Oklahoma Health Care Authority
MEDICAL ADVISORY COMMITTEE

AGENDA

May 14, 2020
1:00 PM – 3:30 PM
Teleconference
Oklahoma City, Oklahoma

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

Teleconference Participants

Ms. Sarah Baker – Zoom teleconference
Ms. Debra Billingsley – Zoom Teleconference
Ms. Kristi Blackburn – Zoom teleconference
Ms. Mary Brinkley – Zoom teleconference
Dr. Joe Catalano – Zoom teleconference
Mr. Victor Clay – Zoom teleconference
Dr. Steven Crawford – Zoom teleconference
Ms. Wanda Felty – Zoom teleconference
Dr. Arlen Foulks – Zoom teleconference
Ms. Terrie Fritz – Zoom teleconference
Ms. Allison Garrison – Zoom teleconference
Dr. Lori Holmquist- Zoom teleconference
Ms. Tina Johnson – Zoom teleconference
Mr. Mark Jones – Zoom teleconference
Ms. Annette Mays – Zoom teleconference
Ms. Melissa Miller – Zoom teleconference
Mr. James Patterson – Zoom teleconference
Dr. J. Daniel Post – Zoom teleconference
Ms. Toni Pratt-Reid – Zoom teleconference
Dr. Jason Rhynes – Zoom teleconference
Dr. Dwight Sublett – Zoom teleconference
Mr. Rick Snyder – Zoom teleconference
Mr. Jeff Tallent – Zoom teleconference
Mr. William Whited – Zoom teleconference
Dr. Paul Wright – Zoom teleconference
Dr. Whitney Yeates – Zoom teleconference
Ms. Lindsey Hanna – Zoom teleconference
Dr. JJ Peek – Zoom teleconference
Ms. Katie Roberts – Zoom teleconference
Ms. Joni Bruce – Zoom teleconference
Ms. Sandra Harrison – Zoom teleconference
Ms. Lois Baer - Zoom Teleconference

Public access via Zoom:
https://okhca.zoom.us/webinar/register/WN_ITVljFb0SfSJGNEpc_Fl7w
Telephone: 1-669-900-6833 Meeting ID: 959 6601 8215

II. Action Item: Approval of the March 12, 2020 MAC Meeting Minutes

III. Public Comments (2 minute limit)

IV. MAC Member Comments/Discussion

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

VI. SoonerCare Operations Update: **Melinda Thomason, Senior Director for Stakeholder Engagement**

VII. Legislative Update: **Christina Foss, Legislative Liaison**

VIII. Proposed Rule Changes: Presentation, Discussion, and Vote: **Sandra Puebla, Director of Federal & State Authorities**

A. **20-05 Continuation of Services Pending Appeals**
B. **20-06A Durable Medical Equipment (DME) and Supplies Benefit moved under the Scope of the Home Health Benefit**
C. **20-06 B, C, and D Durable Medical Equipment (DME) and Supplies Benefit moved under the Scope of the Home Health Benefit**
D. **20-08A and B Medicaid Expansion**
E. **20-09 Patient Centered Medical Home (PCMH)**
F. **20-10 Supplemental Hospital Offset Payment Program (SHOPP)**

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

X. Future Meeting:
July 9, 2020
September 10, 2020
November 12, 2020

XI. Adjourn

Oklahoma Health Care Authority
MEDICAL ADVISORY COMMITTEE
MINUTES of the March 12, 2020 Meeting
4345 N. Lincoln Blvd., Oklahoma City, OK 73105

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

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

***Delegates present were*:** Ms. Debra Billingsly, Ms. Kristi Blackburn, Dr. Erin Balzer, Dr. Joe Catalano, Mr. Victor Clay, Dr. Steven Crawford, Ms. Wanda Felty, Dr. Arlen Foulks, Ms. Tina Johnson, Mr. Mark Jones, Ms. Annette Mays, Ms. Melissa Miller, Dr. Daniel Post, Ms. Toni Pratt-Reid, Dr. Jason Rhynes, Dr. Dwight Sublett, Mr. Rick Snyder, Mr. William Whited, and Dr. Whitney Yeates.

Alternates present were: Ms. Lindsay Hanna and Ms. Frannie Pryor providing a quorum.

***Delegates absent without an alternate were*:** Ms. Mary Brinkley, Mr. Brett Coble, Ms. Allison Garrison, Mr. Steve Goforth, Dr. Lori Holmquist-Day, Mr. James Patterson, Dr. Raymond Smith, Mr. Jeff Tallent, and Dr. Paul Wright.

II. Approval of the January 9, 2020 Minutes

Medical Advisory Committee

The motion to approve the minutes was by Dr. Joe Catalano and seconded by Dr. Steven Crawford and passed unanimously.

III. Public Comments (2 minute limit):

Dennis Hogle, Chief Executive Officer with Diagnostic Laboratory of Oklahoma. DLO is proud to serve the SoonerCare program as the largest state provider for laboratory services. There has been a concern raised regarding the proposed rule regarding the medically necessary PCR Testing for infectious diseases. Over recent years there has been significant scientific advances in the ability to use PCR to identify bacteria using small amounts of DNA. The Infectious Disease Society of America supports the use of PCR as efficient and effective technology for detecting infectious pathogens, such as COVID 19. The CDC also recommends using PCR technology to detect any sexually transmitted diseases. STD's are at an all-time high, causing serve consequences, including newborn deaths. As a payer we understand that a prior authorization is commonly used as an effective lever as a way to keep unnecessary testing down, however, this presents unique challenges, and inequities for labs. We would like to see other alternatives for auditing laboratories and restricting PA's on certain organizations in the state.

IV. MAC Member Comments/Discussion:

Chairman Rhynes introduced Melissa Miller as the new designee for the Oklahoma Department of Mental Health and Substance Abuse Services. Ms. Miller is the Director of Medicaid Behavioral Health Policy and Planning at the Oklahoma Department of Mental Health and Substance Abuse Services. Prior to this position, she worked at the Oklahoma State Department of Health in a variety of capacities, including Assistant Director and Senior Project Manager. Previous to her time at the

Department of Health, she worked at the Center for Learning and Leadership, Oklahoma's University Center for Excellence in Developmental Disabilities. Melissa has a master's degree in social work from the University of Oklahoma and a bachelor's degree in social work from Anderson University.

Mr. Victor Clay discussed the State plan Amendment that was placed on a web alert in January, as it relates to Durable Medical Equipment, supplies and appliances, Home Health and compliance with the 21st century Cures Act. The proposed state plan amendment would bring back some of these items that have been excluded as an optional benefit for those that are 21 years of age and up, such as nebulizers, or CPAPS, but in doing so the state plan amendment also has also outlined a new fee schedule across the board for all products. Which unfortunately for us, it will go to a vote for executive committee on Wednesday of next week. And that fee schedule will be the lowest of the outline fee schedule to in the state of Oklahoma as it pertains to Medicare fee schedules.

Mr. Clay read a letter on behalf of the Oklahoma Medial Equipment Providers Association as an urgent request to reconsider the proposed pricing set fourth for Durable Medical Equipment in July of 2020. The fee schedule you have presented will be detrimental to providers and rural members. Oklahoma has already seen a drastic loss of the DME providers in the rural areas in the last 10 years and have seen a decrease in over 160 DME providers. Our ask is to please set the DME rates in line with the Medicaid rates in line with zip code where the member is living based on this change Medicaid will not pay an overage to Medicare as they have in the past couple of years. The reason being that rural providers are invested with the communities and the people who reside in them. We not only provide jobs for our communities members but we also provide education, service and product ordered by Health Care professionals to improve the well-being of their patients. We spend time with our patients educating and teaching and partnering with them to make sure they are able to successfully use their equipment. DME requires hands on care in order to prevent any resubmissions to hospitals and additional confrontations. In order to get the best return on our investment with the purchase of DME rural providers should be considered a vital resource for your members. Our service education, equipment and supplies will aid in lowering the cost in the healthcare system as a whole. The solution is to tie Medicaid fee schedules to patient zip codes. The purpose of our involvement in this letter is to prevent massive closing of DME providers as seen from 2010 – 2019 by the implementation of Medicare reduction of reimbursement. DME industry has seen 39% decrease of DME providers in the past 10 years. The members of the Oklahoma Health Care Authority need to have quality providers available in the network and not see another drastic closing or rural and mobile DME providers.

Dr. Dwight Sublett supports what Mr. Clay discussed as it was brought to his attention in Stillwater with a lot of concern, and states that it is something that should be considered. Ms. Annette Mays would also like to include Home Health and the 36 visits be lifted and include that Home Health rates also not be cut. Dr. Steven Crawford and MAC committee members are also in support of Mr. Clay, and Ms. Mays.

V. Financial Report:

Aaron Morris, Chief Financial Officer

Mr. Morris presented the financial report ending in November 2019. OHCA is 14.4 million dollars under budget in our expenditures on our program side, which is our payments to our providers. On our Administration side we are also under budget .4 million state dollars. That number comes from having some vacant FTE's. On the revenue side we are under budget in Drug Rebate 1.9 million state dollars. Medical refunds is over budget 1.2 million state dollars, and taxes & fees is over budget 0.4 million state dollars. Total state variance through November is 14.5 million state dollars. For more detailed information, see item 4 in the MAC agenda.

VI. SoonerCare Operations Update:

Melinda Thomason, Senior Director for Stakeholder Engagement

Ms. Thomason presented the SoonerCare Operations update to the committee. Information is based on data for January 2020. Patient Centered Medical Home enrollment is at 524,604 which is up by 3,944. Sooner Care Traditional has a current enrollment of 230,709 which is 3,854 less than the previous month. SoonerPlan is down by 236, giving a total number of 26,457. Insure Oklahoma has a total enrollment of 18,257, of which 13,058 are in the Employee Sponsored Plan, and 5,199 are in the individual plan. In total, SoonerCare enrollment is at 800,027. Total in-state providers is up 445, giving a total of 45,200. For more detailed information see agenda item 5 in the MAC agenda.

VII. Legislative Update:

Christina Foss, Legislative Liaison

Ms. Foss presented a legislative update for the committee members discussing Governor Stitt's vision for the healthcare in Oklahoma and shared his vision for SoonerCare 2.0. Part of that is expansion. We submitted our State Plan Amendment last week to CMS to expand Medicaid. Part of the discussion in legislature is how to fund that state share portion which is about $150 million. SHOPP is one of the programs being looked at, and some other additional funding options, like TSET. Another vision was looking at how to integrate health agencies, so there is a bill out right now, that starts that first process in giving authority to start integrating our agency with Department of Mental Health. One of our requested bills is initiating a shared savings program with our Tribal partners, which has a lot of potential savings for our state.

VIII. Proposed Rule Changes: Presentation, Discussion, and Vote:

Sandra Puebla, Director of Federal & State Authorities

Face-to-face tribal consultations regarding the following proposed changes were held on Tuesday, May 7, 2019, Tuesday, July 2, 2019, Tuesday, September 3, 2019, Tuesday, November 5, 2019, and Tuesday, January 7, 2020 in the Charles Ed McFall Boardroom of the Oklahoma Health Care Authority (OHCA).

The following work folders were posted on the OHCA public website for a 30-day comment period.

19-10 American Indian/Alaska Native (AI/AN) cost sharing exemptions — The proposed rule changes will align policy with Oklahoma's Medicaid State Plan language and 42 Code of Federal Regulations (C.F.R.) § 447.56(a)(x). Section 5006 of the American Recovery and Reinvestment Act (ARRA) precludes states from imposing Medicaid premiums or any other Medicaid cost sharing on Indian applicants and participants served by Indian health providers.
Budget Impact: Budget neutral
The rule change motion to approve was by Dr. Steven Crawford and seconded by Dr. Joe Catalano and passed unanimously.

19-15 Rural Health Clinic (RHC) — The proposed rule changes will update policy to come into compliance with the Benefits Improvement and Protection Act of 2000. Policy changes will reflect a revised payment methodology for RHCs increasing access to care in rural areas. Further revisions will update policy to reflect current business practices.
Budget Impact: The estimated budget impact for SFY 2020 will be an increase in the total amount of $17,657,446; with $6,160,683 in state share.
The rule change motion to approve was by Dr. Dwight Sublett and seconded by Dr. Steven Crawford and passed unanimously.

19-24 Urine Drug Screening and Laboratory Services Policy — The proposed rule changes will update urine drug screening policy by removing the word "urine", in order to clarify that this policy applies to multiple specimens and not just urine specimens. Additionally, the proposed revisions will update laboratory services policy to clarify that laboratory testing for routine diagnostic or screening purposes are compensable when they are recommended by the clinical guidelines of nationally recognized professional medical academies or societies, and those sources meet medical necessity criteria, as outlined in OHCA rules.
Budget Impact: Budget neutral
The rule change motion to approve was by Dr. Arlen Foulks and seconded by Dr. Steven Crawford and passed unanimously.

19-25 Polymerase Chain Reaction (PCR) Testing for Infectious Diseases — The proposed rule changes will establish guidelines to assure medical necessity and consistency in the prior authorization (PA) process for PCR testing. The guidelines include criteria to meet medical necessity and required documentation for approval of the PA.
Budget Impact: Agency staff has determined that the proposed rule changes will result in a budget savings by decreasing reimbursement of medically unnecessary PCR tests. The total spending for calendar year 2018, on PCR infectious disease testing CPT codes which will now be subject to prior authorization was $6,282,503. With an estimated denial rate of 50% for lack of medical necessity, total estimated budget savings will be $3,141,252 annually, of which $1,067,397 is state dollars.

The rule change motion to approve was by Dr. Steven Crawford and seconded by Dr. Dwight Sublett with one opposed from Dr. Joe Catalano, and passed.

19-26 Countable Income and Resources for the Aged, Blind and Disabled (ABD) Eligibility Groups and Eligibility as a Qualified Medicare Beneficiary (QMB) Plus Member — The proposed rule changes will update policy regarding the determination of countable income for ABD individuals. The rule changes will incorporate federal Supplemental Security Income (SSI) standards, including earned and unearned income which is to be excluded, and clarifies guidance on how income is deemed from certain individuals to another, for example, ineligible spouses to the applicant. Additional rule changes will update policy so that the value of a life estate may be established by a written estimate instead of a written appraisal. Additional rule changes will update QMB Plus policy so that the intent of the rule regarding income and resource standards for individuals and couples is clearly stated. Finally, the QMB Plus policy will be aligned with other Medicare savings programs.
Budget Impact: Budget neutral
The rule change motion to approve was by Dr. Steven Crawford and seconded by Dr. Daniel Post and passed unanimously.

19-27 Ground Emergency Medical Transportation (GEMT) Supplemental Payment Program — The proposed rule changes will establish rules consistent with the Oklahoma's Medicaid State Plan which outlines the GEMT Supplemental Payment Program. The GEMT is a voluntary program which provides supplemental payments to eligible providers for specific allowable and uncompensated costs incurred for providing ground ambulance services to SoonerCare recipients and certified on an annual cost report. Payments are made in the form of an interim payment and a later reconciliation payment (i.e. settle-up payment).
Budget Impact: There is no estimated federal budget impact for federal fiscal year (FFY) 2019. The estimated federal budget impact for FFY 2020 is $17,258,031. It is estimated that the revisions will be budget neutral for the State as participating GEMT providers will bear the cost of providing the state share for the program, as well as, any administrative costs.
The rule change motion to approve was by Dr. Steven Crawford and seconded by Dr. Joe Catalano and passed unanimously.

19-29 Reasonable Limits for Necessary Medical and Remedial Care Not covered under the Oklahoma Medicaid State Plan — The proposed rule changes will revise the formula for calculating the vendor payment for SoonerCare members receiving services in a nursing facility (NF) or an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID). The vendor payment is the monthly amount the member must contribute toward the cost of their care in a long-term care facility. The revisions will establish limitations and/or reasonable requirements before a medical expense can be deducted from the individual's post-eligibility income when determining the vendor payment. Currently, there are no limitations or established criteria by which expenses are quantified or determined to be allowed for deduction. Similar reasonable limits have been implemented by numerous State Medicaid agencies, including that of Arkansas, Colorado, Massachusetts, and Texas.
Budget Impact: The OHCA anticipates, but cannot reliably estimate, a budget impact for the proposed changes, because the amount of expenses for medical or remedial care that are not subject to third party payment (hereinafter, 'Expenses') will: 1) vary from person to person; and 2) be unknown until the person or his or her representative reports them to the OHCA. Currently,

there are no limitations or established criteria by which Expenses are quantified or determined to be allowable for deduction. Accordingly, implementing reasonable limits on these types of Expenses should minimize total potential losses to the agency, over the long term.
The rule change motion to approve was by Mr. Victor Clay and seconded by Dr. Steven Crawford, with one opposed from Dr. Joe Catalano, and passed.

19-32 Inpatient Psychiatric Services and Service Quality Review (SQR) Revisions — The proposed rule changes will amend inpatient psychiatric services policy for members under twenty-one (21) to reflect current practice, update obsolete references, and reorganize sections for consistent application of policy. The proposed rule changes will also address SQR findings of deficiency regarding inpatient psychiatric facilities' compliance with federal regulations and OHCA administrative rules. Additionally, the proposed rule changes will create a general specialty add-on payment for children and adolescents with specialized treatment needs who are being served in a psychiatric residential treatment facility (PRTF), Acute II unit of a psychiatric hospital and general hospital with an Acute II psychiatric.
Budget Impact: The proposed rule changes that amend inpatient psychiatric services policy for members under twenty-one would be budget neutral. The proposed rule changes that address SQR findings of deficiency would potentially result in savings; however, the agency is unable to provide a measurable savings amount. The proposed rule changes that create a general specialty add-on payment would potentially result in an annual total cost of $5,747,126; $2,000,000 state share for SFY2021. The state share will be paid by the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS).
The rule change motion to approve was by Dr. Dwight Sublett and seconded by Mr. Victor Clay and passed unanimously.

19-34 ADvantage Waiver — The proposed rule changes, to the ADvantage Waiver policy, will add new language addressing the State Plan Personal Care eligibility provider exception criteria. Additionally revisions will update existing policy that will clarify the criteria an applicant must meet to receive ADvantage services and the type of living arrangements that are not eligible for ADvantage members.
Budget Impact: Budget neutral
The rule change motion to approve was by Dr. Steven Crawford and seconded by Dr. Daniel Post and passed unanimously.

19-35 Developmental Disabilities Services (DDS) — The proposed rule changes to the DDS policy will allow for self-directed services to be an option under the Community waiver. Additional revisions will add language to note the daily hourly limits on services provided by the self-directed habilitation training specialist. Other revisions will establish guidelines for the DDS Home and Community-Based Services waiver's Electronic Visit Verification (EVV) billing procedures.
Budget Impact: Budget neutral
The rule change motion to approve was by Dr. Steven Crawford and seconded by Ms. Melissa Miller and passed unanimously.

19-37 Mobile and Portable Dental Treatment Facilities — The proposed rule changes will add coverage and reimbursement for preventive dental services received through mobile and portable dental treatment facilities. Additionally, revisions will add provider participation requirements

pursuant to the Oklahoma State Dentistry Act and the OHCA contracting requirements, while also defining coverage and limitations for preventive dental services, billing requirements, basic consent form requirements, and follow-up care requirements.
Budget Impact: The estimated budget impact for SFY 2021 will be an increase in the total amount of $115,753; with $37,921 in state share.
The rule change motion to approve was by Dr. Dwight Sublett and seconded by Dr. Arlen Foulks and passed unanimously.

19-41A Patient-Centered Medical Homes (PCMH), Health Access Networks (HAN) and Health Management Program (HMP) Updates — The proposed rule changes will update the policy for Patient-Centered Medical Homes (PCMH) and Health Access Networks (HAN). Additionally, a new section of policy will be added to address the Health Management Program (HMP) which will provide an overview of the program and outline provider participation guidelines. Finally, policy changes will include general policy cleanup and align policy with current business practices.
Budget Impact: Budget neutral
The rule change motion to approve was by Mr. Victor Clay and seconded by Dr. Steven Crawford and passed unanimously.

19-41B Insure Oklahoma Individual Plan (IP) and Insure Oklahoma Employer Sponsored Insurance (ESI) — The proposed rule changes will add language to the Insure Oklahoma IP and ESI policy on how a newborn child can be deemed eligible on their date of birth for SoonerCare benefits when the child is born to a member of the Insure Oklahoma IP or ESI. Additionally, the proposed policy changes will define eligibility criteria for the newborn to receive SoonerCare benefits.
Budget Impact: Budget neutral
The rule change motion to approve was by Dr. Steven Crawford and seconded by Dr. Dwight Sublett and passed unanimously.

19-42 Adult Inpatient Rehabilitation Days — The proposed rule changes will increase the number of covered inpatient rehabilitation hospital days for adult SoonerCare members from twenty-four (24) days per state fiscal year to ninety (90) days per state fiscal year. These changes are necessary to meet the health care needs of SoonerCare members by increasing access to stabilization services in an inpatient rehabilitation setting.
Budget Impact: The estimated budget impact for SFY 2021 will be an increase in the total amount of $584,266 total; with $187,023 in state share. The estimated budget impact for SFY 2022 will be an increase in the total amount of $779,021; with $187,023 in state share.
The rule change motion to approve was by Dr. Joe Catalano and seconded by Mr. Victor Clay and passed unanimously.

19-43A and B Coverage Definitions for Children and Adults — The proposed rule changes will add definitions to clarify what the OHCA views as a child and an adult, unless otherwise specified by federal and/or state law. Additional revisions will involve limited rewriting aimed at clarifying text, fixing any grammatical errors, and aligning rules with current business practices.
Budget Impact: Budget neutral
The rule change motion to approve was by Mr. Clay Victor and seconded by Dr. Arlen Foulks and passed unanimously.

19-44 Organ Transplant — The proposed rule changes will update organ transplant requirements and guidelines to reflect current practice.
Budget Impact: Budget neutral
The rule change motion to approve was by Dr. Steven Crawford and seconded by Dr. Dwight Sublett and passed unanimously.

19-45 Private Duty Nursing (PDN) Revisions — The proposed rule changes will update and strengthen PDN policy by defining the place of services where/that PDN is allowed. Additional revisions will include adding language to allow for medically necessary PDN services outside of the home if certain requirements are met. Further revisions will clarify which PDN services will and will not be authorized. Finally, the proposed revisions will involve limited rewriting aimed at clarifying text, fixing any grammatical errors, and aligning rules with current business practices.
Budget Impact: Budget neutral
The rule change motion to approve was by Ms. Toni Pratt-Reid and seconded by Dr. Steven Crawford and passed unanimously.

