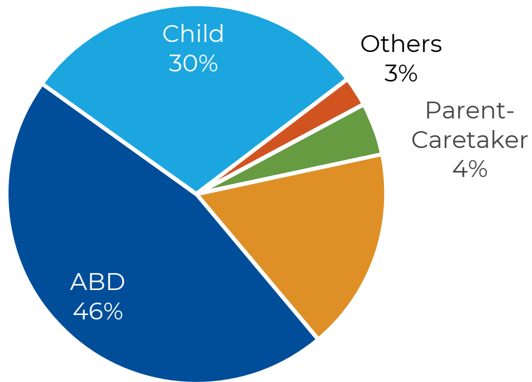
Month	2020	2021
January	$ 58,227,191	$ 44,269,268
February	$ 56,664,871	$ 44,290,006
March	$ 52,426,571	$ 61,385,227

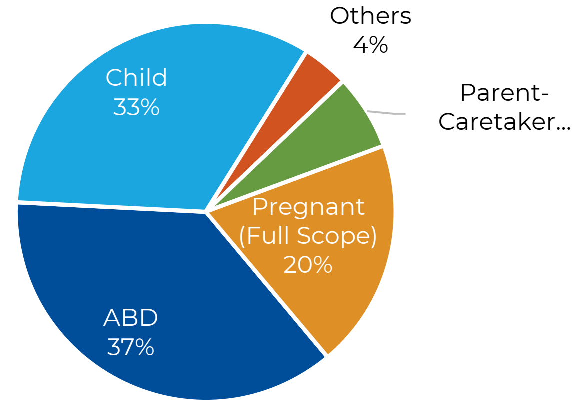
Month	Count Change	Percent Change
January	$ (13,957,923)	-24%
February	$ (12,374,864)	-22%
March	$ 8,958,656	17%

Quarterly Percent Change	-10%

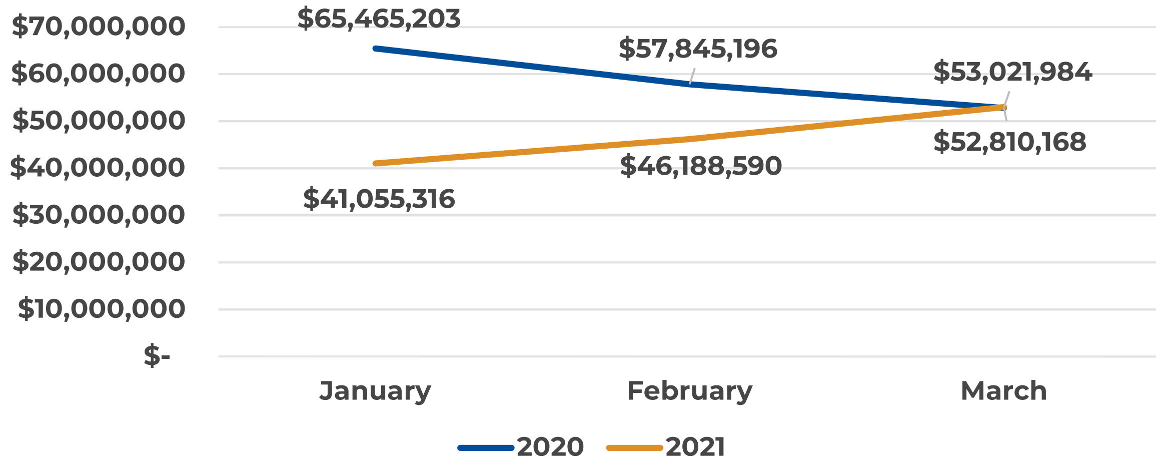
Financials (Cont.)

Inpatient Services Members Utilization by Qualifying Group





Nursing Facility Expenditures



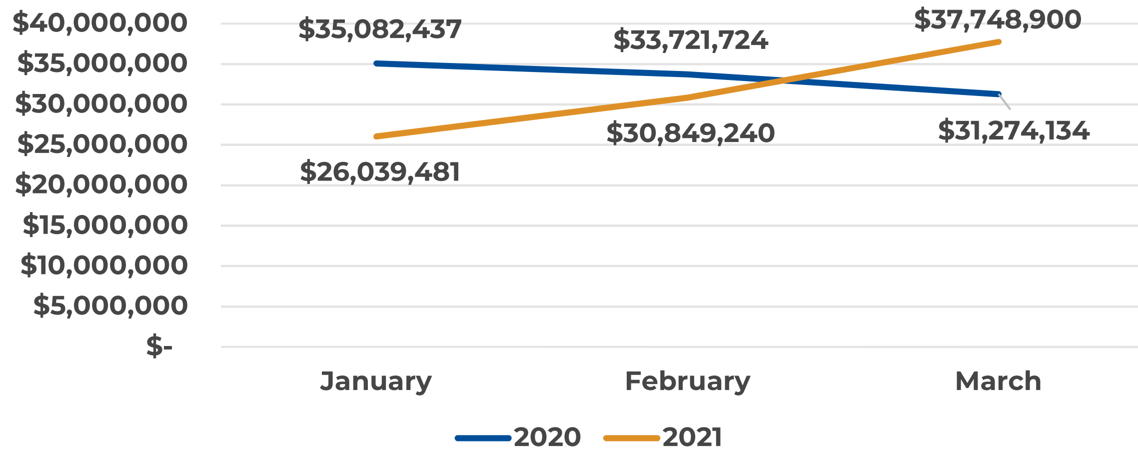
Month	2020	2021
January	$ 65,465,203	$ 41,055,316
February	$ 57,845,196	$ 46,188,590
March	$ 52,810,168	$ 53,021,984

Month	Count Change	Percent Change
January	$ (24,409,888)	-37%
February	$ (11,656,606)	-20%
March	$ 211,817	0%

Quarterly Percent Change	-20%

Financials (Cont.)

