

Oklahoma Health Care Authority

It is very important that you provide your comments regarding the proposed rule change by the comment due date. Comments are directed to the [Oklahoma Health Care Authority \(OHCA\) Proposed Changes Blog](#).

OHCA COMMENT DUE DATE: January 15, 2017

The proposed policy is a Permanent Rule. The proposed policy was presented at the September 6, 2016 Tribal Consultation and is scheduled to be presented to the Medical Advisory Committee on January 19, 2017 and the OHCA Board of Directors on February 9, 2017.

Reference: APA WF 16-27

SUMMARY:

Home Health Face to Face Requirement- Proposed Home Health revisions add language that directs Home Health providers to conduct and document a face-to-face encounter in accordance with federal regulation.

LEGAL AUTHORITY

The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; 42 CFR 440.70

RULE IMPACT STATEMENT:

STATE OF OKLAHOMA OKLAHOMA HEALTH CARE AUTHORITY

TO: Tywanda Cox
Federal and State Policy

From: Likita Gunn
Federal and State Authorities

SUBJECT: Rule Impact Statement
APA WF # 16-27

A. Brief description of the purpose of the rule:

Proposed Home Health policy revisions add language in accordance with federal regulation that requires the ordering physician and/or qualified provider to conduct and document a

face-to-face encounter with a member for the initiation of home health services. The regulation is applicable to home health services that are billed by Home Health agencies and reimbursed under Title XIX.

- 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:

Home Health agencies will be affected by the proposed change as the face to face encounter is now explicitly expressed in rules as a condition of payment.

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

No classes of persons will benefit from the proposed rule.

- 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:

The proposed rule should have no economic impact and no fee changes.

- 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 affect on state revenues, including a projected net loss or gain in such revenues if it can be projected by the agency:

Agency staff has determined that the proposed rule is 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 will not have an economic impact on any political subdivision or require their cooperation in implementing or enforcing the rule.

- 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 proposed rule will not have an adverse effect on small businesses as provided by the Oklahoma Small Business Regulatory Flexibility Act.

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

The agency has taken measures to determine that there is no less costly or non-regulatory method or less intrusive method for achieving the purpose of the proposed rule. Opportunities for public input are provided throughout the rulemaking process, in addition to formal public comment periods and tribal consultations.

- 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 should not have any effect on the public health, safety or environment.

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

The agency does not anticipate any detrimental effects on the public health, safety or environment if the proposed rule is not implemented.

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

This rule impact statement was prepared on October 20, 2016.

RULE TEXT

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 3. HOSPITALS

317:30-5-42.16. Related services

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

(b) **Home health care.** Hospital based home health providers must be Medicare certified and have a current Home Health Agency contract with the 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.

(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~~ 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.

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 encounter has occurred in accordance with provisions of 42 CFR 440.70.

(1) **Adults.** Payment is made for home health services provided in the ~~patient's~~ 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.