19-46 School-based/Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Revisions — The proposed rule changes will cleanup the school-based policy to separate and differentiate between services provided in a school setting under EPSDT benefit versus those school-based services that are pursuant to an Individual Education Plan (IEP).
Budget Impact: Budget neutral
The rule change motion to approve was by Dr. Joe Catalano and seconded by Dr. Daniel Post and passed unanimously.

19-47 Medically Necessary Extractions Revisions — In an effort to improve dental access and coverage for adults, the proposed rule changes will amend the rule that limits dental services for adults to "emergency" extractions only by changing it to "medically necessary" extractions. Additionally, the proposed rule revisions will add definitions for medically necessary oral healthcare and medically necessary extractions. Finally, the proposed revisions will involve limited rewriting aimed at clarifying text, fixing any grammatical errors, and aligning rules with current business practices.
Budget Impact: The estimated budget impact for SFY 2020 will be an increase in the total amount of $1,734,313; with $605,102 in state share.
The rule change motion to approve was by Dr. Steven Crawford and seconded by Dr. Whitney Yeates and passed unanimously.

20-01 High-Investment Drugs Carve-Out — The proposed rule changes will allow certain high-investment drugs to be reimbursed outside of the inpatient and outpatient hospital payment methodologies. Additionally, the proposed rule changes will require inpatient and outpatient hospitals to seek prior authorization of high-investment drugs and follow applicable requirements and conditions of payment. Lastly, revisions will align policy with current practice and correct grammatical errors.

Budget Impact: The proposed rule changes will be budget neutral as high-investment drugs are included in the pharmacy budget.
The rule change motion to approve was by Dr. Joe Catalano and seconded by Dr. Steven Crawford and passed unanimously.

20-03 Treatment of Lottery or Gambling Winnings for Income Eligibility — The proposed rule changes are in response to the Advancing Chronic Care, Extenders and Social Services Act, referred to as the ACCESS Act and included in Public Law No. 115-123 § 53103, which changed the way qualified lottery winnings or qualified gambling winnings of $80,000 and above are treated when determining MAGI-based income eligibility. Previous federal regulations and OHCA rules required that all lump sum income, including lottery and gambling winnings, be counted as income only in the month received. Winnings will still be counted as income against the SoonerCare household in the month received; however, winnings of $80,000 and above that are paid out in a single payout option, will be counted in multiple months and in equal monthly installments against the individual household member receiving the winnings. Lottery winnings that are paid out in installments over a period of time would be treated as recurring income. The formula for counting winnings of $80,000 and above is set forth in the new OHCA policy at OAC 317:35-6-55(b) and (c).
Budget Impact: Agency staff has determined that the impact of the proposed rule changes on the budget is unknown as the number of SoonerCare members who will have lottery or gambling winnings is unknown; however, savings could potentially be realized if a member lost eligibility for multiple months due to receipt of lottery or gambling winnings above $80,000 paid out in a single payout.
The rule change motion to approve was by Mr. Victor Clay and seconded by Dr. Dwight Sublett and passed unanimously.

IX. New Business: Chairman, Jason Rhynes, O.D.

No new business was identified.

X. Future Meetings

May 14, 2020
July 9, 2020
September 10, 2020
November 12, 2020

XI. Adjournment

Chairman Rhynes asked for a motion to adjourn. Motion was provided by Dr. Steven Crawford and seconded by Ms. Annette Mays. There was no dissent and the meeting adjourned at 2:36.

OKLAHOMA
Health Care Authority

FINANCIAL REPORT

For the Seven Month Period Ended January 31, 2020
Submitted to the CEO & Board

- Revenues for OHCA through January, accounting for receivables, were **$2,699,774,564** or **1.1% under** budget.
- Expenditures for OHCA, accounting for encumbrances, were **$2,679,953,801** or **1.9% under** budget.
- The state dollar budget variance through January is a positive **$20,523,989.**
- The budget variance is primarily attributable to the following (in millions):

Expenditures:		
Medicaid Program Variance		15.5
Administration		1.8
Revenues:		
Drug Rebate		1.0
Medical Refunds		1.4
Taxes and Fees		0.8
Total FY 20 Variance	**$**	**20.5**

ATTACHMENTS

OKLAHOMA HEALTH CARE AUTHORITY
Summary of Revenues & Expenditures: OHCA
SFY 2020, For the Seven Month Period Ending January 31, 2020

REVENUES	FY20 Budget YTD	FY20 Actual YTD	Variance	% Over/ (Under)
State Appropriations	$ 607,999,332	$ 607,999,332	$ -	0.0%
Federal Funds	1,625,488,452	1,586,894,481	(38,593,971)	(2.4)%
Tobacco Tax Collections	25,731,711	27,919,194	2,187,483	8.5%
Quality of Care Collections	49,603,490	48,050,761	(1,552,730)	(3.1)%
Prior Year Carryover	20,110,285	20,110,285	-	0.0%
Federal Deferral - Interest	201,717	201,717	-	0.0%
Rate Preservation Fund	17,127,103	17,127,103	-	0.0%
Drug Rebates	200,364,384	203,295,522	2,931,138	1.5%
Medical Refunds	20,917,720	24,805,929	3,888,208	18.6%
Supplemental Hospital Offset Payment Program	145,910,692	145,910,692	-	0.0%
GME Federal Disallowance Repayment - OU/OSU	13,127,949	13,127,949	-	0.0%
Other Revenues	4,210,079	4,331,600	121,521	2.9%
TOTAL REVENUES	**$ 2,730,792,914**	**$ 2,699,774,564**	**$ (31,018,350)**	**(1.1)%**

EXPENDITURES	FY20 Budget YTD	FY20 Actual YTD	Variance	% (Over)/ Under
ADMINISTRATION - OPERATING	**$ 34,728,553**	**$ 31,160,322**	**$ 3,568,231**	**10.3%**
ADMINISTRATION - CONTRACTS	**$ 82,753,580**	**$ 78,973,473**	**$ 3,780,106**	**4.6%**
MEDICAID PROGRAMS				
Managed Care:				
SoonerCare Choice	26,152,281	24,851,701	1,300,581	5.0%
Acute Fee for Service Payments:				
Hospital Services	593,528,959	590,746,719	2,782,240	0.5%
Behavioral Health	10,900,518	11,049,558	(149,040)	(1.4)%
Physicians	241,533,225	235,978,635	5,554,590	2.3%
Dentists	81,969,240	80,456,873	1,512,367	1.8%
Other Practitioners	39,131,698	33,312,572	5,819,127	14.9%
Home Health Care	15,993,612	16,574,364	(580,752)	(3.6)%
Lab & Radiology	15,972,452	14,276,342	1,696,111	10.6%
Medical Supplies	34,198,659	32,060,465	2,138,194	6.3%
Ambulatory/Clinics	167,795,448	156,873,980	10,921,468	6.5%
Prescription Drugs	399,655,047	389,190,892	10,464,155	2.6%
OHCA Therapeutic Foster Care	11,706	151,316	(139,610)	(1192.6)%
Other Payments:				
Nursing Facilities	380,019,744	378,794,637	1,225,107	0.3%
Intermediate Care Facilities for Individuals with Intellectual Disabilities Private	38,888,777	39,027,601	(138,824)	(0.4)%
Medicare Buy-In	103,593,914	105,767,977	(2,174,063)	(2.1)%
Transportation	44,233,382	42,616,584	1,616,797	3.7%
Money Follows the Person-OHCA	188,188	98,880	89,308	47.5%
Electronic Health Records-Incentive Payments	94,105	94,105	-	0.0%
Part D Phase-In Contribution	59,406,048	59,558,806	(152,758)	(0.3)%
Supplemental Hospital Offset Payment Program	354,168,636	354,168,636	-	0.0%
Telligen	6,488,987	4,169,366	2,319,622	35.7%
Total OHCA Medical Programs	**2,613,924,626**	**2,569,820,006**	**44,104,620**	**1.7%**
OHCA Non-Title XIX Medical Payments	89,382	-	89,382	0.0%
TOTAL OHCA	**$ 2,731,496,141**	**$ 2,679,953,801**	**$ 51,542,339**	**1.9%**
REVENUES OVER/(UNDER) EXPENDITURES	**$ (703,226)**	**$ 19,820,762**	**$ 20,523,989**	

OKLAHOMA HEALTH CARE AUTHORITY

Total Medicaid Program Expenditures
by Source of State Funds
SFY 2020, For the Seven Month Period Ending January 31, 2020

Category of Service	Total	Health Care Authority	Quality of Care Fund	HEEIA	SHOPP Fund	BCC Revolving Fund	Other State Agencies
SoonerCare Choice	$ 24,907,663	$ 24,846,274	$ -	$ 55,962	$ -	$ 5,427	$ -
Inpatient Acute Care	722,352,723	372,680,048	283,901	2,151,604	269,338,432	574,746	77,323,993
Outpatient Acute Care	290,362,410	214,124,468	24,269	3,617,544	69,536,841	3,059,288	-
Behavioral Health - Inpatient	47,784,554	6,349,231	-	280,228	14,045,312	-	27,109,783
Behavioral Health - Psychiatrist	5,948,377	4,698,346	-	-	1,248,050	1,981	-
Behavioral Health - Outpatient	10,735,895	-	-	-	-	-	10,735,895
Behavioral Health-Health Home	13,217,058	-	-	-	-	-	13,217,058
Behavioral Health Facility- Rehab	132,992,334	-	-	-	-	77,678	132,992,334
Behavioral Health - Case Management	1,779,823	-	-	-	-	-	1,779,823
Behavioral Health - PRTF	7,337,197	-	-	-	-	-	7,337,197
Behavioral Health - CCBHC	49,802,191	-					49,802,191
Residential Behavioral Management	8,208,295	-	-	-	-	-	8,208,295
Targeted Case Management	39,507,128	-	-	-	-	-	39,507,128
Therapeutic Foster Care	151,316	151,316	-	-	-	-	-
Physicians	286,207,526	233,886,182	33,892	3,925,769	-	2,058,560	46,303,122
Dentists	80,474,204	80,449,840	-	17,331	-	7,033	-
Mid Level Practitioners	1,485,812	1,476,389	-	8,183	-	1,240	-
Other Practitioners	32,163,368	31,519,340	260,379	328,425	-	55,224	-
Home Health Care	16,578,326	16,573,140	-	3,962	-	1,224	-
Lab & Radiology	14,689,905	14,175,746	-	413,564	-	100,595	-
Medical Supplies	32,189,071	30,462,067	1,581,727	128,606	-	16,671	-
Clinic Services	157,788,813	152,708,111	-	1,146,680	-	148,132	3,785,890
Ambulatory Surgery Centers	4,132,940	4,011,902	-	115,203	-	5,835	-
Personal Care Services	6,284,083	-	-	-	-	-	6,284,083
Nursing Facilities	378,794,788	240,657,974	138,136,663	151	-	-	-
Transportation	42,537,699	40,786,571	1,595,827	64,910	-	90,392	-
IME/DME/GME	83,051,940	-	-	-	-	-	83,051,940
ICF/IID Private	39,027,601	32,003,280	7,024,321	-	-	-	-
ICF/IID Public	16,624,703	-	-	-	-	-	16,624,703
CMS Payments	165,326,783	165,064,825	261,958	-	-	-	-
Prescription Drugs	399,193,072	387,620,462	-	10,002,180	-	1,570,429	-
Miscellaneous Medical Payments	143,795	138,239	-	-	-	5,556	-
Home and Community Based Waiver	129,606,972	-	-	-	-	-	129,606,972
Homeward Bound Waiver	46,715,172	-	-	-	-	-	46,715,172
Money Follows the Person	98,880	98,880	-	-	-	-	-
In-Home Support Waiver	15,372,581	-	-	-	-	-	15,372,581
ADvantage Waiver	96,103,725	-	-	-	-	-	96,103,725
Family Planning/Family Planning Waiver	2,201,272	-	-	-	-	-	2,201,272
Premium Assistance*	31,087,980	-	-	31,087,979.98	-	-	-
Telligen	4,169,366	4,169,366	-	-	-	-	-
Electronic Health Records Incentive Payments	94,105	94,105	-	-	-	-	-
Total Medicaid Expenditures	**$ 3,437,231,445**	**$ 2,058,746,101**	**$ 149,202,936**	**$ 53,348,281**	**$ 354,168,636**	**$ 7,780,011**	**$ 814,063,157**

* Includes $30,820,936.91 paid out of Fund 245

OKLAHOMA HEALTH CARE AUTHORITY

Summary of Revenues & Expenditures:
Other State Agencies
SFY 2020, For the Seven Month Period Ending January 31, 2020

REVENUE	FY20 Actual YTD
Revenues from Other State Agencies	$ 320,341,540
Federal Funds	535,909,356
TOTAL REVENUES	**$ 856,250,896**

EXPENDITURES	Actual YTD
Department of Human Services	
Home and Community Based Waiver	129,606,972
Money Follows the Person	-
Homeward Bound Waiver	46,715,172
In-Home Support Waivers	15,372,581
ADvantage Waiver	96,103,725
Intermediate Care Facilities for Individuals with Intellectual Disabilities Public	16,624,703
Personal Care	6,284,083
Residential Behavioral Management	4,757,851
Targeted Case Management	35,093,580
Total Department of Human Services	**350,558,668**
State Employees Physician Payment	
Physician Payments	46,303,122
Total State Employees Physician Payment	**46,303,122**
Education Payments	
Graduate Medical Education	31,622,608
Indirect Medical Education	35,874,676
Direct Medical Education	15,554,656
Total Education Payments	**83,051,940**
Office of Juvenile Affairs	
Targeted Case Management	1,369,638
Residential Behavioral Management	3,450,444
Total Office of Juvenile Affairs	**4,820,083**
Department of Mental Health	
Case Management	1,779,823
Inpatient Psychiatric Free-standing	27,109,783
Outpatient	10,735,895
Health Homes	13,217,058
Psychiatric Residential Treatment Facility	7,337,197
Certified Community Behavioral Health Clinics	49,802,191
Rehabilitation Centers	132,992,334
Total Department of Mental Health	**242,974,280**
State Department of Health	
Children's First	216,571
Sooner Start	1,345,931
Early Intervention	2,101,838
Early and Periodic Screening, Diagnosis, and Treatment Clinic	1,016,499
Family Planning	241,153
Family Planning Waiver	1,954,453
Maternity Clinic	-
Total Department of Health	**6,876,445**
County Health Departments	
EPSDT Clinic	413,335
Family Planning Waiver	5,665
Total County Health Departments	**418,999**
State Department of Education	**78,951**
Public Schools	**646,550**
Medicare DRG Limit	**72,267,584**
Native American Tribal Agreements	**1,010,126**
Department of Corrections	**1,940,179**
JD McCarty	**3,116,231**
Total OSA Medicaid Programs	**$ 814,063,157**
OSA Non-Medicaid Programs	**$ 58,796,311**
Accounts Receivable from OSA	**$ 16,608,572**

OKLAHOMA HEALTH CARE AUTHORITY
SUMMARY OF REVENUES & EXPENDITURES:
Fund 205: Supplemental Hospital Offset Payment Program Fund
SFY 2020, For the Seven Month Period Ending January 31, 2020

REVENUES		FY 20 Revenue
SHOPP Assessment Fee		145,808,590
Federal Draws	$	229,672,091
Interest		102,102
Penalties		-
State Appropriations		(22,650,000)
TOTAL REVENUES	$	352,932,782

EXPENDITURES	Quarter	Quarter	Quarter	Quarter		FY 20 Expenditures
Program Costs:	7/1/19 - 9/30/19	10/1/19 - 12/31/19	1/1/20 - 3/31/20	4/1/20 - 6/30/20		
Hospital - Inpatient Care	85,252,282	101,785,980	82,300,171		$	269,338,432
Hospital -Outpatient Care	23,774,225	26,396,190	19,366,426			69,536,841
Psychiatric Facilities-Inpatient	4,602,238	6,087,933	3,355,142			14,045,312
Rehabilitation Facilities-Inpatient	383,416	456,157	408,477			1,248,050
Total OHCA Program Costs	114,012,161	134,726,259	105,430,215	-	$	354,168,636
Total Expenditures					$	354,168,636

CASH BALANCE		
	$	(1,235,853)

*** Expenditures and Federal Revenue processed through Fund 340

OKLAHOMA HEALTH CARE AUTHORITY
SUMMARY OF REVENUES & EXPENDITURES:
Fund 230: Nursing Facility Quality of Care Fund
SFY 2020, For the Seven Month Period Ending January 31, 2020

REVENUES	Total Revenue	State Share
Quality of Care Assessment	**$ 48,018,730**	**$ 48,018,730**
Interest Earned	**32,031**	**32,031**
TOTAL REVENUES	**$ 48,050,761**	**$ 48,050,761**

EXPENDITURES	FY 20 Total $ YTD	FY 20 State $ YTD	Total State $ Cost
Program Costs			
Nursing Facility Rate Adjustment	$ 135,941,280	$ 48,214,425	
Eyeglasses and Dentures	165,983	58,930	
Personal Allowance Increase	2,029,400	720,892	
Coverage for Durable Medical Equipment and Supplies	1,581,727	562,146	
Coverage of Qualified Medicare Beneficiary	602,441	214,107	
Part D Phase-In	261,958	261,958	
ICF/IID Rate Adjustment	3,154,173	1,120,234	
Acute Services ICF/IID	3,870,147	1,375,127	
Non-emergency Transportation - Soonerride	1,595,827	567,101	
Total Program Costs	**$ 149,202,936**	**$ 53,094,919**	**$ 53,094,919**
Administration			
OHCA Administration Costs	$ 340,773	$ 170,387	
DHS-Ombudsmen	88,861	88,861	
OSDH-Nursing Facility Inspectors	76,195	76,195	
Mike Fine, CPA	-	-	
Total Administration Costs	**$ 505,829**	**$ 335,443**	**$ 335,443**
Total Quality of Care Fee Costs	**$ 149,708,766**	**$ 53,430,361**	
TOTAL STATE SHARE OF COSTS			**$ 53,430,361**

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

OKLAHOMA HEALTH CARE AUTHORITY

SUMMARY OF REVENUES & EXPENDITURES:

Fund 245: Health Employee and Economy Improvement Act Revolving Fund

SFY 2020, For the Seven Month Period Ending January 31, 2020

REVENUES	FY 19 Carryover	FY 20 Revenue	Total Revenue
Prior Year Balance	$ 8,433,128		
State Appropriations	-		
Federal Draws - Prior Year	258,236		
Total Prior Year Revenue			8,691,364
Tobacco Tax Collections	-	22,962,626	22,962,626
Interest Income	-	160,030	160,030
Federal Draws	-	20,690,423	20,690,423
TOTAL REVENUES	**$ 8,691,364**	**$ 43,813,080**	**$ 52,504,443**

EXPENDITURES		FY 19 Expenditures	FY 20 Expenditures	Total State $ YTD
Program Costs:				
	Employer Sponsored Insurance		$ 30,820,937	$ 30,820,937
	College Students/ESI Dental		267,043	95,142
Individual Plan				
	SoonerCare Choice		$ 54,633	$ 19,428
	Inpatient Hospital		2,138,477	751,672
	Outpatient Hospital		3,579,056	1,270,149
	BH - Inpatient Services-DRG		274,148	97,193
	BH -Psychiatrist		-	-
	Physicians		3,876,453	1,376,639
	Dentists		17,077	6,005
	Mid Level Practitioner		7,636	2,698
	Other Practitioners		323,672	115,020
	Home Health		3,962	1,398
	Lab and Radiology		405,835	143,350
	Medical Supplies		127,867	45,302
	Clinic Services		1,119,181	398,150
	Ambulatory Surgery Center		114,650	40,570
	Skilled Nursing		151	51
	Prescription Drugs		9,895,408	3,502,924
	Transportation		64,540	22,945
	Premiums Collected		-	(298,928)
Total Individual Plan			**$ 22,002,746**	**$ 7,494,566**
	College Students-Service Costs		**$ 257,555**	**$ 92,099**
Total OHCA Program Costs			**$ 53,348,281**	**$ 38,502,744**
Administrative Costs				
	Salaries	$ 43,006	$ 1,318,999	$ 1,362,005
	Operating Costs	1,501	8,630	10,131
	Health Dept-Postponing	-	-	-
	Contract - HP	81,669	508,742	590,411
Total Administrative Costs		**$ 126,176**	**$ 1,836,371**	**$ 1,962,547**
Total Expenditures				**$ 40,465,291**
NET CASH BALANCE		**$ 8,565,188**	**$ 3,473,964.62**	**$ 12,039,152**

OKLAHOMA HEALTH CARE AUTHORITY

SUMMARY OF REVENUES & EXPENDITURES:

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

SFY 2020, For the Seven Month Period Ending January 31, 2020

REVENUES	FY 20 Revenue	State Share
Tobacco Tax Collections	$ 458,270	$ 458,270
TOTAL REVENUES	**$ 458,270**	**$ 458,270**

EXPENDITURES	FY 20 Total $ YTD	FY 20 State $ YTD	Total State $ Cost
Program Costs			
SoonerCare Choice	$ 5,427	$ 1,353	
Inpatient Hospital	574,746	144,835	
Outpatient Hospital	3,059,288	761,146	
Inpatient Services-DRG	-	-	
Psychiatrist	1,981	522	
TFC-OHCA	-	-	
Nursing Facility	-	-	
Physicians	2,058,560	511,401	
Dentists	7,033	1,725	
Mid-level Practitioner	1,240	323	
Other Practitioners	55,224	13,686	
Home Health	1,224	297	
Lab & Radiology	100,595	25,196	
Medical Supplies	16,671	4,111	
Clinic Services	148,132	36,850	
Ambulatory Surgery Center	5,835	1,507	
Prescription Drugs	1,570,429	389,952	
Transportation	90,392	22,550	
Miscellaneous Medical	5,556	1,362	
Total OHCA Program Costs	**$ 7,702,333**	**$ 1,916,815**	
OSA DMHSAS Rehab	77,678	19,298	
Total Medicaid Program Costs	**$ 7,780,011**	**$ 1,936,113**	
TOTAL STATE SHARE OF COSTS			**$ 1,936,113**

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

OHCA Monthly Metrics
May 2020
(March 2020 Data)