Outpatient Hospital Expenditures



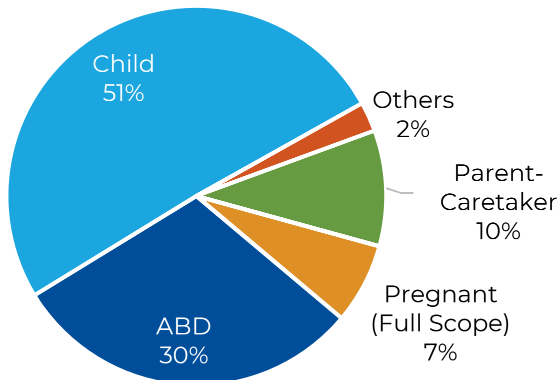
Month	2020	2021
January	$ 35,082,437	$ 26,039,481
February	$ 33,721,724	$ 30,849,240
March	$ 31,274,134	$ 37,748,900

Month	Count Change	Percent Change
January	$ (9,042,956)	-26%
February	$ (2,872,483)	-9%
March	$ 6,474,766	21%

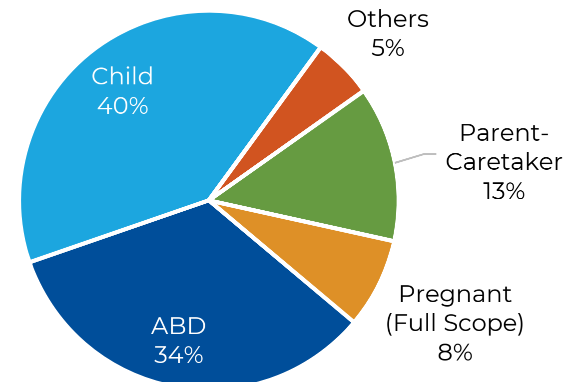
Quarterly Percent Change	-5%

Outpatient Hospital Members Utilization by Qualifying Group

Q3 2020

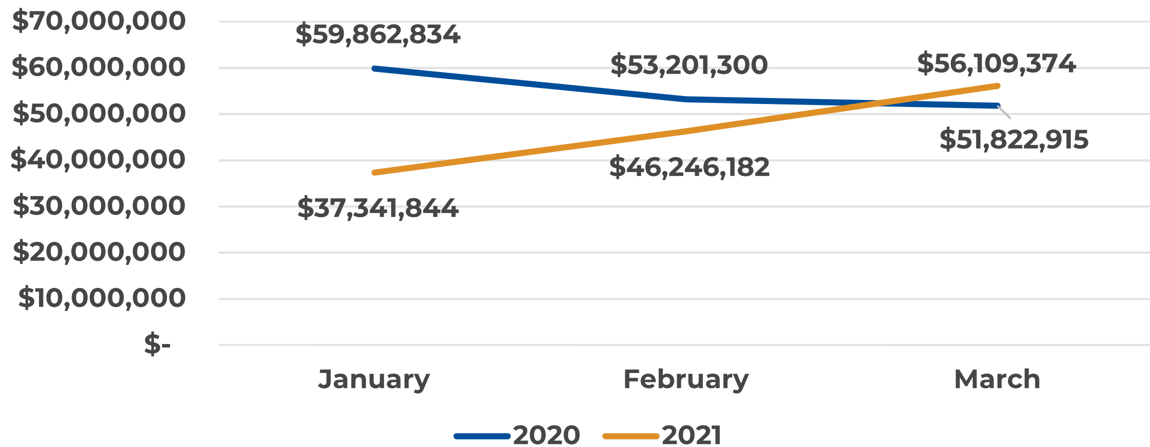


Q3 2021



Financials (Cont.)

Physician Expenditures

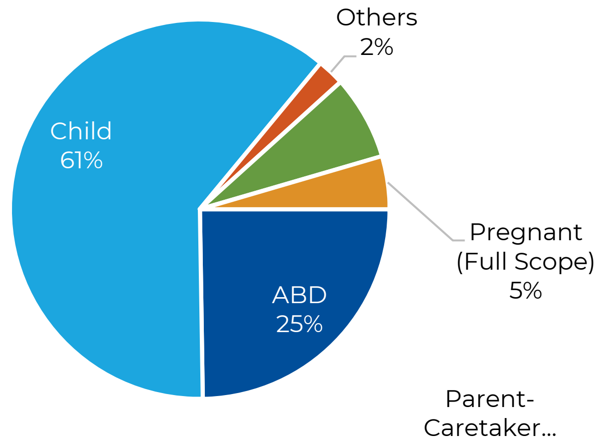


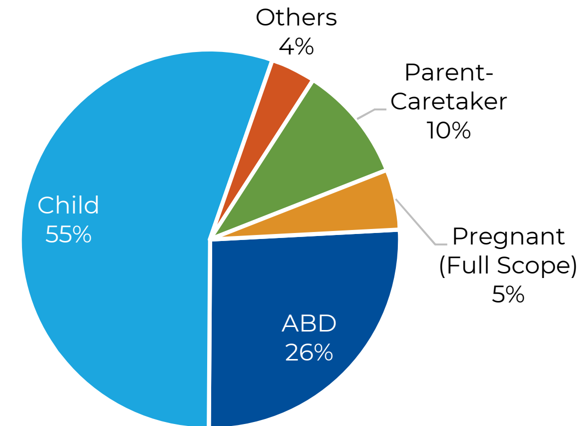
Month	2020	2021
January	$ 59,862,834	$ 37,341,844
February	$ 53,201,300	$ 46,246,182
March	$ 51,822,915	$ 56,109,374

Month	Count Change	Percent Change
January	$ (22,520,991)	-38%
February	$ (6,955,118)	-13%
March	$ 4,286,460	8%

