

Oklahoma Health Care Authority

The Oklahoma Health Care Authority (OHCA) values your feedback and input. It is very important that you provide your comments regarding the proposed rule change by the comment due date. Comments can be submitted on the OHCA's [Proposed Changes Blog](#).

OHCA COMMENT DUE DATE: May 13, 2020

Reference: APA WF 20-06D Emergency Rule

SUMMARY:

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.

LEGAL AUTHORITY

The Oklahoma Health Care Authority Act, Section 5007 (C)(2) of Title 63 of Oklahoma Statutes; The Oklahoma Health Care Authority Board; Section 6407 of the Affordable Care Act; Section 504 of the Medicare Access and CHIP Reauthorization Act of 2015; CMS-2348-F Final Rule; Public Law 114-10; 42 Code of Federal Regulations (C.F.R.) § 440.70; and 42 C.F.R. § 440.120

RULE IMPACT STATEMENT:

STATE OF OKLAHOMA OKLAHOMA HEALTH CARE AUTHORITY

SUBJECT: Rule Impact Statement
APA WF # 20-06D

A. Brief description of the purpose of the rule:

The proposed revisions to the Medically Fragile Waiver Services policy is 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. Durable medical equipment was changed to medical supplies, equipment and appliances to match language in federal regulation.

- B. A description of the classes of persons who most likely will be affected by the proposed rule, including classes that will bear the cost of the proposed rule, and any information on cost impacts received by the agency from any private or public entities:

No classes of persons will be affected by the proposed rule. This rule should not place any cost burden on private or public entities. No information on any cost impacts were received from any entity.

- C. A description of the classes of persons who will benefit from the proposed rule:

No classes of person will benefit from this rule change.

- D. A description of the probable economic impact of the proposed rule upon the affected classes of persons or political subdivisions, including a listing of all fee changes and, whenever possible, a separate justification for each fee change:

There is no probable economic impact and there are no fee changes associated with the rule change for the above classes of persons or any political subdivision.

- E. The probable costs and benefits to the agency and to any other agency of the implementation and enforcement of the proposed rule, the source of revenue to be used for implementation and enforcement of the proposed rule, and any anticipated effect on state revenues, including a projected net loss or gain in such revenues if it can be projected by the agency:

Budget neutral.

- F. A determination of whether implementation of the proposed rule will have an economic impact on any political subdivisions or require their cooperation in implementing or enforcing the rule:

The proposed rule changes will not have an economic impact on any political subdivision or require their cooperation in implementing or enforcing the rule changes.

- G. A determination of whether implementation of the proposed rule will have an adverse effect on small business as provided by the Oklahoma Small Business Regulatory Flexibility Act:

The agency does not anticipate that the proposed rule changes will have an adverse effect on small businesses.

- H. An explanation of the measures the agency has taken to minimize compliance costs and a determination of whether there are less costly or non-regulatory methods or less intrusive methods for achieving the purpose of the proposed rule:

The agency has taken measures to determine that there are no other legal methods to achieve the purpose of the proposed rule. Measures included a formal public comment period and tribal consultation.

- I. A determination of the effect of the proposed rule on the public health, safety and environment and, if the proposed rule is designed to reduce significant risks to the public health, safety and environment, an explanation of the nature of the risk and to what extent the proposed rule will reduce the risk:

The proposed rule changes are not designed to reduce any significant risks to the public health, safety, and environment.

- J. A determination of any detrimental effect on the public health, safety and environment if the proposed rule is not implemented:

The agency anticipates that in the absence of these rule changes, there would not be any detrimental effect on the public health, safety, and environment.

- K. The date the rule impact statement was prepared and if modified, the date modified:

Prepared date: April 9, 2020

RULE TEXT:

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.**

(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 HCPChealthcare common procedure code. (HCPC). Reoccurring supplies which are shipped to the member are compensable only when the member remains eligible for ~~Waiver~~ wave 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.~~ Advanced Supportive/Restorative Assistance.

(A) ~~Advanced Supportive/Restorative Assistance.~~ 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.