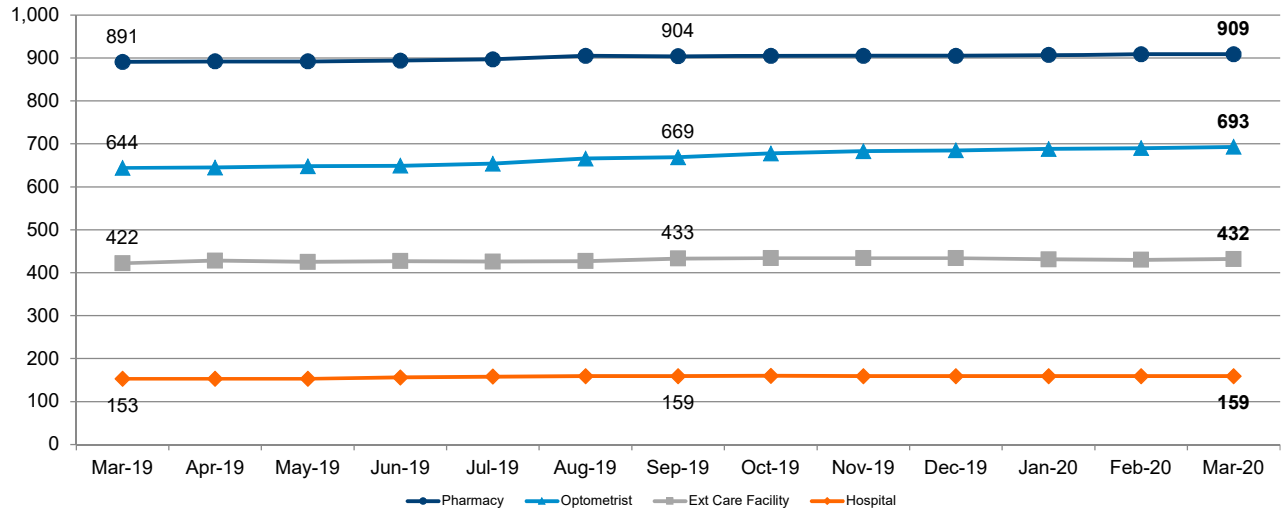
SOONERCARE ENROLLMENT/EXPENDITURES

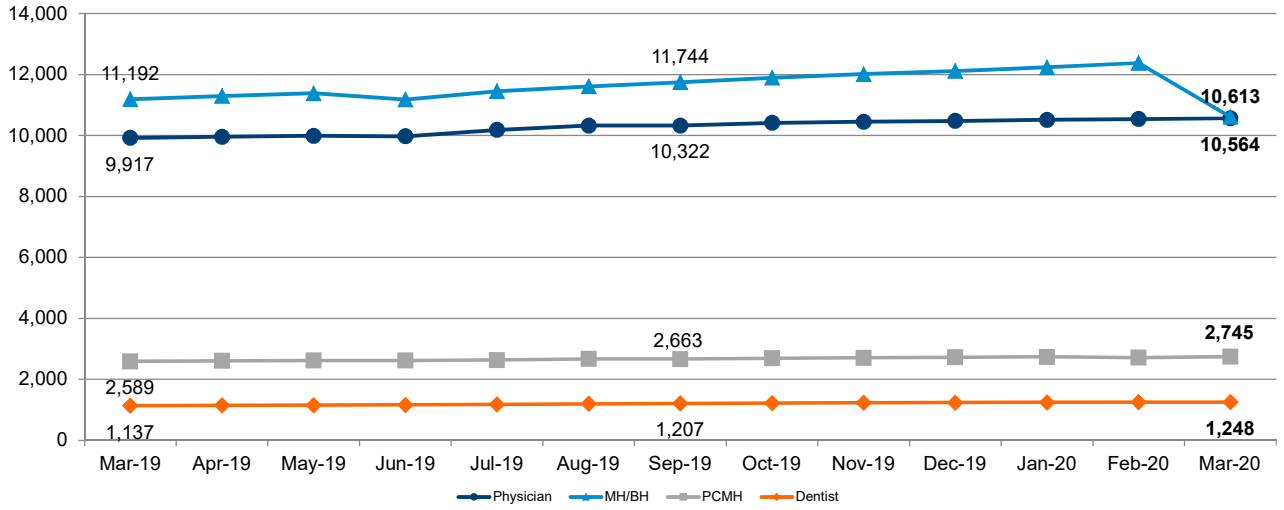
Delivery System			Enrollment March 2020	Children March 2020	Adults March 2020	Enrollment Change	Total Expenditures March 2020	PMPM March 2020
SoonerCare Choice Patient-Centered Medical Home			**524,659**	**437,630**	**87,029**	**-2,165**	**$158,314,803**	
	Lower Cost	*(Children/Parents; Other)*	482,249	424,390	57,859	-2,177	$109,120,960	$226
	Higher Cost	*(Aged, Blind or Disabled; TEFRA; BCC)*	42,410	13,240	29,170	12	$49,193,844	$1,160
SoonerCare Traditional			**254,416**	**98,885**	**155,531**	**22,835**	**$277,618,207**	
	Lower Cost	*(Children/Parents; Other; Q1; SLMB)*	137,773	94,246	43,527	22,863	$125,932,839	$914
	Higher Cost	*(Aged, Blind or Disabled; LTC; TEFRA; BCC & HCBS Waiver)*	116,643	4,639	112,004	-28	$151,685,368	$1,300
Insure Oklahoma			**19,777**	**647**	**19,130**	**984**	**$3,972,031**	
	Employer-Sponsored Insurance		13,855	381	13,474	450	$1,450,959	$105
	Individual Plan		5,922	266	5,656	534	$2,521,072	$426
SoonerPlan			**28,827**	**2,066**	**26,761**	**1,866**	**$185,546**	$6
TOTAL			**827,679**	**539,228**	**288,451**	**23,520**	**$440,090,587**	

Enrollment totals include all members enrolled during the report month. Members may not have expenditure data. Children are members aged 0 - 20 or for Insure Oklahoma enrolled as Students or Dependents.
Dual Eligibles (Medicare & Medicaid) are in the Traditional delivery system in both the Low Cost (Q1 & SLMB) and High Cost (ABD) groups. OTHER includes DDSD, PKU, Q1, Refugee, SLMB, STBS and TB.

IN-STATE CONTRACTED PROVIDERS

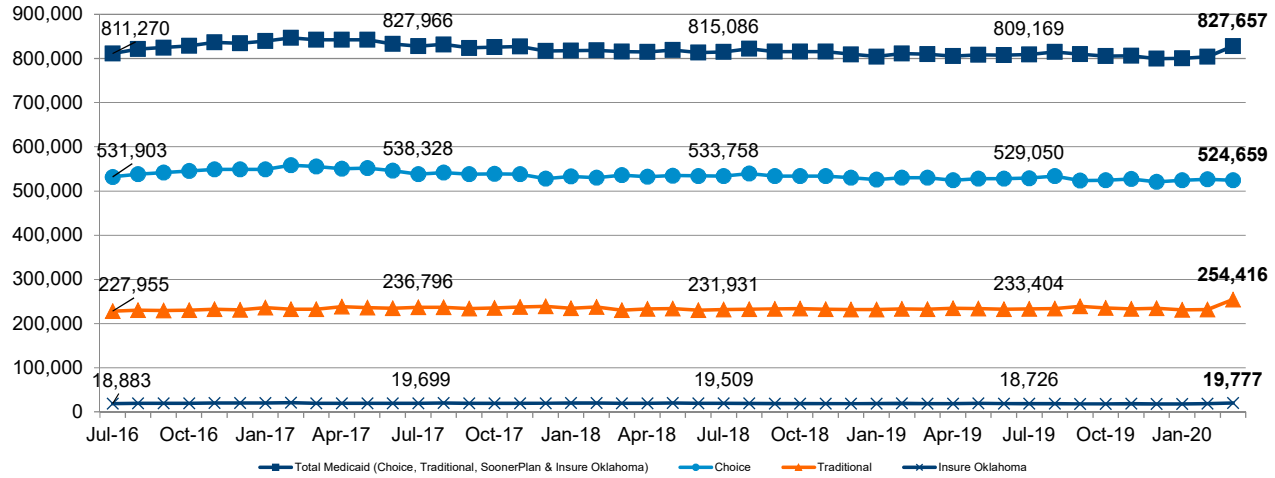
Total In-State Providers: 43,903 (-1,444) **(In-State Providers counted multiple times due to multiple locations, programs, types, and specialties)**

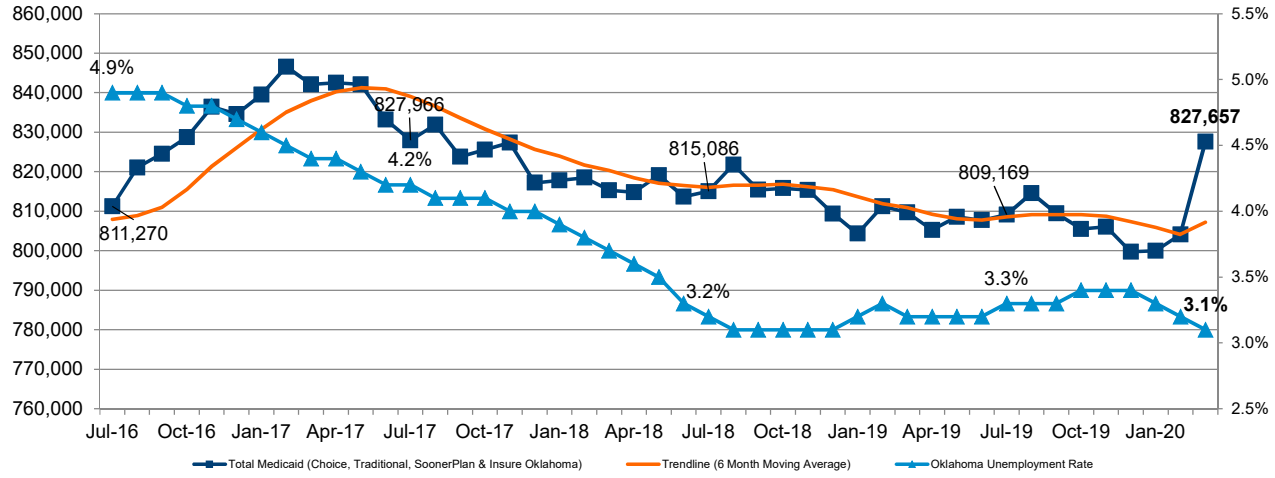




*In general, decreases are due to contract renewal. Decrease during contract renewal period is typical during all renewal periods.
MH/BH is Mental Health and Behavioral Health providers. PCMH is Patient-Centered Medical Home (Choice) providers.

ENROLLMENT BY MONTH





Oklahoma Unemployment Rate is from the Bureau of Labor Statistics 'Local Area Unemployment Statistics' (https://www.bls.gov/lau/) and is seasonally adjusted. Data was extracted on August 22, 2018.
In June 2017 there were changes to the passive renewal system criteria that reduced the number of passively renewed members by 2/3rds. Increase in March 2020 due to COVID-19 economic impact and relief measures (Continuity of care by postponing recertifications).

May MAC
Proposed Rule Amendment Summaries

Face-to-face tribal consultations regarding the following proposed changes were held on Tuesday, January 7, 2020, Tuesday, March 3, 2020, and Wednesday, April 1, 2020 in the Charles Ed McFall Boardroom of the Oklahoma Health Care Authority (OHCA).

The following work folders were posted on the OHCA public website for a public comment period.

20-05 Continuation of Services Pending Appeals — The proposed new rule will comply with Section 431.230 of Title 42 of the Code of Federal Regulations by describing the conditions in which Medicaid benefits will continue or be reinstated pending an appeal. Additionally, the proposed new rule will describe the application, obligations, and implications for the appellant when Medicaid benefits are continued or reinstated pending an appeal.
Budget Impact: Budget neutral

20-06A Durable Medical Equipment (DME) and Supplies Benefit Moved under the Scope of the Home Health Benefit — The proposed revisions to medical supplier, home health agency, long-term care facilities, hospitals, and general provider policies are needed to comply with the home health final rule in which the DME and supplies benefit was revised from an optional benefit to a mandatory benefit and was made subject to the scope of the home health benefit. Prosthetics and orthotics are under a separate regulation and remain as an optional benefit. DME will now be called medical supplies, equipment and appliances to match language in federal regulation. Policy references which indicate limitations on coverage of medical supplies, equipment, and appliances will be removed. Revisions will require long-term care facilities to provide certain medical supplies, equipment, and appliances as part of their daily per diem payment. Additional revisions will update the place of service for which medical supplies, equipment, and appliances may be received to any setting in which normal life activities take place except for inpatient settings. Further revisions will require and define a face-to-face encounter between a patient and a practitioner before the provision of medical supplies, equipment, and appliances. Revisions will define enteral food; medical supplies, equipment, and appliances; oxygen; supplies; and parenteral equipment and food.

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

Finally, a reference regarding the new adult eligibility group (ages 19 to 64) will be added, family planning references will be removed, and other changes will be made to shift policy to more appropriate sections as well as grammar and language cleanup.
Budget Impact: The estimated budget impact for State Fiscal Year (SFY) 2021 and SFY2022 will be an increase in the total amount of $2,615,007, with $912,376 in state share.

20-06B, C, and D Durable Medical Equipment (DME) and Supplies Benefit Moved under the Scope of Home Health Benefit — The proposed revisions are needed to comply with the home health final rule in which the DME and supplies benefit was revised from an optional benefit to a mandatory benefit and was made subject to the scope of the home health benefit. Prosthetics and orthotics are under a separate regulation and remain an optional benefit.
Budget Impact: Budget neutral

20-08A and B Medicaid Expansion — The proposed rule changes will expand Medicaid eligibility for individuals, age nineteen (19) or older and under age sixty-five (65), with incomes at or below 133% of the federal poverty level (FPL) by creating a "new adult group" as per Section 435.119 of Title 42 of the Code of Federal Regulations. Additionally, the proposed changes will remove any references to the SoonerPlan program as it is being terminated. The adults currently being served by SoonerPlan will transition to the new adult Medicaid expansion population and will be eligible to receive more comprehensive services. Finally, revisions will align and better clarify policy to reflect current business practice and correct grammatical errors.
Budget Impact: The estimated budget impact for SFY2021 will be an increase in the total amount of $1,134,994,140 with $148,654,454 in state share. The estimated budget impact for SFY2022 will be an increase in the total amount of $1,206,287,815 with $164,790,227 in state share.

20-09 Patient Centered Medical Home (PCMH) — The proposed revisions will add the newly eligible low-income adults, individuals who are nineteen (19) or older and under age sixty-five (65) who meet eligibility criteria set by Section 435.119 of Title 42 of the Code of Federal Regulations, as a covered group under the existing 1115 waiver in order to allow services to be provided by the patient centered medical home (PCMH) service delivery model.
Budget Impact: The estimated budget impact will potentially result in a combined federal and state spending of $11,240,411 total, with $3,653,134 in state share for SFY2021. The estimated budget impact for SFY2022 would potentially result in a combined federal and state spending of $11,240,411, with $3,610,420 in state share.

20-10 Supplemental Hospital Offset Payment Program (SHOPP) — The proposed revisions will amend the Supplemental Hospital Offset Payment Program (SHOPP) assessment policy. According to current policy, the base year Medicare cost report used to calculate the hospital assessment is required to be updated every two years based on the hospital's fiscal year that ended two years prior. The proposed policy revisions will update the base year Medicare cost report used to calculate the hospital assessment to be every year based on the hospital's fiscal year that ended two years prior. These proposed revisions to the annual recalculation of the tax base will allow the OHCA to maximize SHOPP assessments as needed to fund coverage of the new adult expansion population. Finally, other changes are for grammar and language cleanup.
Budget Impact: Budget neutral

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 2. GRIEVANCE PROCEDURES AND PROCESS

317:2-1-2.6. Continuation of benefits or services pending appeal

(a) In accordance with Section 431.230 of Title 42 of the Code of Federal Regulations, if an Appellant submits a written request for a hearing within ten (10) days of the notice of the adverse agency action, the Appellant may also request that benefits or services (hereinafter, collectively referred to as "services") be continued or reinstated until the earlier of dismissal of the appeal, Appellant's withdrawal of the appeal, or an initial hearing decision adverse to the Appellant.

(b) If the Appellant fails to indicate a preference as to continuation or reinstatement of services in a written request for hearing made within ten (10) days of the notice of the adverse agency action, services shall be continued or reinstated. Provided, however, that a SoonerCare member shall not be entitled to continuation or reinstatement of services pending an appeal related to the following:

(1) When a service is denied because the member has exceeded the limit applicable to that service;

(2) When a request for a prior authorization is denied for a prescription drug. However:

(A) The Oklahoma Health Care Authority (OHCA) may authorize a single seventy-two (72) hour emergency supply of the drug, in accordance with Oklahoma Administrative Code (OAC) 317:30-5-77.2;

(B) A SoonerCare provider may initiate a step therapy exception request on behalf of a member, in accordance with OAC 317:30-5-77.4;

(3) When coverage of a prescription drug or service is denied because the requested drug or service is not a category or class of drugs or services covered by OHCA;

(4) When coverage for a prescription drug is denied because the enrollee has been locked into one (1) pharmacy and the member seeks to fill a prescription at another pharmacy; or

(5) When a physician or other licensed health care practitioner has failed to prescribe or order the service or level of service for which continuation or reinstatement is requested.

(c) If services are continued or reinstated during the appeals process and the hearing is not decided in the Appellant's favor, OHCA may seek to recover reimbursement of all services received pending the hearing decision.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-ELIGIBILITY

SUBCHAPTER 3. GENERAL PROVIDER POLICIES

PART 3. GENERAL MEDICAL PROGRAM INFORMATION

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

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

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

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

(3) HCBS waiver services:

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

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

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

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

(4) HCBS waiver services must be:

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

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

(i) The IP:

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

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

provide services.

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

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

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

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

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

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

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

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

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

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

The following are general SoonerCare coverage guidelines for the categorically needy and adult group, nineteen (19) to sixty-four (64) years of age, as per Section (§) 435.119 of Title 42 of the Code of Federal Regulations (C.F.R.):

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

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

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

(2) Emergency department services.

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

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

(5) Outpatient surgical services - facility payment for selected outpatient-surgical procedures to hospitals which have a contract with ~~OHCA~~the Oklahoma Health Care Authority (OHCA).
(6) Outpatient mental health services for medical and remedial care including services provided on an outpatient basis by certified ~~hospital based~~hospital-based facilities that are also qualified mental health clinics.
(7) Rural health clinic (RHC) services and other ambulatory services furnished by ~~rural health clinic~~an RHC.
(8) Optometrists' services - only as listed in Subchapter 5, Part 45, Optometrist specific rules of this Chapter.
(9) Maternity clinic services.
(10) Outpatient diagnostic x-rays and lab services. Other outpatient services provided to adults, not specifically addressed, are covered only when prior authorized by the agency's Medical Authorization Unit.
(11) Medically necessary screening mammography. Additional follow-up mammograms are covered when medically necessary.
(12) ~~Nursing~~Long-term care facility services (other than services in an institution for tuberculosis or mental diseases).
(13) Early and Periodic Screening, ~~Diagnosis~~Diagnostic and Treatment Services (EPSDT) are available for members under twenty-one (21) years of age to provide access to regularly scheduled examinations and evaluations of the general physical and mental health, growth, development, and nutritional status of infants, children, and youth. Federal regulations also require that diagnosis and treatment be provided for conditions identified during a screening whether or not they are covered under the State Plan, as long as federal funds are available for these services. These services must be necessary to ameliorate or correct defects and physical or mental illnesses or conditions and require prior authorization. EPSDT/OHCA ~~Child Health~~child-health services are outlined in OAC 317:30-3-65.2 through ~~317:30-3-65.4~~317:30-3-65.12.

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

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

(C) Immunizations.

(D) Outpatient care.

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

(F) Optometrists' services. The EPSDT periodicity schedule provides for at least one (1) visual screening and glasses

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

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

(H) Prescribed drugs.

(I) Outpatient-psychological 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 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.

(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)~~(14) Physicians' services whether furnished in the office, the member's home, a hospital, a ~~nursing~~long-term care facility, Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID), or elsewhere. For adults, payment is made for compensable hospital days described at OAC 317:30-5-41. Office visits for adults are limited to four (4) per month except when in connection with conditions as specified in OAC 317:30-5-9(b).

~~(16)~~(15) Medical care and any other type of remedial care recognized under state law, furnished by licensed practitioners within the scope of their practice as defined by state law. See applicable provider ~~section~~Section for limitations to covered services for:

(A) Podiatrists' services;

(B) Optometrists' services;

(C) Psychologists' services;

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

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

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

(G) Anesthesiologist ~~Assistants~~assistants.

~~(17)~~(16) Free-standing ambulatory surgery centers.

~~(18)~~(17) Prescribed drugs not to exceed a total of six (6) prescriptions with a limit of two (2) brand name prescriptions per month. Exceptions to the six (6) prescription limit are:

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

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

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

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

~~(19)~~(18) Rental and/or purchase of ~~durable medical equipment~~medical supplies, equipment, and appliances.

~~(20)~~(19) Adaptive equipment, when prior authorized, for members residing in private ICF/IID's.

~~(21)~~(20) Dental services for members residing in private ICF/IID's in accordance with the scope of dental services for members under age twenty-one (21).

~~(22) Prosthetic devices limited to catheters and catheter accessories, colostomy and urostomy bags and accessories, tracheostomy accessories, nerve stimulators, hyperalimentation and accessories, home dialysis equipment and supplies, external breast prostheses and support accessories, oxygen/oxygen concentrator equipment and supplies, respirator or ventilator equipment and supplies, and those devices inserted during the course of a surgical procedure.~~(21) Orthotic and prosthetic devices for members under age twenty-one (21). For adults, orthotics and prosthetics are limited to breast prosthesis and support accessories. See OAC 317:30-5-210.1 and OAC 317:30-5-211.13.

~~(23)~~(22) Standard medical supplies.

~~(24)~~(23) 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)~~(24) Blood and blood fractions for members when administered on an outpatient basis.
~~(26)~~(25) 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~~(26) Long-term care facility services, limited to members preauthorized and approved by OHCA for such care.
~~(28)~~(27) 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)~~(28) 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)~~(29) 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~~(30) Long-term care facility services for members under twenty-one (21) years of age.
~~(32)~~(31) Personal care in a member's home, prescribed in accordance with a plan of treatment and rendered by a qualified person under supervision of a Registered Nurse (RN).
~~(33)~~(32) Part A deductible and Part B Medicare Coinsurance and/or deductible.
~~(34)~~(33) ~~Home and Community-Based Waiver Services~~HCBS for the intellectually disabled.
~~(35)~~(34) Home-health services limited to thirty-six (36) visits per year and standard supplies for one (1) month in a twelve (12) month period. The visits are limited to any combination of ~~Registered Nurse~~an RN and nurse aide visits, not to exceed thirty-six (36) per year.
~~(36)~~(35) Medically necessary solid organ and bone marrow/stem cell transplantation services for children and adults are covered services based upon the conditions listed in (A)-(D) of this paragraph:

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

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

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

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

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

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

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

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

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

~~(37)~~(36) HCBS for intellectually disabled members who were determined to be inappropriately placed in a ~~nursing~~long-term care facility (Alternative Disposition Plan - ADP).