Quarterly Percent Change	-15%

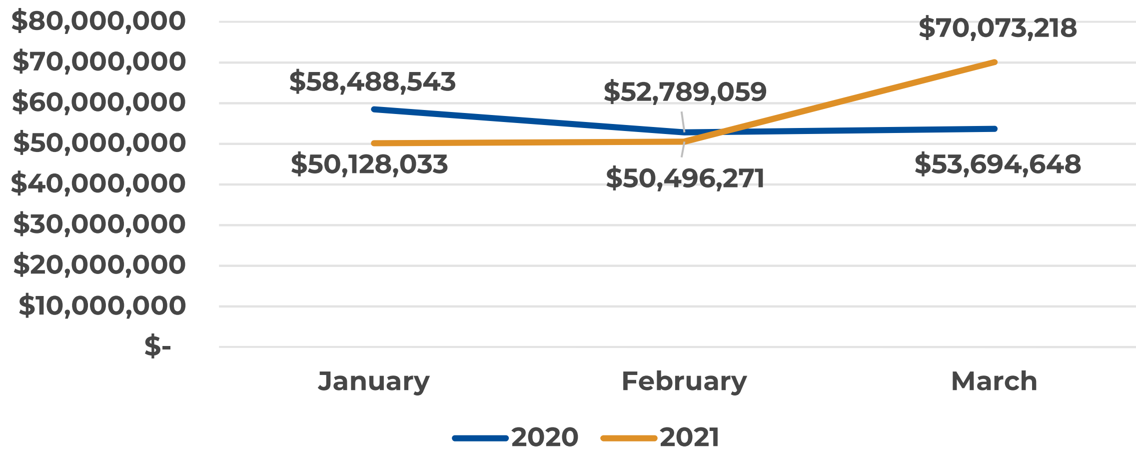
Physician Members Utilization By Qualifying Group





Financials (Cont.)

Prescribed Drugs Expenditures

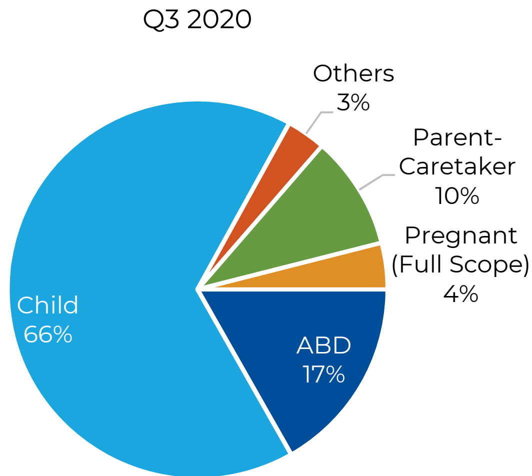


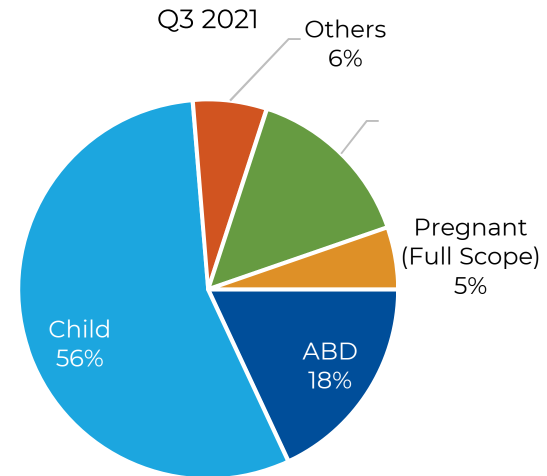
Month	2020	2021
January	$ 58,488,543	$ 50,128,033
February	$ 52,789,059	$ 50,496,271
March	$ 53,694,648	$ 70,073,218

Month	Count Change	Percent Change
January	$ (8,360,510)	-14%
February	$ (2,292,788)	-4%
March	$ 16,378,570	31%

Quarterly Percent Change	3%

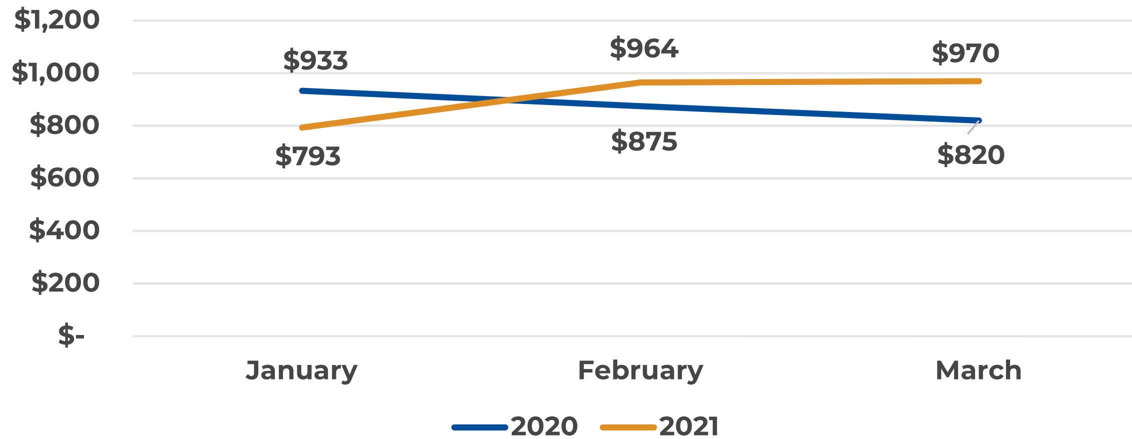
Prescribed Drugs Members Utilization By Qualifying Group





Financials (Cont.)

Average Per Total Member Served

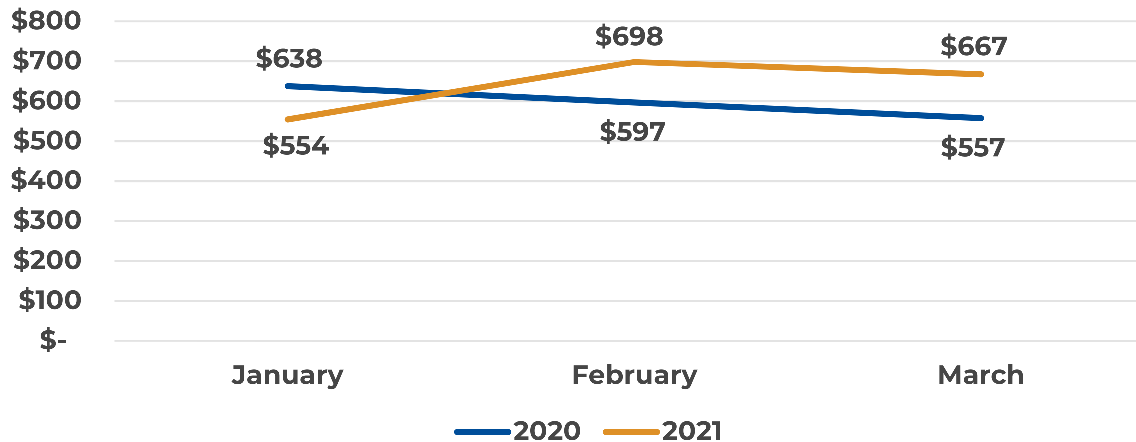


Month	2020	2021
January	$ 933	$ 793
February	$ 875	$ 964
March	$ 820	$ 970

Month	Count Change	Percent Change
January	$ (140)	-15%
February	$ 89	10%
March	$ 150	18%