~~(38)~~(37) Case management services for the chronically and/or severely mentally ill.

~~(39)~~(38) Emergency medical services including emergency labor and delivery for illegal or ineligible aliens.

~~(40)~~(39) Services delivered in Federally Qualified Health Centers (FQHCs). Payment is made on an encounter basis.

~~(41)~~(40) Early ~~Intervention~~intervention services for children ages zero (0) to three (3).

~~(42)~~(41) Residential behavior management in therapeutic foster care setting.

~~(43)~~(42) Birthing center services.

~~(44)~~(43) Case management services through the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS).

~~(45)~~(44) HCBS for aged or physically disabled members.

~~(46)~~(45) Outpatient ambulatory services for members infected with tuberculosis.

~~(47)~~(46) Smoking and tobacco use cessation counseling for children and adults.

~~(48)~~(47) 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)~~(48) OHCA contracts with designated agents to provide disease state management for individuals diagnosed with certain chronic conditions. Disease state management treatments are based on protocols developed using evidence-based guidelines.

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

The following are excluded from SoonerCare coverage for adults:

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

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

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

(4) Refractions and visual aids.

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

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

(7) Non-therapeutic hysterectomies.

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

(9) Medical services considered experimental or investigational.

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

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

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

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

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

(15) Payment for more than four (4) outpatient visits per month (home or office) per member, except those visits ~~in connection with family planning or~~ related to emergency medical conditions.
(16) Payment for more than two (2) ~~nursing~~long-term care facility visits per month.
(17) More than one (1) inpatient visit per day per physician.
(18) Payment for removal of benign skin lesions.
(19) Physician services which are administrative in nature and not a direct service to the member including such items as quality assurance, utilization review, treatment staffing, tumor board review or multidisciplinary opinion, dictation, and similar functions.
(20) Charges for completion of insurance forms, abstracts, narrative reports or telephone calls.
(21) Payment for the services of social workers, licensed family counselors, registered nurses or other ancillary staff, except as specifically set out in ~~OHCA~~the Oklahoma Health Care Authority (OHCA) rules.
(22) Mileage.
(23) A routine hospital visit on the date of discharge unless the member expired.
(24) Direct payment to perfusionist as this is considered part of the hospital reimbursement.
(25) Inpatient chemical dependency treatment.
(26) Fertility treatment.
(27) Payment to the same physician for both an outpatient visit and admission to hospital on the same date.
~~(28) Sleep studies.~~

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 3. HOSPITALS

317:30-5-42.16. Related services

(a) **Ambulance.** Ambulance services furnished by the facility are covered separately if otherwise compensable under the ~~Authority's Medical Programs~~SoonerCare program.
(b) **Home health care.** ~~Hospital based~~Hospital-based home health providers must be Medicare certified and have a current Home Health Agency contract with the ~~OHCA~~Oklahoma Health Care Authority (OHCA). For home health services, a qualified provider must conduct and document a face-to-face encounter with the member in accordance with provisions of ~~42 CFR §440.70~~42 Code of Federal Regulations (C.F.R.) § 440.70. Refer to Oklahome Administrative Code (OAC) 317:30-5-546 and OAC 317:30-5-547 for additional policy related to

coverage and reimbursement for home health care services.

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

~~(2) Payment is made for a maximum of 36 visits per year for eligible members 21 years of age or older. Payment for any combination of skilled and home health aide visits can not exceed 36 visits per year.~~

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

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

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

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

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

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

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

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

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

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

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

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

~~member's illness, symptom control, or to enable the individual to maintain activities of daily living and basic functional skills.~~

~~(1) Payment is made for home based hospice services for terminally ill individuals under the age of 21 with a life expectancy of six months or less when the member and/or family has elected hospice benefits. Hospice services are available to eligible members without forgoing any other service to which the member is entitled under SoonerCare for curative treatment of the terminal illness. Once the member has elected hospice care, the hospice medical team assumes responsibility for the member's medical care for the terminal illness in the home environment. Hospice providers are not responsible for curative treatments for members that elect such services while on hospice. Hospice care includes nursing care, physician services, medical equipment and supplies, drugs for symptom control and pain relief, home health aide and personal care, physical, occupational and/or speech therapy, medical social services, dietary counseling and grief and bereavement counseling to the member and/or family.~~

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

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

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

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

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

(1) Inpatient admission for diagnostic studies that could be performed on an outpatient basis.
(2) Procedures that result in sterilization which do not meet the guidelines set forth in this Chapter ~~of rules~~.
(3) Reversal of sterilization procedures for the purposes of conception are not covered.
(4) Medical services considered experimental or investigational.
(5) Payment for removal of benign skin lesions for adults.
(6) Visual aids.
(7) Charges incurred while the member is in a skilled nursing or swing bed.
~~(8) Sleep studies for adults.~~

PART 9. LONG-TERM CARE FACILITIES

317:30-5-133.1. Routine services

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

highest practicable physical, mental and psycho-social well-being of each resident, nursing care, and activities programs (costs for a private duty nurse or sitter are not allowed).
(4) Personal services - personal laundry services for residents (does not include dry cleaning).
(5) Personal hygiene items (personal care items required to be provided does not include electrical appliances such as shavers and hair dryers, or individual personal batteries), to include:
(A) ~~shampoo~~Shampoo, comb, and brush;
(B) ~~bath~~Bath soap;
(C) ~~disinfecting~~Disinfeting soaps or specialized cleansing agents when indicated to treat or prevent special skin problems or to fight infection;
(D) ~~razor~~Razor and/or shaving cream;
(E) ~~nail~~Nail hygiene services; and
(F) ~~sanitary~~Sanitary napkins, douche supplies, perineal irrigation equipment, solutions, and disposable douches.
(6) Routine oral hygiene items, including:
(A) ~~toothbrushes~~Toothbrushes;
(B) ~~toothpaste~~Toothpaste;
(C) ~~dental~~Dental floss;
(D) ~~lemon~~Lemon glycerin swabs or equivalent products; and
(E) ~~denture~~Denture cleaners, denture adhesives, and containers for dental prosthetic appliances such as dentures and partial dentures.
(7) Necessary items furnished routinely as needed to all members, e.g., water pitcher, cup and tray, towels, wash cloths, hospital gowns, emesis basin, bedpan, and urinal.
(8) The facility will furnish as needed items such as alcohol, applicators, cotton balls, tongue depressors and, first aid supplies, including small bandages, ointments and preparations for minor cuts and abrasions, and enema supplies, disposable enemas, gauze, 4 x 4's ABD pads, surgical and micropore tape, telfa gauze, ace bandages, etc.
(9) Over the counter drugs (non-legend) not covered by the prescription drug program (PRN or routine). In general, ~~nursing~~long-term care facilities are not required to provide any particular brand of non-legend drugs, only those items necessary to ensure appropriate care.
(A) If the physician orders a brand specific non-legend drug with no generic equivalent, the facility must provide the drug at no cost to the member. If the physician orders a brand specific non-legend drug that has a generic equivalent, the facility may choose a generic equivalent, upon approval of the ordering physician;
(B) If the physician does not order a specific type or brand

of non-legend drug, the facility may choose the type or brand;

(C) If the member, family, or other responsible party (excluding the ~~nursing~~long-term care facility) prefers a specific type or brand of non-legend drug rather than the ones furnished by the facility, the member, family or responsible party may be charged the difference between the cost of the brand the resident requests and the cost of the brand generally provided by the facility. (Facilities are not required to provide an unlimited variety of brands of these items and services. It is the required assessment of resident needs, not resident preferences, that will dictate the variety of products facilities need to provide);

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

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

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

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

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

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

(A) If the assessment and care planning process determines that it is medically necessary for the resident to use diapers as part of a plan to achieve proper management of incontinence, and if the resident has a current physician

order for adult diapers, then the facility must provide the diapers without charge;

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

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

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

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

the provision of dentures services, the OHCA will be the final authority. All members and/or families must be informed of their right to appeal at the time of admission and yearly thereafter. The member cannot be denied admission to a facility because of the need for denture services.

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

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

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

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

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

(B) It is the responsibility of the ~~nursing~~long-term care facility to ensure that the member has adequate assistance in the proper care, maintenance, identification and replacement of these items. When vision services have been identified as a needed service, ~~nursing~~long-term care facility staff will make timely arrangements for provision of these services by licensed ophthalmologists or optometrists. If a difference of opinion occurs between the ~~nursing~~long-term care facility, member, and/or family regarding the provision of vision services, the OHCA will be the final authority. All members and/or families must be

informed of their right to appeal at admission and yearly thereafter. The member cannot be denied admission to the facility because of the need for vision services.

(19) An attendant to accompany SoonerCare eligible members during SoonerRide ~~Non-Emergency Transportation~~non-emergency transportation (NET). Please refer to ~~OAC~~Oklahoma Administrative Code (OAC) 317:30-5-326 through OAC 317:30-5-327.9 for SoonerRide rules regarding members residing in a ~~nursing~~long-term care facility~~. And~~; and

(20) Influenza and pneumococcal vaccinations.

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

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

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

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

~~(B) Ventilators and supplies.~~

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

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

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

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

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

~~(C) Tracheostomy supplies.~~

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

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

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

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

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

~~(1) Diapers.~~

~~(2) Underpads.~~

~~(3) Medicine cups.~~

~~(4) Eating utensils.~~

~~(5) Personal comfort items.~~

PART 17. MEDICAL SUPPLIERS

317:30-5-210. Eligible providers

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

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

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

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

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

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

(C) Employs as a W-2 employee at least one 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)~~medical supplies, equipment, and appliances for adults ~~is specified in~~complies with 42 Code of Federal Regulations (C.F.R.) § 440.70 and is specified in ~~OAC~~ Oklahoma Administrative Code (OAC) 317:30-5-211.1 through OAC ~~317:30-5-211.18~~317:30-5-211.19. Orthotics and prosthetics are not a covered service for adults with the exception of breast prosthetics and support acessories (Refer to OAC 317:30-5-211.13).

317:30-5-210.2. Coverage for children

(a) **Coverage.** ~~Coverage of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS)~~Medical supplies, equipment, and appliances are covered for children. ~~includes the specified coverage for adults found in OAC 317:30-5-210.2 through OAC 317:30-5-211.18. In addition the following are covered items for children only:~~

~~(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).~~

In addition, orthotics and prosthetics are covered items for children only, except as specified in OAC 317:30-5-211.3.

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

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

317:30-5-211.1. Definitions

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

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

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

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

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

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

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

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

"Complex rehabilitation technology" means medically necessary durable medical equipment and items that are individually configured to meet specific and unique medical, physical, and functional needs and capacities for basic activities of daily living and instrumental activities of daily living of a complex needs patient. 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, fitted, or adapted in consideration of the the member's body size, disability, period of need, or intended use;

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

(C) 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 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 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.

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

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

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

317:30-5-211.2. Medical necessity

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

(1) Routine personal hygiene;

(2) Education;

(3) Exercise;

(4) Convenience, safety, or restraint of the member, or his or her family or caregiver;

(5) Participation in sports; and/or

(6) Cosmetic purposes.

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

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

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

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

~~(1) date of the order;~~

~~(2) name and address of the prescriber;~~

~~(3) name and address of the member;~~

~~(4) name or description and quantity of the prescribed item;~~

~~(5) diagnosis for the item requested;~~

~~(6) directions for use of the prescribed item; and~~

~~(7) prescriber's signature.~~

(1) The member's name;

(2) The prescribing practitioner's name;

(3) The date of the prescription;

(4) All items, options, or additional features that are separately billed. The description can be either a narrative description (e.g. lightweight wheelchair base), a Healthcare Common Procedure Coding System (HCPCS) code, a HCPCS code narrative, or a brand name/model number; and

(5) The prescribing practitioner's signature and signature date.

~~(c)~~(d) **Certificate of medical necessity (CMN).** For certain items or services, the supplier must receive a signed CMN/OHCA CMN from

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

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

(1) ~~OHCA~~The Oklahoma Health Care Authority (OHCA) covers ~~DMEPOS~~medical supplies, equipment, and appliances for use in the member's place of residence ~~except if the member's place of residence is 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 residing in a hospital, ~~nursing~~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, ~~most~~ medical supplies, equipment, and appliances ~~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.~~

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

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

(1) services that exceed quantity/frequency limits;

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

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

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

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

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

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

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

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

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

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

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

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

(6) **PA of manually-priced items.** Manually-priced items must be prior authorized. For reimbursement of manually priced items, see OAC 317:30-5-218.

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

(a) **Repairs.** Repairs to equipment that either the Oklahoma Health Care Authority or a member owns are covered when they are necessary

to make the equipment usable. The repair charge includes the use of "loaner" equipment as required. If the expense for repairs exceeds the estimated expense of purchasing or renting another item of equipment for the remaining period of medical need, payment cannot be made for the amount in excess. Repairs of rented equipment are not covered.

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

(c) **Replacement.**

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

(2) Replacement parts must be billed with the appropriate ~~HCPCS~~Healthcare Common Procedure Coding System (HCPCS) code that represents the item or part being replaced along with a pricing modifier and replacement modifier. If a part that has not been assigned a HCPCS code is being replaced, the provider should use a miscellaneous HCPCS code to bill each part. Each claim that contains miscellaneous codes for replacement parts must include a narrative description of the item, the brand name, model name/number of the item, and an invoice.

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

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

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

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

317:30-5-211.6. General documentation requirements

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

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

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

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

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

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

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

(b) **Certificate of medical necessity (CMN)**. Certain items of ~~DME~~medical supplies, equipment, and appliances require a CMN/OHCA CMN which should be submitted with the request for prior authorization. These items ~~(with form numbers)~~ 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 ~~DME~~medical supplies, equipment, and appliances per 42 CFR 440.70. Refer to Title 317,

Chapters 40 and 50 for home modifications covered under ADvantage Waiver and Home and Community Based Services Waivers.

317:30-5-211.12. Oxygen rental

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

~~(i) lost;~~

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

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

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

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

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

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

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

(A) Payment is limited to:

(i) one (1) prosthetic garment with mastectomy form every twelve (12) months for use in the postoperative period prior to a permanent breast prosthesis or as an alternative to a mastectomy bra and breast prosthesis;

(ii) two (2) mastectomy bras per year; and

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

(iv) one (1) foam prosthetic per side every six (6) months.

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

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

(D) A breast prosthesis can be replaced if:

(i) lost;

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

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

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

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

317:30-5-211.14. Nutritional support

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

~~(A) ventilators and supplies;~~

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

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

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

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

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

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

~~(C) tracheostomy supplies;~~

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

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

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

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

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

~~(1) diapers;~~

~~(2) underpads;~~

~~(3) medicine cups;~~

~~(4) eating utensils; and~~

~~(5) personal comfort items.~~

317:30-5-211.17. Wheelchairs

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

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

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

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

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

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

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

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

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

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

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

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

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

(d) **Coverage and limitations.**

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

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

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

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

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

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

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

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

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

(f) **Documentation.**

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

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

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

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

317:30-5-211.20. Enteral nutrition

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

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

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

(1) Diagnosis;

(2) Certificate of Medical Necessity (CMN);

(3) Ratio data;

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

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

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

317:30-5-211.21. Incontinence supplies

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

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

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

(4) Requests submitted for underwear/pull-on(s) the member must be ambulatory or in a toilet training program;
(5) The member may qualify for incontinence supplies for a short period of time when the member has documented full-skin thickness injuries;
(6) When requesting wipes as incontinence supplies, documentation must be submitted specific to the supply being requested. Disposable wipes are only allowed when diapers have been approved;
(7) For full guidelines, please refer to www.okhca.org/mau.

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

(e) **Non-covered items.** The following are non-covered items:
(1) Incontinence supplies for members under the age of four (4) years;
(2) Reusable underwear and/or reusable pull-ons;
(3) Reusable briefs and/or reusable diapers;
(4) Diaper service for reusable diapers;
(5) Feminine hygiene products;
(6) Disposable penile wraps; and
(7) Shipping costs.

317:30-5-211.22. Pulse oximeter

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

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

(c) **Documentation.** All documentation submitted to request services must demonstrate, through adequate objective medical records, evidence sufficient to justify the member's need for the service, in accordance with OAC 317:30-3-1(f)(2). Documentation must include:
(1) A current oxygen order signed and dated by an OHCA-contracted physician, along with a certificate of medical necessity (CMN);

(2) Pertinent information relating to the member's underlying diagnosis and condition which results in the need for the oximeter and supplies, including documentation of unstable airway events and documentation of current monitor readings if available; and

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

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

(d) **Reimbursement.**

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

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

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

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

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

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

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

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

(1) Documentation must include:

(A) Type of surgery performed;

(B) Date of surgery;

(C) Date of application of CPM;

(D) Date of discharge from the hospital; and

(E) Written prescription issued by a licensed prescriber that is signed and dated no more than thirty (30) days prior to the first date of service and that defines the specific "from" and "to" dates that reflect the actual days the CPM device is to be utilized.

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

(d) **Reimbursement.**

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

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

317:30-5-211.24. Parenteral nutrition

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

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

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

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

(2) A certificate of medical necessity;

(3) A prescription; and

(4) Caloric Intake.

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

(d) **Reimbursement.**

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

(2) Pumps are rented as a capped rental.

317:30-5-211.25. Continuous glucose monitoring

(a) **Continuous Glucose Monitoring (CGM).** CGM means a minimally invasive system that measures glucose levels in subcutaneous or interstitial fluid. CGM provides blood glucose levels and can help

members make more informed management decisions throughout the day.

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

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

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

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

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

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

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

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

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

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

317:30-5-211.26. Bathroom equipment

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

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

itself shall not constitute medical necessity. The Oklahoma Health Care Authority (OHCA) shall serve as the final authority pertaining to all determinations of medical necessity. Refer to Oklahoma Administrative Code (OAC) 317:30-5-211.2 and OAC 317:30-3-1(f) for policy on medical necessity.

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

(1) Current written prescription for specific medical supply, equipment, and appliance item;

(2) Letter of Medical Necessity;

(3) Product Information;

(4) Manufacturer's Suggested Retail Price (MSRP) for each item requested;and

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

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

(a) **PAP devices.** PAP devices are both a single level continuous positive airway pressure device (CPAP), and/or a bi-level respiratory assist device with or without back-up rate when it is used in the treatment of obstructive sleep apnea.

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

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

(1) A face-to-face clinical evaluation by the treating qualified medical professional within six (6) months prior to receiving device;

(2) Qualifying polysomnogram, performed in a sleep diagnostic testing facility, that is dated within one (1) year of the prior authorization request submission;

(3) The patient and/or his or her caretaker have received instruction from the supplier of the device in the proper use and care of the equipment; and

(4) Medical records supporting the need for a PAP device.

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

317:30-5-211.28. Sleep studies

(a) **Sleep studies.** Sleep studies are the continuous and simultaneous monitoring and recording of specified physiological and pathophysiological parameters during a period of sleep for six (6) or more hours. The study is used to diagnose a variety of sleep disorders and to evaluate a patient's response to therapies such as continuous positive airway pressure (CPAP). A sleep study requires physician review, interpretation, and report.

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

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

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

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

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

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

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

(d) **Reimbursement.**

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

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

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

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

~~(1) **Required forms.** All required forms are available on the~~

~~OHCA web site at www.okhca.org.~~

~~(2) **Certificate of medical necessity.** The prescribing provider must complete the medical necessity section of the CMN. This section cannot be completed by the supplier. The medical necessity section can be completed by any health care clinician; however, only the member's treating provider may sign the CMN. By signing the CMN, the physician is validating the completeness and accuracy of the medical necessity section. The member's medical records must contain documentation substantiating that the member's condition meets the coverage criteria and the answers given in the medical necessity section of the CMN. These records may be requested by OHCA or its representatives to confirm concurrence between the medical records and the information submitted with the prior authorization request.~~

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

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

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

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

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

317:30-5-218. Reimbursement

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

(1) Reimbursement for ~~durable medical equipment and supplies~~medical supplies, equipment, and appliances will be made using an amount derived from the lesser of the ~~OHCA~~Oklahoma Health Care Authority (OHCA) maximum allowable fee or the provider's usual and customary charge. The maximum allowable

fee is the maximum amount that the OHCA will pay a provider for an allowable procedure. When a code is not assigned a maximum allowable fee for a unit of service, a fee will be established. ~~The fee schedule will be reviewed annually and adjustments to the fee schedule may be made at any time based on efficiency, budget considerations, and quality of care as determined by the OHCA.~~

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

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

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

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

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

(b) **Manually-priced medical equipment and supplies.**

There may be instances when manual pricing is required. When it is, the following pricing methods will be used:

(A) **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.

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

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

(1) Payment for stationary oxygen systems (liquid oxygen systems, gaseous oxygen systems, and oxygen concentrators) is

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

(2) Separate payment will not be made for maintenance, servicing, delivery, or for the supplier to pick up the equipment when it is no longer medically necessary. In addition, the provider/supplier will not be reimbursed for mileage.

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

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

PART 61. HOME HEALTH AGENCIES

317:30-5-545. Eligible providers

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

317:30-5-546. Coverage by category

Payment is made for home health services as set forth in this section when a ~~face to face~~face-to-face encounter has occurred in accordance with provisions of ~~42 CFR 440.70~~42 Code of Federal Regulations (C.F.R.) § 440.70. Payment is made for home health services provided in the member's residence and in any setting in

which normal life activities take place except for a hospital, long-term care facility, or intermediate care facility for individuals with intellectual disabilities. For individuals eligible for Part B of Medicare, payment is made utilizing the Medicaid allowable for comparable services.

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

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

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

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

~~(iii) Standard medical supplies;~~

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

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

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

~~(i) Sales tax;~~

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

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

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

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

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

317:30-5-547. Reimbursement

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

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

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

(1) Payment for oxygen systems (stationary, liquid and oxygen concentrators) is based on continuous rental, i.e., a continuous monthly payment is made as long as it is medically necessary. The rental payment includes all contents and supplies, i.e., regulators, tubing, masks, etc. Portable oxygen systems are also considered continuous rental. Ownership of the equipment remains with the supplier.
(2) Separate payment will not be made for maintenance, servicing, delivery, or for the supplier to pickup the equipment when it is no longer medically necessary.
(3) Payment for oxygen and oxygen equipment and supplies will not exceed the Medicare fee for the same procedure code. ~~Reimbursement for members who reside in a nursing facility may be at a reduced rate.~~ The fee schedule will be reviewed annually and adjustments to the fee schedule may be made at any time based on efficiency, budget considerations, and quality of care as determined by the OHCA.
(4) Physical therapy, occupational therapy, and/or speech pathology and audiology services, are not covered when provided by a home health agency.

317:30-5-548. Procedure codes

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

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

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

PART 85. ADVANTAGE PROGRAM WAIVER SERVICES

317:30-5-763. Description of services

Services included in the ADvantage Program are:

(1) **Case management.**

(A) Case management services, regardless of payment source, assist a member to gain access to medical, social, educational, or other services that may benefit him or her to maintain health and safety. Case managers:

(i) ~~initiate~~Initiate and oversee necessary assessments and reassessments to establish or reestablish waiver program eligibility;

(ii) ~~develop~~Develop the member's comprehensive person-centered service plan, listing only the services

necessary to prevent member institutionalization, ~~of the member,~~ as determined through the assessments;

(iii) ~~initiate~~Initiate the addition of necessary services or deletion of unnecessary services, as dictated by the member's condition and available support; and

(iv) ~~monitor~~Monitor the member's condition to ensure delivery and service appropriateness ~~of services~~ and initiate person-centered service plan reviews. Case managers submit an individualized ~~Form 02CB014, Services Backup Plan,~~services backup plan via electronic submission on all initial service plans, annually at reassessment, and on updates as appropriate throughout the year, reflecting risk factors and measures in place to minimize risks. When a member requires hospital or nursing facility (NF) services, the case manager:

(I) ~~assists~~Assists the member ~~in accessing~~to access institutional care and, as appropriate, periodically monitors the member's progress during the institutional stay;

(II) ~~helps~~Helps the member transition from institution to home by updating the person-centered service plan;

(III) ~~prepares~~Prepared services to start on the date the member is discharged from the institution; and

(IV) ~~must~~Must meet ADvantage Program minimum requirements for qualification and training prior to providing services to ADvantage members.

(B) Providers of ADvantage services for the member or for those who have an interest in or are employed by an ADvantage provider for the member must not provide case management or develop the person-centered service plan, except when the ADvantage Administration (AA) demonstrates the only willing and qualified entity to provide case management and/or develop person-centered service plans in a geographic area, also provides other ADvantage services. Prior to providing services to members receiving Consumer-Directed Personal Assistance Services and Supports (CD-PASS), case manager supervisors, and case managers are required to receive training and demonstrate knowledge regarding the CD-PASS service delivery model, "Independent Living Philosophy," and demonstrate competency person-centered planning.

(C) ~~Providers may only claim time for billable case management activities, described as:~~

~~(i) any task or function, per Oklahoma Administrative Code (OAC) 317:30-5-763(1)(A) that only an ADvantage case manager because of skill, training, or authority can perform on behalf of a member; and~~

~~(ii) ancillary activities, such as clerical tasks including, but not limited to, mailing, copying, filing, faxing, driving time, or supervisory and administrative activities are not billable case management activities. The administrative cost of these activities and other normal and customary business overhead costs are included in the reimbursement rate for billable activities.~~ Providers may only claim time for billable case management activities, described as any task or function, per Oklahoma Administrative Code (OAC) 317:30-5-763(1)(A) that only an ADvantage case manager because of skill, training, or authority can perform on a member's behalf. Ancillary activities, such as clerical tasks including, but not limited to, mailing, copying, filing, faxing, driving time, or supervisory and administrative activities are not billable case management activities. The administrative cost of these activities and other normal and customary business overhead costs are included in the reimbursement rate for billable activities.

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

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

(ii) Very rural/difficult service area rate. ~~case~~Case management services are billed using a very rural/difficult service area rate for billable service activities provided to a member who resides in a county with a population density equal to, or less than twenty-five (25) persons per square mile.~~ Exceptions are services to members who reside in Oklahoma Department of Human Services (DHS) Aging Services identified zip codes in Osage County adjacent to the metropolitan areas of Tulsa and Washington counties. Services to these members are prior authorized and billed using the standard rate. (iii) The latest United States Census, Oklahoma counties population data is the source for determination of whether a member resides in a county with a population density equal to, or less than twenty-five (25) persons per square mile, or resides in a county with a population density greater than twenty-five (25) persons per square mile.~~

(2) **Respite.**

~~(A)~~ Respite services are provided to members who are unable to care for themselves. Services are provided on a short-term basis due to the primary caregiver's absence or need for relief. Payment for respite care does not include room and board costs unless ~~more than seven (7)~~eight (8) or more hours are provided in a NF. Respite care is only utilized when other sources of care and support are exhausted. Respite care is only listed on the service plan when it is necessary to prevent ~~institutionalization of the~~ member~~.~~ Institutionalization. Units of services are limited to the number of units approved on the service plan. Respite services include:

~~(B)~~ (1) In-home respite services are billed per ~~fifteen-minute (15-minute)~~fifteen (15) minute units of service. Within any ~~one-day (1-day)~~one (1) day period, a minimum of eight (8) units [two (2) hours] must be provided with a maximum of ~~twenty-eight (28)~~thirty-one (31) units ~~[seven (7) hours]~~[less than eight (8) hours] provided. The service is provided in the member's home.

~~(C)~~ (2) ~~Facility-based extended respite is filed for a per diem rate when provided in a NF. Extended respite must be at least eight (8) hours in duration.~~In-home extended respite is filed for a per diem rate. A minimum of eight (8) hours must be provided in the member's home.

~~(D)~~ (3) ~~In-home extended respite is filed for a per diem rate. A minimum of eight (8) hours must be provided in the member's home.~~Facility-based extended respite is filed for a per diem rate when provided in a NF. Extended respite must be at least eight(8) hours in duration.

(3) **Adult day health (ADH) care.**

(A) ADH is furnished on a regularly-scheduled basis for one (1) or more days per week in an outpatient setting. It provides both health and social services necessary to ensure the member's optimal functioning. Most assistance with activities of daily living (ADLs), such as eating, mobility, toileting, and nail care are integral services to ADH care service and are covered by the ADH care basic reimbursement rate.

(B) ADH care is a ~~fifteen-minute (15-minute)~~fifteen (15) minute unit of service. No more than eight (8) hours, thirty-two (32) units [eight (8) hours] are authorized per day. The number of units of service a member may receive is limited to the number of units approved on the member's approved service plan.

(C) Physical, occupational, and speech therapies are only provided as an enhancement to the basic ADH care service when authorized by the service plan and are billed as a separate procedure. ADH care therapy enhancement is a maximum of one (1) session unit per day of service.
(D) Meals provided as part of this service do not constitute a full nutritional regimen. One (1) meal, that contains at least one-third (1/3) of the current daily dietary recommended intake (DRI) as established by the Food and Nutrition Board of the Institute of Medicine of the National Academy of Sciences, is provided to those participants who are in the center for four (4) or more hours per day, and does not constitute a full nutritional regimen. Member's access to food at any time must also be available in addition to the required meal and is consistent with an individual not receiving Medicaid-funded services and supports.
(E) Personal-care service enhancement in ADH is assistance in bathing, hair care, or laundry service, authorized by the person-centered service plan and billed as separate procedures. This service is authorized when an ADvantage Waiver member who uses ADH requires assistance with bathing, hair care, or laundry to maintain health and safety. Assistance with bathing, hair care, or laundry service is not a usual and customary ADH care service. ADH personal care enhancement is a maximum of one (1) unit per day of bathing, hair care, or laundry service.
(F) ~~DHS~~Oklahoma Human Services (OKDHS) Home and Community-Based Services (HCBS) Waiver settings have qualities defined in federal regulation, per Section (§) 441.301 (c)(4) of Title 42 of Code of Federal Regulations ~~(CFR)~~(C.F.R.) based on the individual's needs, defined in the member's authorized service plan.

(i) The ADH center is integrated and supports full access of ADvantage members to the greater community, including opportunities to:

(I) ~~seek~~Seek employment and work in competitive integrated ADH Center, not a requirement for persons that are retirement age;

(II) ~~engage~~Engage in community life;

(III) ~~control~~Control personal resources; and

(IV) ~~receive~~Receive services in the community, to the same degree as individuals not receiving ADvantage Program or other Medicaid HBCS Waiver services.

(ii) The ADH is selected by the member from all available service options and given the opportunity to visit and understand the options.

(iii) The ADH ensures the member's rights of privacy, dignity, respect, and freedom from coercion and restraint.

(iv) The ADH optimizes the member's initiative, autonomy, and independence in making life choices including, but not limited to:

(I) ~~daily~~Daily activities;

(II) ~~the~~The physical environment; and

(III) ~~with~~With whom to interact.

(v) The ADH facilitates the member's choice regarding services and supports including the provider.

(vi) Each member has the freedom and support to control his or her own schedules, activities, and access to food at any time.

(vii) Each member may have visitors whenever he or she chooses.

(viii) The ADH center is physically accessible to the member.

(G) ADH centers that are presumed not to be HCBS settings per 42 ~~CFR~~C.F.R. § 441.301(c)(5)(v) include, ADH centers:

(i) in a publicly- or privately-owned facility providing inpatient treatment;

(ii) on the grounds of or adjacent to a public institution; and

(iii) with the effect of isolating individuals from the broader community of individuals not receiving ADvantage Program or another Medicaid HCBS;

(H) When the ADH is presumed not HCBS, according to 42 ~~CFR~~C.F.R. § 441.301(c)(5)(v), it may be subject to heightened scrutiny by AA, OHCA, and Centers for Medicare and Medicaid Services (CMS). The ADH must provide evidence that the ADH portion of the facility has clear administrative, financial, programmatic, and environmental distinctions from the institution and comply with additional monitoring by the AA.

(4) **Environmental modifications.**

(A) Environmental modifications are physical adaptations to the home, required by the member's person-centered service plan that are necessary to ensure the member's health, welfare, and safety or enable the member to function with greater independence in the home, and that without such, the member would require institutionalization. Adaptations or improvements to the home not of direct medical or remedial benefit to the waiver member are excluded.

(B) All services require prior authorization.

(5) **Specialized medical equipment and supplies.**

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

(B) Specialized medical equipment and supplies are billed using the appropriate HealthCare Common Procedure Code (HCPC). Reoccurring supplies shipped and delivered to the member are compensable only when the member remains eligible for Waiver services, continues to reside in the home, and is not institutionalized in a hospital, skilled nursing facility, or nursing home. It is the provider's responsibility to verify the member's status prior to shipping and delivering these items. Payment for medical supplies, equipment, and appliances is ~~limited to the SoonerCare (Medicaid) rate when established, to the Medicare rate, or to actual acquisition cost, plus thirty (30) percent.~~consistent with OHCA rate methodology when available. Certain services, because of their variables, do not lend themselves to a fixed and uniform rate. Payments for these services are paid out at fair market price established through claims review and cost analysis or by selecting the lowest of three (3) bids. All services must have prior authorization.

(6) **Advanced supportive/restorative assistance.**

(A) Advanced supportive/restorative assistance services are maintenance services used to assist a member who has a chronic, yet stable condition. These services assist with ADLs that require devices and procedures related to altered body functions. These services are for maintenance only and are not utilized as treatment services.

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

(7) **Nursing.**

(A) Nursing services are services listed in the person-centered service plan~~ that are~~ within the scope of the

Oklahoma Nursing Practice Act. These services are provided by a registered nurse (RN), a licensed practical nurse (LPN), or a licensed vocational nurse (LVN) under the supervision of an RN licensed to practice in the state. Nursing services may be provided on an intermittent or part-time basis or may be comprised of continuous care. The provision of the nursing service works to prevent or postpone the institutionalization of the member.

(B) Nursing services are services of a maintenance or preventative nature provided to members with stable, chronic conditions. These services are not intended to treat an acute health condition and may not include services reimbursable under either the Medicaid or Medicare Home Health Program. This service primarily provides nurse supervision to the personal care assistant or to the advanced supportive/restorative assistance aide and assesses the member's health and prescribed medical services to ensure they meet the member's needs as specified in the person-centered service plan. A nursing assessment/evaluation, on-site visit is made to each member, with additional visits for members with advanced supportive/restorative assistance services authorized to evaluate the condition of the member and medical appropriateness of services. An assessment/evaluation report is forwarded to the ADvantage Program case manager in accordance with review schedule determined between the case manager and outlined in the member's person-centered service plan, to report the member's condition or other significant information concerning each ADvantage member.

(i) The ADvantage Program case manager may recommend authorization of nursing services as part of the interdisciplinary team planning for the member's person-centered service plan and/or assessment/evaluation of the:

(I) ~~member's~~Member's general health, functional ability, and needs; and/or

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

(ii) In addition to assessment/evaluation, the ADvantage Program case manager may recommend authorization of nursing services to:

(I) ~~prepare~~Prepare a ~~one-week (1-week)~~one (1) week supply of insulin syringes for a person who is blind and has diabetes and can safely self-inject the medication but cannot fill his or her own syringe. This service includes monitoring the member's continued ability to self-administer the insulin;

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

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

(IV) ~~provide~~Provide nail care for the member with diabetes or member who has circulatory or neurological compromise; and

(V) ~~provide~~Provide consultation and education to the member, member's family, or other informal caregivers identified in the person-centered service plan, regarding the nature of the member's chronic condition. Skills training, including return skills demonstration to establish competency, to the member, family, or other informal caregivers as specified in the person-centered service plan for preventive and rehabilitative care procedures are also provided.

(C) Nursing service includes interdisciplinary team planning and recommendations for the member's person-centered service plan development and/or assessment/evaluation or for other services within the scope of the Oklahoma Nursing Practice Act, including private duty nursing. Nursing services are billed per ~~fifteen-minute (15-minute)~~fifteen (15) minute unit of service. A specific procedure code is used to bill for interdisciplinary team planning and recommendations for the member's person-centered service plan other procedure codes may be used to bill for all other authorized nursing services. A maximum of eight (8) units, two (2) hours, per day of nursing for service plan development and assessment evaluation are allowed. An agreement by a provider to perform a nurse evaluation is also an agreement to provide the Medicaid in-home care services for which the provider is certified and contracted. Reimbursement for a nurse evaluation is denied when the provider that produced the nurse evaluation fails to provide the nurse assessment

identified in the Medicaid in-home care services for which the provider is certified and contracted.

(8) **Skilled nursing services.**

(A) Skilled nursing services listed in the person-centered service plan that are within the scope of the state's Nurse Practice Act and are ordered by a licensed physician, osteopathic physician, physician assistant, or an advanced practice nurse and are provided by an RN, LPN, or LVN under the supervision of an RN, licensed to practice in the state. Skilled nursing services provided in the member's home or other community setting are services requiring the specialized skills of a licensed nurse. The scope and nature of these services are intended for treatment of a disease or a medical condition and are beyond the scope of ADvantage nursing services. These intermittent nursing services are targeted toward a prescribed treatment or procedure that must be performed at a specific time or other predictable rate of occurrence. The RN contacts the member's physician to obtain necessary information or orders pertaining to the member's care. When the member has an ongoing need for service activities requiring more or less units than authorized, the RN must recommend, in writing, that the service plan be revised.

(B) Skilled nursing services are provided on an intermittent or part-time basis, and billed per ~~fifteen-minute (15-minute)~~fifteen (15) minute units of service. Skilled nursing services are provided when nursing services are not available through Medicare or other sources or when SoonerCare plan nursing services limits are exhausted. Amount, frequency, and duration of services are prior-authorized in accordance with the member's person-centered service plan.

(9) **Home-delivered meals.**

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

(B) Home-delivered meals are billed per meal, with one (1) meal equaling one (1) unit of service. The limit of the number of units a member is allowed to receive is in accordance with the member's person-centered service plan. The provider must obtain a signature from the member or the

member's representative at the time the meal is delivered. In the event the member is temporarily unavailable, such as at a doctor's appointment and the meal is left at the member's home, the provider must document the reason a signature was not obtained. The signature logs must be available for review.

(10) **Occupational therapy services.**

(A) Occupational therapy services are services that increase functional independence by enhancing the development of adaptive skills and performance capacities of members with physical disabilities and related psychological and cognitive impairments. Services are provided in the member's home and are intended to help the member achieve greater independence enabling him or her to reside and participate in the community. Treatment involves the therapeutic use of self-care, work and play activities, and may include modification of the tasks or environment to enable the member to achieve maximum independence, prevent further disability, and maintain health. Under a physician's order, a licensed occupational therapist evaluates the member's rehabilitation potential and develops an appropriate written, therapeutic regimen. The regimen utilizes paraprofessional, occupational therapy assistant services, within the limitations of his or her practice, working under the supervision of a licensed occupational therapist. The regimen includes education and training for informal caregivers to assist with and/or maintain services when appropriate. The occupational therapist ensures monitoring and documentation of the member's rehabilitative progress and reports to the member's case manager and physician to coordinate the necessary addition or deletion of services, based on the member's condition and ongoing rehabilitation potential.

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

(11) **Physical therapy services.**

(A) Physical therapy services are those services that maintain or improve physical disability through the evaluation and rehabilitation of members disabled by pain, disease, or injury. Services are provided in the member's home and are intended to help the member achieve greater independence to reside and participate in the community. Treatment involves the use of physical therapeutic means, such as massage, manipulation, therapeutic exercise, cold and/or heat therapy, hydrotherapy, electrical stimulation,

and light therapy. Under a physician's order, a licensed physical therapist evaluates the member's rehabilitation potential and develops an appropriate, written, therapeutic regimen. Under the Oklahoma Physical Therapy Practice Act, a physical therapist may evaluate a member's rehabilitation potential and develop and implement an appropriate, written, therapeutic regimen without a referral from a licensed health care practitioner for a period not to exceed ~~thirty-calendar (30-calendar)~~thirty (30) calendar days. Any treatment required after the ~~thirty-calendar (30-calendar)~~thirty (30) calendar day period requires a prescription from a physician or the physician's assistant of the licensee. The regimen utilizes paraprofessional physical therapy assistant services, within the limitations of his or her practice, working under the supervision of the licensed physical therapist. The regimen includes education and training for informal caregivers to assist with and/or maintain services when appropriate. The licensed physical therapist ensures monitoring and documentation of the member's rehabilitative progress and reports to the member's case manager and physician to coordinate the necessary addition or deletion of services, based on the member's condition and ongoing rehabilitation potential.

(B) Physical therapy services are authorized as ADH care therapy enhancement and are a maximum of one (1) session unit per day of service. Payment is not allowed solely for written reports or record documentation.

(12) **Speech and language therapy services.**

(A) Speech and language therapy services are those that maintain or improve speech and language communication and swallowing disorders/disability through the evaluation and rehabilitation of members disabled by pain, disease, or injury. Services are provided in the member's home and are intended to help the member achieve greater independence to reside and participate in the community. Services involve the use of therapeutic means, such as evaluation, specialized treatment, or development and oversight of a therapeutic maintenance program. Under a physician's order, a licensed speech and language pathologist evaluates the member's rehabilitation potential and develops an appropriate, written, therapeutic regimen. The regimen utilizes Speech Language Pathology Assistant services within the limitations of his or her practice, working under the supervision of the licensed Speech and Language Pathologist. The regimen includes education and training for informal caregivers to assist with, and/or maintain services when

appropriate. The Speech and Language Pathologist ensures monitoring and documentation of the member's rehabilitative progress and reports to the member's case manager and physician to coordinate the necessary addition and/or deletion of services, based on the member's condition and ongoing rehabilitation potential.

(B) Speech and language therapy services are authorized as ADH care-therapy enhancement and are a maximum of one (1) session unit per day of service. Payment is not allowed solely for written reports or record documentation.

(13) **Hospice services.**

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

(B) A hospice program offers palliative and supportive care to meet the special needs arising out of the physical, emotional, and spiritual stresses experienced during the final stages of illness, through the end of life, and bereavement. The member signs a statement choosing hospice care instead of routine medical care with the objective to treat and cure the member's illness. Once the member has elected hospice care, the hospice medical team assumes responsibility for the member's medical care for the illness in the home environment. Hospice care services include nursing care, physician services, medical equipment and supplies, drugs for symptom and pain relief, home health aide and personal care services, physical, occupational and

speech therapies, medical social services, dietary counseling, and grief and bereavement counseling to the member and/or the member's family.

(C) A hospice person-centered service plan must be developed by the hospice team in conjunction with the member's ADvantage case manager before hospice services are provided. The hospice services must be related to the palliation or management of the member's terminal illness, symptom control, or to enable the member to maintain ADL and basic functional skills. A member who is eligible for Medicare hospice provided as a Medicare Part A benefit, is not eligible to receive ADvantage hospice services.

(D) Hospice services are billed per diem of service for days covered by a hospice person-centered service plan and while the hospice provider is responsible for providing hospice services as needed by the member or member's family. The maximum total annual reimbursement for a member's hospice care within a ~~twelve-month (12-month)~~twelve (12) month period is limited to an amount equivalent to eighty-five (85) percent of the Medicare hospice cap payment, and must be authorized on the member's person-centered service plan.

(14) **ADvantage personal care.**

(A) ADvantage personal care is assistance to a member in carrying out ADLs, such as bathing, grooming, and toileting or in carrying out instrumental activities of daily living (IADLs), such as preparing meals and laundry service, to ensure the member's personal health and safety, or to prevent or minimize physical health regression or deterioration. Personal care services do not include service provision of a technical nature, such as tracheal suctioning, bladder catheterization, colostomy irrigation, or the operation and maintenance of equipment of a technical nature.

(B) ADvantage home care agency skilled nursing staff working in coordination with an ADvantage case manager is responsible for the development and monitoring of the member's personal care services.

(C) ADvantage personal care services are prior-authorized and billed per ~~fifteen-minute (15-minute)~~fifteen (15) minute unit of service, with units of service limited to the number of units on the ADvantage approved person-centered service plan.