Quarterly Percent Change	0%

Average Per Child (Under 21) Member Served



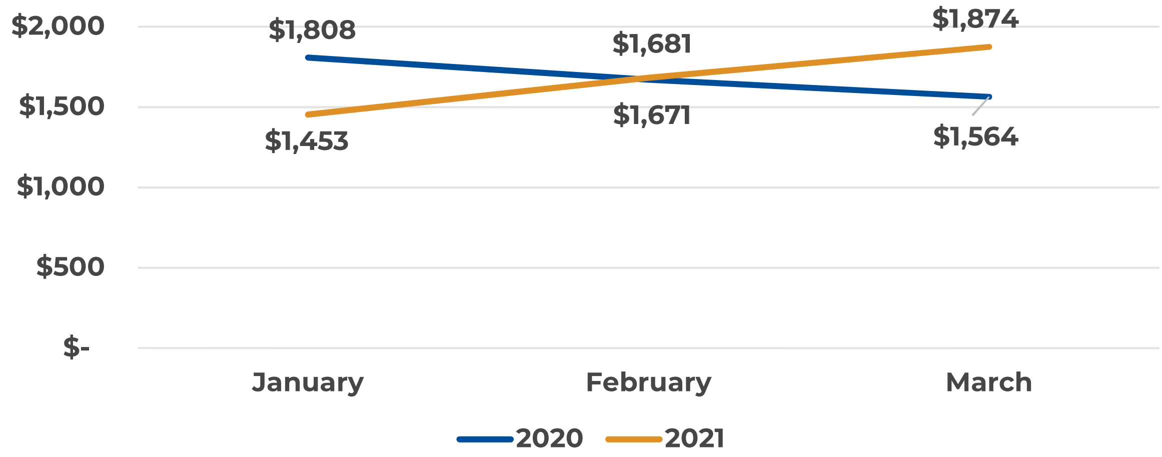
Month	2020	2021
January	$ 638	$ 554
February	$ 597	$ 698
March	$ 557	$ 667

Month	Count Change	Percent Change
January	$ (83)	-13%
February	$ 102	17%
March	$ 110	20%

Quarterly Percent Change	1%

Financials (Cont.)

Average Per Aged/Blind/Disabled Member Served

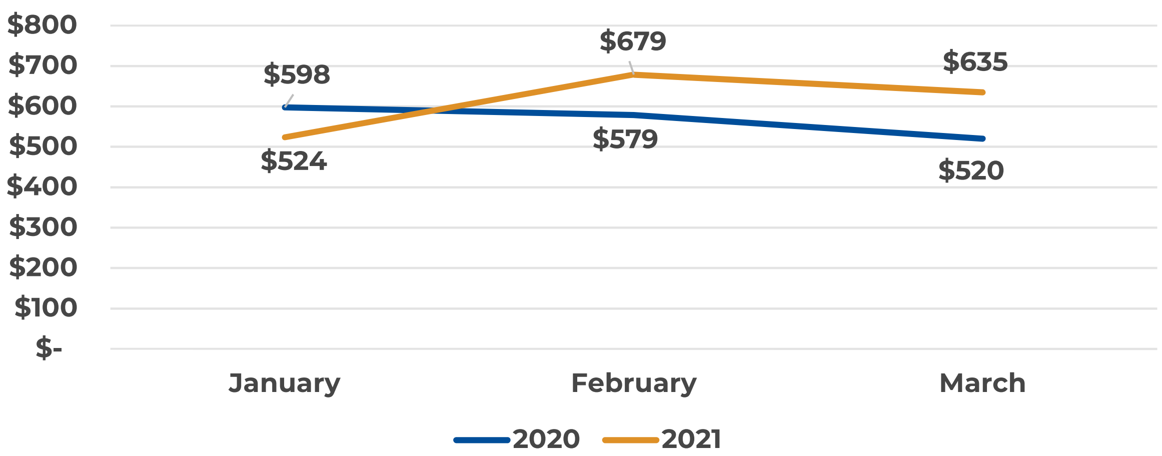


Month	2020	2021
January	$ 1,808	$ 1,453
February	$ 1,671	$ 1,681
March	$ 1,564	$ 1,874

Month	Count Change	Percent Change
January	$ (355)	-20%
February	$ 11	1%
March	$ 311	20%

Quarterly Percent Change	-2%

Average Per Children & Parent/Caretaker Member Served



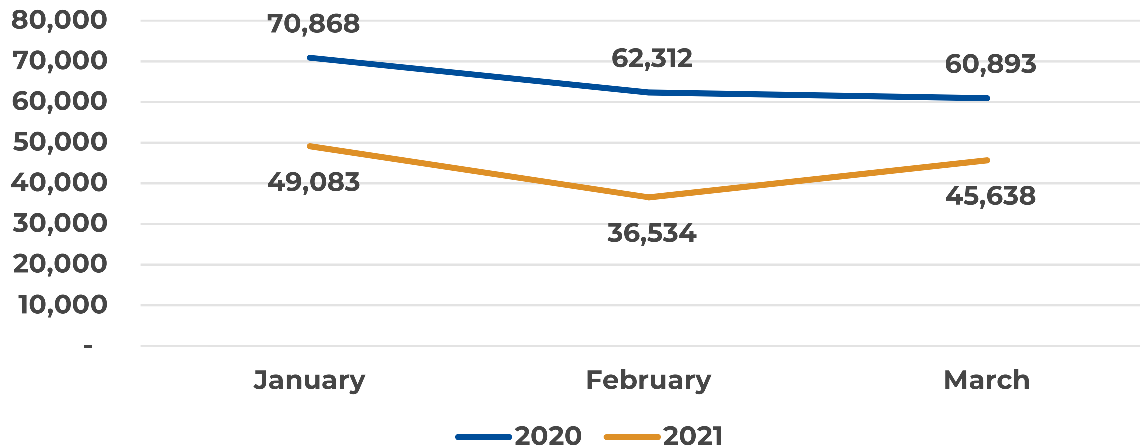
Month	2020	2021
January	$ 598	$ 524
February	$ 579	$ 679
March	$ 520	$ 635