(15) **Personal emergency response system (PERS).**

(A) PERS is an electronic device that enables members at high risk of institutionalization, to secure help in an emergency. Members may also wear a portable "help" button to allow for mobility. PERS is connected to the person's phone

and programmed to signal, per member preference, a friend, relative, or a response center, once the "help" button is activated. For an ADvantage member to be eligible for PERS service, the member must meet all of the service criteria in (i) through (vi). ~~The:~~The member:

(i) ~~member has~~Has a recent history of falls as a result of an existing medical condition that prevents the member from getting up unassisted from a fall;

(ii) ~~member lives~~Lives alone and without a regular caregiver, paid or unpaid, and therefore is left alone for long periods of time;

(iii) ~~member demonstrates~~Demonstrates the capability to comprehend the purpose of and activate the PERS;

(iv) ~~member has~~Has a health and safety plan detailing the interventions beyond the PERS to ensure the member's health and safety in his or her home;

(v) ~~member has~~Has a disease management plan to implement medical and health interventions that reduce the possibility of falls by managing the member's underlying medical condition causing the falls; and

(vi) PERS service avoids premature or unnecessary ~~institutionalization of the~~ member~~.~~ institutionalization.

(B) PERS services are billed using the appropriate Healthcare Common Procedure Coding System (HCPCS) procedure code for installation, monthly service, or PERS purchase. All services are prior authorized per the ADvantage approved service plan.

(16) **CD-PASS.**

(A) CD-PASS are personal services ~~assistance~~assistants (PSA) and advanced personal services ~~assistance~~assistants (APSA) that ~~enables~~enable a member in need of assistance to reside in his or her home and community of choice, rather than in an institution; and to carry out functions of daily living, self-care, and mobility. CD-PASS services are delivered as authorized on the person-centered service plan. The member becomes the employer of record and employs the PSA and the APSA. The member is responsible, with assistance from ADvantage Program Administrative Financial Management Services (FMS), for ensuring the employment complies with state and federal labor law requirements. The member/employer may designate an adult family member or friend, who is not a PSA or APSA to the member, as an "authorized representative" to assist in executing the employer functions. The member/employer:

(i) ~~recruits,~~Recruits, hires and, as necessary, discharges the PSA or APSA;

(ii) ~~is~~Is solely responsible to provide instruction and training to the PSA or APSA on tasks and works with the consumer directed agent/case manager (CDA) to obtain ADvantage skilled nursing services assistance with training, when necessary. Prior to performing an APSA task for the first time, the APSA must demonstrate competency in the tasks in an on-the-job training session conducted by the member and the member must document the attendant's competency in performing each task in the APSA's personnel file;

(iii) ~~determines~~Determines where and how the PSA or APSA works, hours of work, what is to be accomplished and, within individual budget allocation limits, wages to be paid for the work;

(iv) ~~supervises~~Supervises and documents employee work time; and

(v) ~~provides~~Provides tools and materials for work to be accomplished.

(B) The services the PSA may provide include:

(i) ~~assistance~~Assistance with mobility and transferring in and out of bed, wheelchair, or motor vehicle, or all;

(ii) ~~assistance~~Assistance with routine bodily functions, such as:

(I) ~~bathing~~Bathing and personal hygiene;

(II) ~~dressing~~Dressing and grooming; and

(III) ~~eating,~~Eating, including meal preparation and cleanup;

(iii) ~~assistance~~Assistance with home services, such as shopping, laundry, cleaning, and seasonal chores;

(iv) ~~companion~~Companion assistance, such as letter writing, reading mail, and providing escort or transportation to participate in approved activities or events. "Approved activities or events," means community, civic participation guaranteed to all citizens including, but not limited to, exercise of religion, voting or participation in daily life activities in which exercise of choice and decision making is important to the member, and may include shopping for food, clothing, or other necessities, or for participation in other activities or events specifically approved on the person-centered service plan.

(C) An APSA provides assistance with ADLs to a member with a stable, chronic condition, when such assistance requires devices and procedures related to altered body function if

such activities, in the opinion of the attending physician or licensed nurse, may be performed if the member were physically capable, and the procedure may be safely performed in the home. Services provided by the APSA are maintenance services and are never used as therapeutic treatment. Members who develop medical complications requiring skilled nursing services while receiving APSA services are referred to his or her attending physician, who when appropriate, orders home health services. APSA includes assistance with health maintenance activities that may include:

(i) ~~routine~~Routine personal care for persons with ostomies, including tracheotomies, gastrostomies, and colostomies with well-healed stoma, external, indwelling, and suprapubic catheters that include changing bags and soap and water hygiene around the ostomy or catheter site;

(ii) ~~removing~~Removing external catheters, inspecting skin, and reapplication of same;

(iii) ~~administering~~Administering prescribed bowel program, including use of suppositories and sphincter stimulation, and enemas pre-packaged only without contraindicating rectal or intestinal conditions;

(iv) ~~applying~~Applying medicated prescription lotions or ointments and dry, non-sterile dressings to unbroken skin;

(v) ~~using~~Using a lift for transfers;

(vi) ~~manually~~Manually assisting with oral medications;

(vii) ~~providing~~Providing passive range of motion (non-resistive flexion of joint) therapy, delivered in accordance with the person-centered service plan unless contraindicated by underlying joint pathology;

(viii) ~~applying~~Applying non-sterile dressings to superficial skin breaks or abrasions; and

(ix) ~~using~~Using universal precautions as defined by the Centers for Disease Control and Prevention.

(D) FMS are program administrative services provided to participating CD-PASS members/employers by AA. FMS are employer-related assistance that provides Internal Revenue Service (IRS) fiscal reporting agent and other financial management tasks and functions including, but not limited to:

(i) ~~processing~~Processing employer payroll, after the member/employer has verified and approved the employee timesheet, at a minimum of semi-monthly, and associated withholding for taxes, or for other payroll withholdings

performed on behalf of the member as employer of the PSA or APSA;

(ii) ~~other~~Other employer related payment disbursements as agreed to with the member/employer and in accordance with the member/employer's individual budget allocation;

(iii) ~~responsibility~~Responsibility for obtaining criminal and abuse registry background checks on prospective hires for PSA or APSA on the member/employer's behalf;

(iv) ~~providing~~Providing orientation and training regarding employer responsibilities, as well as employer information and management guidelines, materials, tools, and staff consultant expertise to support and assist the member successfully perform employer-related functions; and

(v) ~~making~~Making Hepatitis B vaccine and vaccination series available to PSA and APSA employees in compliance with Occupational Safety and Health Administration (OSHA) standards.

(E) The PSA service is billed per ~~fifteen-minute (15-minute)~~fifteen (15) minute unit of service. The number of units of PSA a member may receive is limited to the number of units approved on the person-centered service plan.

(F) The APSA service is billed per ~~fifteen-minute (15-minute)~~fifteen (15) minute unit of service. The number of units of APSA a member may receive is limited to the number of units approved on the person-centered service plan.

(17) **Institutional transition services.**

(A) Institutional transition services are those services necessary to enable a member to leave the institution and receive necessary support through ADvantage waiver services in his or her home and community.

(B) Transitional case management services are services per OAC 317:30-5-763(1) required by the member and included on the member's person-centered service plan that are necessary to ensure the member's health, welfare, and safety, or to enable the member to function with greater independence in the home, and without which, the member would continue to require institutionalization. ADvantage transitional case management services assist institutionalized members who are eligible to receive ADvantage services in gaining access to needed Waiver and other State plan services, as well as needed medical, social, educational, and other services to assist in the transition, regardless of the funding source for the services to which access is gained. Transitional case management services may be authorized for periodic

monitoring of an ADvantage member's progress during an institutional stay and for assisting the member transition from institution to home by updating the person-centered service plan, including necessary institutional transition services to prepare services and supports to be in place or to start on the date the member is discharged from the institution. Transitional case management services may be authorized to assist individuals that have not previously received ADvantage services, but were referred by DHS AS to the case management provider for assistance in transitioning from the institution to the community with ADvantage services support.

(i) Institutional transition case management services are prior authorized and billed per ~~fifteen-minute (15-minute)~~fifteen (15) minute unit of service using the appropriate HCPC procedure code and modifier associated with the location of residence of the member served, per OAC 317:30-5-763(1)(C).

(ii) A unique modifier code is used to distinguish transitional case management services from regular case management services.

(C) Institutional transition services may be authorized and reimbursed, per the conditions in (i) through (iv).

(i) The service is necessary to enable the member to move from the institution to his or her home.

(ii) The member is eligible to receive ADvantage services outside of the institutional setting.

(iii) Institutional transition services are provided to the member within one-hundred and eighty (180) calendar-days of discharge from the institution.

(iv) Services provided while the member is in the institution are claimed as delivered on the day of discharge from the institution.

(D) When the member receives institutional transition services but fails to enter the waiver, any institutional transition services provided are not reimbursable.

(18) **Assisted living services (ALS).**

(A) ALS are personal care and supportive services furnished to waiver members who reside in a homelike, non-institutional setting that includes twenty-four (24) hour on-site response capability to meet scheduled or unpredictable member needs and to provide supervision, safety, and security. Services also include social and recreational programming and medication assistance, to the extent permitted under State law. The ALS provider is responsible for coordinating services provided by third

parties to ADvantage members in the assisted living center (ALC). Nursing services are incidental rather than integral to the provision of ALS. ADvantage reimbursement for ALS includes services of personal care, housekeeping, laundry, meal preparation, periodic nursing evaluations, nursing supervision during nursing intervention, intermittent or unscheduled nursing care, medication administration, assistance with cognitive orientation, assistance with transfer and ambulation, planned programs for socialization, activities, and exercise, and for arranging or coordinating transportation to and from medical appointments. Services, except for planned programs for socialization, activities, and exercise are to meet the member's specific needs as determined through the individualized assessment and documented on the member's person-centered service plan.

(B) The ADvantage ALS philosophy of service delivery promotes member choice, and to the greatest extent possible, member control. A member has control over his or her living space and his or her choice of personal amenities, furnishings, and activities in the residence. The ADvantage member must have the freedom to control his or her schedule and activities. The ALS provider's documented operating philosophy, including policies and procedures, must reflect and support the principles and values associated with the ADvantage assisted living philosophy and approach to service delivery emphasizing member dignity, privacy, individuality, and independence.

(C) ADvantage ALS required policies for admission and termination of services and definitions.

(i) ADvantage-certified assisted living centers (ALC) are required to accept all eligible ADvantage members who choose to receive services through the ALC, subject only to issues relating to, one (1) or more of the following:

(I) ~~rental~~Rental unit availability;

(II) ~~the~~The member's compatibility with other residents;

(III) ~~the~~The center's ability to accommodate residents who have behavior problems, wander, or have needs that exceed the services the center provides; or

(IV) ~~restrictions~~Restrictions initiated by statutory limitations.

(ii) The ALC may specify the number of units the provider is making available to service ADvantage members. At minimum, the ALC must designate ten (10) residential units for ADvantage members. Residential units designated for ADvantage may be used for other residents at the ALC

when there are no pending ADvantage members for those units. Exceptions may be requested in writing subject to the approval of AA.

(iii) Mild or moderate, cognitive impairment of the applicant is not a justifiable reason to deny ALC admission. Centers are required to specify whether they are able to accommodate members who have behavior problems or wander. Denial of admission due to a determination of incompatibility must be approved by the case manager and the AA. Appropriateness of placement is not a unilateral determination by the ALC. The ADvantage case manager, the member, or member's designated representative, and the ALC in consultation determine the appropriateness of placement.

(iv) The ALC is responsible for meeting the member's needs for privacy, dignity, respect, and freedom from coercion and restraint. The ALC must optimize the member's initiative, autonomy and independence in making life choices. The ALC must facilitate member choices regarding services and supports, and who provides them. Inability to meet those needs is not recognized as a reason for determining an ADvantage member's placement is inappropriate. The ALC agrees to provide or arrange and coordinate all of the services listed in the Oklahoma State Department of Health (OSDH) regulations, per OAC 310:663-3-3, except for specialized services.

(v) In addition, the ADvantage participating ALC agrees to provide or coordinate the services listed in (I) through (III).

(I) Provide an emergency call system for each participating ADvantage member.

(II) Provide ~~up to~~ three (3) meals per day plus snacks sufficient to meet nutritional requirements, including modified special diets, appropriate to the member's needs and choices; and provide members with twenty-four (24) hour access to food by giving members control in the selection of the foods they eat, by allowing the member to store personal food in his or her room, by allowing the member to prepare and eat food in his or her room, and allowing him or her to decide when to eat.

(III) Arrange or coordinate transportation to and from medical appointments. The ALC must assist the member with accessing transportation for integration into the community, including opportunities to seek employment and work in competitive integrated settings, engage in

community life, and control his or her personal resources and receive services in the community to the same degree of access as residents not receiving ADvantage services.

(vi) The provider may offer any specialized service or rental unit for members with Alzheimer's disease and related dementias, physical disabilities, or other special needs the facility intends to market. Heightened scrutiny, through additional monitoring of the ALC by AA, is utilized for those ALC's that also provide inpatient treatment; settings on the grounds of or adjacent to a public institution and/or other settings that tend to isolate individuals from the community. The ALC must include evidence that the ALC portion of the facility has clear administrative, financial, programmatic and environmental distinctions from the institution.

(vii) When the provider arranges and coordinates services for members, the provider is obligated to ensure the provision of those services.

(viii) Per OAC 310:663-1-2, "personal care" is defined as "assistance with meals, dressing, movement, bathing or other personal needs or maintenance, or general supervision of the physical and mental well-being of a person, and includes assistance with toileting." For ADvantage ALS, assistance with "other personal needs" in this definition includes assistance with grooming and transferring. The term "assistance" is clarified to mean hands-on help, in addition to supervision.

(ix) The specific ALS assistance provided along with amount and duration of each type of assistance is based upon the member's assessed need for service assistance and is specified in the ALC's service plan that is incorporated as supplemental detail into the ADvantage comprehensive person-centered service plan. The ADvantage case manager in cooperation with ALC professional staff, develops the person-centered service plan to meet member needs. As member needs change, the person-centered service plan is amended consistent with the assessed, documented need for change in services.

(x) Placement, or continued placement of an ADvantage member in an ALC, is inappropriate when any one (1) or more of the conditions exist.

(I) The member's needs exceed the level of services the center provides. Documentation must support ALC efforts to provide or arrange for the required services to accommodate participant needs.

(II) The member exhibits behavior or actions that repeatedly and substantially interferes with the rights or well-being of other residents and the ALC documented efforts to resolve behavior problems including medical, behavioral, and increased staffing interventions. Documentation must support the ALC attempted interventions to resolve behavior problems.

(III) The member has a complex, unstable, or unpredictable medical condition and treatment cannot be developed and implemented appropriately in the assisted living environment. Documentation must support the ALC attempts to obtain appropriate member care.

(IV) The member fails to pay room and board charges and/or DHS determined vendor payment obligation.

(xi) Termination of residence when inappropriately placed. Once a determination is made that a member is inappropriately placed, the ALC must inform the member, the member's representative, when applicable, the AA and the member's ADvantage case manager. The ALC must develop a discharge plan in consultation with the member, the member's representative, the ADvantage case manager, and the AA. The ALC and case manager must ensure the discharge plan includes strategies for providing increased services, when appropriate, to minimize risk and meet the higher care needs of members transitioning out of the ALC, when the reason for discharge is inability to meet member needs. When voluntary termination of residency is not arranged, the ALC must provide written notice to the member and to the member's representative, with a copy to the member's ADvantage case manager and the AA. The written notice provides intent to terminate the residency agreement and move the member to an appropriate care provider. The thirty (30) calendar-day requirement must not apply when emergency termination of the residency agreement is mandated by the member's immediate health needs or when the termination of the residency agreement is necessary for the physical safety of the member or other ALC residents. The written involuntary termination of residency notice for reasons of inappropriate placement must include:

(I) a full explanation of the reasons for the termination of residency;

(II) the notice date;

(III) the date notice was given to the member and the member's representative, the ADvantage case manager, and the AA;

(IV) the date the member must leave ALC; and

(V) notification of appeal rights and the process for submitting appeal of termination of Medicaid ALS to OHCA.

(D) ADvantage ALS provider standards in addition to licensure standards.

(i) **Physical environment.**

(I) The ALC must provide lockable doors on the entry door of each rental unit and an attached, lockable compartment within each member unit for valuables. Members must have exclusive rights to his or her unit with lockable doors at the entrance of the individual or shared rental unit. Keys to rooms may be held by only appropriate ALC staff as designated by the member's choice. Rental units may be shared only when a request to do so is initiated by the member. Members must be given the right to choose his or her roommate.

(II) The member has a legally enforceable agreement, lease, with the ALC. The member must have the same responsibilities and protections from eviction as all tenants under the landlord tenant law of the state, county, city, or other designated entity.

(III) The ALC must provide each rental unit with a means for each member to control the temperature in the residential unit through the use of a damper, register, thermostat, or other reasonable means under the control of the member and that preserves privacy, independence, and safety, provided that the OSDH may approve an alternate means based on documentation that the design of the temperature control is appropriate to the special needs of each member who has an alternate temperature control.

(IV) For ALCs built prior to January 1, 2008, each ALC individual residential unit must have a minimum total living space, including closets and storage areas, of two-hundred and fifty (250) square feet~~;~~. ~~for ALCs built after December 31, 2007,~~Beginning January 1, 2008, each ALC individual residential unit must have a minimum total living space, including closets and storage areas, of three-hundred and sixty (360) square feet.

(V) The ALC must provide a private bathroom for each living unit that must be equipped with one lavatory, one toilet, and one bathtub or shower stall.

(VI) The ALC must provide at a minimum; a kitchenette, defined as a space containing a refrigerator, adequate storage space for utensils, and a cooking appliance, a microwave is acceptable.

(VII) The member is responsible for furnishing the rental unit. When a member is unable to supply basic furnishings defined as a bed, dresser, nightstand, chairs, table, trash can, and lamp, or if member supplied furnishings pose a health or safety risk, the member's ADvantage case manager in coordination with the ALC, must assist the member in obtaining basic furnishings for the rental unit. The member must have the freedom to furnish and decorate the rental unit within the scope of the lease or residency agreement.

(VIII) The ALC must meet the requirements of all applicable federal and state laws and regulations including, but not limited to, state and local sanitary codes, state building and fire safety codes, and laws and regulations governing use and access by persons with disabilities.

(IX) The ALC must ensure the design of common areas accommodates the special needs of the resident population and that the rental unit accommodates the special needs of the member in compliance with the Americans with Disabilities Act accessibility guidelines per 28 Code of Federal Regulations, Part 36, Appendix A, at no additional cost to the member.

(X) The ALC must provide adequate and appropriate social and recreational space for residents and the common space must be proportionate to the number of residents and appropriate for the resident population.

(XI) The ALC must provide appropriately monitored outdoor space for resident use.

(XII) The ALC must provide the member with the right to have visitors of his or her choosing at any time. Overnight visitation is allowed as permissible by the Landlord/Tenant Agreement.

(XIII) The ALC must be physically accessible to members.

(ii) **Sanitation.**

(I) The ALC must maintain the facility, including its individual rental units in a clean, safe, and sanitary

manner and be insect and rodent free, odorless, and in good repair at all times.

(II) The ALC must maintain buildings and grounds in a good state of repair, in a safe and sanitary condition, and in compliance with the requirements of applicable regulations, bylaws, and codes.

(III) The ALC stores clean laundry in a manner that prevents contamination and changes linens at time intervals necessary to avoid health issues.

(IV) The ALC must provide housekeeping in member rental units to maintain a safe, clean, and sanitary environment.

(V) The ALC must have policies and procedures for members' pets.

(iii) **Health and Safety.**

(I) The ALC must provide building security that protects members from intruders with security measures appropriate to building design, environmental risk factors, and the resident population.

(II) The ALC must respond immediately and appropriately to missing members, accidents, medical emergencies, or deaths.

(III) The ALC must have a plan in place to prevent, contain, and report any diseases considered to be infectious or are listed as diseases that must be reported to the OSDH.

(IV) The ALC must adopt policies for the prevention of abuse, neglect, and exploitation that include screening, training, prevention, investigation, protection during investigation, and reporting.

(V) The ALC must provide services and facilities that accommodate the needs of members to safely evacuate in the event of fires or other emergencies.

(VI) The ALC must ensure staff is trained to respond appropriately to emergencies.

(VII) The ALC must ensure that fire safety requirements are met.

(VIII) The ALC must offer meals that provide balanced and adequate nutrition for members.

(IX) The ALC must adopt safe practices for the preparation and delivery of meals.

(X) The ALC must provide a twenty-four (24) hour response to personal emergencies appropriate to the needs of the resident population.

(XI) The ALC must provide safe transportation to and from ALC sponsored social or recreational outings.

(iv) **Staff to resident ratios.**

(I) The ALC must ensure a sufficient number of trained staff are on duty, awake, and present at all times, twenty-four (24) hours a day, and seven (7) days a week, to meet the needs of residents and to carry out all of the processes listed in the ALC's written emergency and disaster preparedness plan for fires and other disasters.

(II) The ALC must ensure staffing is sufficient to meet ADvantage Program members' needs in accordance with each member's ADvantage person-centered service plan.

(III) The ALC must have plans in place to address situations where there is a disruption to the ALC's regular work force.

(v) **Staff training and qualifications.**

(I) The ALC must ensure staff has qualifications consistent with their job responsibilities.

(II) All staff assisting in, or responsible for, food service must have attended a food service training program offered or approved by OSDH.

(III) The ALC must provide staff orientation and ongoing training to develop and maintain staff knowledge and skills. All direct care and activity staff receive at least eight (8) hours of orientation and initial training within the first month of employment and at least four (4) hours annually thereafter. Staff providing direct care on a dementia unit must receive four (4) additional hours of dementia specific training. Annual first aid and cardiopulmonary resuscitation (CPR) certification do not count toward the four (4) hours of annual training.

(vi) **Staff supervision.**

(I) The ALC must ensure delegation of tasks to non-licensed staff is consistent and in compliance with all applicable state regulations including, but not limited to, the Oklahoma Nurse Practice Act and OSDH Nurse Aide Certification rules.

(II) The ALC must ensure that, where the monitoring of food intake or therapeutic diets is provided at the prescribed services level, a registered dietitian monitors member health and nutritional status.

(vii) **Resident rights.**

(I) The ALC must provide to each member and each member's representative, at the time of admission, a copy of the resident statutory rights listed in

Section 1-1918 of Title 63 of the Oklahoma Statutes (O.S.) amended to include additional rights and the clarification of rights as listed in the ADvantage Member Assurances. A copy of resident rights must be posted in an easily accessible, conspicuous place in the facility. The facility must ensure that staff is familiar with and observes, the resident rights.

(II) The ALC must conspicuously post for display in an area accessible to residents, employees, and visitors, the ALC's complaint procedures and the name, address, and phone number of a person authorized to receive complaints. A copy of the complaint procedure must also be given to each member, the member's representative, or the legal guardian. The ALC must ensure all employees comply with the ALC's complaint procedure.