Month	Count Change	Percent Change
January	$ (74)	-12%
February	$ 100	17%
March	$ 115	22%

Quarterly Percent Change	3%

Call Center

Call Center - Member Calls Answered

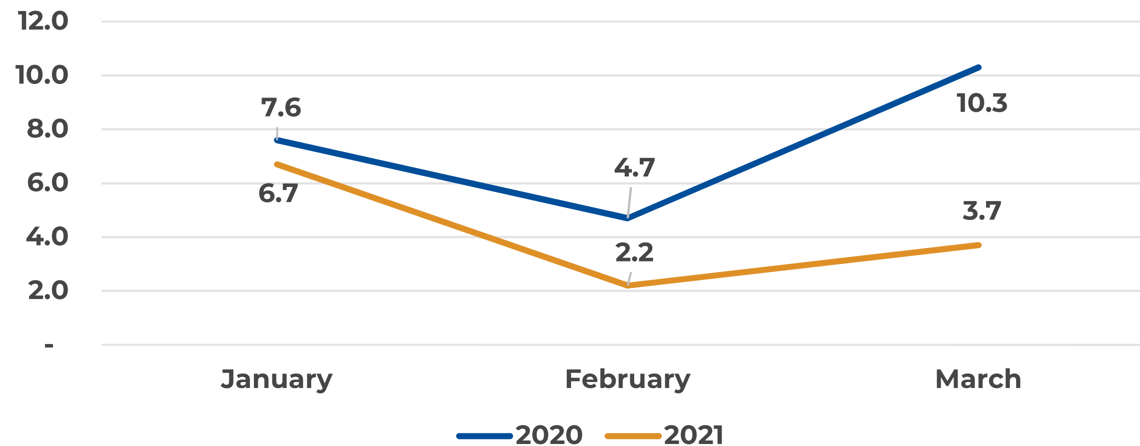


Month	2020	2021
January	70,868	49,083
February	62,312	36,534
March	60,893	45,638

Month	Count Change	Percent Change
January	(21,785)	-31%
February	(25,778)	-41%
March	(15,255)	-25%

Quarterly Percent Change	-32%

Call Center - Average Wait Time (In Seconds)



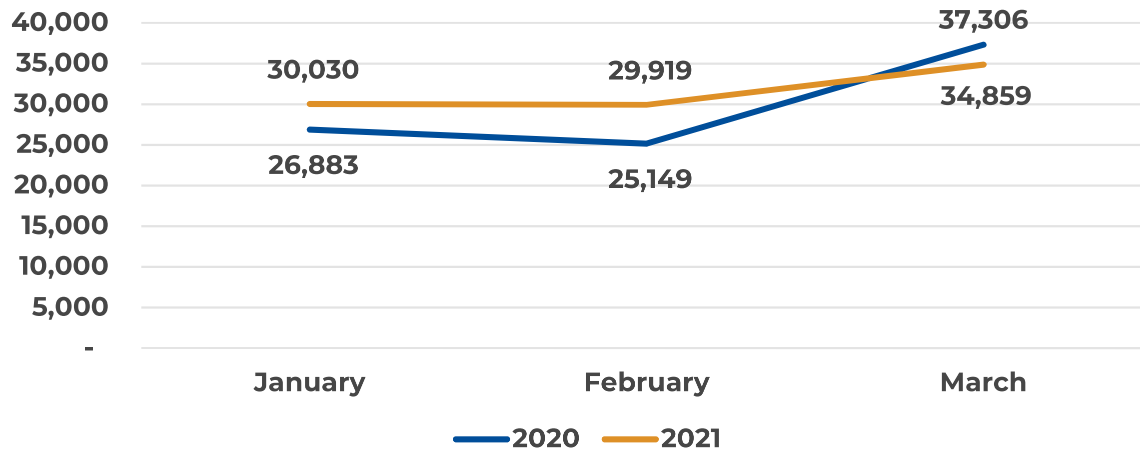
Month	2020	2021
January	7.6	6.7
February	4.7	2.2
March	10.3	3.7

Month	Count Change	Percent Change
January	(1)	-12%
February	(3)	-53%
March	(7)	-64%

Quarterly Percent Change	N/A

Prior Authorization

Prior Authorization - Total Combined - Total Completed PA Volume

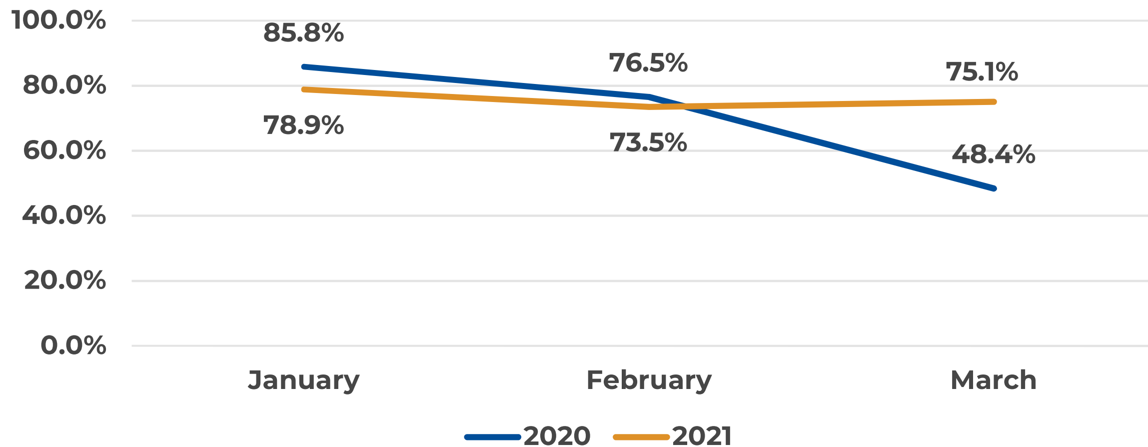


Month	2020	2021
January	26,883	30,030
February	25,149	29,919
March	37,306	34,859

Month	Count Change	Percent Change
January	3,147	12%
February	4,770	19%
March	(2,447)	-7%

Quarterly Percent Change	6%

Prior Authorization - Total Combined - Total Percent Completed 0-6 Days



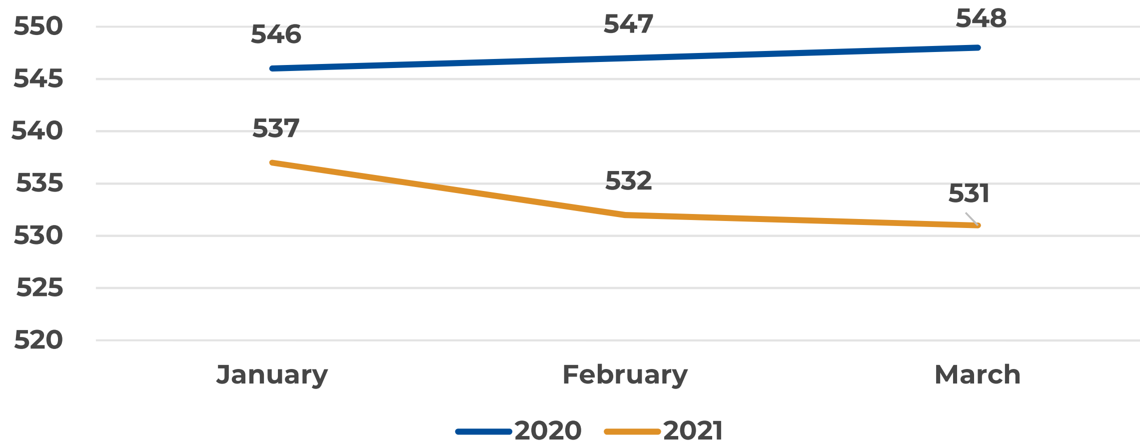
Month	2020	2021
January	85.8%	78.9%
February	76.5%	73.5%
March	48.4%	75.1%

Month	Count Change	Percent Change
January	-7.0%	-8%
February	-3.1%	-4%
March	26.7%	55%

Quarterly Percent Change	15%

Agency Stats & Provider Network

OHCA Admin - Number of FTEs

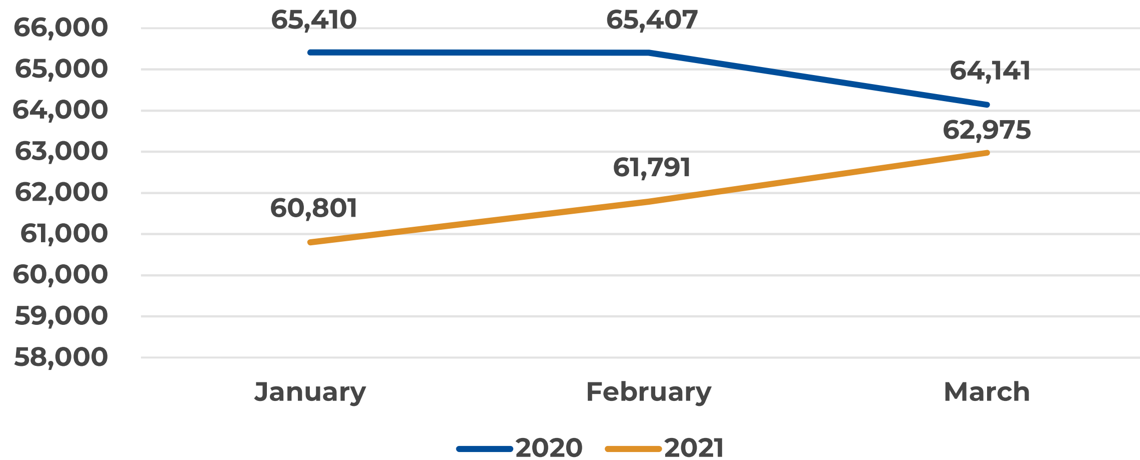


Month	2020	2021
January	546	537
February	547	532
March	548	531

Month	Count Change	Percent Change
January	(9)	-2%
February	(15)	-3%
March	(17)	-3.1%

Quarterly Percent Change	N/A

Total Providers



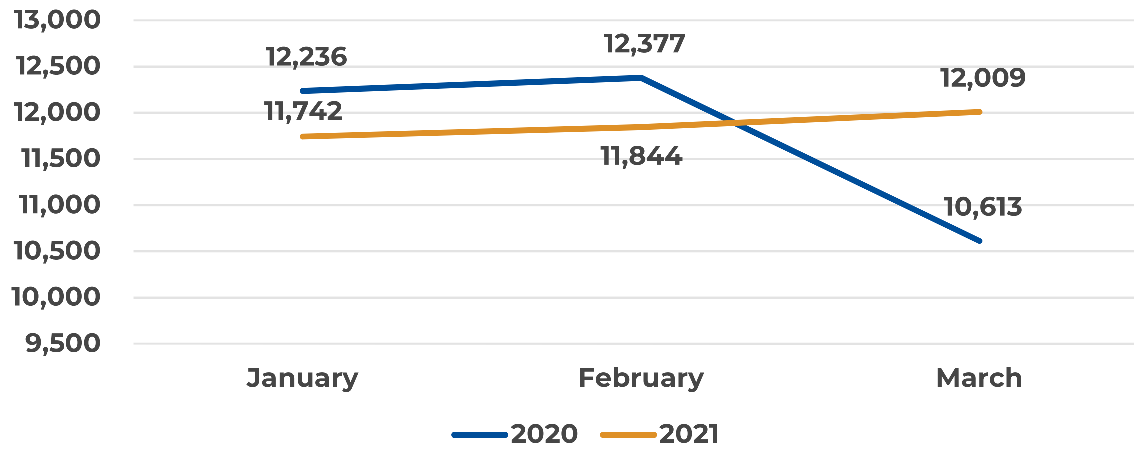
Month	2020	2021
January	65,410	60,801
February	65,407	61,791
March	64,141	62,975

Month	Count Change	Percent Change
January	(4,609)	-7%
February	(3,616)	-6%
March	(1,166)	-2%

Quarterly Percent Change	-5%

Agency Stats & Provider Network (Cont.)