(III) The ALC must provide to each member and member's representative, at the time of admission, information about Medicaid grievance and appeal rights, including a description of the process for submitting a grievance or appeal of any decision that decreases Medicaid services to the member.

(viii) **Incident reporting.**

(I) The ALC must maintain a record of incidents that occur and report incidents to the member's ADvantage case manager and to the AA, utilizing the AA Critical Incident Reporting form. Incident reports are also made to Adult Protective Services (APS) and to the OSDH, as appropriate, per ALC licensure rules, utilizing the specific reporting forms required.

(II) Incidents requiring report by licensed ALC are those defined by OSDH, per OAC 310:663-19-1 and listed on the AA Critical Incident Reporting form.

(III) Reports of incidents must be made to the member's ADvantage case manager and to the AA via electronic submission within one (1) business day of the reportable incident's discovery utilizing the AA Critical Incident Reporting form. When required, a follow-up report of the incident must be submitted via electronic submission to the member's ADvantage case manager and to the AA. The follow-up report must be submitted within ~~five-business (5-business)~~five (5) business days of the incident. The final report must be filed with the member's ADvantage case manager and the AA when the investigation is complete, not to

exceed ~~ten-business (10-business)~~ten (10) business days after the incident.

(IV) Each ALC having reasonable cause to believe that a member is suffering from abuse, neglect, exploitation, or misappropriation of member property must make a report to APS as soon as the person is aware of the situation per ~~O.S. 43A _ 10-104.A.~~43A O.S. § 10-104.A. Reports are also made to OSDH, as appropriate, per ALC licensure rules.

(V) The preliminary incident report must at the minimum, include who, what, when, where, and the measures taken to protect the member and resident(s) during the investigation. The follow-up report must at the minimum, include preliminary information, the extent of the injury or damage, when any, and preliminary investigation findings. The final report at a minimum includes preliminary and follow-up information, a summary of investigative actions representing a thorough investigation, investigative findings and conclusions based on findings, and corrective measures to prevent future occurrences. When it is necessary to omit items, the final report must include why such items were omitted and when they will be provided.

(ix) Provision of or arrangement for necessary health services. The ALC must:

(I) ~~arrange~~Arrange or coordinate transportation for members to and from medical appointments; and

(II) ~~provide~~Provide or coordinate with the member and the member's ADvantage case manager for delivery of necessary health services. The ADvantage case manager is responsible for monitoring all health-related services required by the member as identified through assessment and documented on the person-centered service plan, are provided in an appropriate and timely manner. The member has the freedom to choose any available provider qualified by licensure or certification to provide necessary health services in the ALC.

(E) ALS are billed per diem of service for days covered by the ADvantage member's person-centered service plan and during which the ALS provider is responsible for providing ALS for the member. The per diem rate for ADvantage assisted living services for a member is one (1) of three (3) per diem rate levels based on a member's need for type of, intensity of, and frequency of service to address member

ADLs, instrumental activities of the daily living(IADLs), and health care needs. The rate level is based on the Uniform Comprehensive Assessment Tool (UCAT) assessment by the member's ADvantage case manager employed by a case management agency independent of the ALS provider. The determination of the appropriate per diem rate is made by the AA clinical review staff.

(F) The ALC must notify AA ~~ninety-calendar (90-calendar)~~ninety (90) calendar days before terminating or not renewing the ALC's ADvantage contract.

(i) The ALC must give notice in writing to the member, the member's representative(s), the AA, and the member's ADvantage case manager ninety-calendar (90-calendar) days before:

(I) ~~voluntary~~Voluntary cessation of the ALC's ADvantage contract; or

(II) ~~closure~~Closure of all or part of the ALC.

(ii) The notice of closure must include:

(I) ~~the~~The proposed ADvantage contract termination date;

(II) ~~the~~The termination reason;

(III) ~~an~~An offer to assist the member to secure an alternative placement; and

(IV) ~~available~~Available housing alternatives.

(iii) The facility must comply with all applicable laws and regulations until the closing date, including those related to resident transfer or discharge.

(iv) Following the last move ~~to~~of the last ADvantage member, the ALC must provide in writing to the AA:

(I) ~~the~~The effective date of closure based on the discharge date of the last resident;

(II) ~~a~~A list of members transferred or discharged and where they relocated~~,~~; and

(III) ~~the~~The plan for storage of resident records per OAC 310:663-19-3(g), relating to preservation of resident records and the name, address, and phone numbers of the person responsible for the records.

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

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

317:35-18-6. PACE program benefits

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

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

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

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

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

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

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

(7) Nutritional counseling~~.~~;

(8) Recreational therapy~~.~~;

(9) Transportation~~.~~;

(10) Meals~~.~~;

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

(A) Anesthesiology~~.~~;

(B) Audiology~~.~~;

(C) Cardiology~~.~~;

(D) Dentistry~~.~~;

(E) Dermatology~~.~~;

(F) Gastroenterology~~.~~;

(G) Gynecology~~.~~;

(H) Internal medicine~~.~~;

(I) Nephrology~~.~~;

(J) Neurosurgery~~.~~;

(K) Oncology~~.~~;

(L) Ophthalmology~~.~~;

(M) Oral surgery~~.~~;

(N) Orthopedic surgery~~.~~;

(O) Otorhinolaryngology~~.~~;

(P) Plastic surgery~~.~~;

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

(R) Podiatry~~.~~;

(S) Psychiatry~~.~~;

(T) Pulmonary disease~~.~~;

(U) Radiology~~.~~;

(V) Rheumatology~~.~~;

(W) General surgery~~.~~;

(X) Thoracic and vascular surgery~~.~~; and

(Y) Urology.

(12) Laboratory tests, x-rays, and other diagnostic procedures~~.~~;

(13) Drugs and biologicals~~.~~;

(14) Prosthetics, orthotics, ~~durable medical equipment,~~medical supplies, equipment, and appliances, corrective vision devices, such as eyeglasses and lenses, hearing aids, dentures, and repair and maintenance of these items~~.~~;

(15) Acute inpatient care, including the following:

(A) Ambulance~~.~~;

(B) Emergency room care and treatment room services~~.~~;

(C) Semi-private room and board~~.~~;

(D) General medical and nursing services~~.~~;

(E) Medical surgical/intensive care/coronary care unit~~.~~;

(F) Laboratory tests, x-rays, and other diagnostic procedures~~.~~;

(G) Drugs and biologicals~~.~~;

(H) Blood and blood derivatives~~.~~;

(I) Surgical care, including the use of anesthesia~~.~~;

(J) Use of oxygen~~.~~;

(K) Physical, occupational, respiratory therapies, and speech-language pathology services~~.~~; and

(L) Social services.

(16) Nursing facility (NF) care, including:

(A) Semi-private room and board;

(B) Physician and skilled nursing services;

(C) Custodial care;

(D) Personal care and assistance;

(E) Drugs and biologicals;

(F) Physical, occupational, recreational therapies, and speech-language pathology, if necessary;

(G) Social services; and

(H) Medical supplies, equipment, and appliances.

(17) Other services determined necessary by the ~~interdisciplinary team~~IDT to improve and maintain the participant's overall health status.

(b) The following services are excluded from coverage under PACE:

(1) Any service that is not authorized by the ~~interdisciplinary team,~~IDT, even if it is a required service, unless it is an emergency service.
(2) In an inpatient facility, private room and private duty nursing (PDN) services (unless medically necessary), and non-medical items for personal convenience such as telephone charges and radio or television rental (unless specifically authorized by the ~~interdisciplinary team~~IDT as part of the participant's plan of care).
(3) Cosmetic surgery, which does not include surgery that is required for improved functioning of a malformed part of the body resulting from an accidental injury or for reconstruction following mastectomy.
(4) Experimental medical, surgical, or other health procedures.
(5) Services furnished outside of the United States, except as follows:
(A) ~~in~~In accordance with 42 ~~CFR~~C.F.R. § 424.122 through 42 ~~CFR~~ C.F.R. § 424.124, and
(B) ~~as~~As permitted under the State's approved Medicaid ~~plan.~~State Plan.
(c) In the event that a PACE participant is in need of permanent placement in a ~~nursing facility,~~NF, a Medicaid premium will be imposed. OKDHS will calculate a vendor co-payment for those participants using the same methodology as is used for any Oklahoma Medicaid member who is accessing ~~nursing facility~~NF level of care. However, for a PACE participant, the ~~participants~~participant's responsibility will be to make payment directly to the PACE provider~~.~~, the amount to be specified by the OKDHS worker. There are no other share of costs requirements for PACE.
(d) All PACE ~~Program Benefits~~program benefits are offered through the duration of the PACE participant's enrollment in the PACE program. PACE enrollment does not cease once a participant's condition necessitates or the PACE IDT recommends that ~~they~~he or she be institutionalized.

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

SUBCHAPTER 5. MEMBER SERVICES

PART 9. SERVICE PROVISIONS

317:40-5-104. Specialized medical supplies (a) **Applicability.** The rules in this ~~section~~Section apply to ~~specialized medical supplies~~medical supplies, equipment, and appliances provided through ~~Home and Community Based Services (HCBS) Waivers~~home and community-based waiver services operated by the Oklahoma Department of Human Services (OKDHS) Developmental Disabilities Services ~~Division (DDSD).~~(DDS).

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

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

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

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

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

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

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

(B) ~~nutritional~~Nutritional supplements;

(C) ~~supplies~~Supplies for respirator or ventilator care;
(D) ~~decubitus~~Decubitus care supplies;
(E) ~~supplies~~Supplies for catheterization; and
(F) ~~supplies~~Supplies needed for health conditions.

(6) Items that cannot be purchased as~~ specialized~~ medical supplies, equipment, and appliances include:
(A) ~~over the counter~~Over-the-counter medications(s);
(B) ~~personal~~Personal hygiene items;
(C) ~~medicine~~Medicine cups;
(D) ~~items~~Items that are not medically necessary; and
(E) ~~prescription~~Prescription medication(s).

(7) ~~Specialized medical supplies~~Medical supplies, equipment, and appliances must be:
(A) ~~necessary~~Necessary to address a medical condition;
(B) ~~of~~Of direct medical or remedial benefit to the member;
(C) ~~medical~~Medical in nature; and
(D) ~~consistent~~Consistent with accepted health care practice standards and guidelines for the prevention, diagnosis, or treatment of symptoms of illness, disease, or disability.

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

(1) ~~incontinence~~Incontinence wipes, ~~300~~three-hundred (300) wipes per month;
(2) ~~non-sterile~~Non-sterile gloves, as approved by the Team;
(3) ~~disposable~~Disposable underpads, ~~60~~sixty (60) pads per month; and
(4) ~~incontinence~~Incontinence briefs, ~~180~~one-hundred and eighty (180) briefs per month.
(A) Adult briefs are purchased only in accordance with the implementation of elimination guidelines developed by the ~~Team.~~team.
(B) Exceptions to the requirement for implementation of elimination guidelines may be approved by the ~~DDSD~~DDS nurse when the member has a medical condition that precludes implementation of elimination guidelines, such as atonic bladder, neurogenic bladder, or following a surgical procedure.

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

(1) When a member's ~~Team~~team determines that the member needs medical supplies that:
(A) ~~are~~Are not available through SoonerCare and for which no ~~Health Care Procedure Code~~healthcare common procedure code exists, the case manager e-mails pertinent information

regarding the member's medical supply need to the programs manager responsible for ~~Specialized Medical Supplies.~~medical supplies, equipment, and appliances. The e-mail includes all pertinent information that supports the need for the supply, including but not limited to, quantity and purpose; or

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

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

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

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

SUBCHAPTER 1. MEDICALLY FRAGILE WAIVER SERVICES

317:50-1-14. Description of services

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

(1) **Case Management.**

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

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

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

can perform on behalf of a member;

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

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

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

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

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

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

(E) Providers of Home and ~~Community Based Services~~Community-Based waiver services (HCBS) for the member, or those who have an interest in or are employed by a provider of HCBS for the member, must not provide case management or develop the person-centered service plan, except when the State

demonstrates that the only willing and qualified entity to provide case management and/or develop person-centered service plans in a geographic area also provides HCBS.

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

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

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

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

(3) **Respite.**

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

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

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

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

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

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

(B) All services require prior authorization.

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

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

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

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

(B) ~~Specialized medical equipment and supplies~~Medical supplies, equipment, and supplies are billed using the appropriate ~~HCPC~~healthcare common procedure code~~.~~ (HCPC). Reoccurring supplies which are shipped to the member are compensable only when the member remains eligible for ~~Waiver~~waiver services, continues to reside in the home and is not institutionalized in a hospital, skilled ~~nursing facility~~(NF) or nursing home. It is the provider's

responsibility to verify the member's status prior to shipping these items. Payment for ~~medical supplies~~medical supplies, equipment, and supplies is limited to the Medicare rate, or the SoonerCare rate, or is determined through manual pricing. If manual pricing is used, the provider is reimbursed at the provider's documented ~~Manufacturer's Suggested Retail Price~~manufacturer's suggested retail price (MSRP) minus thirty (30) percent or invoice cost plus thirty (30) percent, whichever is the lesser of the two~~.~~ (2). OHCA may establish a fair market price through claims review and analysis.

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

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

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

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

SUBCHAPTER 3. GENERAL PROVIDER POLICIES
PART 1. GENERAL SCOPE AND ADMINISTRATION

317:30-3-1. 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 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) guidelines.

(f) Services, provided within the scope of the Oklahoma Medicaid ~~Program~~program, shall meet medical necessity criteria. Requests by medical services 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, upon meeting medical necessity and in alignment with the Oklahoma State Plan, for members in the adult

group, age nineteen (19) or older and under age sixty-five (65), and as defined by Section 435.119 of Title 42 of the Code of Federal Regulations. 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 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.

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 1. PHYSICIANS

317:30-5-9. Medical services

(a) **Use of medical modifiers.** The ~~Physicians'~~ physicians' Current Procedural Terminology (CPT) and the second level ~~HCPCS~~Healthcare

Common Procedure Coding System (HCPCS) provide for ~~2-digit~~two(2) digit medical modifiers to further describe medical services. Modifiers are used when appropriate.

(b) **Covered office services.**

(1) Payment is made for four (4) office visits (or home) per month per member, for adults ~~(over age 21)~~[over age twenty-one (21)], regardless of the number of physicians involved. Additional visits per month are allowed for services related to emergency medical conditions.

(2) Visits for the purpose of family planning are excluded from the four per month limitation.

~~(3)~~(2) Payment is allowed for the insertion and/or implantation of contraceptive devices in addition to the office visit.

~~(4)~~(3) Separate payment will be made for the following supplies when furnished during a physician's office visit.

(A) Casting materials

(B) Dressing for burns

(C) Contraceptive devices

(D) IV ~~Fluids~~fluids

~~(5)~~(4) Payment is made for routine physical exams only as prior authorized by the ~~OKDHS~~Oklahoma Department of Human Services (OKDHS) and are not counted as an office visit.

~~(6)~~(5) Medically necessary office lab and X-rays are covered.

~~(7)~~(6) Hearing exams by physician for members between the ages of ~~21 and 65~~twenty-one (21) and sixty-five (65) are covered only as a diagnostic exam to determine type, nature and extent of hearing loss.

~~(8)~~(7) Hearing aid evaluations are covered for members under ~~21~~twenty-one (21) years of age.

~~(9) IPPB (Intermittent Positive Pressure Breathing)~~(8) Intermittent positive pressure breathing (IPPB) is covered when performed in physician's office.

~~(10)~~(9) Payment is made for an office visit in addition to allergy testing.

~~(11)~~(10) Separate payment is made for antigen.

~~(12)~~(11) Eye exams are covered for members between ages ~~21 and 65~~twenty-one (21) and sixty-five (65) for medical diagnosis only.

~~(13)~~(12) If a physician personally sees a member on the same day as a dialysis treatment, payment can be made for a separately identifiable service unrelated to the dialysis.

~~(14)~~(13) Separate payment is made for the following specimen collections:

(A) Catheterization for collection of specimen; and

(B) Routine ~~Venipuncture~~venipuncture.

~~(15)~~(14) The ~~Professional Component~~professional component for electrocardiograms, electroencephalograms, electromyograms,

and similar procedures are covered on an inpatient basis as long as the interpretation is not performed by the attending physician.

~~(16)~~ (15) Cast removal is covered only when the cast is removed by a physician other than the one who applied the cast.

(c) **Non-covered office services.**

(1) Payment is not made separately for an office visit and rectal exam, pelvic exam or breast exam. Office visits including one of these types of exams should be coded with the appropriate office visit code.

(2) Payment cannot be made for prescriptions or medication dispensed by a physician in his office.

(3) Payment will not be made for completion of forms, abstracts, narrative reports or other reports, separate charge for use of office or telephone calls.

(4) Additional payment will not be made for mileage.

(5) Payment is not made for an office visit where the member did not keep appointment.

(6) Refractive services are not covered for persons between the ages of ~~21 and 65~~twenty-one (21) and sixty-five (65).

(7) Removal of stitches is considered part of post-operative care.

(8) Payment is not made for a consultation in the office when the physician also bills for surgery.

(9) Separate payment is not made for oxygen administered during an office visit.

(d) **Covered inpatient medical services.**

(1) Payment is allowed for inpatient hospital visits for all SoonerCare covered admissions. Psychiatric admissions must be prior authorized.

(2) Payment is allowed for the services of two (2) physicians when supplemental skills are required and different specialties are involved.

(3) Certain medical procedures are allowed in addition to office visits.

(4) Payment for critical care is all-inclusive and includes payment for all services that day. Payment for critical care, first hour is limited to one (1) unit per day.

(e) **Non-covered inpatient medical services.**

(1) For inpatient services, all visits to a member on a single day are considered one (1) service except where specified. Payment is made for only one (1) visit per day.

(2) A hospital admittance or visit and surgery on the same day would not be covered if post-operative days are included in the surgical procedure. If there are no post-operative days, a physician can be paid for visits.

(3) Drugs administered to inpatients are included in the hospital payment.
(4) Payment will not be made to a physician for an admission or new patient work-up when the member receives surgery in out-patient surgery or ambulatory surgery center.
(5) Payment is not made to the attending physician for interpretation of tests on his own patient.

(f) **Other medical services.**
(1) Payment will be made to physicians providing ~~Emergency Department~~emergency department services.
(2) Payment is made for two (2) nursing facility visits per month. The appropriate CPT code is used.
(3) When payment is made for "~~Evaluation~~evaluation of arrhythmias" or "~~Evaluation~~evaluation of sinus node", the stress study of the arrhythmia includes inducing the arrhythmia and evaluating the effects of drugs, exercise, etc. upon the arrhythmia.
(4) When the physician bills twice for the same procedure on the same day, it must be supported by a written report.

317:30-5-12. Family planning

(a) **Adults.** Payment is made for the following family planning services:
(1) physical examination to determine the general health of the member and most suitable method of contraception;
(2) complete general history of the member and pertinent history of immediate family members;
(3) laboratory services for the determination of pregnancy, detection of certain sexually transmitted infections and detection of cancerous or pre-cancerous conditions of the reproductive anatomy;
(4) education and counseling regarding issues related to reproduction and contraception;
(5) annual supply of chosen contraceptive;
(6) insertion and removal of contraceptive devices;
(7) vasectomy and Tubal Ligation procedures; and
(8) additional visits for members experiencing difficulty with a particular contraceptive method or having concerns related to their reproductive health.

(b) **Children.** Payment is made for children as set forth in this Section for adults. However payment cannot be made for the sterilization of persons under the age of 21.

~~(c) **SoonerPlan Members.** Non-pregnant women and men ages 19 and older not enrolled in SoonerCare may apply for the SoonerPlan program. Eligible members receive family planning services set forth in this Section as well as family planning related services (vaccinations for the prevention of certain sexually transmitted~~

~~infections and male exams). SoonerPlan eligibility requirements are found at OAC 317:35-7-48.~~

~~(d)~~(c) **Individuals eligible for Part B of Medicare.** Payment is made utilizing the Medicaid allowable for comparable services. Claims for services which are not covered by Medicare should be filed directly with the Fiscal Agent for payment within the scope of the program.

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, advanced practice registered nurse, or physician assistant 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 registered nurse 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 registered nurses (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)~~(3) **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

317:30-5-546. Coverage by category

Payment is made for home health services as set forth in this ~~section~~Section when a ~~face to face~~face-to-face encounter has occurred in accordance with provisions of ~~42 CFR 440.70~~Section (§) 440.70 of Title 42 of the Code of Federal Regulations (C.F.R.).

(1) **Adults.** Payment is made for home health services provided in the member's residence to all categorically needy adults and adults, age nineteen (19) or older and under age sixty-five (65), as defined per 42 C.F.R. § 435.119. 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 DMEPOS~~Medical supplies, equipment, 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~~Home health services are covered for persons under age ~~21~~twenty-one (21).

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

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)~~(9) Optometry and podiatric services other than for dual eligible for Part B of Medicare; and

~~(11)~~(10) 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 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 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 the adult group, age nineteen (19) or older and under age sixty-five (65), the categorical relationship is established and defined by 42 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 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~~and 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 program is established in accordance with OAC 317:35-

21. ~~Categorical relationship for the SoonerPlan Family Planning Program is established in accordance with OAC 317:35-5-8.~~ Categorical relationship for ~~pregnancy related~~pregnancy-related benefits covered under Title XXI is established in accordance with OAC 317:35-22. 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, also 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~~
~~(10)~~(9) Benefits for pregnancies covered under Title XXI;
~~(11)~~(10) Former foster care children; or
(11) Adult group, age nineteen (19) or older and under age sixty-five (65).

(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 (21) receiving active treatment as inpatients in public psychiatric facilities or programs if inpatient psychiatric services for individuals under age 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 (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.

317:35-5-8. Determining categorical relationship for the SoonerPlan Family Planning Program [REVOKED]

~~All non-pregnant women and men ages 19 and older, regardless of pregnancy or paternity history, who are otherwise ineligible for SoonerCare are categorically related to the SoonerPlan Family Planning Program. If eligible for SoonerCare benefits, the individual can choose to enroll only in SoonerPlan with the option of applying for SoonerCare at any time.~~

317:35-5-9. Determining categorical relationship to the adult group, age nineteen (19) or older and under age sixty-five (65).

All adults, age nineteen (19) or older and under age sixty-five (65), as established and defined by 42 C.F.R. § 435.119, are categorically related to the adult group.

PART 5. COUNTABLE INCOME AND RESOURCES

317:35-5-48. Determination of income and resources for categorical relationship to the adult group, age nineteen (19) or older and under age sixty-five (65).