Mental Health Providers (In-State Only)

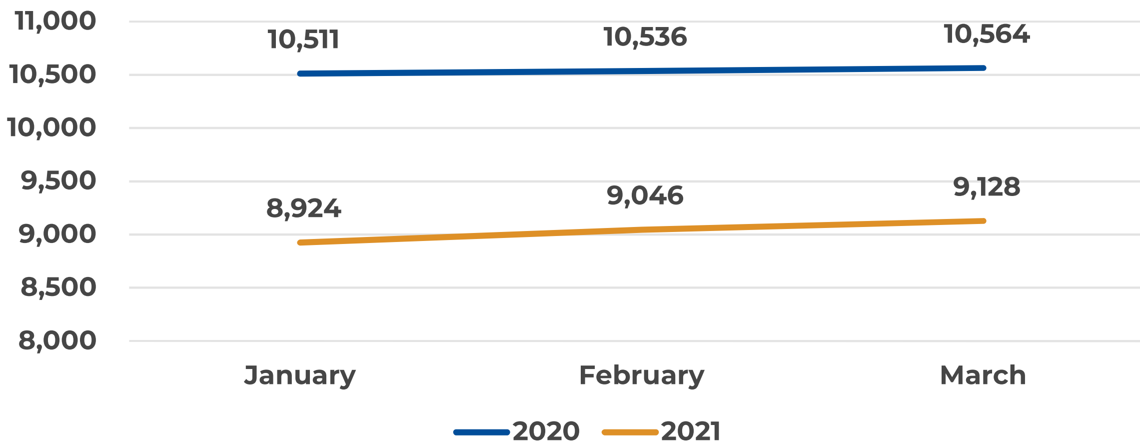


Month	2020	2021
January	12,236	11,742
February	12,377	11,844
March	10,613	12,009

Month	Count Change	Percent Change
January	(494)	-4%
February	(533)	-4%
March	1,396	13%

Quarterly Percent Change	-4%

Physicians (In-State Only)



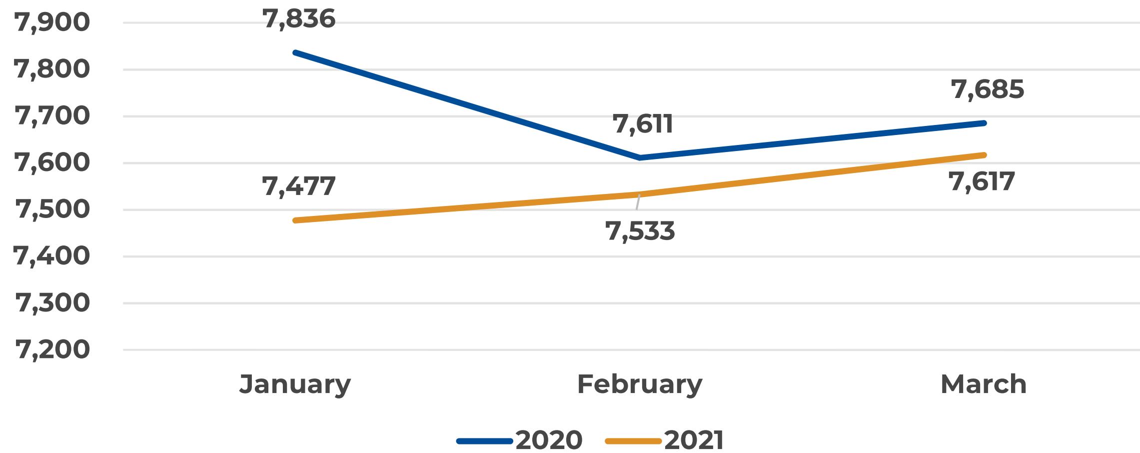
Month	2020	2021
January	10,511	8,924
February	10,536	9,046
March	10,564	9,128

Month	Count Change	Percent Change
January	(1,587)	-15%
February	(1,490)	-14%
March	(1,436)	-14%

Quarterly Percent Change	-14%

Agency Stats & Provider Network (Cont.)

Primary Care Providers (In-State Only)

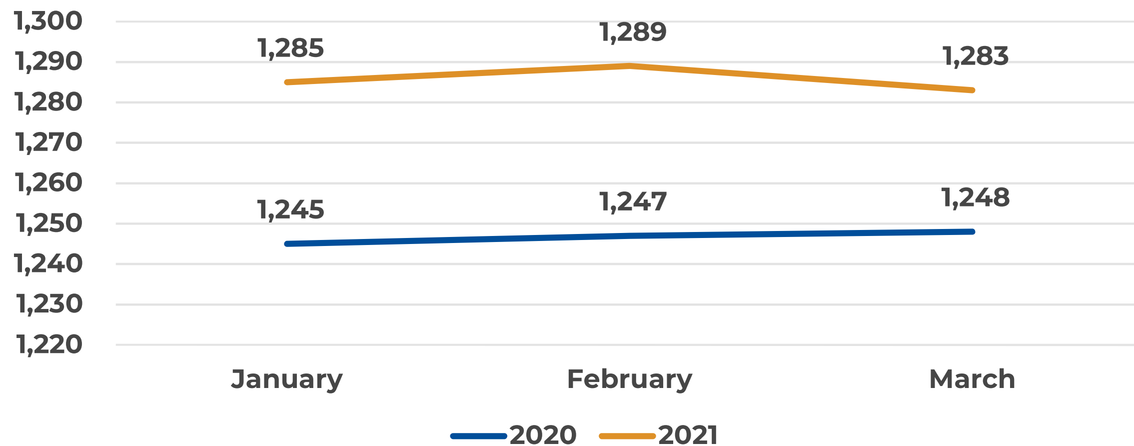


Month	2020	2021
January	7,836	7,477
February	7,611	7,533
March	7,685	7,617

Month	Count Change	Percent Change
January	(359)	-5%
February	(78)	-1%
March	(68)	-1%

Quarterly Percent Change	-4%

Dentists (In-State Only)



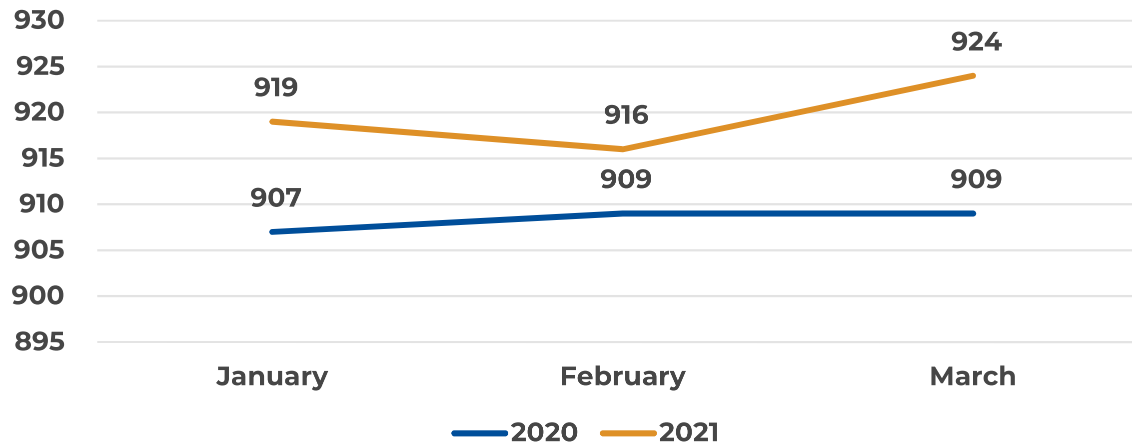
Month	2020	2021
January	1,245	1,285
February	1,247	1,289
March	1,248	1,283

Month	Count Change	Percent Change
January	40	3%
February	42	3%
March	35	3%

Quarterly Percent Change	4%

Agency Stats & Provider Network (Cont.)

Pharmacy (In-State Only)

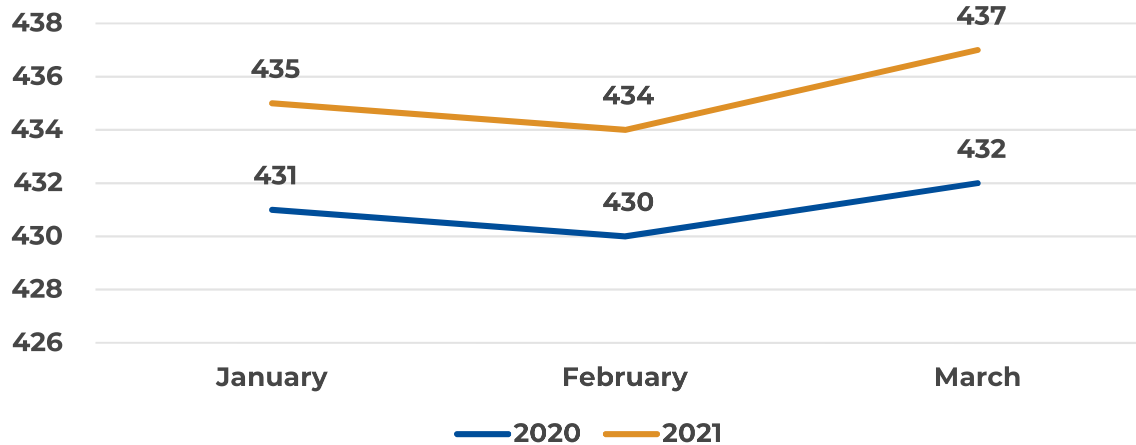


Month	2020	2021
January	907	919
February	909	916
March	909	924

Month	Count Change	Percent Change
January	12	1%
February	7	1%
March	15	2%

Quarterly Percent Change	2%

Extended Care Facilities (In-State Only)



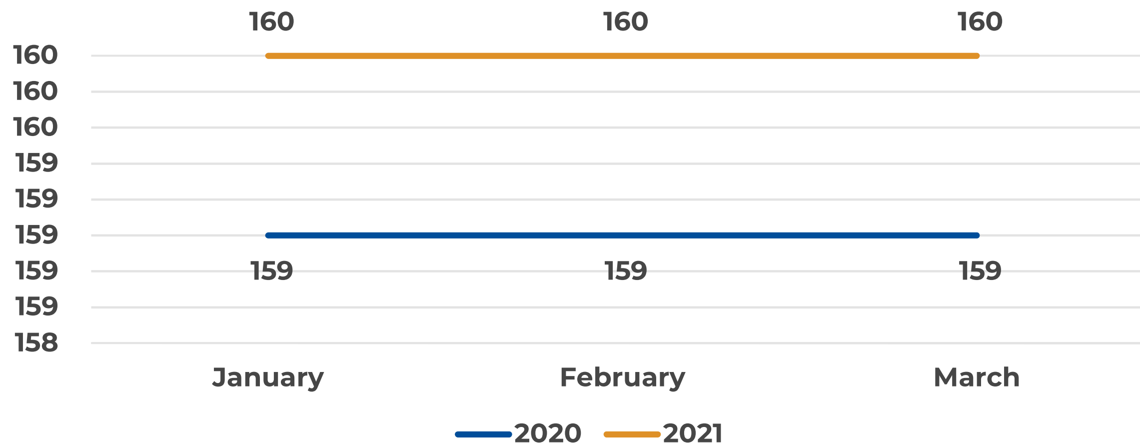
Month	2020	2021
January	431	435
February	430	434
March	432	437

Month	Count Change	Percent Change
January	4	1%
February	4	1%
March	5	1%

Quarterly Percent Change	1%

Agency Stats & Provider Network (Cont.)

Hospitals (In-State Only)



Month	2020	2021
January	159	160
February	159	160
March	159	160

Month	Count Change	Percent Change
January	1	1%
February	1	1%
March	1	1%

Quarterly Percent Change	1%