Income is determined in accordance with the Modified Adjusted Gross Income (MAGI) methodology for individuals related to the adult group. 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 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 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 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 OHCA.** OHCA is responsible for determining eligibility for the following eligibility groups:

(1) ~~children~~Children;

(2) ~~newborns~~Newborn 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~~Breast and cervical cancer (BCC) treatment program; and
~~(8) SoonerPlan Family Planning~~
(8) Adult group, age nineteen (19) or older and under age sixty-five (65), who are not related to the aged, blind, or disabled groups.

(b) **Determination of eligibility by OKDHS.** 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 program,~~

~~(6)~~ (5) Independent foster care adolescents~~,~~;

~~(7) Inpatients~~ (6) Individuals under age twenty-one (21) in public psychiatric facilities ~~under 21, and~~;

~~(8)~~ (7) Tuberculosis~~.~~;

(8) Former foster care children;

(9) Children with non IV-E adoption assistance;

(10) Individuals in adoptions subsidized in full or part by a public agency; and

(11) Adult group, age nineteen (19) or older and under age sixty-five (65), who are not related to the aged, blind, or disabled groups.

(b) See ~~42 Code of Federal Regulation, Sec. 435.603~~42 C.F.R. § 453.603 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~~pregnant women, families with children, and adults [age nineteen (19) or older and under age sixty-five (65)]. forms

(a) **Application.** An application for pregnant women ~~and~~ , families with children, and adults [age nineteen (19) or older and under age sixty-five (65)] who are not related to the aged, blind, or disabled groups 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 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 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 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 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 adults[age nineteen (19) or older and under age sixty-five (65)]

(a) **~~Prior to October 1, 2013.~~** ~~In determining~~When determining financial eligibility for an individual related to AFDC or pregnancy-related services or adults [age nineteen (19) or older and under age sixty-five (65)] who are not related to the aged, blind, or disabled, 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 (1) 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.

(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) **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.
~~(c) 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 adults [age nineteen (19) or older and under age sixty-five (65)]

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 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) Adults [age nineteen (19) or older and under age sixty-five (65)] who are not aged, blind or disabled. Individuals who meet financial eligibility criteria for the adults [age nineteen (19) or older and under age sixty-five (65)] 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.

(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; and
(v) Breast and ~~Cervical Cancer Treatment~~cervical cancer (BCC) treatment program~~; and~~.
~~(vi) SoonerPlan Family planning.~~

(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)~~"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.

(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~~breast and cervical cancer (BCC) treatment program are limited to qualified hospitals that are also qualified entities through the 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, 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 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,~~ may not be eligible for reimbursement by the OHCA.

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; Qualified Medicare Beneficiary Plus (QMBP); Qualified Disabled Working Individual (QDWI); Specified Low-Income Medicare Beneficiary (SLMB); and Qualifying Individual (QI-1).

PART 5. DETERMINATION OF ELIGIBILITY FOR MEDICAL SERVICES

317:35-7-48. Eligibility for the SoonerPlan Family Planning Program [REVOKED]

~~(a) Non-pregnant women and men ages 19 and above are eligible to receive family planning services if they meet all of the conditions of eligibility in paragraphs (1), (2), (3), and (4) of this~~

~~Subsection. This is regardless of pregnancy or paternity history and includes women who gain eligibility for SoonerCare family planning services due to a pregnancy, but whose eligibility ends 60 days postpartum.~~

~~(1) MAGI financial eligibility rules are used to determine eligibility for SoonerPlan.~~

~~(2) MAGI household composition rules are used to determine eligibility for SoonerPlan.~~

~~(3) SoonerPlan members with minor dependent children and a parent absent from the home are required to cooperate with the Oklahoma Department of Human Services, Child Support Services Division (OCSS) in the collection of child support payments. Federal regulations provide a waiver of this requirement when cooperation is not in the best interest of the child.~~

~~(4) Individuals eligible for SoonerCare can choose to enroll only in the SoonerPlan Family Planning Program with the option of applying for SoonerCare at any time.~~

~~(5) Persons who have Medicare or creditable health insurance coverage are not precluded from applying for the SoonerPlan Family Planning program.~~

~~(b) All health insurance is listed on applicable systems in order for OHCA Third Party Liability Unit to verify insurance coverage. The OHCA is the payer of last resort.~~

~~(c) Income for the SoonerPlan Family Planning Program does not require verification, unless questionable. If the income is questionable the worker must verify the income.~~

~~(d) There is not an asset test for the SoonerPlan Family Planning Program.~~

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.**

(1) The rules in this Section apply to the following categories of eligibles:

(A) Categorically needy SoonerCare members who are categorically related to Aged, Blind, and Disabled (ABD);

(B) Categorically needy SoonerCare members who are categorically related to ABD, and are eligible for one of the following:

(i) Qualified Medicare Beneficiary Plus (QMBP);
(ii) Qualified Disabled and Working Individual (QDWI);
(iii) Specified Low-Income Medicare Beneficiary (SLMB);
(iv) Tuberculosis (TB) related services;
(v) Qualifying Individual (QI); or
(vi) 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 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.** 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)~~(c) **Certification of individuals categorically related to ABD and eligible as Qualified Disabled and Working Individual.** The Social Security Administration 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 receives referrals from 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 months prior to October 1, if all eligibility criteria are met during the three 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)~~(d) **Certification of individuals categorically related to ABD and eligible as Specified Low-Income Medicare Beneficiary (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)~~(e) **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)~~(f) **Certification of individuals categorically related to ABD and eligible as Qualifying Individuals.** 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)~~(g) **Certification of individuals 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.

317:35-7-60.1. Certification for the SoonerPlan Family Planning Program [REVOKED]

~~The effective date of certification for the SoonerPlan Family~~

~~Planning Program is the date of application or later. The period of certification may not be for a retroactive period. An individual determined eligible for the SoonerPlan Family Planning Program is assigned a certification period of 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 eligibility is required.~~

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,~~ adult group[age nineteen (19) or older and under age sixty-five (65)] who are not aged, blind or disabled, 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.

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, or~~ Title XIX and XXI pregnancy eligibility groups or the adult group [age nineteen (19) or older and under age sixty-five (65)]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 policy, is taken into consideration in determining need. Income is considered available both when 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 SSI recipient's income in computing eligibility for the AFDC or Pregnancy related unit. The MAGI methodology rules determine whose income is considered in a particular household for MAGI eligibility groups as defined in 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. 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 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) 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 month's income, if possible, to determine income eligibility. Less than two 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 25. SOONERCARE CHOICE

SUBCHAPTER 7. SOONERCARE

PART 1. GENERAL PROVISIONS

317:25-7-12. Enrollment/eligibility requirements

(a) Eligible SoonerCare members mandatorily enrolled in SoonerCare Choice include persons categorically related to ~~AFDC, Pregnancy-related services and Aged, Blind or Disabled who are not~~Aid to Families with Dependent Children; pregnancy-related services; ABD; and adult group [individuals who are nineteen (19) or older and under age sixty-five (65), as defined by Section 435.119 of Title 42 of the Code of Federal Regulations]. To be eligible for SoonerCare Choice, an individual cannot be dually-eligible for SoonerCare and Medicare.

(b) Children in foster care may voluntarily enroll into SoonerCare Choice.

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 3. HOSPITALS

317:30-5-58. Supplemental Hospital Offset Payment Program

(a) **Purpose.** The Supplemental Hospital Offset Payment Program (SHOPP) is a hospital assessment fee that is eligible for federal matching funds when used to reimburse SoonerCare services in accordance with Section 3241.1 of Title 63 of the Oklahoma Statutes (O.S.).

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

(1) **"Base Year"** means a hospital's fiscal year ending in 2009, as reported in the Medicare Cost Report or as determined by the Oklahoma Health Care Authority (OHCA) if the hospital's data is not included in a Medicare Cost Report.

(2) **"Fee"** means supplemental hospital offset assessment pursuant to Section (§) 3241.1 of Title 63 of the ~~Oklahoma Statutes~~O.S.

(3) **"Hospital"** means an institution licensed by the State Department of Health as a hospital pursuant to ~~Section~~§ 1-701.1 of Title 63 of the ~~Oklahoma Statutes~~O.S. maintained primarily for the diagnosis, treatment, or care of patients.

(4) **"Hospital Advisory Committee"** means the Committee established for the purposes of advising the OHCA and recommending provisions within and approval of any state plan amendment or waiver affecting the Supplemental Hospital Offset Payment Program.

(5) **"NET hospital patient revenue"** means the gross hospital revenue as reported on Worksheet G-2 (Columns 1 and 2, Lines "Total inpatient routine care services", "Ancillary services", "Outpatient services") of the Medicare ~~Cost Report~~cost report, multiplied by hospital's ratio of total net to gross revenue, as reported on Worksheet G-3(Column 1, Line 3)"Net patient revenues"~~)~~ and Worksheet G-2 (Part I, Column 3, Line "Total patient revenues").

(6) **"Medicare ~~Cost Report~~cost report"** means the ~~Hospital Cost Report~~hospital cost report, Form CMS-2552-96 or subsequent versions.

(7) **"Upper payment limit"(UPL)"** means the maximum ceiling imposed by ~~42 C F R '' 447.272 and 447.~~42 Code of Federal Regulations (C.F.R.) §§ 447.272 and 447.321 on hospital Medicaid reimbursement for inpatient and outpatient services,

other than to hospitals owned or operated by state government.
(8) **"Upper payment limit gap"** means the difference between the upper payment limit and SoonerCare payments not financed using hospital assessments.

(c) **Supplemental Hospital Offset Payment Program.**

(1) Pursuant to 63 ~~Okla. Stat.~~O.S. §§ 3241.1 through 3241.6 the ~~Oklahoma Health Care Authority (OHCA)~~OHCA is mandated to assess hospitals licensed in Oklahoma, unless exempted under (c) (2) of this Section, a supplemental hospital offset payment fee.

(2) The following hospitals are exempt from the SHOPP fee:

(A) ~~a~~A hospital that is owned or operated by the state or a state agency, or the federal government, as determined by OHCA, using most recent Medicare cost report worksheet S-2, column 1, line 18 or other line that indicates ownership, or by a federally recognized Indian tribe or Indian Health Services, as determined by OHCA, using the most recent IHS/Tribal facility list for Oklahoma as updated by the Indian Health Service Office of Resource Access and Partnerships in Partnership with the Centers for Medicare and Medicaid Services and ~~State~~state operations.

(B) ~~a~~A hospital that provides more than fifty percent (50%) of its inpatient days under a contract with a state agency other than the OHCA, as determined by OHCA, using data provided by the hospital;

(C)~~a~~A hospital for which the majority of its inpatient days are for any one of the following services, as determined by OHCA, using the Inpatient Discharge Data File published by the Oklahoma State Department of Health, or in the case of a hospital not included in the Inpatient Discharge Data File, using substantially equivalent data provided by the hospital:

(i) ~~treatment~~Treatment of a neurological injury;

(ii) ~~treatment~~Treatment of cancer;

(iii) ~~treatment~~Treatment of cardiovascular disease;

(iv) ~~obstetrical~~Obstetrical or childbirth services; or

(v) ~~surgical~~Surgical care except that this exemption will not apply to any hospital located in a city of less than five hundred thousand (500,000) population and for which the majority of inpatient days are for back, neck, or spine surgery.

(D) ~~a~~A hospital that is certified by the Centers for Medicare and Medicaid Services (CMS) as a long term acute hospital, according to the most recent list of LTCH's published on the CMS http://www.cms.gov/LongTermCareHospitalPPS/08download.asp or as a children's hospital; and

(E) ~~a~~A hospital that is certified by CMS as a critical access hospital, according to the most recent list published by

Flex Monitoring Team for Critical Access Hospital (CAH) Information at http://www.flexmonitoring.org/cahlistRA.cgi, which is based on CMS quarterly reports, augmented by information provided by state Flex Coordinators.

(d) **The Supplemental Hospital Offset Payment Program Assessment.**

(1) The SHOPP assessment is imposed on each hospital, except those exempted under (c) (2) of this Section, for each calendar year in an amount calculated as a percentage of each hospital's net hospital patient revenue. The assessment rate until December 31, 2012, is two and one-half percent (2.5%). At no time in subsequent years will the assessment rate exceed four percent (4%).

~~(2) OHCA will review and determine the amount of annual assessment in December of each year.~~

~~(3)~~(2) A hospital may not charge any patient for any portion of the SHOPP assessment.

~~(4)~~ The ~~Method~~method of collection is as follows:

(A) The OHCA will send a notice of assessment to each hospital informing the hospital of the assessment rate, the hospital's net hospital patient revenue calculation, and the assessment amount owed by the hospital for the applicable year.

(B) The hospital has thirty (30) days from the date of its receipt of a notice of assessment to review and verify the hospital's net patient revenue calculation, and the assessment amount.

(C) New hospitals will only be added at the beginning of each calendar year.

(D) The annual assessment imposed is due and payable on a quarterly basis. Each quarterly installment payment is due and payable by the fifteenth day of the first month of the applicable quarter (i.e. January 15th, April 15th, etc.)

(E) Failure to pay the amount by the 15th or failure to have the payment mailing postmarked by the 13th ~~will~~may result in a debt to the State of Oklahoma and is subject to penalties of ~~5%~~five percent (5%) of the amount and interest of ~~1.25%~~one and a quarter percent (1.25%) per month.

(F) If a hospital fails to timely pay the full amount of a quarterly assessment, OHCA ~~will~~may add to the assessment:

(i) ~~a~~A penalty assessment equal to five percent (5%) of the quarterly amount not paid on or before the due date, and

(ii) ~~on~~On the last day of each quarter after the due date until the assessed amount and the penalty imposed under section (i) of this paragraph are paid in full, an additional five percent (5%) penalty assessment on any unpaid quarterly and unpaid penalty assessment amounts.

(iii) ~~the~~The quarterly assessment including applicable penalties and interest must be paid regardless of any appeals action requested by the facility. If a provider fails to pay the OHCA the assessment within the time frames noted on the invoice to the provider, the assessment, applicable penalty, and interest will be deducted from the facility's payment. Any change in payment amount resulting from an appeals decision in which a recoupment or additional allocation is necessary will be adjusted in future payments in accordance with ~~OAC~~Oklahoma Administrative Code (OAC) 317:2-1-15 SHOPP appeals.

(iv) If additional allocation or recoupment resulting from an appeal is for the current calendar year and another SHOPP payment is scheduled for the calendar year, an adjustment to the next payment will be calculated. If additional allocation or recoupment is for a prior calendar year, a separate payment/account receivable (AR) will be issued.

(G) The SHOPP assessments excluding penalties and interest are an allowable cost for cost reporting purposes.

(e) **Supplemental Hospital Offset Payment Program Cost Reports.**

(1) The report referenced in paragraph (b)(6) must be signed by the preparer and by the Owner, authorized Corporate Officer or Administrator of the facility for verification and attestation that the reports were compiled in accordance with this section.

(2) The Owner or authorized Corporate Officer of the facility must retain full accountability for the report's accuracy and completeness regardless of report submission method.

(3) Penalties for false statements or misrepresentation made by or on behalf of the provider are provided at 42 ~~U.S.C.~~United States Constitution (U.S.C.) Section 1320a-7b which states, in part, "Whoever...(2) at any time knowingly and willfully makes or causes to be made any false statement of a material fact for use in determining rights to such benefits or payment...shall (i) in the case of such statement, representation, failure, or conversion by any person in connection with furnishing (by the person) of items or services for which payment is or may be under this title (42 U.S.C. § 1320 et seq.), be guilty of a felony and upon conviction thereof fined not more than ~~$25,000~~twenty-five thousand dollars ($25,000) or imprisoned for not more than five (5) years or both, or (ii) in the case of such a statement, representation, concealment, failure or conversion by any other person, be guilty of a misdemeanor and upon conviction thereof fined not more than ~~$10,000~~ten thousand dollars ($10,000) or imprisoned for not more than one year, or both."

(4) Net hospital patient revenue is determined using the data from each hospital's applicable Medicare ~~Cost Report~~cost report contained in the Centers for Medicare and Medicaid Services' Healthcare Cost Report Information System (HCRIS) file.

(A) Through 2013, the base year for assessment shall be the hospital's fiscal year that ended in 2009, as contained in the HCRIS file dated December 31, 2010;

(B) For years 2014 and 2015, the base year for assessment shall be the hospital's fiscal year that ended in 2012, as contained in the HCRIS file dated June 30, 2013; and

~~(C) For subsequent two-year periods the base year for assessment shall be the hospital's fiscal year that ended two years prior (e.g.,2016 & 2017 B 2014 fiscal year; 2018 & 2019 B 2016 fiscal year), as contained in the HCRIS file dated June 30 of the following year.~~

(C) For two (2) year periods from 2016 through 2020, the base year for assessment shall be the hospital's fiscal year that ended two years prior (e.g.,2016 & 2017 B 2014 fiscal year; 2018 & 2019 B 2016 fiscal year), as contained in the HCRIS file dated June 30 of the following year.

(D) Beginning in 2021 and subsequent years, the base year for assessment shall be the hospital's fiscal year that ended that ended two years prior (e.g. 2021 B 2019 fiscal year), as contained in the HCRIS file dated June 30 of the following year.

(5) If a hospital's applicable Medicare ~~Cost Report~~cost report is not contained in the Centers for Medicare and Medicaid Services' HCRIS file, the hospital will submit a copy of the hospital's applicable Medicare ~~Cost Report~~cost report to the ~~Oklahoma Health Care Authority (OHCA)~~OHCA in order to allow the OHCA to determine the hospital's net hospital patient revenue for the base year.

(6) If a hospital commenced operations after the due date for a Medicare ~~Cost Report~~cost report, the hospital will submit its initial Medicare ~~Cost Report~~cost report to ~~Oklahoma Health Care Authority (OHCA)~~OHCA in order to allow the OHCA to determine the hospital's net patient revenue for the base year.

(7) Partial year reports may be prorated for an annual basis. Hospitals whose assessments were based on partial year cost reports will be reassessed the following year using a cost report that contains a full year of operational data.

(8) In the event that a hospital does not file a uniform cost report under 42 U.S.C., Section 1396a(a)(40), the OHCA will provide a data collection sheet for such facility.

(f) **Closure, merger and new hospitals.**

(1) If a hospital ceases to operate as a hospital or for any reason ceases to be subject to the fee, the assessment for the

year in which the cessation occurs is adjusted by multiplying the annual assessment by a fraction, the numerator of which is the number of days in the year during which the hospital is subject to the assessment and denominator of which is 365. Within 30 days of ceasing to operate as a hospital, or otherwise ceasing to be subject to the assessment, the hospital will pay the assessment for the year as so adjusted, to the extent not previously paid.

(2) Cost reports required under (e)(5),(e)(6),or (e)(8) of this subsection for assessment calculation must be submitted to OHCA by September 30 of each year.

(g) **Disbursement of payment to hospitals.**

(1) All in-state inpatient hospitals are eligible for hospital access payments each year as set forth in this subsection except for those listed in OAC 317:30-5-58 (c) (2):

(A) In addition to any other funds paid to inpatient critical access hospital for services provided to SoonerCare members, each critical access hospital will receive hospital access payments equal to the amount by which the payment for these services was less than one hundred one percent (101%) of the hospital's cost of providing these services.

(B) In addition to any other funds paid to hospitals for inpatient hospital services to SoonerCare members, each eligible hospital will receive inpatient hospital access payments each year equal to the hospital's pro rata share of the inpatient supplemental payment pool as reduced by payments distributed in paragraph (1) (A) of this Section. The pro rata share will be based upon the hospital's SoonerCare payment for inpatient services divided by the total SoonerCare payments for inpatient services of all eligible hospitals within each class of hospital and cannot exceed the UPL for the class.

(2) All in-state outpatient hospitals are eligible for hospital access payments each year as set forth in this subsection except for those listed in OAC 317:30-5-58 (c) (2):

(A) In addition to any other funds paid to outpatient critical access hospital for services provided to SoonerCare members, each critical access hospital will receive hospital access payments equal to the amount by which the payment for these services was less than one hundred one percent (101%) of the hospital's cost of providing these services.

(B) In addition to any other funds paid to hospitals for outpatient hospital services to SoonerCare members, each eligible hospital will receive outpatient hospital access payments each year equal to the hospital's pro rata share of the outpatient supplemental payment pool as reduced by payments distributed in paragraph (2) (A) of this Section.

The pro rata share will be based upon the hospital's SoonerCare payment for outpatient services divided by the total SoonerCare payments for outpatient services of all eligible hospitals within each class of hospital and cannot exceed the UPL for the class.

(3) Medicaid payments to a group of facilities within approved categories may not exceed the upper payment limit in accordance with 42 ~~CFR~~C.F.R. 447.272 (b) (2) and 42 ~~CFR~~C.F.R 447.321 (b) (2). If any audit determines that a class of hospitals has exceeded the inpatient and/or outpatient UPL the overpayment will be recouped and redistributed based on the following methods:

(A) If it is determined prior to issuance of hospital access payments that the pool of hospitals would exceed the upper payment limit estimate of that pool, the amount above the UPL estimate will be allocated to another pool of hospitals that does not exceed the upper payment limit estimate of that pool. The reallocation can be applied to multiple pools if necessary.

(B) If the overpayment cannot be redistributed due to all classes being paid at their UPL, the overpayment will be deposited in to the SHOPP fund.

(4) In order to ensure sufficient funds to make payments effective July 1, 2013 OHCA shall reduce the next quarterly payment by 1.4% (OHCA will pay out 23.6% of the assessment rather than 25%). This reduction will be distributed in the fourth (4th) quarter of the year as soon as all assessments are received. This payment will also be increased by penalties collected within the year as long as the penalties do not cause the payment to exceed the UPL estimate. If all assessments are received prior to the ~~4th~~fourth (4th) quarterly payment being processed the ~~4th~~fourth (4th) quarter may be adjusted to pay out 26.4% plus accrued penalties.

(5) Effective for all subsequent calendar years the OHCA will distribute payments in the following quarterly percentages: 23.6%, 25%, 25%, 25%. A ~~5th~~fifth (5th) payment of 1.4% in the fourth (4th) quarter of each calendar year will also be made as soon as all assessments are received. This payment will also be increased by any penalties collected within the year as long as the penalties do not cause the payment to exceed the UPL estimate. If all assessments are received prior to the ~~4th~~fourth (4th) quarterly payment being processed the ~~4th~~fourth (4th) quarter payment may be adjusted to pay out 26.4% plus accrued penalties.